

PRODUCT MONOGRAPH

PrRAN-CITALOPRAM

Citalopram Hydrobromide Tablets

20 mg & 40 mg as citalopram

Antidepressant

**Ranbaxy Pharmaceuticals Canada Inc.
2630 Skymark Avenue, Suite 701
Mississauga, ON
L4W 5A4**

**DATE OF PREPARATION
May 11, 2005**

Control # 098552

PRODUCT MONOGRAPH

PrRAN-CITALOPRAM

**Citalopram Hydrobromide Tablets
20 mg and 40 mg as citalopram**

THERAPEUTIC CLASSIFICATION

Antidepressant

ACTION AND CLINICAL PHARMACOLOGY

RAN-CITALOPRAM (citalopram hydrobromide) is a highly selective and potent serotonin (5-hydroxytryptamine, 5-HT) reuptake inhibitor with minimal effects on the neuronal reuptake of norepinephrine (NE) and dopamine (DA). The ability of citalopram to potentiate serotonergic activity in the central nervous system *via* inhibition of neuronal reuptake of serotonin is thought to be responsible for its antidepressant action. Tolerance to the inhibition of serotonin reuptake is not induced by long-term (14 days) treatment of rats with citalopram.

Citalopram has no or very low affinity for a series of receptors including serotonin 5-HT_{1A}, 5-HT₂, dopamine D₁ and D₂, α_1 -, α_2 -, β -adrenergic, histamine H₁, muscarinic cholinergic, benzodiazepine, gamma aminobutyric acid (GABA) and opioid receptors.

Pharmacokinetics:

Absorption

Following the administration of a single oral dose of citalopram (40 mg) to healthy male volunteers, peak blood levels occurred at about 4 hours (range 1 to 6 hours). The absolute bioavailability of citalopram was about 80% (range 52 to 93%) relative to an intravenous dose. Absorption was not affected by food.

Distribution

After intravenous infusion in healthy male volunteers, the apparent volume of distribution (V_d) β was about 12 L/kg (range 9-17 L/kg), indicating a pronounced tissue distribution; (V_d) β oral was about 17 L/kg (range 14-21 L/kg). The binding of citalopram and its demethylated metabolites to human plasma proteins is about 80%.

Steady-state

The single- and multiple-dose pharmacokinetics of citalopram are linear and dose-proportional in a dose range of 10 to 60 mg/day. Steady-state plasma levels are achieved in patients in 1-2 weeks. At a daily dose of 40 mg, the average plasma concentration is about 83 ng/mL (n=114) with a range from 30 to 200 ng/mL. Citalopram does not accumulate during long-term treatment. A clear relationship between citalopram plasma levels and therapeutic response or side effects has not been established.

Metabolism

Citalopram is metabolized in the liver to demethylcitalopram (DCT), didemethylcitalopram (DDCT), citalopram-N-oxide, and a deaminated propionic acid derivative. *In vitro* studies show that DCT, DDCT and citalopram -N-oxide also inhibit the neuronal reuptake of serotonin but are less selective and less potent than the parent compound and are of minor clinical importance. Unchanged citalopram is the predominant compound in plasma.

In vitro studies indicated that the biotransformation of citalopram to its demethyl metabolites depends on both CYP2C19 and CYP3A4, with a small contribution from CYP2D6.

Elimination

The elimination half-life of citalopram ($t_{1/2\beta}$) is approximately 37 hours (range: 30-42 hours) which allows recommendation of once-daily dosing. The systemic citalopram plasma clearance (Cl_s) is 0.33 L/min. Citalopram is eliminated primarily via the liver (85%) and the remainder via the kidneys; approximately 12% (range 6-21%) of the daily dose is excreted in urine as unchanged citalopram.

Special Populations

Elderly Patients

Elderly patients (4 males and 7 females aged 73-90 years), received a 20 mg/day dose of citalopram for 3-4 weeks. In the elderly, steady state plasma levels were elevated (106 ng/mL), half-life prolonged (1.5-3.75 days) and clearance decreased (0.08-0.3 L/min). Elevation of citalopram plasma levels occurred at an earlier age in females than in males. In this population, lower doses and a lower maximum dose of citalopram are recommended (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Reduced Hepatic Function

The pharmacokinetics of citalopram were compared in patients with reduced hepatic function (3 female and 6 male patients aged 41-60 years) to those seen in 12 healthy male volunteers (aged 21-43 years). In patients with reduced hepatic function the half-life of citalopram was approximately doubled (83 hours *versus* 37 hours), steady state citalopram concentrations increased by 61% and oral clearance decreased by 37%. Consequently the use of citalopram in patients with reduced hepatic function should be approached with caution and lower maximal doses should be prescribed (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Reduced Renal Function

In patients with mild to moderate reduction of the renal function (4 female and 3 male patients aged 30-55 years), citalopram was being eliminated more slowly than in 12 healthy male volunteers (aged 21-43 years); half-lives being 49 hours *versus* 37 hours. However, mild to moderate renal impairment had no major influence on the kinetics of citalopram. At present, no information is available for chronic treatment of patients with severely reduced renal function (creatinine clearance <20 mL/min). (See PRECAUTIONS)

Clinical Trials

The efficacy of citalopram hydrobromide in the treatment of depression was established in five placebo-controlled studies in patients who met the DSM-III or DSM-III-R criteria for major depression. Response to treatment was evaluated by the Hamilton Depression Rating Scale (HAMD) and/or the Montgomery Asberg Depression Rating Scale (MADRS),

as well as the Clinical Global Impression (CGI) Severity Scale. On the HAMD and MADRS, total scores, selected single items, and percentage of responders (defined as patients whose HAMD/MADRS total score decreased by at least 50% *versus* baseline) were assessed.

In a 6-week fixed-dose, dose-response study, patients received citalopram hydrobromide, at doses of 10, 20, 40, or 60 mg/day or placebo (n=129 to 131 per group). The 40 and 60 mg/day doses were titrated, with patients reaching these designated doses within 4 and 8 days, respectively. The study showed that the 40 and 60 mg/day doses were significantly more effective than placebo, although the 60 mg/day dose was not more effective than the 40 mg/day dose. The lower doses did not show statistically significant superiority over placebo, except on the MADRS; on this scale the percent of 'responders' was significantly higher in all the citalopram hydrobromide-treated groups than in the placebo-treated group.

The second study was a 4-week flexible-dose study in which 85% of the depressed patients met the criteria for melancholia. At entry, 89 and 91 patients were randomized to the citalopram hydrobromide and placebo groups, respectively. This was the only study in which more male than female patients participated (64% *versus* 36%). The initial dose of citalopram hydrobromide, 20 mg/day, could be titrated to the maximal tolerated dose or a maximum dose of 80 mg/day. Patients treated with citalopram hydrobromide showed significantly greater improvement than patients treated with placebo. At week 4, the average daily dose was 63 mg, with 52% of patients receiving the 80 mg/day dose.

In a 6-week fixed-dose study, patients received citalopram hydrobromide, 20 or 40 mg/day, or placebo (n=64 to 70 per group). Patients treated with citalopram hydrobromide, 40 mg/day, showed significantly greater improvement than placebo-treated patients. The difference between the lower dose of citalopram hydrobromide and placebo was not significant.

In another 6-week fixed-dose study, patients received citalopram hydrobromide, 20 or 40 mg/day or placebo (n=88 to 97 per group). Although citalopram hydrobromide-treated patients improved to a somewhat greater degree than the placebo-treated patients, the

differences between drug and control groups did not reach statistical significance due to a high placebo response, i.e., substantial improvement in the placebo group.

A 6-week, flexible-dose study was conducted in elderly, depressed patients (the mean age of male and female patients was 75 and 77 years, respectively) to determine the antidepressant effect and safety of citalopram hydrobromide in this subpopulation. The number of patients who received citalopram hydrobromide and placebo was 98 and 51, respectively. The study allowed patients to enter with lower baseline HAMD scores than are usually acceptable (≥ 18 in clinical trials). However, only a small percentage of patients had HAMD scores of less than 18 at entry. The dose of citalopram hydrobromide was titrated from a starting dose of 10 mg/day to a maximum dose of 30 mg/day. Patients treated with citalopram hydrobromide showed significantly greater improvement than patients treated with placebo. The final dose of citalopram hydrobromide was 10, 20 and 30 mg/day in 5%, 51% and 44% of patients, respectively.

The effectiveness of citalopram hydrobromide in preventing relapse was assessed in two long-term studies. Depressed patients who responded to citalopram hydrobromide during an initial 6 or 8 weeks of acute treatment (fixed doses of 20 or 40 mg/day in one study and flexible doses of 20-60 mg/day in the second study) were randomized to continue on citalopram hydrobromide or receive placebo. The number of patients who received citalopram hydrobromide and placebo was 257 and 116, respectively. In both studies, patients who continued on citalopram hydrobromide experienced significantly lower relapse rates over the subsequent 6 months compared to those receiving placebo. In the fixed-dose study, the relapse rates were similar at the 20 and 40 mg/day doses, namely 10% and 12%, respectively. Of the placebo-treated patients, 31% experienced relapse. In the flexible-dose study, the relapse rates were 14% and 24% in the citalopram hydrobromide and placebo-treated patients, respectively. While the majority of patients (76%) were maintained on 20 or 40 mg/day of citalopram hydrobromide during most of the study, some patients received 60 mg/day, while a few patients were maintained on less than 20 mg/day.

