Avon & Wiltshire Mental Health Partnership NHS Trust (AWP), BaNES, Swindon & Wiltshire (BSW) CCG and Bristol, North Somerset & South Gloucestershire (BNSSG) CCG

SHARED CARE AGREEMENT

Lithium for Mania/Bipolar Affective Disorder/Aggressive or self-harming behaviour/Recurrent Depression (incl. antidepressant augmentation) – Adults

Amber TLS – 3 Months

Principles of Shared Care

Shared care agreements provide a framework for the seamless transfer of care from a hospital or specialist service setting to general practice, where this is appropriate and in the patient's best interest. When a specialist considers a patient's condition to be stable or predictable, they may seek the agreement of the GP (or other primary care prescriber) concerned and the patient to share their care.

Patients and/or carers must be centrally involved in any decision-making process. They should be supported by good quality information that helps them to both come to an informed decision about engagement in a shared care arrangement and sets out the practical arrangements for ongoing supplies of medicines.

The existence of a shared care agreement does not necessarily mean that the GP has to agree to and accept clinical and legal responsibility for prescribing; they should only do so if they feel clinically confident in managing that condition. Clinical responsibility for prescribing is held by the person signing the prescription, who must also ensure adequate monitoring.

Responsibilities of Secondary Care Specialist (DO NOT EDIT)

- Initiate treatment and prescribe for the length of time agreed (3 months) – this should be a sufficient amount of time to allow optimisation of treatment and demonstrate that the patient's response is consistent.
- Discuss the benefits and side effects of treatment with the patient.
- Review concurrent medications for potential interactions prior to initiation.
- Undertake the clinical assessment and relevant monitoring at baseline and during the initiation period.
- Communicate details of treatment to GP (in writing or via secure email) within the first month of treatment and ask the GP whether he or she is willing to participate in shared care.
- Discuss shared care arrangements with the patient/carer, obtain their consent and explain their responsibilities.
- Review the patient's condition and monitor response to treatment regularly where indicated.
- Inform the GP after each clinic attendance if there is any change to treatment or monitoring.
- Supply GP with clinic letter or discharge summary within 14 days of an outpatient review or inpatient admission, and inform GP if patient does not attend scheduled clinic appointments.
- Ensure that clear arrangements exist for GPs to obtain advice and support.
- Report adverse events to the MHRA via the Yellow Card scheme.
- Stop treatment where appropriate or provide GP with advice on when to stop.

Responsibilities of GP/Primary Care Prescriber (DO NOT EDIT)

- Reply to the request as soon as practicable if they are unable to support shared care (in writing or via secure email)
- Prescribe medicine at the dose recommended after the initiation period (3 months).
- Undertake ongoing clinical assessment and relevant monitoring following initiation period.
- Review any new concurrent medications for potential interactions.
- Refer promptly to specialist when any loss of clinical efficacy is suspected (e.g. worsening of disease-related symptoms, new symptoms suggestive of disease recurrence or progression) or intolerance to therapy occurs.
- Report to and seek advice from the specialist on any aspect of patient care that is of concern and may affect treatment.
- Report adverse events to the specialist and the MHRA via the Yellow Card scheme.
- Stop treatment on the advice of the specialist.

Responsibilities of Patient/Carer (DO NOT EDIT)

- Report to the specialist or GP if he or she does not have a clear understanding of the treatment.
- Share any concerns in relation to treatment with medicine.
- Report any adverse effects to the specialist or GP whilst taking the medicine.

• Attend appointments for clinical review and monitoring.	
1. Summary of condition and treatment aims Include links to relevant clinical guidelines e.g. NICE	Treatment with lithium aims to control symptoms and prevent relapse in patients with the following conditions. • Treatment and prophylaxis of mania or hypomania • Treatment and prophylaxis of bipolar disorder • Treatment and prophylaxis of recurrent depression where treatment with other antidepressants has been unsuccessful. • Treatment and prophylaxis of aggressive or self-harming behaviour • Management of recurrent depression as augmentation of antidepressants [unlicensed indication] Lithium has been shown to reduce the severity and duration of episodes in bipolar disorder, increase the length of time between episodes and reduce the risk of suicide and premature mortality. Lithium should only be offered to patients who are motivated to take it regularly for at least one year. Failing that, the benefits of taking it may be outweighed by the costs of an increased relapse rate on abrupt discontinuation. Lithium has a narrow therapeutic window and is toxic in overdose. Patients require regular blood tests to check lithium levels as well as to monitor renal, thyroid and parathyroid function. Patients who can not comply with blood tests or are likely to take impulsive or planned overdoses should not be prescribed lithium. Treatment with lithium aims to maintain a plasma lithium level between 0.6-0.8mmol/L for most patients. National Institute for Health & Care Excellence. Bipolar disorder: assessment and management. Clinical Guideline [CG 185], 2014, updated Feb 2020 https://www.nice.org.uk/guidance/cg185 National Institute for Health & Care Excellence. Depression in adults: recognition and management Clinical guideline [CG90] Published date: 28 October 2009 https://www.nice.org.uk/guidance/cg90
2. Details of medicine and indication Please state whether licensed or unlicensed (off-label) use. Note that shared care is generally unsuitable for off-label prescribing unless it is a widely recognised use (e.g. included in BNF)	Lithium salts are available in several different preparations and must always be prescribed by brand name because of the different bioavailability of the preparations. The preferred preparation in AWP is **Priadel®** as it allows more tailored dosing than the alternatives. Lithium salts are licensed to be used for the conditions listed in section 1, apart from for the management of recurrent depression as augmentation of antidepressants, which is an unlicensed use. **Priadel®** (lithium carbonate) 200mg modified-release tablets 400mg modified-release tablets Tablets are scored, can be broken in half to aid dose adjustment **Priadel® liquid** (lithium citrate 520mg/5ml oral syrup) **Lithium citrate 520mg is equivalent to lithium carbonate 204mg** **Li-Liquid®** (lithium citrate) **NB two strengths available** Lithium citrate tetrahydrate 509mg/5ml oral syrup Lithium citrate tetrahydrate 1018mg/5ml oral syrup **Lithium citrate tetrahydrate 509mg is equivalent to lithium carbonate 200mg** **Other preparations available:** **Liskonum** (lithium carbonate) 450mg modified-release tablets

