

For More Information

Books

Allen D. *Getting Things Done: The Art of Stress-Free Productivity*. Viking Press, 2001. This best-seller outlines a system for how to manage time and get everything done by organizing “to-do” items and freeing your mind.

Allen D. *Making It All Work: Winning at the Game of Work and Business of Life*. Viking Adult, 2008. Mr. Allen’s newest book delves deeper into the principles outlined in his earlier books and touches on their more subtle and universal aspects.

de Graaf J. *Take Back Your Time: Fighting Overwork and Time Poverty in America*. Berrett-Koehler Publishers, 2003. Thirty powerful essays make up this volume, which is considered the official handbook of the Take Back Your Time movement.

Honore C. *In Praise of Slowness: How a Worldwide Movement is Challenging the Cult of Speed*. HarperCollins Publishers, Inc., 2004. It was Gandhi who said, “There is more to life than increasing its speed.” If that quote hits home, you’ll want to read this well-written book.

Robinson J. *Work to Live: The Guide to Getting a Life*. Perigee Trade, 3rd Ed., 2003. Take more time off to keep burnout at bay. Easy to say, not always easy to do. Read this one if you’re ready to weave more leisure time into your life.

Schwartz B. *The Paradox of Choice: Why More is Less*. Harper Perennial, 2005. If you’ve ever felt overwhelmed by too many choices, read this book to find out why—and what to do about it.

Tracy B. *Eat That Frog! 21 Great Ways to Stop Procrastinating and Get More Done in Less Time*. Berrett-Koehler Publishers,

2006. The title? If you had to eat a frog, wouldn't you want to do it first thing in the morning and get it out of the way?

Websites

Productivity expert and author of several books, **David Allen** offers productivity tips and training on his Website, www.davidco.com.

David Bohl, former venture capitalist turned life coach, has started the "Slow Down Fast" process. He discusses it and other tips for life balance at www.slowdownfast.com.

Peter Lencioni is an expert in organizational development and the author of eight books, including *The Five Dysfunctions of a Team* (Jossey-Bass, 2002) and *Death by Meeting* (Jossey-Bass, 2004). His Website is www.tablegroup.com.

MomMD (www.mommd.com) is an online resource and community for women juggling medical careers and children.

Peter Moskowitz, MD, founder and director of the Center for Professional & Personal Renewal, offers career and life coaching for physicians (www.cppr.com).

Joe Robinson (www.worktolive.info) is an author, speaker, and coach who focuses on work/life balance and burnout prevention.

Pam Vaccaro, nationally recognized speaker and owner of Designs On Time, offers time management tips at www.designsontime.com.

Elizabeth Woodcock, practice management expert and author of *Mastering Patient Flow: Using Lean Thinking to Improve Your Practice Operations* (MGMA Press, 2007), offers time-management tips (www.elizabethwoodcock.com).

LEXAPRO® (escitalopram oxalate) TABLETS/ORAL SOLUTION

Rx Only

Brief Summary: For complete details, please see full Prescribing Information for Lexapro.

Suicidality and Antidepressant Drugs Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Lexapro or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on an antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients. (See WARNINGS: Clinical Worsening and Suicide Risk, PRECAUTIONS: Information for Patients, and PRECAUTIONS: Pediatric Use.)

INDICATIONS AND USAGE Major Depressive Disorder Lexapro (escitalopram) is indicated for the treatment of major depressive disorder. The efficacy of Lexapro in the treatment of major depressive disorder was established in three, 8-week, placebo-controlled trials of outpatients whose diagnoses corresponded most closely to the DSM-IV category of major depressive disorder (see CLINICAL PHARMACOLOGY). A major depressive episode (DSM-IV) implies a prominent and relatively persistent (nearly every day for at least 2 weeks) depressed or dysphoric mood that usually interferes with daily functioning, and includes at least five of the following nine symptoms: depressed mood, loss of interest in usual activities, significant change in weight and/or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, a suicide attempt or suicidal ideation. The efficacy of Lexapro in hospitalized patients with major depressive disorders has not been adequately studied. The efficacy of Lexapro in maintaining a response, in patients with major depressive disorder who responded during an 8-week, acute-treatment phase while taking Lexapro and were then observed for relapse during a period of up to 36 weeks, was demonstrated in a placebo-controlled trial (see CLINICAL PHARMACOLOGY). Nevertheless, the physician who elects to use Lexapro for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient (see DOSAGE AND ADMINISTRATION). Generalized Anxiety Disorder Lexapro is indicated for the treatment of Generalized Anxiety Disorder (GAD). The efficacy of Lexapro was established in three, 8-week, placebo-controlled trials in patients with GAD (see CLINICAL PHARMACOLOGY). Generalized Anxiety Disorder (DSM-IV) is characterized by excessive worry and/or (apprehensive) expectation that is persistent for at least 6 months and which the person finds difficult to control. It must be associated with at least 3 of the following symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance. The efficacy of Lexapro in the long-term treatment of GAD, that is, for more than 3 weeks, has not been systematically evaluated in controlled trials. The physician who elects to use Lexapro for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient. **CONTRAINDICATIONS** Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see WARNINGS). Concomitant use in patients taking pimozide is contraindicated (see Drug Interactions – Pimozide and Cereza).