Comparative Bioavailability

A comparative bioavailability study was performed using healthy human volunteers. The rate and extent of absorption of citalopram hydrobromide measured and compared following oral administration of a 40 mg dose of **RAN-CITALOPRAM** (1 x 40 mg) tablet or Celexa[®] (1 x 40 mg) tablet. The results from measured data are summarised as follows:

TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA Citalopram (1 x 40 mg) From Measured Data Geometric Mean Arithmetic Mean (CV%)				
Parameter	Test RAN-CITALOPRAM Tablets	Reference Celexa [®] † Tablets	% Ratio of Geometric Means	90 % Confidence Interval
AUC ₀₋₇₂ (ng.h/mL)	1271 1301.5265 (23.69)	1295 1308.2016 (21.10)	98.1	93.5 - 103.0
C _{MAX} (ng/mL)	41.3 42.0113 (18.91)	41.5 41.9765 (16.88)	99.7	95.9 - 103.6
T _{MAX} (h)*	4.2353 (38.1)	5.0588 (26.6)	-	-
T _{1/2} (h)*	40.0535 (41.1)	35.0618 (28.9)	-	-

†Celexa[®] manufactured by Lundbeck Canada Inc. was purchased in Canada.

*expressed as arithmetic mean (CV%) only.

Based on these results, the Ranbaxy Pharmaceuticals Canada Inc. (RAN-CITALOPRAM) and Lundbeck Canada Inc. (Celexa[®]) 40 mg citalopram hydrobromide tablets are bioequivalent under fasting conditions.

INDICATIONS AND CLINICAL USE

RAN-CITALOPRAM (citalopram hydrobromide) is indicated for the symptomatic relief of depressive illness.

The relapse rate was significantly lower in citalopram hydrobromide- treated patients than in placebo-treated patients in two placebo-controlled studies, that were conducted over a 24-week period in patients who responded to 6 or 8 weeks of acute treatment with citalopram hydrobromide (see Clinical Trials under ACTION AND CLINICAL PHARMACOLOGY). Nevertheless, the physician who elects to use citalopram

hydrobromide for extended periods should periodically reevaluate the long-term usefulness of the drug for the individual patient.

CONTRAINDICATIONS

RAN-CITALOPRAM (citalopram hydrobromide) is contraindicated in patients with known hypersensitivity to citalopram hydrobromide or the excipients of the drug product.

Monoamine Oxidase Inhibitors

In patients, receiving selective serotonin reuptake inhibitors (SSRIs) 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, including 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 a MAOI. Some cases presented with features resembling serotonin syndrome.

Therefore, **RAN-CITALOPRAM** should not be used in combination with a MAOI or within 14 days of discontinuing treatment with a MAOI. Similarly, at least 14 days should elapse after discontinuing **RAN-CITALOPRAM** treatment before starting a MAOI.

WARNINGS

POTENTIAL ASSOCIATION WITH THE OCCURENCE BEHAVIOURAL AND EMOTIONAL CHANGES, INCLUDING SELF-HARM.

Pediatrics: Placebo-Controlled Clinical Trial Data

- **Recent analyses of placebo-controlled clinical trial safety databases from SSRIs and other newer anti-depressants suggests that use of these drugs in patients under the age of 18 may be associated with behavioural and**

emotional changes, including an increased risk of suicidal ideation and behaviour over that of placebo.

- The small denominators in the clinical trial database, as well as the variability in placebo rates, preclude reliable conclusions on the relative safety profiles among these drugs.

Adults and Pediatrics: Additional data

- There are clinical trial and post-marketing reports with SSRIs and other newer anti-depressants, in both pediatrics and adults, of severe agitation-type adverse events coupled with self-harm or harm to others. The agitation-type events include: akathisia, agitation, disinhibition, emotional lability, hostility, aggression, depersonalization. In some cases, the events occurred within several weeks of starting treatment.

Rigorous clinical monitoring for suicidal ideation or other indicators of potential for suicidal behaviour is advised in patients of all ages. This includes monitoring for agitation-type emotional and behavioural changes.

Discontinuation Symptoms

Patients currently taking RAN-CITALOPRAM (citalopram hydrobromide) should NOT be discontinued abruptly, due to risk of discontinuation symptoms. At the time that a medical decision is made to discontinue an SSRI or other newer anti-depressant drug, a gradual reduction in the dose rather than an abrupt cessation is recommended.

PRECAUTIONS

Suicide

The possibility of a suicide attempt is inherent in depression and may persist until remission occurs. Therefore, high risk patients should be closely supervised throughout therapy with **RAN-CITALOPRAM** (citalopram hydrobromide) and consideration should be given to the possible need for hospitalization. In order to minimize the opportunity for overdose,

prescription for **RAN-CITALOPRAM** should be written for the smallest quantity of drug consistent with good patient management. (see **WARNINGS: POTENTIAL ASSOCIATION WITH BEHAVIORAL AND EMOTIONAL CHANGES, INCLUDING SELF-HARM**)

Activation of Mania/Hypomania

In placebo-controlled trials with citalopram hydrobromide, some of which included patients with bipolar disorder, mania/hypomania was reported in 0.1% of 1027 patients treated with citalopram hydrobromide versus none of the 426 patients treated with placebo. Activation of mania/hypomania has also been reported in a small proportion of patients with major affective disorders treated with other marketed antidepressants. If a patient enters a manic phase, **RAN-CITALOPRAM** should be discontinued.

Seizures

Citalopram hydrobromide has not been systematically evaluated in patients with a seizure disorder. These patients were excluded from clinical studies during the premarketing testing of citalopram hydrobromide. In clinical trials, seizures occurred in 0.25% of patients treated with citalopram hydrobromide and in 0.23% patients treated with placebo. Like other antidepressants, citalopram hydrobromide should be used with caution in patients with a history of seizure disorder. The drug should be discontinued in any patient who develop seizures.

Discontinuation of Treatment with Citalopram Hydrobromide

When discontinuing treatment, patients should be monitored for symptoms which may be associated with discontinuation (e.g. dizziness, abnormal dreams, sensory disturbances [including paresthesias and electric shock sensations], agitation, anxiety, emotional indifference, impaired concentration, headache, migraine, tremor, nausea, vomiting and sweating or other symptoms which may be of clinical significance. (see **ADVERSE REACTIONS**). A gradual reduction in the dosage over several weeks, rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, dose titration should be

managed on the basis of the patient's clinical response. (See ADVERSE REACTIONS and DOSAGE and ADMINISTRATION).

Serotonin Syndrome

Rarely, the occurrence of serotonin syndrome has been reported in patients receiving SSRIs. A combination of symptoms, possibly including agitation, confusion, tremor, myoclonus and hyperthermia, may indicate the development of this condition.

Serotonergic Drugs

There have been rare postmarketing reports describing patients with weakness, hyperreflexia and incoordination, following the concomitant use of a SSRI and the antimigraine drug sumatriptan, a 5-HT₁ agonist. Such interaction should be considered if citalopram hydrobromide is to be used in combination with a 5-HT₁ agonist. St-John's Wort: In common with other SSRI's, pharmacodynamic interactions between citalopram and the herbal remedy St-John's Wort may occur and may result in undesirable effects.

Hyponatremia

Hyponatremia and SIADH (syndrome of inappropriate antidiuretic hormone secretion) have been reported as a rare adverse event with use of citalopram hydrobromide as with other SSRIs. Elderly female patients in particular seem to be a group at risk.

Pregnancy and Nursing Mothers

The safety of citalopram hydrobromide during pregnancy and lactation has not been established. Therefore, citalopram hydrobromide should not be used during pregnancy, unless, in the opinion of the physician, the expected benefits to the patient markedly outweigh the possible hazards to the fetus.

Citalopram hydrobromide is excreted in human milk. Citalopram hydrobromide should not be administered to nursing mothers unless, in the opinion of the treating physician, the expected benefits to the patient markedly outweigh the possible hazards to the child.

Pediatric Use

Safety and effectiveness in patients below the age of 18 have not been established.

Geriatric Use

In premarketing clinical trials, 800 elderly patients (≥ 65 years of age) have been treated with citalopram hydrobromide. Of these patients 298 were ≥ 75 years old. In a pharmacokinetic study (N=11, age 73 to 90 years), clearance was substantially decreased and half-life prolonged (see Pharmacokinetics). In a 6-week placebo-controlled study, approximately equal numbers of patients received citalopram hydrobromide at 20 or 30 mg per day, as the final dose. In about 5% of patients, the final dose was 10 mg per day (see Clinical Trials under ACTION AND CLINICAL PHARMACOLOGY). Consequently, elderly patients should be administered lower doses and a lower maximum dose (see DOSAGE AND ADMINISTRATION).

Hepatic Impairment

In subjects with hepatic impairment, citalopram hydrobromide clearance was significantly decreased and plasma concentrations, as well as elimination half-life significantly increased (see Pharmacokinetics). Consequently, the use of citalopram hydrobromide in hepatically impaired patients should be approached with caution and a lower maximum dosage is recommended (see DOSAGE AND ADMINISTRATION).

Renal Impairment

No dosage adjustment is needed in patients with mild to moderate renal impairment. Since, no information is available on the pharmacokinetic or pharmacodynamic effects of citalopram hydrobromide in patients with severely reduced renal function (creatinine clearance < 20 mL/min), citalopram hydrobromide should be used with caution in these patients.

Use in Patients with Cardiac Disease

Citalopram 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 trials during the drug's premarketing assessment. However, the electrocardiograms of patients, who received citalopram hydrobromide in clinical trials, indicate that citalopram hydrobromide was not associated with the development of clinically significant ECG abnormalities.

In clinical trials, citalopram hydrobromide caused small but statistically significant decreases in heart rate (see ECG under ADVERSE REACTIONS). Consequently, caution should be observed when citalopram is initiated in patients with pre-existing slow heart rate.

