Milnacipran undergoes minimal CYP450 related metabolism, with the majority of metabolism occurring through Phase II conjugation reactions. The excretion of unchanged milnacipran is less than 1% of the dose. In several animal studies, milnacipran was found not to be mutagenic. In in vitro studies, milnacipran was negative for clastogenic and for a SCE response. In rats and in vivo studies showed that milnacipran is unlikely to be involved in clinically significant pharmacologic drug interactions. No effective methods for detection of milnacipran in urine are available. Several studies have been carried out to investigate the potential for milnacipran to interact with other drugs. In vitro Using the isolated perfused rat lung technique, it was shown that milnacipran did not produce any measurable changes in airway resistance. In vivo No clinical studies have been conducted with milnacipran and other CNS-active drugs; therefore, it is not possible to reliably estimate their frequency or establish a causal relationship to drug exposure. These events include Blood and Lymphatic System Disorders: anemia, leukopenia, lymphopenia, neutropenia, thrombocytopenia. Cardiac Disorders: supraventricular tachycardia. Eye Disorders: accommodation disorder; Enterohepatic Disorders: constipation; Endocrine Disorders: hyperprolactinemia; Hematopoietic and Lymphatic Disorders: anemia; Hematopoietic Neoplasms: myelodysplastic syndrome. Laboratory abnormalities may be associated with changes in hematologic and serum transaminase enzymes, which are consistent with adverse hematologic effects. Postural hypotension and tachycardia have been reported in patients with hypertension treated with milnacipran. Given the limited data on the SSRI effects of milnacipran on serotonin reuptake inhibitors late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon birth or within several days of birth and may include respiratory distress syndrome, hyperbilirubinemia, seizures, apnea, hypotension, temperature instability, feeding difficulty, vomiting, hypertension, hypotension, hypothermia, tachypnea, tachycardia, and hyperactivity. Management of marijuana exposure in infants includes supportive care and specific treatment (such as with cyproheptadine and/or temperature control) may be considered. In case of overdose, the patient should be monitored carefully and ventilatory, respiratory, and circulatory support should be provided. Induction of emesis is not recommended. Gastric lavage with activated charcoal and cathartic should be considered. In cases of severe exposure, administration of charcoal and cathartic should be considered. In cases of severe exposure, administration of charcoal and cathartic should be considered. In cases of severe exposure, administration of charcoal and cathartic should be considered. In cases of severe exposure, administration of charcoal and cathartic should be considered. In cases of severe exposure, administration of charcoal and cathartic should be considered.

**Disclaimers:**

Dr. Calabrese disclosed serving as a paid consultant to Genentech, Reche, Argem Inc., Centocor Inc., UCB Pharma Inc., Sanofi-Aventis, and Wyeth.

**References:**

- Forest Pharmaceuticals, Inc.
- Licensed from Pierre Fabre Medicaments and Cypress Bioscience, Inc.
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