Lexapro is contraindicated in patients with a hypersensitivity to escitalopram or citalopram or any of the inactive ingredients in Lexapro. **WARNINGS** Pimozide/Clinical Worsening and Suicide Risk **Clinical Worsening and Suicide Risk** Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Suicide is a known risk of depression and certain other psychiatric disorders, and these disorders themselves are strong predictors of suicide. There has been a long-standing concern, however, that antidepressants may have a role in inducing or worsening depression and the emergence of suicidality in certain patients during the early phases of treatment. Pooled analyses of short-term placebo-controlled trials of antidepressant drugs (SSRIs and SNRIs) also showed that the use of these drugs increases the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults (ages 18-24) with major depressive disorder (MDD) and other psychiatric disorders. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction with antidepressants compared to placebo in adults aged 65 and older. The pooled analyses of placebo-controlled trials in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders included a total of 24 short-term trials of 9 antidepressant drugs in over 4000 patients. The pooled analyses of placebo-controlled trials in adults with MDD or other psychiatric disorders included a total of 225 short-term trials (median duration of 2 months) of 11 antidepressant drugs in over 77000 patients. There was considerable variation in risk of suicidality among drugs, but a tendency toward an increase in the younger patients for almost all drugs studied. There were differences in absolute risk of suicidality across the different indications, with the highest incidence in MDD. The risk differences (drug vs placebo), however, were relatively stable over age strata and across indications. These risk differences (drug-placebo difference in the number of cases of suicidality per 1000 patients treated) are provided in Table 1. **TABLE 1. Age Range and Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated:** Increases Compared to Placebo; <18 (14 additional cases); 18-24 (5 additional cases); Decreases Compared to Placebo; 25-64 (1 fewer case); ≥65 (6 fewer cases). No suicides occurred in any of the pediatric trials. There were suicides in the adult trials, but the number was not sufficient to reach any conclusion about drug effect on suicide. It is unknown whether the suicidality risk extends to longer-term use, i.e., beyond several months. However, there is substantial evidence from placebo-controlled maintenance trials in adults with depression that the use of antidepressants can delay the recurrence of depression. **All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see PRECAUTIONS AND DOSAGE AND ADMINISTRATION—Discontinuation of Treatment with Lexapro, for a description of the risks of discontinuation of Lexapro). **Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers. Such monitoring should include daily observation by families and caregivers.** Prescriptions for Lexapro should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. **Screening Patients for Bipolar Disorder:** A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Lexapro is not approved for use in treating bipolar depression. **Potential for Interaction with Monoamine Oxidase Inhibitors in patients receiving serotonin reuptake inhibitor drugs in combination with a monoamine oxidase inhibitor (MAOI).** There have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRI treatment and have been started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. Furthermore, limited animal data on the effects of combined use of SSRIs and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that Lexapro should not be used in combination with an MAOI, or within 14 days of discontinuing treatment with an MAOI. Similarly, at least 14 days should be allowed after stopping Lexapro before starting an MAOI. Serotonin syndrome has been reported in two patients who were concomitantly receiving linezolid, an antibiotic which is a reversible non-selective MAOI. **Serotonin Syndrome:** The development of a potentially life-threatening serotonin syndrome may occur with SNRIs and SSRIs, including Lexapro treatment, particularly with concomitant use of serotonergic drugs (including triptans) and with drugs which impair metabolism of serotonin (including MAOIs). Serotonin syndrome symptoms may include mental status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea). The concomitant use of Lexapro with MAOIs intended to treat depression is contraindicated (see CONTRAINDICATIONS and WARNINGS – Potential for Interaction with Monoamine Oxidase Inhibitors).

If concomitant treatment of Lexapro with a 5-hydroxytryptamine receptor agonist (triptan) is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see PRECAUTIONS – Drug Interactions). The concomitant use of Lexapro with serotonin precursors (such as tryptophan) is not recommended (see PRECAUTIONS – Drug Interactions). **PRECAUTIONS – General Discontinuation of Treatment with Lexapro** During marketing of Lexapro and other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with Lexapro. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate (see DOSAGE AND ADMINISTRATION). **Abnormal Bleeding** SSRIs and SNRIs, including Lexapro, may increase the risk of bleeding events. Concomitant use of aspirin, nonsteroidal anti-inflammatory drugs, warfarin, and other anticoagulants may add to the risk. Case reports and epidemiological studies (case-control and cohort design) have demonstrated an association between use of drugs that interfere with serotonin reuptake and the occurrence of gastrointestinal bleeding. Bleeding events related to SSRI and SNRI use have ranged from ecchymoses, hematomas, epistaxis, and petechiae to life-threatening hemorrhages. Patients should be cautioned about the risk of bleeding associated with the concomitant use of Lexapro and NSAIDs, aspirin, or other drugs that affect coagulation. **Hypomania** Hypomania may occur as a result of treatment with SSRIs and SNRIs, including Lexapro. In many cases, this hypomania appears to be the result of the syndrome of inappropriate antidiuretic hormone secretion (SIADH), and was reversible when Lexapro was discontinued. Cases with serum sodium lower than 110 mmol/L have been reported. Elderly patients may be at greater risk of developing hypomania with SSRIs and SNRIs. Also, patients taking diuretics or who are otherwise volume-depleted may be at greater risk (see Geriatric Use). Discontinuation of Lexapro should be considered in patients with symptomatic hypomania and appropriate medical intervention should be instituted. Signs and symptoms of hypomania include headache, difficulty concentrating, memory impairment, confusion, weakness, and unsteadiness, which may lead to falls. Signs and symptoms associated with more severe and/or acute cases have included hallucination, seizure, coma, respiratory arrest, and death. **Activation of Mania/Hypomania** In placebo-controlled trials of Lexapro in major depressive disorder, activation of mania/hypomania was reported in one (0.1%) of 715 patients treated with Lexapro and in none of the 592 patients treated with placebo. One additional case of hypomania has been reported in association with Lexapro treatment. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorders treated with racemic citalopram and other marketed drugs effective in the treatment of major depressive disorder. As with all drugs effective in the treatment of major depressive disorder, Lexapro should be used cautiously in patients with a history of mania. **Seizures** Although anticonvulsant effects of racemic citalopram have been observed in animal studies, Lexapro has not been systematically evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the product's premarketing testing. In a clinical trial of Lexapro, cases of convulsion have been reported in association with Lexapro treatment. Like other drugs effective in the treatment of major depressive disorder, Lexapro should be introduced with care in patients with a history of seizure disorder. **Interference with Cognitive and Motor Performance** In a study in normal volunteers, Lexapro 10 mg/day did not produce impairment of intellectual function or psychomotor performance. Because any psychoactive drug may impair judgment, thinking, or motor skills, however, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. **Use in Patients with Concomitant Illness** Clinical experience with Lexapro in patients with certain concomitant systemic illnesses is limited. Caution is advisable in using Lexapro in patients with diseases or conditions that produce altered metabolism or hemodynamic responses. Lexapro has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. In subjects with hepatic impairment, clearance of racemic citalopram was decreased and plasma concentrations were increased. The recommended dose of Lexapro in hepatically impaired patients is 10 mg/day (see DOSAGE AND ADMINISTRATION). Because escitalopram is extensively metabolized, excretion of unchanged drug in urine is a minor route of elimination. Until adequate numbers of patients with severe renal impairment have been evaluated during chronic treatment with Lexapro, however, it should be used with caution in such patients (see DOSAGE AND ADMINISTRATION). **Information for Patients** Physicians are advised to discuss the following issues with patients for whom they prescribe Lexapro. Patients should be cautioned about the risk of serotonin syndrome with the concomitant use of Lexapro and triptans, tramadol or other serotonergic agents. In a study in normal volunteers, Lexapro 10 mg/day did not impair psychomotor performance. The effect of Lexapro on psychomotor coordination, judgment, or thinking has not been systematically examined in controlled studies. Because psychoactive drugs may impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Lexapro therapy does not affect their ability to engage in such activities. Patients should be told that, although Lexapro has not been shown in experiments with normal subjects to increase the mental and motor skill impairments caused by alcohol, the concomitant use of Lexapro and alcohol in depressed patients is not advised. Patients should be made aware that escitalopram is the active isomer of Citalopram (hydrobromide) and that the two medications should not be taken concomitantly. Patients should be advised to inform their physician if they are taking, or plan to take, any prescription or over-the-counter drugs, as there is a potential for interactions. Patients should be cautioned about the concomitant use of Lexapro and NSAIDs, aspirin, warfarin, or other drugs that affect coagulation since combined use of psychotropic drugs that interfere with serotonin reuptake and these agents has been associated with an increased risk of bleeding. Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during