Use in Diabetic Patients

Citalopram hydrobromide has not been systematically evaluated in diabetic patients since diabetes constituted an exclusion criterion. Although 13 patients did receive insulin during the studies, this number is too small to determine whether citalopram hydrobromide affects the response to insulin. Rare events of hypoglycemia were reported. Citalopram hydrobromide should be used with caution in diabetic patients on insulin or other antidiabetic drugs.

Interference with Cognitive and Motor Performance

In studies in normal volunteers, citalopram hydrobromide in doses of 40 mg/day did not impair cognitive function or psychomotor performance. However, psychotropic medications may impair judgement, thinking or motor skills. Consequently, patients should be cautioned against driving a car or operating hazardous machinery until they are reasonably certain that citalopram hydrobromide does not affect them adversely.

Electroconvulsive Therapy (ECT)

The safety and efficacy of the concurrent use of citalopram hydrobromide and ECT have not been studied.

Bleeding Disorders

There have been reports of cutaneous bleeding abnormalities such as ecchymosis and purpura with SSRIs. Caution is advised in patients taking SSRIs, particularly in concomitant use with drugs known to affect platelet function (e.g., atypical antipsychotics and phenothiazines, most tricyclic antidepressants, acetylsalicylic acid, and non-steroidal anti-inflammatory drugs (NSAIDs)) as well as in patients with a history of bleeding disorders.

Drug Interactions

Monoamine Oxidase Inhibitors (MAOI)

For interactions between citalopram hydrobromide and MAOI, see CONTRAINDICATIONS.

General

The studies described in this section were carried out in young, healthy, mostly male volunteers. In addition, some of the studies, namely interactions with metoprolol, warfarin, digoxin, imipramine, and levomepromazine, utilized only single doses of these drugs, although citalopram hydrobromide was given repeatedly to attain steady state. Thus, data are not available in patients who would be receiving these drugs on an ongoing basis at therapeutic doses.

Metoprolol

Coadministration of citalopram hydrobromide (40 mg/day for 22 days) and the β -adrenergic blocking agent metoprolol (single dose of 150 mg), resulted in a twofold increase in the plasma levels of metoprolol. However, the effect of metoprolol on blood pressure and heart rate was not affected.

Warfarin

Administration of citalopram hydrobromide (40 mg/day for 21 days), did not affect either the pharmacokinetics or the pharmacodynamics (prothrombin time) of a single, 25 mg dose of warfarin.

Digoxin

Administration of citalopram hydrobromide (40 mg/day for 21 days) did not affect the pharmacokinetics of digoxin (single dose of 1 mg), although the serum levels of citalopram hydrobromide were slightly lower in the presence of digoxin.

Imipramine

Coadministration of citalopram hydrobromide (40 mg/day for 10 days) and the tricyclic antidepressant, imipramine (single dose of 100 mg), did not affect the pharmacokinetics of either drug. However, in the presence of citalopram hydrobromide, the concentration of desipramine, the metabolite of imipramine, increased by approximately 50% and its half-life was prolonged. The results indicate that citalopram hydrobromide does not interfere with the demethylation of imipramine to desipramine but does inhibit the metabolism of desipramine to its 2-hydroxy metabolite. Consequently, concomitant treatment with citalopram hydrobromide and imipramine/desipramine should be undertaken with caution.

Levomepromazine

Coadministration of citalopram hydrobromide (40 mg/day for 10 days) and levomepromazine (single dose of 50 mg), did not affect the pharmacokinetics of either drug.

Lithium

Coadministration of citalopram hydrobromide (40 mg/day for 10 days) and lithium (30 mmol/day for 5 days), did not affect the pharmacokinetics of either drug. However, since lithium may increase serotonergic neurotransmission, concomitant treatment with these two drugs should be undertaken with caution.

Cimetidine

Citalopram hydrobromide 40 mg/day was administered for 29 days. During the last 8 days of treatment, cimetidine (400 mg bid) was added to the treatment regimen. In the presence of cimetidine, a potent inhibitor of hepatic cytochrome P450 enzymes, the C_{max} and AUC of citalopram hydrobromide was increased by 39% and 41%, respectively. Thus, caution

should be exercised at the upper end of the dose range of citalopram hydrobromide when it is used concomitantly with high doses of cimetidine.

Carbamazepine

Carbamazepine, titrated to 400 mg/day, was given for 21 days alone and then in combination with citalopram hydrobromide (40 mg/day) for an additional 14 days. Citalopram hydrobromide did not affect the plasma levels of either carbamazepine, a CYP3A4 substrate, or its metabolite, carbamazepine-epoxide. However, since carbamazepine is a microsomal enzyme inducer, the possibility that carbamazepine may increase the clearance of citalopram hydrobromide should be considered if the two drugs are given concomitantly.

Cytochrome P450 Isozymes

Using *in vitro* models of human liver microsomes, the biotransformation of citalopram to its demethyl metabolites was shown to depend on both CYP2C19 and CYP3A4, with a small contribution from CYP2D6. Studies have also indicated that citalopram is a weak inhibitor of CYP2D6 and CYP2C19 and a weak or negligible inhibitor of CYP3A4 and CYP1A2.

One *in vitro* study using human liver microsomes has shown that ketoconazole and omeprazole reduced the rate of formation of the demethylcitalopram metabolite of citalopram to 45-60% and 75-85% of control, respectively. As data are not available from multi-dose pharmacokinetic studies, the possibility that the clearance of citalopram will be decreased when citalopram hydrobromide is administered with a potent inhibitor of CYP3A4 (e.g., ketoconazole, itraconazole, fluconazole or erythromycin), or a potent inhibitor of CYP2C19 (e.g., omeprazole), should be considered.

Alcohol

Although citalopram hydrobromide did not potentiate the cognitive and psychomotor effects of alcohol in volunteers, the concomitant use of alcohol and citalopram hydrobromide should be avoided.

Other Drugs

No pharmacodynamic interactions have been noted in clinical trials where citalopram hydrobromide has been given concomitantly with benzodiazepines (anxiolytics/hypnotics), analgesics (NSAIDs, non-NSAIDs), antihistamines, antihypertensives or other cardiovascular drugs. Pharmacokinetic interactions between citalopram and these drugs were not specifically studied.

ADVERSE REACTIONS

During the premarketing clinical development, 3652 patients received citalopram hydrobromide for the treatment of depression. Of these patients, 66% were females and 34% were males. The mean age of the patients was 50 years, with 70% being <60 years old (30% <40 years old, 40% 40 to 59 years old) and 30% being ≥60 years old. Adverse events observed with citalopram hydrobromide are in general mild and transient. They usually attenuate during the first one or two weeks of treatment.

Adverse Findings Observed in Short-term, Placebo-controlled Trials**Adverse Reactions Leading to Discontinuation of Treatment**

From the short-term (4 to 6 weeks) placebo-controlled, Phase III clinical trials, 15.9% (163/1027) of the citalopram hydrobromide- treated patients discontinued treatment due to an adverse event. The discontinuation rate in the placebo-treated patients was 7.7% (33/426).

The events associated with discontinuation of citalopram hydrobromide in 1% or more of patients at a rate of at least twice that of placebo, were as follows:

Nausea (4.1% *versus* 0.0%), insomnia (2.4% *versus* 1.2%), somnolence (2.4% *versus* 1.2%), dizziness (2.3% *versus* 0.7%), vomiting (1.3% *versus* 0.0%), agitation (1.2% *versus* 0.0%), asthenia (1.1% *versus* 0.5%), and dry mouth (1.1% *versus* 0.2%).

Incidence of Adverse Events in Placebo-controlled Studies

Table 1 enumerates the incidence of treatment emergent adverse events that occurred in 1027 depressed patients who received citalopram hydrobromide at doses ranging from 10 to 80 mg/day in placebo-controlled trials of up to 6 weeks in duration. Events included are those occurring in 2% or more of patients treated with citalopram hydrobromide, and for which the incidence in patients treated with citalopram hydrobromide was greater than the incidence in placebo-treated patients. Reported adverse events were classified using the standard World Health Organization (WHO)-based dictionary terminology.

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.

TABLE 1
Treatment-Emergent Adverse Events*
Incidence in Placebo-Controlled Clinical Trials

Body System/Adverse Event	Percentage of Patients Reporting	
	Citalopram (N = 1027)	Placebo (N = 426)
Body as a Whole		
Fatigue	5.2	3.1
Fever ¹	2.4	0.2
Autonomic Nervous System		
Dry mouth ¹	19.4	12.2
Sweating increased	10.5	8.0
Central and Peripheral Nervous System		
Tremor	8.4	6.3
Gastrointestinal System		
Nausea ¹	20.6	13.4
Diarrhea	8.1	5.4
Dyspepsia	4.3	3.5
Vomiting	3.9	2.6
Abdominal pain	3.1	2.1
Psychiatric		
Somnolence ¹	17.3	9.9
Anorexia ¹	4.2	1.6
Nervousness	3.6	3.5
Anxiety	3.3	2.1
Agitation ¹	2.4	0.7
Libido decreased ¹	2.2	0.2
Yawning ¹	2.1	0
Reproductive, Female²		
Dysmenorrhea (<50 years)	2.7	1.6
Reproductive, Male³		
Ejaculation disorder ¹	6.2	1.1
Impotence ³	3.2	0.6
Respiratory System		
Upper respir. Tract infection	5.1	4.7
Rhinitis	4.9	3.3
Pharyngitis	3.4	2.8
Sinusitis ¹	2.4	0.2
Urinary System		
Micturition disorder	2.3	2.1

* Events included are those occurring in 2% or more of patients treated with citalopram hydrobromide, and for which the incidence in patients treated with citalopram hydrobromide was greater than the incidence in placebo-treated patients.

