

Serotonin and Sexual Dysfunction

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promote treatment nonadherence resulting in depression relapses. The importance of adherence should be reemphasized to patients. Patients also need to be informed of antidepressant withdrawal symptoms during drug holidays (especially with paroxetine), such as gastrointestinal symptoms, dizziness, and paresthesias. This strategy is not recommended for patients who have a history of treatment nonadherence or only partial response to antidepressant treatment.

If the above strategies are not successful, many clinicians may choose to add an antidote to treat sexual dysfunction. Bupropion is usually the most preferred agent because of lack of serotonergic activity and its dopamine- and NE-enhancing properties. This may be the mechanism for improving SSRI-related sexual side effects that result from the suppression of these neurotransmitters. Studies and case reports suggest that the addition of bupropion can restore libido and also may relieve anorgasmia. Bupropion is a mild cytochrome P450 2D6 inhibitor and use of this drug may require an assessment for potential drug interactions, as well as precautions regarding seizures at high doses and past history of eating disorders. Bupropion also may aggravate symptoms of anxiety and jitteriness associated with depression, other agents, such as amantadine, buspirone, cyproheptadine, dextroamphetamine, ginkgo biloba, methylphenidate, sildenafil, and yohimbine, have been used to manage SSRI-induced sexual dysfunction; however, evidence regarding efficacy is limited [5]. Buspirone is a partial agonist of the 5-HT_{1A} receptor that decreases 5-HT transmission and increases dopamine activity. Although some reports suggest efficacy in improving libido and delayed orgasm, a randomized, controlled trial failed to confirm this finding. Reports sug