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therapy. Patients should be advised to notify their physician if they are breastfeeding an infant. While patients may notice improvement with Lexapro therapy in 1 to 4 weeks, they should be advised to continue therapy as directed. Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with Lexapro and should counsel them in its appropriate use. A Patient Medication Guide about "Antidepressant Medicines, Depression and other Serious Mental Illness, and Suicide Thoughts or Actions" is available for Lexapro. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking Lexapro. **Clinical Worsening and Suicide Risk:** Patients, their families, and their caregivers should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during antidepressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to look for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication. **Laboratory Tests:** There are no specific laboratory tests recommended. **Concomitant Administration with Racemic Citalopram Clotapram:** Since escitalopram is the active enantiomer of racemic citalopram (Celexa), the two agents should not be coadministered. **Drug Interactions Serotonergic Drugs:** Based on the mechanism of action of SSRIs and SSRIIs including Lexapro, and the potential for serotonin syndrome, caution is advised when Lexapro is coadministered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, lincosolid (an antibiotic which is a reversible non-selective MAOI), lithium, tramadol, or St. John's Wort (see **WARNINGS-Serotonin Syndrome**). The concomitant use of Lexapro with other SSRIs, SNRIs or tryptophan is not recommended (see **PRECAUTIONS - Drug Interactions**). **Triptans:** There have been rare postmarketing reports of serotonin syndrome with use of an SSRI and a triptan. If concomitant treatment of Lexapro with a triptan is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases (see **WARNINGS - Serotonin Syndrome**). **CNS Drugs:** Given the primary CNS effects of escitalopram, caution should be used when it is taken in combination with other centrally-acting drugs. Alcohol - Although Lexapro did not potentiate the cognitive and motor effects of alcohol in a clinical trial, as with other psychotropic medications, the use of alcohol by patients taking Lexapro is not recommended. Monoclonal Antibodies (MAOs) - See **CONTRAINDICATIONS** and **WARNINGS. Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.)** Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin may potentiate the risk of bleeding. Altered anticoagulant effects, including increased bleeding, have been reported when SSRIs and SNRIs are coadministered with warfarin. Patients receiving warfarin therapy should be carefully monitored when Lexapro is initiated or discontinued. Cimetidine - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of 400 mg/day cimetidine for 8 days resulted in an increase in citalopram AUC and C_{max} of 43% and 39%, respectively. The clinical significance of these findings is unknown. Digoxin - In subjects who had received 21 days of 40 mg/day racemic citalopram, combined administration of citalopram and digoxin (single dose of 1 mg) did not significantly affect the pharmacokinetics of either citalopram or digoxin. Lithium - Co-administration of racemic citalopram (40 mg/day for 10 days) and lithium (30 mmol/day for 5 days) had no significant effect on the pharmacokinetics of citalopram or lithium. Nevertheless, plasma lithium levels should be monitored with appropriate adjustment to the lithium dose in accordance with standard clinical practice. Because lithium may enhance the serotonergic effects of escitalopram, caution should be exercised when Lexapro and lithium are coadministered. Pimozide and Celexa - In a controlled study, a single dose of pimozide 2 mg co-administered with racemic citalopram 40 mg given once daily for 11 days was associated with a mean increase in QTc values of approximately 10 msec compared to pimozide given alone. Racemic citalopram did not alter the mean AUC or C_{max} of pimozide. The mechanism of this pharmacodynamic interaction is not known. Sumatriptan - There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of an SSRI and sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram) is clinically warranted, appropriate observation of the patient is advised. Theophylline - Combined administration of racemic citalopram (40 mg/day for 21 days) and the CYP1A2 substrate theophylline (single dose of 300 mg) did not affect the pharmacokinetics of theophylline. The effect of theophylline on the pharmacokinetics of citalopram was not evaluated. Warfarin - Administration of 40 mg/day racemic citalopram for 21 days did not affect the pharmacokinetics of warfarin, a CYP3A4 substrate. Prothrombin time was increased by 5%, the clinical significance of which is unknown. Carbamazepine - Combined administration of racemic citalopram (40 mg/day for 14 days) and carbamazepine (treated to 400 mg/day for 35 days) did not significantly affect the pharmacokinetics of either citalopram, a CYP3A4 substrate. Although through citalopram plasma levels were unaffected, given the enzyme-inducing properties of carbamazepine, the possibility that carbamazepine might increase the clearance of escitalopram should be considered if the two drugs are coadministered. Triazolam - Combined administration of racemic citalopram (titrated to 40 mg/day for 28 days) and the CYP3A4 substrate triazolam (single dose of 0.25 mg) did not significantly affect the pharmacokinetics of either citalopram or triazolam. Ketoconazole - Combined administration of racemic citalopram (40 mg) and ketoconazole (200 mg), a potent CYP3A4 inhibitor, decreased the C_{max} and AUC of ketoconazole by 21% and 10%, respectively, and did not significantly affect the pharmacokinetics of citalopram. Ritonavir - Combined administration of a single dose of ritonavir (600 mg), both a CYP3A4 substrate and a potent inhibitor of CYP3A4, and escitalopram (20 mg) did not affect the pharmacokinetics of either ritonavir or escitalopram. CYP3A4 and -2C19 Inhibitors - *In vitro* studies indicated that CYP3A4 and -2C19 are the primary enzymes involved in the metabolism of escitalopram. However, coadministration of escitalopram (20 mg) and ritonavir (600 mg), a potent inhibitor of CYP3A4, did not significantly affect the pharmacokinetics of escitalopram. Because escitalopram is metabolized by multiple enzyme systems, inhibition of a single enzyme may not appreciably decrease escitalopram clearance. Drugs Metabolized by Cytochrome P4502D6 - *In vivo* studies did not reveal an inhibitory effect of escitalopram on CYP2D6. In addition, steady state levels of racemic citalopram were not significantly different in poor metabolizers and extensive CYP2D6 metabolizers after multiple-dose administration of citalopram, suggesting that coadministration, with escitalopram, of a drug that inhibits CYP2D6 is unlikely to have clinically significant effects on escitalopram metabolism. However, there are limited *in vivo* data suggesting a modest CYP2D6 inhibitory effect for escitalopram, i.e., coadministration of escitalopram (20 mg/day for 21 days) with the tricyclic antidepressant desipramine (single dose of 50 mg), a substrate for CYP2D6, resulted in a 40% increase in C_{max} and a 100% increase in AUC of desipramine. The clinical significance of this finding is unknown. Nevertheless, caution is indicated in the coadministration of escitalopram and drugs metabolized by CYP2D6. Metoprolol - Administration of 20 mg/day Lexapro for 21 days in healthy volunteers resulted in a 50% increase in C_{max} and 82% increase in AUC of the beta-adrenergic blocker metoprolol (given in a single dose of 100 mg). Increased metoprolol plasma levels have been associated with decreased cardiotoxicity. Coadministration of Lexapro and metoprolol had no clinically significant effects on blood pressure or heart rate. Electrocardiographic Therapy (ECT) - There are no clinical studies of the combined use of ECT and escitalopram. **Carcinogenesis, Mutagenesis, Impairment of Fertility Carcinogenesis:** Racemic citalopram was administered in the rat to NMRI/BOM strain mice and COBS W1 strain rats for 18 and 24 months, respectively. There was no evidence for carcinogenicity of racemic citalopram in mice receiving up to 240 mg/kg/day. There was an increased incidence of small intestine carcinomas in rats receiving 8 or 24 mg/kg/day racemic citalopram. A no-effect dose for this finding was not established. The relevance of these findings to humans is unknown. **Mutagenesis:** Racemic