¹ Statistically significantly higher incidence in the citalopram group (p <0.05)

² Denominator used was for females only (N=623 for citalopram hydrobromide; N=245 for Placebo).

³ Denominator used was for males only (N=404 for citalopram hydrobromide; N=181 for Placebo).

The following events had an incidence on placebo \geq citalopram hydrobromide: asthenia, back pain, headache, dizziness, constipation, palpitation, insomnia, abnormal vision.

Most Frequent Adverse Events

Adverse events that occurred in citalopram hydrobromide-treated patients in the course of the short-term, placebo-controlled trials with an incidence greater than, or equal to, 10% were: nausea, dry mouth, somnolence, and increased sweating (Table 1).

Dose Dependency of Adverse Events

The potential relationship between the dose of citalopram hydrobromide and the incidence of an adverse event was examined in a fixed dose short-term, placebo-controlled study in which patients received citalopram hydrobromide at doses of 10, 20, 40 or 60 mg per day. The incidence of diarrhea, dry mouth, fatigue, insomnia, increased sweating, nausea and somnolence was dose-related.

Male and Female Sexual Dysfunction with SSRIs

While sexual dysfunction is often part of depression and other psychiatric disorders, there is increasing evidence that treatment with selective serotonin reuptake inhibitors (SSRIs) may induce sexual side effects. This is a difficult area to study because patients may not spontaneously report symptoms of this nature, and therefore, it is thought that sexual side effects with SSRIs may be underestimated.

In placebo-controlled, short-term clinical trials, the reported incidence of decreased libido, ejaculation disorders (primarily ejaculation delay and ejaculation failure), and impotence in male depressed patients receiving citalopram hydrobromide (N=404) was 3.7%, 6.2%, and 3.2%, respectively. In female depressed patients receiving citalopram hydrobromide (N=623), the reported incidence of decreased libido and anorgasmia was 1.3% and 1.1, respectively. The reported incidence of each of these adverse events was $\leq 1\%$ among male and female depressed patients receiving placebo.

Weight Changes

Patients treated with citalopram hydrobromide in controlled trials experienced a weight loss of about 0.5 kg compared to no change for placebo patients.

ECG

Respective analyses of electrocardiograms in citalopram hydrobromide-treated (N=779 <60 years and N=313 ≥60 years) and placebo-treated (N=74 <60 years and N=43 ≥60 years) patients indicated that citalopram hydrobromide decreases heart rate. In patients <60 years old, the mean decrease was approximately 5 bpm, while in patients ≥60 years old, mean decreases ranged between 5 to 10 bpm. Following the initial drop, heart rate remained decreased but stable over prolonged periods of time (up to one year in over 100 younger and over 50 elderly patients). The effect was reversible within approximately a week after stopping treatment.

In the 6-week, fixed dose, dose-response study, the mean decreases in heart rate ranged between 2-6 bpm in the 20-60 mg/day dose range, but the effect did not seem to be dose-related and was independent of gender. In placebo-treated patients heart rates remained unaffected. The differences in heart rates between citalopram hydrobromide and placebo-treated patients were statistically significant.

ECG parameters, including QT interval, remained unaffected.

Adverse Reactions Following Discontinuation of Treatment (or Dose Reduction)

There have been reports of adverse reactions upon the discontinuation of citalopram hydrobromide (particularly when abrupt), including but not limited to the following: dizziness, abnormal dreams, sensory disturbances (including paresthesias and electric shock sensations), agitation, anxiety, emotional indifference, impaired concentration, headache, migraine, tremor, nausea, vomiting and sweating or other symptoms which may be of clinical significance, (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Patients should be monitored for these or any other symptoms. A gradual reduction in the dosage over several weeks, rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, dose titration should be managed on the basis of the patient's clinical response. These events are generally self-limiting. Symptoms associated with

discontinuation have been reported for other selective serotonin reuptake inhibitors. (see PRECAUTIONS and DOSAGE AND ADMINISTRATION)

Additional Adverse Events Observed During the Premarketing Evaluation of Citalopram hydrobromide

The events listed below include all adverse events that were reported in the overall development program of citalopram hydrobromide (N=3652). All reported events are included except those already listed in Table 1 and those events which occurred in only one patient. It is important to emphasize that, although the events reported occurred during treatment with citalopram hydrobromide, they were not necessarily caused by it. The events are enumerated using the following criteria: *frequent*: adverse events that occurred on one or more occasions in at least 1/100 patients; *infrequent*: adverse events that occurred in less than 1/100 patients but at least in 1/1000 patients; *rare*: adverse events that occurred in fewer than 1/1000 patients.

Body as a Whole - General Disorders - *Frequent*: Influenza-like symptoms, non-pathological trauma, pain. *Infrequent*: Alcohol intolerance, allergic reaction, allergy, chest pain, edema, hot flushes, leg pain, malaise, rigors, syncope. *Rare*: Peripheral edema, sudden death, traumatic injury.

Cardiovascular Disorder- *Frequent*: Postural hypotension, tachycardia. *Infrequent*: Angina pectoris, arrhythmia, bradycardia, cardiac failure, cerebrovascular disorders, edema dependent, extrasystoles, flushing, hypertension, hypotension, myocardial infarction, myocardial ischemia, peripheral ischemia. *Rare*: Aggravated hypertension, bundle branch block, cardiac arrest, coronary artery disorder, ECG abnormal, heart disorder, phlebitis, supraventricular extrasystoles.

Central and Peripheral Nervous System Disorders- *Frequent*: Migraine, paraesthesia. *Infrequent*: Abnormal gait, ataxia, convulsions, dysphonia, dystonia, extrapyramidal disorder, hyperkinesia, hypertonia, hypoesthesia, hypokinesia, involuntary muscle

contractions, leg cramps, neuralgia, speech disorder, vertigo. *Rare:* Abnormal coordination, convulsions grand mal, hyperesthesia, ptosis, sensory disturbance, stupor.

Collagen Disorders- *Rare:* Rheumatoid arthritis.

Endocrine Disorders- *Rare:* Goiter, gynecomastia, hypothyroidism.

Gastrointestinal System Disorders- *Frequent:* Flatulence. *Infrequent:* Colitis, dental abscess, dysphagia, eructation, gastritis, gastroenteritis, gastrointestinal disorder (not specified), hemorrhoids, increased saliva, teeth-grinding, toothache. *Rare:* Appendicitis, esophaitis, gastric ulcer, gastroesophageal reflux, gingivitis, stomatitis, tooth disorder, ulcerative stomatitis.

Hematopoietic and Lymphatic Disorders- *Infrequent:* Anemia, epistaxis, leukocytosis, purpura. *Rare:* Coagulation disorder, gingival bleeding, granulocytopenia, hematoma, leukopenia, lymphadenopathy, lymphocytosis, pulmonary embolism.

Liver and Biliary System Disorders- *Infrequent:* Cholecystitis, cholelithiasis, increased gamma-GT, increased SGPT. *Rare:* Bilirubinemia, increased SGOT, jaundice.

Metabolic and Nutritional Disorders- *Frequent:* Appetite decreased, Weight decrease, weight increase. *Infrequent:* Leg edema, xerophthalmia. *Rare:* Dehydration, edema, hypoglycemia, hypokalemia, increased alkaline phosphatase, obesity, thirst.

Musculo-Skeletal System Disorders- *Infrequent:* Arthralgia, arthritis, arthrosis, dystonia, muscle weakness, myalgia. *Rare:* Bone disorder, bursitis, osteoporosis, tendon disorder.

Neoplasm- *Rare:* Breast neoplasm malignant female.

Psychiatric Disorders- *Frequent:* Abnormal dreaming, aggravated depression, amnesia, apathy, confusion, depression, impaired concentration, increased appetite, sleep disorder,

suicide attempt. *Infrequent:* Abnormal thinking, aggressive reaction, delusion, depersonalization, drug abuse, drug dependence, emotional lability, euphoria, hallucination, increased libido, manic reaction, neurosis, paranoid reaction, paroniria, psychosis, psychotic depression. *Rare:* Catatonic reaction, hysteria, personality disorder.

Reproductive Disorders, Female- *Frequent:* Abnormal orgasm. *Infrequent:* Amenorrhea, breast pain, lactation nonpuerperal, menorrhagia, menstrual disorder, premenstrual syndrome, salpingitis, unintended pregnancy, vaginal dryness, vaginitis. *Rare:* Breast enlargement, vaginal hemorrhage.

Reproductive Disorders, Male- *Infrequent:* Penis disorder, prostatic disorder, testis disorder.

Resistance Mechanism Disorders- *Infrequent:* Abscess, fungal infection, herpes simplex infection, otitis media, viral infection. *Rare:* Bacterial infection, moniliasis, sepsis.

Respiratory System Disorders- *Infrequent:* Bronchitis, coughing, dyspnea, pneumonia. *Rare:* Asthma, bronchospasm, increased sputum, laryngitis, pneumonitis, respiratory disorder.

Skin and Appendage Disorders- *Frequent:* Pruritus, rash. *Infrequent:* Acne, alopecia, dermatitis, dry skin, eczema, photosensitivity reaction, psoriasis, rash erythematous, rash maculo-papular, skin discoloration, urticaria. *Rare:* Cellulitis, decreased sweating, hypertrichosis, melanosis, pruritus ani.

Special Senses, Vision, Hearing and Vestibular Disorder- *Frequent:* Abnormal accommodation. *Infrequent:* Conjunctivitis, earache, eye pain, mydriasis, taste perversion, tinnitus. *Rare:* Eye abnormality, keratitis, photophobia.

