Updated September 2026

Sertraline

Brand name - Zoloft. *Oral adult dosing for major depressive disorder*

Sertraline is a selective serotonin reuptake inhibitor (SSRI). Its therapeutic mechanism is thought to be related to increasing serotonergic activity in the CNS by inhibiting reuptake of serotonin. It is FDA-approved for major depressive disorder (MDD), obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and social anxiety disorder, and sometimes used off-label for other anxiety disorders.

	MDD	PTSD, panic disorder, social anxiety
Initial Dose	50mg qd	25mg qd
Titration Timeline	Increase by 25-50mg/day as indicated and tolerated. Wait at least a week between dose increases.	
Usual range	50-200mg/day	
Maximum	200mg	

Prescribing Pearls

- Start with low dose, 25 mg qd, in pts with high sensitivity to meds, older age, tolerability concerns.
- **Mild hepatic impairment.** Use half the usual starting dose and therapeutic range
- Moderate or severe hepatic impairment: sertraline is not recommended
- **Assess for a history of mania/hypomania** and other bipolar-spectrum risk factors. Antidepressants may precipitate a manic, mixed, or hypomanic episode in vulnerable individuals.
- Common side effects include nausea, diarrhea, anxiety, insomnia, headache, increased sweating, decreased appetite, and sexual dysfunction.
- Transient activation/anxiety may occur early in treatment in some patients; distinguish this from worsening of the underlying anxiety disorder or emerging mania.
- Wait ≤14 days after stopping MAOI before starting sertraline. Wait ≤14 days after stopping sertraline before starting an MAOI. Review other serotonergic meds. Monitor for serotonin syndrome.
- Avoid abrupt discontinuation. Gradually taper and monitor for discontinuation symptoms like dizziness, irritability, anxiety, sensory disturbances, headache, insomnia, or mood change.

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Safety

- **Pregnancy.** Use an individualized risk-benefit assessment. Available epidemiologic studies of first-trimester sertraline exposure overall do not show a higher rate of major congenital malformations than background populations. Some studies have reported associations with specific defects, but results are inconclusive. Untreated depression and anxiety also carry maternal and perinatal risks.
- **Late-pregnancy SSRI exposure** may be associated with poor neonatal adaptation, including respiratory distress, feeding difficulty, temperature instability, abnormal muscle tone, tremor, jitteriness, irritability, and other symptoms. Some infants may require respiratory support, tube feeding, or prolonged hospitalization. SSRI exposure later in pregnancy has also been associated with persistent pulmonary hypertension of the newborn (PPHN).
- SSRI exposure, particularly near delivery, has also been associated with a modest increase in **postpartum hemorrhage risk**.
- **Lactation.** Sertraline and its metabolites are present at low levels in human milk. A small sample of breastfed infants had low serum levels, and no adverse reactions were reported in that sample. Consider the maternal need for treatment, benefits of breastfeeding, and the infant's clinical status. Monitor the breastfed infant clinically for feeding difficulty, excessive sleepiness, irritability, or poor weight gain when concerns arise.
- Monitor for clinical worsening, unusual behavioral changes, and suicidal thoughts, particularly in young adults and around treatment changes.
- **Bleeding risk.** SSRIs may increase bleeding risk, particularly with NSAIDs, aspirin, antiplatelet therapy, or anticoagulants.
- May cause hyponatremia, particularly in older adults, patients taking diuretics, or volume-depleted patients.
- **QT risk.** Use additional caution in patients with clinically important QT-prolongation risk, electrolyte abnormalities, significant cardiac disease, or other QT-prolonging medications.

Disclaimer

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