citalopram was mutagenic in the *in vitro* bacterial reverse mutation assay (Ames test) in 2 of 5 bacterial strains (Salmonella TA98 and TA1537) in the absence of metabolic activation. It was clastogenic in the *in vitro* Chinese hamster lung cell assay for chromosomal aberrations in the presence and absence of metabolic activation. Racemic citalopram was not mutagenic in the *in vivo* mammalian forward gene mutation assay (HPRT) in mouse lymphoma cells or in a coupled *in vitro* unscheduled DNA synthesis (UDS) assay in rat liver. It was not clastogenic in the *in vitro* chromosomal aberration assay in human lymphocytes or *in vivo* in mouse micronucleus assays. **Impairment of Fertility:** When racemic citalopram was administered orally to 16 male and 24 female rats prior to and throughout mating and gestation at doses of 32, 48, and 72 mg/kg/day, mating was decreased at all doses, and fertility was decreased at doses ≥ 2 mg/kg/day. Gestation duration was increased at 48 mg/kg/day. **Pregnancy Pregnancy Category C:** In a rat embryo/fetal development study, oral administration of escitalopram (56, 112, or 150 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased fetal body weight and associated delays in ossification at the two higher doses (approximately ≥ 6 times the maximum recommended human dose [MRHD] of 20 mg/day on a body surface area [mg/m^2] basis). Maternal toxicity (clinical signs and decreased body weight gain and food consumption), mild to severe C_{max} was present at all dose levels. The developmental no-effect dose of 56 mg/kg/day is approximately 28 times the MRHD on a mg/m^2 basis. No teratogenicity was observed at any of the doses tested (as high as 75 times the MRHD on a mg/m^2 basis). When female rats were treated with escitalopram (6, 12, 24, or 48 mg/kg/day) during pregnancy and through weaning, slightly increased offspring mortality and growth retardation were noted at 48 mg/kg/day which is approximately 24 times the MRHD on a mg/m^2 basis. Slight maternal toxicity (clinical signs and decreased body weight gain and food consumption) was seen at this dose. Slightly increased offspring mortality was seen at 24 mg/kg/day. The no-effect dose was 12 mg/kg/day which is approximately 6 times the MRHD on a mg/m^2 basis. In animal reproduction studies, racemic citalopram has been shown to have adverse effects on embryo/fetal and postnatal development, including teratogenic effects, when administered at doses greater than human therapeutic doses. In two rat embryo/fetal development studies, oral administration of racemic citalopram (32, 56, or 112 mg/kg/day) to pregnant animals during the period of organogenesis resulted in decreased embryo/fetal growth and survival and an increased incidence of fetal abnormalities (including cardiovascular and skeletal defects) at the high dose. This dose was also associated with maternal toxicity (clinical signs, decreased body weight gain). The developmental no-effect dose was 56 mg/kg/day. In a rabbit study, no adverse effects on embryo/fetal development were observed at doses of racemic citalopram (up to 16 mg/kg/day). Thus, teratogenic effects of racemic citalopram were observed at a maternally toxic dose in the rat and were not observed in the rabbit. When female rats were treated with racemic citalopram (4.8, 12.8, or 32 mg/kg/day) from late gestation through weaning, increased offspring mortality during the first 4 days after birth and persistent offspring growth retardation were observed at the highest dose. The no-effect dose was 12.8 mg/kg/day. Similar effects on offspring mortality and growth were seen when dams were treated throughout gestation and early lactation at doses ≥ 24 mg/kg/day. A no-effect dose was not determined in that study. There are no adequate and well-controlled studies in pregnant women; therefore, escitalopram should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Pregnancy-Nonteratogenic Effects:** Neonates exposed to Lexapro and other SSRIs or SNRIs, late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (see **WARNINGS**). Infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newborn (PPHN). PPHN occurs in 1.2 per 1000 live births in the general population and is associated with substantial neonatal morbidity and mortality. In a retrospective, case-control study of 377 women whose infants were born with PPHN and 636 women whose infants were born healthy, the risk for developing PPHN was approximately six-fold higher for infants exposed to SSRIs after the 20th week of gestation compared to infants who had not been exposed to antidepressants during pregnancy. There is currently no corroborative evidence regarding the risk for PPHN following exposure to SSRIs in pregnancy; this is the first study that has investigated the potential risk. The study did not include enough cases with exposure to individual SSRIs to determine if all SSRIs posed similar levels of PPHN risk. When treating a pregnant woman with Lexapro during the third trimester, the physician should carefully consider both the potential risks and benefits of treatment (see **DOSEAGE AND ADMINISTRATION**). Physicians should note that in a prospective longitudinal study of 201 women with a history of major depression who were euthymic at the beginning of pregnancy, women who discontinued antidepressant medication during pregnancy were more likely to experience a relapse of major depression than women who continued antidepressant medication. **Labor and Delivery:** The effect of Lexapro on labor and delivery in humans is unknown. **Nursing Mothers:** Racemic citalopram, like many other drugs, is excreted in human breast milk. There have been two reports of infants experiencing excessive somnolence, decreased feeding, and weight loss in association with breastfeeding from a citalopram-treated mother; in one case, the infant was reported to recover completely upon discontinuation of citalopram by its mother and, in the second case, no follow-up information was available. The decision whether to continue or discontinue either nursing or Lexapro therapy should take into account the risks to racemic citalopram exposure for the infant and the benefits of Lexapro treatment for the mother. **Pediatric Use:** Safety and effectiveness in the pediatric population have not been established (see **BOXED WARNING** and **WARNINGS - Clinical Worsening and Suicide Risk**). One placebo-controlled trial in 264 pediatric patients with MDD has been conducted with Lexapro, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of Lexapro in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use:** Approximately 6% of the 1144 patients receiving escitalopram in controlled trials of Lexapro in major depressive disorder had Lexapro were 60 years of age or older; elderly patients in these trials received daily doses of Lexapro between 10 and 20 mg. The number of elderly patients in these trials was insufficient to adequately assess for possible differential efficacy and safety measures on the basis of age. Nevertheless, greater sensitivity of some elderly individuals to effects of Lexapro cannot be ruled out. SSRIs and SNRIs, including Lexapro, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse effect (see **PRECAUTIONS, Hyponatremia**). In two pharmacokinetic studies, escitalopram half-life was increased by approximately 50% in elderly subjects as compared to young subjects and C_{max} was unchanged (see **CLINICAL PHARMACOLOGY**). 10 mg/day is the recommended dose for elderly patients (see **DOSEAGE AND ADMINISTRATION**). Of 4122 patients in clinical studies of racemic citalopram, 1357 were 60 and over, 1034 were 65 and over, and 457 were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but again, greater sensitivity of some elderly individuals cannot be ruled out. **ADVERSE REACTIONS:** Adverse event information for Lexapro was collected from 715 patients with major depressive disorder who were exposed to escitalopram and from 592 patients who were exposed to placebo in double-blind, placebo-controlled trials. An additional 284 patients with major depressive disorder were newly exposed to escitalopram in open-label trials. The adverse event information for Lexapro in patients with GAD was collected from 243 patients exposed to escitalopram and from 427 patients exposed to placebo in double-blind, placebo-controlled trials. Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and tabulations that follow, standard World Health Organization (WHO) terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. **Adverse Events Associated with Baseline Evaluation:**