Urinary System Disorders- *Frequent:* Polyuria. *Infrequent:* Abnormal urine, cystitis, hematuria, micturition frequency, urinary incontinence, urinary retention, urinary tract infection. *Rare:* Dysuria, facial edema, oliguria, renal calculus, renal pain.

Events Observed During the Post-Marketing Evaluation of Citalopram hydrobromide

Adverse events which have been reported to be temporally (but not necessarily causally) associated with citalopram hydrobromide treatment in at least 3 patients since its market introduction include:

Abnormal hepatic function, acute renal failure, aggravated condition, aggravated migraine, akathisia, anaphylaxis, angioedema, asthma, choreoathetosis, convulsion NOS, decreased drug level, decreased prothrombin time, delirium, dyskinesia, ecchymosis, eosinophilia, epidermal necrolysis, erythema multiforme, gastrointestinal hemorrhage, gynecological problems, hemolytic anemia, hepatitis, hypersensitivity NOS, hyperprolactinemia, hypomania, hyponatremia, increased drug level, increased prothrombin time, menometrorrhagia, myoclonic jerks, neuroleptic malignant syndrome, neuropathy, nystagmus, pancreatitis, pancytopenia, purpura NOS, rhabdomyolysis, serotonin syndrome, SIADH, spontaneous abortion/fetal death, suicide ideation, thrombocytopenia, vasodilatation, ventricular arrhythmia, Torsades de pointes, withdrawal syndrome.

SYMPTOMS AND TREATMENT OF OVERDOSAGE

Citalopram hydrobromide has a wide margin of safety in overdose. Cases of overdoses involved the ingestion of Citalopram hydrobromide either alone or in combination with other drugs and/or alcohol. Cases of overdoses of Citalopram hydrobromide ranging from 180 mg to 2000 mg have been reported during the pre-marketing clinical development. All patients recovered. One patient, ingesting over 1500 mg Citalopram hydrobromide, had reversible ECG abnormalities, the most important of which was prolongation of QTc.

Citalopram hydrobromide is given to patients at potential risk of suicide and reports of attempted suicide have been received after its market introduction. Post-marketing reports of drug overdoses involving citalopram have included fatalities with citalopram alone as well as non-fatal overdoses of up to 5200 mg. In many cases, details regarding the precise dose of citalopram or combination with other drugs and/or alcohol are often lacking. Although most patients recovered without sequelae, fatalities have been reported at doses of citalopram hydrobromide up to 3920 mg.

Fatal cases of serotonin syndrome have been reported in patients who took overdoses of moclobemide (Manerix) and citalopram hydrobromide. The plasma concentrations of moclobemide were between 16 and 90 mg/L (therapeutic range: 1 to 3 mg/L) and those of citalopram hydrobromide between 0.3 and 1.7 mg (therapeutic concentration: 0.3 mg/L). This indicates that a relatively low dose of citalopram hydrobromide, given with an overdose of moclobemide represents a serious risk for the patient.

Symptoms most often accompanying citalopram hydrobromide overdose included dizziness, sweating, nausea, vomiting, tremor, and somnolence. In more rare cases, observed symptoms included confusion, loss of consciousness, convulsions, coma, sinus tachycardia, cyanosis, hyperventilation and rhabdomyolysis.

Management Of Overdosage

Establish and maintain an airway to ensure adequate ventilation and oxygenation. Gastric lavage and use of activated charcoal should be considered. Cardiac and vital sign monitoring are recommended, along with general symptomatic and supportive measures. There are no specific antidotes for citalopram hydrobromide.

Due to the large volume of distribution of citalopram hydrobromide, forced diuresis, dialysis, hemoperfusion and exchange transfusion are unlikely to be of benefit.

In managing overdose, the possibility of multiple drug involvement must be considered.

DOSAGE AND ADMINISTRATION

General

RAN-CITALOPRAM (citalopram hydrobromide) should be administered once daily, in the morning or evening, with or without food.

Children:

RAN-CITALOPRAM (citalopram hydrobromide) is not indicated for use in children under 18 years of age. (see **WARNINGS: POTENTIAL ASSOCIATION WITH THE OCCURRENCE BEHAVIORAL AND EMOTIONAL CHANGES, INCLUDING SELF-HARM**)

Adults

RAN-CITALOPRAM (citalopram hydrobromide) should be administered as a single oral dose of 20 mg/day. In patients who do not respond adequately, an increase of dosage to 40 mg/day should be considered. Certain patients may require 60 mg/day. However, in a dose-response study, the 60 mg/day dose did not demonstrate an advantage regarding effectiveness over the 40 mg/day dose.

Dose increases should usually occur in increments of 20 mg, at intervals of no less than one week.

Elderly Patients

A single oral dose of 20 mg/day is the recommended dose for most elderly patients. Some patients may respond to a 10 mg/day dose (see Clinical Trials under **ACTION AND CLINICAL PHARMACOLOGY**). The dose may be titrated to a maximum of 40 mg/day if needed and tolerated. As with other SSRIs, caution should be exercised in treating elderly

female patients who may be more susceptible to adverse events such as hyponatremia and SIADH (syndrome of inappropriate antidiuretic hormone secretion). (See PRECAUTIONS).

Hepatic Impairment

Patients with reduced hepatic function should receive dosages of no more than 30 mg/day.

Renal Impairment

No dosage adjustment is necessary for patients with mild to moderate renal impairment. Since there is no information available on the pharmacokinetic or pharmacodynamic effects of citalopram hydrobromide in patients with severe renal impairment, citalopram hydrobromide should be used with caution in these patients.

Maintenance Treatment

Evaluation of citalopram hydrobromide in two placebo-controlled studies has shown that its antidepressant efficacy was maintained for periods of up to 24 weeks, following 6 or 8 weeks of initial treatment (total of 32 weeks) (See Clinical Trials under ACTION AND CLINICAL PHARMACOLOGY). In the flexible dose study, the great majority of patients were receiving 20 mg or 40 mg/day doses both at 12 and 24 weeks. During maintenance therapy, the dosage should be kept at the lowest effective level and patients should be periodically reassessed to determine the need for continued treatment.

Switching Patients To or From a Monoamine Oxidase Inhibitor (MAOI)

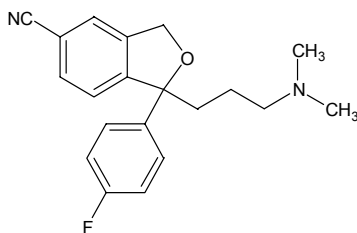
At least 14 days should elapse between discontinuation of a MAOI and initiation of therapy with citalopram hydrobromide. Similarly, at least 14 days should be allowed after stopping citalopram hydrobromide before starting a MAOI (see CONTRAINDICATIONS).

Discontinuation of Citalopram Hydrobromide Treatment

Symptoms associated with the discontinuation or dosage reduction of citalopram hydrobromide have been reported. Patients should be monitored for these and other

symptoms when discontinuing treatment or during dosage reduction (See PRECAUTIONS and ADVERSE REACTIONS).

A gradual reduction in the dose over several weeks rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, dose titration should be managed on the basis of the patient's clinical response. (See PRECAUTIONS and ADVERSE REACTIONS).

PHARMACEUTICAL INFORMATION**Drug Substance:****Proper name:** Citalopram hydrobromide**Chemical name:** 1-[3-Dimethylamino)propyl]-1-(4-fluorophenyl)-1,3-dihydro-5-isobenzofuran carbonitrile, hydrobromide**Molecular formula:** C₂₀H₂₁N₂OHBr**Molecular weight:** 405.35**Structural formula:**

. HBr

Description: White to off-white, crystalline powder.**Melting point:** 184° - 188°C**pH:** 5.5-6.5 (0.4% solution)**pKa:** 9.5 (microtitration)**Solubility:**
Water (sparingly soluble)
Ethanol (soluble)
Chloroform (freely soluble)
Diethylether (very slightly soluble)

Partition Coefficient: Log P (octanol/phosphate buffer pH 7.4) - 1.57

Composition: **RAN-CITALOPRAM** tablets contains citalopram hydrobromide corresponding to 20 mg and 40 mg citalopram, and the following non-medicinal ingredients: Colloidal Silicon Dioxide, Croscarmellose Sodium, Hydroxypropyl Methylcellulose, Lactose Monohydrate, Magnesium stearate, Microcrystalline Cellulose, Polydextrose, Polyethylene Glycol, Titanium Dioxide, and Triacetin.

Stability and storage: **RAN-CITALOPRAM** tablets should be stored in a dry place at room temperature between 15° and 30 °C.

AVAILABILITY OF DOSAGE FORMS

RAN-CITALOPRAM (citalopram hydrobromide) is available as film-coated, white tablets.

20 mg tablets: White colour, oval, biconvex film-coated tablet with bisect on one side and rph 285X on the other side. Available in bottles of 100 tablets and in blister packages of 30 tablets.

40 mg tablets: White colour, oval biconvex film-coated tablet with bisect on one side and rph 285Y on the other side. Available in bottles of 100 tablets and in blister packages of 30 tablets.

INFORMATION FOR THE PATIENT

Please read this information before you start to take your medicine. Keep the leaflet while you are taking **RAN-CITALOPRAM** (citalopram hydrobromide); you may want to read it again. This leaflet does not contain all the information about this medicine. **For further information or advice please see your doctor or pharmacist.**

Always keep medicines out of the reach of children.

What you should know about RAN-CITALOPRAM?

RAN-CITALOPRAM belongs to the family of medicines called SSRIs (Selective Serotonin Reuptake Inhibitors).

RAN-CITALOPRAM has been prescribed to you by your doctor to relieve your symptoms of depression. **Treatment with these types of medications is most safe and effective when you and your doctor have good communication about how you are feeling.**

What you should tell your doctor before taking RAN-CITALOPRAM.

- All your medical conditions, including heart problems, history of seizures, liver or kidney disease, diabetes, bleeding disorders.
- Any medications (prescription or non-prescription) which you are taking or have taken within the last 14 days, especially a monoamine oxidase inhibitor (e.g., phenelzine, tranylcypromine, moclobemide or selegiline), or any other antidepressant, lithium, tryptophan, or cimetidine, as well as any herbal product such as St. John's Wort, which may interact with citalopram hydrobromide.
- If you ever had an allergic reaction to any medication.
- If you are pregnant or thinking of becoming pregnant, or if you are breast feeding.
- Your habits of alcohol consumption.

When not to use RAN-CITALOPRAM.

- You should not be taking **RAN-CITALOPRAM** if you are pregnant or breast feeding.

- Do not take **RAN-CITALOPRAM** if you are allergic to it, or to any of the components of its formulation (for list of components see the section on “What does **RAN-CITALOPRAM** contain”).
- Stop taking **RAN-CITALOPRAM** and contact your doctor immediately if you experience an allergic reaction or any severe side effect.

How to take RAN-CITALOPRAM.

- It is important that you take **RAN-CITALOPRAM** exactly as your doctor has instructed.
- Usually your doctor will prescribe 20 mg per day, which you will take as a single dose either in the morning or in the evening. This dose may be increased. Never change the dose of **RAN-CITALOPRAM** unless your doctor tells you to.
- You should continue to take **RAN-CITALOPRAM** even if you do not feel better, as it may take several weeks for your medication to work. Improvement may be gradual.
- Continue to take **RAN-CITALOPRAM** for as long as your doctor recommends it. Do not stop taking your tablets even if you begin to feel better, unless you are told to do so by your doctor. Your doctor may tell you to continue to take **RAN-CITALOPRAM** for several months. Continue to follow your doctor’s instructions.
- Swallow the tablets whole with a drink of water. Do not chew them. **RAN-CITALOPRAM** can be taken with or without food.
- If you miss a dose, do not worry. Do not take the missed tablet(s) - just take the next dose when it is due.

Precautions when taking RAN-CITALOPRAM.

- **RAN-CITALOPRAM** may cause unwanted effects (side-effects). These may include nausea, dry mouth, increased sweating, tremor, diarrhea and sexual problems. Other effects may include dizziness and sleep disturbance.
- **Particularly in the first few weeks or when doses are adjusted, a small number of patients taking drugs of this type may feel worse instead of better; for example, they may experience unusual feelings of agitation, hostility or anxiety, or have impulsive or disturbing thoughts such as thoughts of self-**

harm or harm to others. Should this happen to you, consult your doctor immediately; do not discontinue your medication on your own.

- Contact your doctor before stopping or reducing your dosage of **RAN-CITALOPRAM**. Symptoms such as dizziness, abnormal dreams, electric shock sensations, agitation, anxiety, emotional indifference, difficulty concentrating, headache, migraine, tremor (shakiness), nausea, vomiting, sweating or other symptoms may occur after stopping or reducing the dosage of **RAN-CITALOPRAM**. Such symptoms may also occur if a dose is missed. These symptoms usually disappear without needing treatment. Tell your doctor immediately if you have these or any other symptoms. Your doctor may adjust the dosage of **RAN-CITALOPRAM** to reduce the symptoms.
- Side-effects are often mild and may disappear after a few days. If they are troublesome or persistent, or if you develop any other unusual side-effects while taking **RAN-CITALOPRAM**, please consult your doctor.
- Usually **RAN-CITALOPRAM** does not affect patients' ability to carry out normal daily activities. However, you should not drive a car or operate machinery until you are reasonably certain that **RAN-CITALOPRAM** does not affect you adversely.
- Avoid drinking alcohol while taking **RAN-CITALOPRAM**.

What to do in case of overdose.

If you have accidentally taken too much **RAN-CITALOPRAM** contact your doctor or nearest hospital emergency department immediately, even if you do not feel sick. If you go to the doctor or the hospital, take the **RAN-CITALOPRAM** container with you.

What does RAN-CITALOPRAM contain.

RAN-CITALOPRAM (citalopram hydrobromide) is available as white 20 mg or 40 mg tablets. Citalopram is the active ingredient. The non-medicinal ingredients in the tablets are: Colloidal Silicon Dioxide, Croscarmellose Sodium, Hydroxypropyl Methylcellulose, Lactose Monohydrate, Magnesium stearate, Microcrystalline Cellulose, Polydextrose, Polyethylene Glycol, Titanium Dioxide, and Triacetin.

How to store RAN-CITALOPRAM.

- As with all medicines, keep **RAN-CITALOPRAM** out of the reach of children. Store your tablets at room temperature (15°-30°C) in a dry place.
- Keep the container tightly closed.
- If your doctor tells you to stop taking your medicine you should return any left-over tablets to the pharmacist, unless the doctor tells you to keep them at home.

Who manufactures RAN-CITALOPRAM.

Ranbaxy Pharmaceuticals Canada Inc.
2350 Skymark Avenue, Suite 701
Mississauga, ON
L4W 5A4

REMEMBER: This medicine is for YOU. Only a doctor can prescribe it, so never offer it to any other person, even if their symptoms seem to be the same as yours.

PHARMACOLOGY

Citalopram is a racemic mixture with the S (+) enantiomer mediating the pharmacological effects. The R (-) enantiomer contributes little to the activity of citalopram .

In vitro Experiments

(a) Neuronal reuptake of serotonin, norepinephrine and dopamine

The primary pharmacological effects of citalopram is inhibition of the 5-HT reuptake mechanism. Citalopram was shown to inhibit 5-HT uptake in rabbit blood platelets, with an IC_{50} of 14 nM. Similarly, the drug inhibits 5-HT uptake in rat brain synaptosomal preparations.

Uptake of 3H Amines into Rat Brain Synaptosomes

IC_{50} nM

	5-HT	NE	DA	NE/5-HT
citalopram	1.8	8800	41 000	4889
demethylcitalopram	7.4	780	26 000	105
didemethylcitalopram	24	1500	12 000	63
citalopram-N-oxide	56	3200	>100 000	57

The data indicate that citalopram is a potent and specific 5-HT uptake inhibitor with no activity on the neuronal reuptake of norepinephrine (NE) or dopamine (DA). The metabolites of citalopram are also specific inhibitors of 5-HT reuptake, albeit less active than the parent drug.

The ratio between the concentrations inhibiting the *in vitro* uptake of NE and 5-HT determine the selectivity of a SSRI. According to this criterion citalopram is a highly selective SSRI.

(b) Effect on neurotransmitter receptors

Citalopram has no or very low affinity for a series of receptors including 5-HT_{1A}, 5-HT₂, dopamine D₁ and D₂ receptors, α_1 -, α_2 -, β -adrenoreceptors, histamine H₁, muscarinic cholinergic, benzodiazepine, and opioid receptors.

A series of functional *in vitro* tests in isolated organs as well as functional *in vivo* tests have confirmed the lack of receptor affinity.

Behavioral Effects

In a 'behavioral despair paradigm', mice, trained to swim in a glass jar, eventually exhibit immobility. This behavior was dose-dependently reversed by citalopram.

The 5-HT precursors, tryptophan and 5-HTP, induce in mice and rats the 5-HT syndrome, characterized by tremor, hyperactivity, abnormal gait, lordosis, and abduction of the hind limbs. Citalopram potentiated these behavioral manifestations. The demethyl, didemethyl, and N-oxide metabolites were less potent than the parent drug.

The characteristic head twitches, induced by a combined treatment with a MAOI and 5-HTP, were potentiated by citalopram. However, head twitches induced by quipazine, a direct 5-HT mimetic, were not affected by citalopram, indicating that the drug has no anti-5-HT activity.

Although citalopram has no antinociceptive activity *per se*, it potentiated the antinociceptive effect of morphine.

In a food reinforcement paradigm, delivered under a multiple schedule, citalopram did not affect the responding in pigeons but potentiated the 5-HTP-induced decrease in responding.

In rats, citalopram did not facilitate self-stimulation, did not substitute for d-amphetamine, d-LSD, or 8-OHDPAT in a drug discrimination paradigm and did not increase ethanol consumption in an ethanol/water preference test. In the latter experiment, citalopram

actually decreased ethanol consumption. These experiments indicate that citalopram would not be abused and would not cause dependence.

Citalopram had a slight protective effect against maximal electroshock-induced convulsions, isoniazide-induced convulsions and audiogenic seizure. However, in toxicity studies convulsions have been observed at very high plasma levels of citalopram (see TOXICOLOGY).

Cardiovascular Effects

In conscious dogs, single oral doses of 5 mg/kg of citalopram caused pronounced fluctuation of the blood pressure and heart rate. A 10 mg/kg dose caused tachycardia and elevated blood pressure. The ECG was unchanged.

In anaesthetized cats, single oral doses of 35 mg/kg decreased the following parameters: mean arterial blood pressure, left ventricular end diastolic pressure, contractility, cardiac performance, stroke volume, and cardiac output. Peripheral resistance was increased. ECG abnormalities included alterations in conduction, changes in rhythm and T-wave inversion in 2 of 6 cats.

Additional cardiovascular effects of citalopram and a metabolite are described under TOXICOLOGY.

PHARMACOKINETICS

Absorption

The kinetics of citalopram in mouse, rat, and dog are characterized by rapid absorption, with T_{max} ranging from 0.5 to 4 hours. In contrast to man, reduced systemic bioavailability due to extensive first-pass metabolism has been demonstrated in animals.