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Major Depressive Disorder Among the 715 depressed patients who received Lexapro in placebo-controlled trials, 6% discontinued treatment due to an adverse event, as compared to 2% of 592 patients receiving placebo. In two fixed-dose studies, the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro was not significantly different from the rate of discontinuation for adverse events in patients receiving placebo. The rate of discontinuation for adverse events in patients assigned to a fixed dose of 20 mg/day Lexapro was 10%, which was significantly different from the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro (4%) and placebo (3%). Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice that of placebo, were nausea (2%) and ejaculation disorder (2% of male patients). **Generalized Anxiety Disorder** Among the 429 GAD patients who received Lexapro 10-20 mg/day in placebo-controlled trials, 8% discontinued treatment due to an adverse event, as compared to 4% of 427 patients receiving placebo. Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice the incidence rate, were nausea (2%), insomnia (1%), and fatigue (1%). **Incidence of Adverse Events in Placebo-Controlled Clinical Trials Major Depressive Disorder Table 2** enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred among 715 depressed patients who received Lexapro at doses ranging from 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The prescriber should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were insomnia, ejaculation disorder (primarily ejaculatory delay), nausea, sweating increased, fatigue, and somnolence (see TABLE 2).

TABLE 2: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Major Depressive Disorder* (Percentage of Patients Reporting Event) Body System/Adverse Event (Lexapro (N=715) and Placebo (N=592): Autonomic Nervous System Disorders: Dry Mouth (6% and 5%); Sweating Increased (5% and 2%); **Central & Peripheral Nervous System Disorders:** Dizziness (5% and 3%); **Gastrointestinal Disorders:** Nausea (15% and 7%); Diarrhea (8% and 5%); Constipation (3% and 1%); Indigestion (3% and 1%); Abdominal Pain (2% and 1%). **General:** Influenza-like Symptoms (5% and 4%); Fatigue (5% and 2%).