Distribution

Pharmacokinetic analysis of single dose i.v. data suggests two-compartment distribution characteristics. High levels of drug and demethylated metabolites were found in the lungs, liver, and kidneys, and lower levels in the heart and brain. Citalopram and the demethylated metabolites were shown to pass the placental barrier and were excreted in small amounts in milk.

The plasma protein binding of citalopram has been estimated to be 70-80%. The binding protein(s) has not been identified.

Both in mice and dogs, tissue concentrations of parent drug as well as those of the demethylated metabolites increased with increasing doses, although not necessarily in a dose-related manner. Levels of the didemethylated metabolites were higher in dogs than in mice in relation to the parent drug, resulting in smaller citalopram/ didemethylcitalopram ratios in the dog, particularly in the heart and kidneys.

Metabolism

There are no major qualitative differences in the metabolism of citalopram between animals and man. Citalopram is metabolized to demethylcitalopram, didemethylcitalopram, citalopram-N-oxide, and the deaminated propionic acid.

Demethylcitalopram and didemethylcitalopram levels are more prominent in mouse, rat and dog than in man.

Elimination

Elimination of citalopram after a single dose is rapid, the half-life ranging from 1.5-2 hours in the mouse to 3.5-8 hours in the dog. In the dog, the half-life is prolonged with increasing doses due to saturation of the first-pass metabolism.

Following the administration of ¹⁴C-labelled citalopram to rats, at a dose of 20 mg/kg, approximately equal amounts of the dose were excreted in the urine and feces, with total recovery being about 80%.

Toxicokinetics

Plasma levels were determined in several long-term toxicity studies. The table below summarizes the results seen in some of these studies.

Species	Study	Dose mg/kg	CT^a ng/mL	DCT^b ng/mL	DDCT^c ng/mL
Rat^d	12-month tox po (diet)	32	male 330 female 334	474391	246204
		60	male 690 female 826	989862	497290
		120	male 1163 female 1286	19471655	758577
Dog^e	12-month tox po (in capsules)	1	19	22	95
		3	350	170	314
		8	1218	586	574
Man	multiple dose po 6 week	0.3	39	13	3.7
		0.6	83	28	5.2
		0.9	121	41	6.3

a: citalopram; b: demethylcitalopram; c: didemethylcitalopram; d: average value at Week 52; e: 2 hours post dose - Week 52 (1 and 3 mg/kg dose groups), Week 57 (8 mg/kg dose group).

The data indicate that the plasma levels of citalopram, as well as those of the demethylated metabolites, are considerably higher in animals than in man. The approximate 0.9 mg/kg

dose in man corresponds to the highest recommended dose (60 mg/day). The plasma levels of the parent drug, seen in rats and dogs at the highest doses, are approximately 10 times higher in animals than in man, while the levels of didemethyl metabolites are almost 100 fold higher. In the rat, a NOEL (no observable effect level) could not be established in this study; at the low dose minimal vacuolization of hepatocytes with fatty infiltration, and foam cell accumulation in lung were noted. The changes were reversible. In dogs, the NOEL was 3 mg/kg.

TOXICOLOGY

Acute Toxicity

The LD₅₀ values of citalopram ranged between 900-1700 mg/kg after oral administration and 38-74 mg/kg after intravenous administration. However, some mortality was also seen in the 400-600 mg/kg dose range, indicating a very flat dose-response curve regarding mortality. Signs of toxicity were sedation and tremor, while convulsions occurred at doses close to or above the LD₅₀ values.

LD₅₀ Values in the Mouse and Rat (mg/kg body weight)

Species	Sex	i.v.	p.o.	i.p.	s.c.	i.m.
Mouse	Male	72 ± 9	1140 ± 190	220 ± 9	534 ± 71	> 400
	Female	74 ± 10	900 ± 120	207 ± 20	-	-
Rat	Male	40 ± 4	1710 ± 292	157 ± 27	1950 ± 364	> 400
	Female	38 ± 7	1426 ± 554	133 ± 17	-	-

A number of single dose toxicity studies have been carried out in dogs to investigate the potential cardiovascular toxicity of citalopram. In these studies, cardiotoxicity was not observed, but tonic-clonic convulsions were seen after oral administration of 20-40 mg/kg, as well as after slow intravenous infusion of 20-24 mg/kg. The critical plasma concentration for convulsions was about 1950 ng/mL.

Long-term Toxicity

Toxicological studies, including daily dosing for periods up to 26 weeks in mice and 52 weeks in rats and dogs, have been carried out. Plasma drug monitoring in the long-term safety studies documented that animals have been exposed to average citalopram levels of up to about 1200 ng/mL (dogs and rats) and 2900 ng/mL (mice), as well as substantial levels of demethylcitalopram [up to about 1800 ng/mL (rats), 600 ng/mL (dogs), 1150 ng/mL (mice)] and didemethylcitalopram [up to about 650 ng/mL (rats), 600 ng/mL (dogs), 300 ng/mL (mice)].

Apart from behavioral and functional characteristics of exaggerated 5-HT stimulation (e.g., hyperactivity, tremor, tail rigidity, mydriasis, reduced food consumption, and reduced body weight gain), two treatment-related findings have been demonstrated in rodents, namely fatty infiltration of the liver and lipidosis (vacuolization of lymphocytes). Both of the findings were reversible. In addition, retinal degeneration and testicular atrophy were also observed in rats.

In dogs, two treatment-related effects were found. Firstly, convulsions and death when plasma citalopram levels exceeded 1950 ng/mL (p.o. or i.v.). Secondly, fatal ventricular arrhythmias at combined high levels of the didemethyl metabolite (about 300 ng/mL) and citalopram (about 1950 ng/mL) were seen following i.v. infusion.

Hepatic Fatty Infiltration in Rodents

Fatty infiltration in the liver was first observed in a 3-month gavage study in rats given 8-32 mg/kg/day of citalopram. This administration resulted in dose-related hepatic fatty infiltration in all male rats but not in female rats at any of the doses. The fatty infiltration in male rats was also observed in a 4-week study, however, only at considerably higher doses (>160 mg/kg). In female rats only minimal fatty infiltration was seen at a 200 mg/kg/day dose.

Lipidosis (phospholipids) in Rodents

Phospholipidosis, which has been seen in rodents, is an abnormal accumulation of phospholipids in phagocytic cells and cells which catabolize biomembranes, such as pulmonary alveolar macrophages and circulating leucocytes (especially lymphocytes).

Phospholipidosis developed in rats receiving citalopram at daily doses of 120 mg/kg and slight vacuolization of peripheral lymphocytes was observed in mice at daily doses of 100 mg/kg, in the 52-week and 26-week studies, respectively. Both conditions were reversible within 3-4 weeks.

Retinal Degeneration/Atrophy in Rats

In the rat carcinogenicity study, a slight, dose-related increase in lens opacity was seen, affecting males only. In addition, increased incidence/severity of retinal degeneration/atrophy was seen in the high-dose group (80 mg/kg/day). The incidence was higher in females, however, more female than male rats survived the study. It was concluded by an independent pathologist that the retinal changes were most likely related to drug-induced pupillary dilatation (mydriasis) which increased the risk of retinal damage in the already light-sensitive albino rat.

Testicular Atrophy in Rats

In the 52-week rat toxicity study, testicular atrophy was seen at the 60 and 120 mg/kg/day doses of citalopram.

Convulsions and Death in Dogs

Toxicity studies in dogs revealed that citalopram administration led to fatal ventricular arrhythmias. Consequently, studies were undertaken to elucidate the mechanism of this effect and to determine its relevance to humans.

The studies have shown that (1) i.v. infusion of citalopram, at a dose of 20 mg/kg, led to convulsions. The blood levels of citalopram were 1950 ng/mL at this dose. In the presence of diazepam, also infused intravenously, higher doses of citalopram could be infused, namely up to 70 mg/kg (6800 ng/mL). (2) Intravenous infusion of the didemethyl metabolite of citalopram caused QT prolongation in a dose range of 5 to 22 mg/kg. The blood levels of the metabolite were 300 ng/mL at the 5 mg/kg dose. The QT prolongation was dose-dependent. (3) When citalopram, 20 mg/kg, and didemethylcitalopram, 5 mg/kg, were infused concomitantly (in the presence of diazepam in order to prevent convulsions), 5 out of 9 dogs died due to ventricular fibrillation. At these doses, the plasma levels of citalopram and didemethylcitalopram were 1950 ng/mL and 300 ng/mL, respectively.

As shown in the table below, there is a substantial difference in the plasma levels of citalopram and its metabolite in dogs and in humans at the recommended therapeutic doses.

Treatment	Dog ventricular fibrillation	Patients at steady state after a 60 mg/day dose of citalopram
citalopram, 20 mg/kg plus didemethylcitalopram, 5 mg/kg	1950 ng/mL 300 ng/mL	121 ng/mL 6.3 ng/mL

Reproduction Studies

Citalopram did not affect the reproductive performance of rats at dosages up to 16 mg/kg/day (males) and 32 mg/kg/day (females).

In the teratology studies in rats, effects were observed in the conceptuses at dosages that were toxic to the dams. Minimal developmental toxicity was evident at 32 mg/kg/day: manifested as low incidences of resorptions, slightly reduced fetal and pup weights, and small reversible delays in ossifications and postnatal development.

In rabbits, dosage of 4.8 mg/kg/day and above were toxic to the dams, and 16 mg/kg/day and above caused deaths. There were no effects on embryo-fetal development at the highest dose that could be assessed (16 mg/kg/day).

Mutagenic Potential

Citalopram did not have mutagenic activity in most of the *in vitro* tests (Ames Salmonella assay; chromosome aberration assay in cultured human lymphocytes; gene mutation assay in cultured mouse lymphoma L5178Y) and *in vivo* tests (micronucleus test; unscheduled DNA synthesis). However, citalopram was mutagenic in some *in vitro* studies (Ames Salmonella assay and Chinese hamster lung cell assay).

Carcinogenicity

Citalopram did not show any carcinogenic potential in mice at daily doses of 40-240 mg/kg (1.5 years) and in rats at 8-80 mg/kg (2 years). There was an increased incidence of small intestine carcinoma in rats treated with 8 and 24 mg/kg/day of citalopram but not in rats treated with an 80 mg/kg/day dose.

BIBLIOGRAPHY

1. Ahlfors UG, Elovaara S, Harma P, *et al.* Clinical multicentre study of citalopram compared double-blindly with mianserin in depressed patients in Finland. *Nord Psykiatr Tidsskr* 1988; 42(3): 201-210.
2. Anderson J, Bech P, Benjaminsen S, *et al.* Citalopram: clinical effect profile in comparison with clomipramine. A controlled multicentre study. *Psychopharmacology* 1986; 90: 131-138.
3. Baldwin D, Johnson FN. Tolerability and safety of citalopram. *Rev Contemp Pharmacother* 1995; 6: 315-325.
4. Baumann P. Pharmacokinetic-pharmacodynamic relationship of the selective serotonin reuptake inhibitors. *Clin Pharmacokinet* 1996; 31(6): 444-469.
5. Baumann P, Souche A, Montaldi S, *et al.* A double-blind, placebo-controlled study of citalopram with and without lithium in the treatment of therapy-resistant depressive patients: a clinical, pharmacokinetic, and pharmacogenetic investigation. *J Clin Psychopharmacol* 1996; 16(4): 307-314.
6. Bertilsson L, Dahl M-L. Polymorphic drug oxidation: Relevance to the treatment of psychiatric disorder. *CNS Drug* 1996; 5(3): 200-223.
7. Bouchard JM, Delaunay J, Delisle JP, *et al.* Citalopram versus maprotiline: a controlled clinical multicentre trial in depressed patients. *Acta psychiatr scand* 1987; 76: 583-592.
8. Christensen P, Thomsen HY, Pedersen OL, *et al.* Orthostatic side effects of clomipramine and citalopram during treatment for depression. *Psychopharmacology* 1985; 86: 383-385.
9. de Wilde J, Mertens C, Overø KF, *et al.* Citalopram versus mianserin. A controlled, double-blind trial in depressed patients. *Acta psychiatr scand* 1985; 72: 89-96.
10. Fuglum E, Rosenberg C, Damsbo N, *et al.* Screening and treating depressed patients. A comparison of two controlled citalopram trials across treatment settings: hospitalized patients vs. patients treated by their family doctors. *Acta Psychiatr Scand* 1996; 94(1): 18-25.
11. Gottfries CG. Scandinavian experience with citalopram in the elderly. *Int Clin Psychopharmacol* 1996; 11 (Suppl 1): 41-44.

12. Gravem A, Amthor KF, Astrup C, et al. A double-blinded comparison of citalopram (Lu 10-171) and amitriptyline in depressed patients. *Acta psychiatr scand* 1987; 75: 478-486.
13. Greenblatt DJ, von Moltke LL, Harmatz JS, et al. Drug interactions with newer antidepressants: Role of human cytochromes P450. *J Clin Psychiatry* 1998; 59 (Suppl 15): 19-27.
14. Haffmans PMJ, Timmerman L, Hoogduin CAL, et al. Efficacy and tolerability of citalopram in comparison with fluvoxamine in depressed outpatients: a double-blinded multicentre study. *Int Clin Psychopharmacol* 1996; 11(3): 157-164.
15. Hyttel J, Arnt J, Sánchez C. The pharmacology of citalopram. *Rev Contemp Pharmacother* 1995; 6: 271-285.
16. Jeppesen U, Gram LF, Vistisen K, et al. Dose-dependent inhibition of CYP1A2, CYP2C19 and CYP2D6 by citalopram, fluoxetine, fluvoxamine and paroxetine. *Eur J Clin Pharmacol* 1996; 51 (1): 73-78.
17. Mertens C. Citalopram versus mianserin: a controlled double-blind trial in depressed patients. In: Montgomery SA, ed. *Citalopram - The New Antidepressant from Lundbeck Research*. Proceedings of a Symposium, Aug 11, 1988 (XXII Nord Psykiater-Kongres, Aug. 10-13, 1988). *Excerpta, Amsterdam*, 1989;50-55.
18. Møller SE, de Beurs P, Timmerman L, et al. Plasma tryptophan and tyrosine ratios to competing amino acids in relation to antidepressant response to citalopram and maprotiline. A preliminary study. *Psychopharmacology* 1986; 88: 96-100.
19. Montgomery SA, Rasmussen JGC, Lyby K, et al. Dose response relationship of citalopram 20 mg, citalopram 40 mg and placebo in the treatment of moderate and severe depression. *Int Clin Psychopharmacol* 1992; 6(Suppl 5): 65-70.
20. Montgomery SA, Rasmussen JGC. Citalopram 20 mg, citalopram 40 mg and placebo in the prevention of relapse of major depression. *Int Clin Psychopharmacol* 1993; 8: 181-188.
21. Montgomery SA, Pedersen V, Tanghøj, et al. The optimal dosing regimen for citalopram - a meta-analysis of nine placebo-controlled studies. *Int Clin Psychopharmacol* 1994; 9(Suppl 1): 35-40.
22. Montgomery SA, Pedersen V, Tanghøj, et al. The optimal dosing regimen for citalopram - a meta-analysis of non placebo-controlled studies. *Int Clin Psychopharmacol* 1994; 9(Suppl 1): 35-40.

23. Muldoon C. The safety and tolerability of citalopram. *Int Clin Psychopharmacol* 1996; 11(Suppl 1): 35-40.
24. Neuvonen PJ, Pohjola-Sintonen S, Tacke U, et al. Five fatal cases of serotonin syndrome after moclobemide-citalopram or moclobemide-clomipramine overdoses. *Lancet* 1993; 342: 1419.
25. Nyth AL, Gottfries CG, LYBY K, et al. A controlled multicenter clinical study of citalopram and placebo in elderly depressed patients with and without concomitant dementia. *Acta psychiatr scand* 1992; 86: 138-145.
26. Östrom M, Eriksson A, Thorson J, et al. Fatal overdose with citalopram. *Lancet* 1996; 348: 339-340.
27. Patris M, Bouchard J-M, Bougerol T, et al. Citalopram versus fluoxetine: A double-blind, controlled, multicentre, phase III trial in patients with unipolar major depression treated in general practice. *Int Clin Psychopharmacol* 1996; 11(2): 129-136.
28. Priskorn M, Sidhu JS, Larsen F, et al. Investigation of multiple dose citalopram on the pharmacokinetics and pharmacodynamics of racemic warfarin. *Br J Clin Pharmacol* 1997; 44: 199-202.
29. Robert PH, Montgomery SA. Citalopram in doses of 20-40 mg is effective in depression relapse prevention: a placebo-controlled 6 month study. *Int Clin Psychopharmacol* 1995; 10(Suppl 1): 29-35.
30. Rochat B, Amey M, Baumann P. Identification of cytochrome P450 isozymes involved in N-demethylation of citalopram in human microsomes. *Experientia* 1996; 52:A85. (Abstract)
31. Rosenberg C, Damsbo N, Fuglum E, et al. Citalopram and imipramine in the treatment of depressive patients in general practice. A Nordic multicentre clinical study. *Int Clin Psychopharmacol* 1994; 9(Suppl 1): 41-48.
32. Seifritz E, Hatzinger M, Müller MJ, et al. Hair loss associated with fluoxetine but not with citalopram. *Can J Psychiatry* 1995; 40(6): 362. (Letter to the Editor)
33. Shaw DM, Crimmins R. A multicenter trial of citalopram and amitriptyline in major depressive illness. In: Montgomery SA, ed. *Citalopram, The New Antidepressant from Lundbeck Research. Proceedings of a Symposium, August 11, 1988 (XXII Nord Psykiater-Kongres, August 10-13, 1988)*. Excerpta Medica, Amsterdam 1989; 43-49.

34. Skjelbo E, Brøsen K. Inhibitors of imipramine metabolism by human liver microsomes. *Br J Clin Pharmacol* 1992; 34: 256-261.
35. Timmerman L, de Beurs P, Tan BK, et al. A double-blind comparative clinical trial of citalopram vs maprotiline in hospitalized depressed patients. *In Clin Psychopharmacol* 1987; 2: 239-253.
36. Timmerman L, Haffmans PMJ, Hoogduin CAL, et al. Citalopram in major depression: a comparative study with fluvoxamine, preliminary results. *In: Beigel A, Lopez Ibor JJ, Costa e Silva JA, eds. Past, Present and Future of Psychiatry, IX World Congress of Psychiatry, Volume II, Rio De Janiero, Brazil, June 6-12, 1993. World Scientific, London, 1994; 982-986.*
37. Von Moltke L.L. *et al.* Citalopram and desmethylcitalopram in vitro: human cytochromes mediating transformation, and cytochrome inhibitory effects. *Biol Psychiatry* 1999; 46 (6): 839-849
38. Product Monograph, Celexa® (citalopram hydrobromide) Tablets, Lundbeck Canada Inc., Date of Revision: September 10, 2003.
39. Comparative bioavailability study, ratiopharm inc., on file.