Psychiatric Disorders: Insomnia (9% and 4%); Somnolence (6% and 2%); Appetite Decreased (3% and 1%); Libido Decreased (3% and 1%). **Respiratory System Disorders:** Rhinitis (5% and 4%); Sinusitis (3% and 2%). **Urogenital:** Ejaculation Disorder: (9% and <1%); Impotence (3% and <1%); Anorgasmia (2% and <1%). *Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo > Lexapro: headache, upper respiratory tract infection, back pain, pharyngitis, inflamed injury, anxiety. †Primarily ejaculatory delay. ‡Denominator used was for males only (N=225 Lexapro; N=188 placebo). ††Denominator used was for females only (N=490 Lexapro; N=404 placebo). **Generalized Anxiety Disorder Table 3** enumerates the incidence, rounded to the nearest percent of treatment-emergent adverse events that occurred among 429 GAD patients who received Lexapro 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were nausea, ejaculation disorder (primarily ejaculatory delay), insomnia, fatigue, decreased libido, and anorgasmia (see TABLE 3).

TABLE 3: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder* (Percentage of Patients Reporting Event) Body System/Adverse Event (Lexapro (N=429) and Placebo (N=427): Autonomic Nervous System Disorders: Dry Mouth (9% and 5%); Sweating Increased (4% and 1%). **Central & Peripheral Nervous System Disorders:** Headache (24% and 17%); Paresthesia (2% and 1%). **Gastrointestinal Disorders:** Nausea (18% and 8%); Diarrhea (8% and 6%); Constipation (5% and 4%); Indigestion (3% and 2%); Vomiting (3% and 1%); Abdominal Pain (2% and 1%); Flatulence (2% and 1%). **General:** Fatigue (8% and 2%); Influenza-like symptoms (5% and 4%). **Musculoskeletal:** Neck/Shoulder Pain (3% and 1%). **Psychiatric Disorders:** Somnolence (13% and 7%); Insomnia (12% and 6%); Libido Decreased (7% and 2%); Dreaming Abnormal (3% and 2%); Appetite Decreased (3% and 1%); Lethargy (3% and 1%); Yawning (2% and 1%). **Urogenital:** Ejaculation Disorder: (14% and 2%); Anorgasmia (6% and <1%); Menstrual Disorder (2% and 1%).

*Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo > Lexapro: inflamed injury, dizziness, back pain, upper respiratory tract infection, rhinitis, pharyngitis. †Primarily ejaculatory delay. ††Denominator used was for males only (N=182 Lexapro; N=195 placebo). †††Denominator used was for females only (N=247 Lexapro; N=232 placebo). **Dose Dependency of Adverse Events** The potential dose dependency of common adverse events (defined as an incidence rate of 5% in either the 10 mg or 20 mg Lexapro groups) was examined on the basis of the combined incidence of adverse events in two fixed-dose trials. The overall incidence rates of adverse events in 10 mg Lexapro-treated patients (66%) was similar to that of the placebo-treated patients (61%), while the incidence rate in 20 mg/day Lexapro-treated patients was greater (86%). **Table 4** shows common adverse events that occurred in the 20 mg/day Lexapro group with an incidence that was approximately twice that of the 10 mg/day Lexapro group and approximately twice that of the placebo group. **TABLE 4: Incidence of Common Adverse Events* in Patients with Major Depressive Disorder Receiving Placebo (N=311), 10 mg/day Lexapro (N=310), 20 mg/day Lexapro (N=125): Insomnia (4%, 7%, 14%); Diarrhea (5%, 6%, 14%); Dry Mouth (3%, 4%, 9%); Somnolence (1%, 4%, 9%); Dizziness (2%, 4%, 7%); Sweating Increased (<1%, 3%, 8%); Constipation (1%, 3%, 6%); Fatigue (2%, 2%, 6%); Indigestion (1%, 2%, 6%).** Adverse events with an incidence rate of at least 5% in either of the Lexapro groups and with an incidence rate in the 20 mg/day Lexapro group that was approximately twice that of the 10 mg/day Lexapro group and the placebo group. **Male and Female Sexual Dysfunction with SSRIs** Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. **Table 5** shows the incidence rates of sexual side effects in patients with major depressive disorder and GAD who placebo-controlled trials. **TABLE 5: Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials (In Males Only: Adverse Event: Lexapro (N=407) and Placebo (N=383):** Ejaculation Disorder (primarily ejaculatory delay) (12% and 1%); Libido Decreased (6% and 2%); Impotence (2% and <1%). [In Females Only: Lexapro (N=737) and Placebo (N=636): Libido Decreased (3% and 1%); Anorgasmia (3% and <1%). There are no adequately designed studies examining sexual dysfunction with escitalopram treatment. Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. **Vital Sign Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, and diastolic blood pressure) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses did not reveal any clinically important changes in vital signs associated with Lexapro treatment. In addition, a comparison of supine and standing vital sign measures in subjects receiving Lexapro indicated that Lexapro treatment is not associated with orthostatic changes. **Weight Changes** Patients treated with Lexapro in controlled trials did not differ from placebo-treated patients with regard to clinically important change in body weight. **Laboratory Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables, and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Lexapro treatment. **ECG Changes** Electrocardiograms from Lexapro (N=625), racemic citalopram (N=351), and placebo (N=527) groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed (1) a decrease in heart rate of 2.2 bpm for Lexapro and 2.7 bpm for racemic citalopram, compared to an increase of 0.3 bpm for placebo and (2) an increase in QTc interval of 3.9 msec for Lexapro and 3.7 msec for racemic citalopram, compared to 0.5 msec for placebo. Neither Lexapro nor racemic citalopram were associated with the development of clinically significant ECG abnormalities. **Other Events Observed During the Premarketing Evaluation of Lexapro** Following is a list of WHO terms that reflect treatment-emergent adverse events, as defined in the introduction to the **ADVERSE REACTIONS** section, reported by the 1428 patients treated with Lexapro for periods of up to one year in double-blind or open-label clinical trials during its premarketing evaluation. All reported events are included except those already listed in **Tables 2 & 3**, those occurring in only one patient, event terms that are so general as to be uninformative, and those that are unlikely to be drug related. It is important to emphasize that, although the events reported occurred during treatment with Lexapro, they were not necessarily caused by it. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in less than 1/100 patients but at least 1/1000 patients. **Cardiovascular - Frequent:** palpitation, hypertension. **Infrequent:** bradycardia, tachycardia, ECG abnormal, flushing, varicose vein. **Central and Peripheral Nervous System Disorders - Frequent:** light-headed feeling, migraine. **Infrequent:** tremor, vertigo, restlessness, leg, shaking, twitching, dyspareunia, lightheadedness, tics, carpal tunnel syndrome, muscle contractions involuntary, sluggishness, coordination abnormal, fairness, hyperreflexia, muscular tone increased. **Gastrointestinal Disorders - Frequent:** heartburn, abdominal cramp, gastroenteritis. **Infrequent:** gastroesophageal reflux, bloating, abdominal distention, dyspepsia, increased stool frequency, belching, gastritis, hemorrhoids, gagging, polyposis gastric, swallowing difficult. **General - Frequent:** allergy, pain in limb, fever, hot flashes, chest pain. **Infrequent:** edema of extremities, chills, lightness of chest, leg pain, asthma, syncope, malaise, anaphylaxis, flat, hemic and lymphatic Disorders - **Infrequent:** bruise, anemia, nosebleed, hematoma, lymphadenopathy cervical. **Metabolic and Nutritional Disorders - Frequent:** increased weight. **Infrequent:** decreased weight, hyperglycemia, thirst, bilirubin increased, hepatic enzymes increased, gout, hypercholesterolemia. **Musculoskeletal System Disorders - Frequent:** arthralgia, myalgia. **Infrequent:** jaw stiffness, muscle cramp, muscle stiffness, arthritis, muscle weakness, back aggravated, arthropathy, jaw pain, joint stiffness. **Psychiatric Disorders - Frequent:** appetite increased, lethargy, irritability, concentration impaired. **Infrequent:** jitteriness, panic reaction, agitation, apathy, forgetfulness, depression aggravated, nervousness, restlessness aggravated, suicide attempt, amnesia, anxiety, attack, bruxism, carbohydrate craving, confusion, depersonalization, disorientation, emotional lability, feeling unreal, tremulousness nervous, crying abnormal, depression, excitability, auditory hallucination, suicidal tendency. **Reproductive Disorders/Female - Frequent:** menstrual cramps, menstrual disorder. **Infrequent:** menorrhagia, breast neoplasm, pelvic inflammation, premenstrual syndrome, spotting between menses. *Based on female subjects only; N=905 Respiratory System Disorders - **Frequent:** bronchitis, sinus congestion, coughing, nasal congestion, sinus headache. **Infrequent:** asthma, breath shortness, laryngitis, pneumonia, tracheitis, sinus and Appendages Disorders - **Frequent:** rhinitis, ear, alopecia, eczema, dermatitis, dry skin, folliculitis, lipoma, furunculosis, dry lips, skin nodule. **Special Senses - Frequent:** vision blurred, tinnitus. **Infrequent:** taste alteration, earache, conjunctivitis, vision abnormal, dry eyes, eye irritation, visual disturbance, eye infection, pupils dilated, metallic taste. **Urinary System Disorders - Frequent:** urinary frequency, urinary tract infection. **Infrequent:** urinary urgency, kidney stone, dysuria, blood in urine. **Events Reported Subsequent to the Marketing of Escitalopram** - Although no causal relationship to escitalopram treatment has been found, the following adverse events have been reported to have occurred in patients and to be temporally associated with escitalopram treatment during postmarketing spontaneous and clinical trial experience and were not observed during the premarketing evaluation of escitalopram: **Blood and Lymphatic System Disorders:** hemolytic anemia, leukopenia, thrombocytopenia. **Cardiac Disorders:** atrial fibrillation, cardiac failure, myocardial infarction, torsade de pointes, ventricular arrhythmia, ventricular tachycardia. **Endocrine Disorders:** diabetes mellitus, hyperprolactinemia. **SIADH.** **Eye Disorders:** diplopia, glaucoma. **Gastrointestinal Disorders:** gastrointestinal hemorrhage, pancreatitis, rectal hemorrhage. **General Disorders and Administration Site Conditions:** abnormal gait. **Hepatobiliary Disorders:** fulminant hepatitis, hepatic failure, hepatic necrosis, hepatitis. **Immune System Disorders:** allergic reaction. **Investigations:** electrocardiogram QT prolongation. **IRR increased.** **Prothrombin decreased.** **Metabolism and Nutrition Disorders:** hypoglycemia, hypokalemia. **Musculoskeletal and Connective Tissue Disorders:** rhabdomyolysis. **Nervous System Disorders:** akathisia, choroathetosis, dysarthria, dyskinesia, dystonia, extrapyramidal disorders, grand mal seizures (or convulsions), hypoesthesia, myoclonus, neuroleptic malignant syndrome, nystagmus, seizures, serotonin syndrome, tardive dyskinesia. **Pregnancy, Puerperium and Perinatal Conditions:** spontaneous abortion. **Psychiatric Disorders:** acute psychosis, aggression, anger delirium, delusion, nightmare, paranoia, visual hallucinations. **Renal and Urinary Disorders:** acute renal failure. **Reproductive System and Breast Disorders:** priapism. **Respiratory, Thoracic and Mediastinal Disorders:** pulmonary embolism. **Skin and Subcutaneous Tissue Disorders:** angiodema, ecchymosis, erythema multiforme, photosensitivity reaction, Stevens Johnson Syndrome, toxic epidermal necrolysis, urticaria. **Vascular Disorders:** deep vein thrombosis, hypotension, orthostatic hypotension, phlebitis, thrombosis.

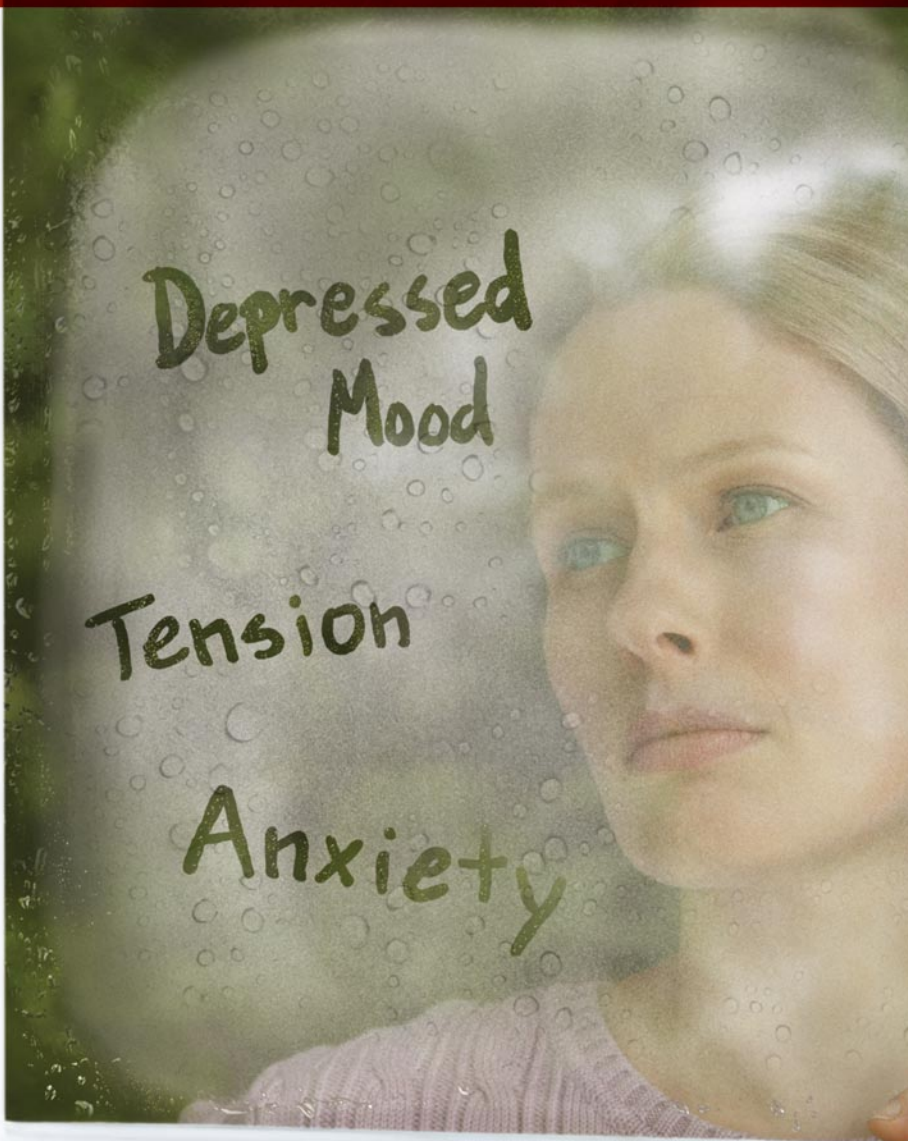
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IMPORTANT SAFETY INFORMATION – Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Antidepressants increased the risk of suicidality (suicidal thinking and behavior) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of antidepressants in children, adolescents or young adults must balance the risk to clinical need. Patients of all ages started on antidepressant therapy should be closely monitored and observed for clinical worsening, suicidality or unusual changes in behavior, especially at the beginning of therapy or at the time of dose changes. This risk may persist until significant remission occurs. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Lexapro is not approved for use in pediatric patients.

Lexapro is contraindicated in patients taking monoamine oxidase inhibitors (MAOIs), pimozide [see DRUG INTERACTIONS – Pimozide and Celexa], or in patients with hypersensitivity to escitalopram oxalate. As with other SSRIs, caution is indicated in the coadministration of tricyclic antidepressants (TCAs) with Lexapro. SSRIs and SNRIs (including Lexapro) and other psychotropic drugs that interfere with serotonin reuptake may increase the risk of bleeding events. Concomitant use of aspirin, NSAIDs, warfarin, and other anticoagulants may add to the risk. Patients should be cautioned about these risks. SSRIs and SNRIs have been associated with clinically significant hyponatremia. Elderly patients or patients taking diuretics or who are otherwise volume-depleted appear to be at a greater risk. Discontinuation of Lexapro should be considered in patients with symptomatic hyponatremia, and appropriate medical intervention should be instituted. The most common adverse events with Lexapro versus placebo (approximately 5% or greater and approximately 2x placebo) were nausea, insomnia, ejaculation disorder, somnolence, increased sweating, fatigue, decreased libido, and anorgasmia.

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Please see the accompanying brief prescribing information for LEXAPRO.

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