	Camcolit (lithium carbonate) 400mg modified-release tablets **Lithium carbonate (Essential Pharma/Alliance/AAH)** 250mg tablets	
3. Pharmaceutical aspects	Route of administration:	Oral
	Formulation:	Tablets, MR tablets or liquid
	Administration details:	Initially, lithium doses are divided throughout the day, but once daily administration is preferred when serum-lithium concentration stabilised. Lithium should be taken as a single dose at 10pm each evening to facilitate testing of plasma lithium levels 12 hours post dose (range 10-14 hours).
	Other important information:	Lithium should always be prescribed by brand name. **Priadel®** MR tablets are the preferred formulation in AWP. Patients should be maintained on the same brand during treatment and any change to brand or preparation will require close monitoring of plasma lithium levels. Particular care should be taken when changing from lithium carbonate tablets to a lithium citrate liquid as the doses are not equivalent.

4. Usual dose and frequency (including details of dose adjustments, e.g. in renal impairment) and duration of therapy

Transfer of monitoring and prescribing to Primary care is normally after the patient is on regular dose and with satisfactory investigation results.
All dose or formulation adjustments will be the responsibility of the initiating specialist unless directions have been discussed and agreed with the primary care clinician.
The duration of treatment will be determined by the specialist, based on clinical response and tolerability.
Termination of treatment will be the responsibility of the specialist.

Initiation of treatment

Preparation	Frequency and dose of administration
Priadel® MR lithium carbonate tablets Tablets can be broken in half to aid dose adjustment	**Adults (body weight up to 49kg):** Initially: 200mg once daily at 10pm. **Adults (body weight 50kg and above):** Initially: 400mg once daily at 10pm **Older Adults:** Initially: 200mg daily
Priadel® liquid Lithium citrate 520mg/5ml oral syrup **Lithium citrate 520 mg is equivalent to lithium carbonate 204 mg**	**Adult (body-weight up to 50 kg):** Initially 520 mg twice daily **Adult (body-weight 50 kg and above):** Initially 1.04g twice daily **Older Adults:** Initially 520 mg twice daily
Li-Liquid® **NB** two strengths available Lithium citrate tetrahydrate 509mg/5ml oral syrup Lithium citrate tetrahydrate 1018mg/5ml oral syrup **Lithium citrate tetrahydrate 509 mg is equivalent to lithium carbonate 200 mg**	**Adult (body-weight up to 50 kg):** Initially 509 mg daily in 2 divided doses **Adult (body-weight 50 kg and above):** Initially 1.018g daily in 2 divided doses **Older Adults:** Initially 509 mg daily in 2 divided doses
Other lithium preparations are available	**See BNF/SPC for dosage details**

Doses should then be adjusted according to the patients target plasma lithium level which will be decided and documented by the specialist initiating treatment. **Most patients will have a target lithium level of 0.6-0.8mmol/L**. A target of 0.8-1.0mmol/L may be used for patients who have had a relapse on lithium or are taking lithium and have subthreshold symptoms with functional impairments. Levels at the lower end are occasionally used for older patients and those with other risk factors.

See section 7 for further information on lithium blood monitoring results.
Duration of treatment depends on patient response and tolerability, and full benefit may not occur for 6 to 12 months. In those with a positive response treatment is likely to be long term. If planning to stop lithium therapy, dose should be reduced gradually over at least a period of four weeks (but preferably over 3 months) as per specialist advice.

Action to take if impaired renal function

Lithium is nephrotoxic and long-term treatment may result in impaired renal function (reversible or irreversible) although robust monitoring and management of plasma levels to avoid toxicity significantly reduces this risk. Any decision to stop lithium because of renal impairment should be made jointly after discussion with the renal **and** psychiatric specialist **and** the patient. A review should be prompted if:

Urea and creatinine levels become elevated, or **eGFR falls over 2 or more tests**	Assess the rate/trend of deterioration of renal function. Seek advice from renal specialist or a psychiatrist
eGFR between 25-30ml/min/1.73m^2	Seek advice from renal specialist or psychiatrist
eGFR falls by 5ml/min/1.73m^2 or more annually	Referral to renal team is indicated

5. Baseline investigations

Baseline investigations

- Weight/BMI, Urea and Electrolytes (U&Es) including calcium and eGFR, Full blood count (FBC),

<table>
<tr><td>and initial monitoring to be undertaken by specialist</td><td colspan="2">thyroid functions tests (TFTs), blood pressure (BP) and pulse, plus ECG for patients with cardiovascular disease or who have high risk factors for cardiovascular disease</td></tr>
<tr><td></td><td>Monitoring</td><td>Frequency</td></tr>
<tr><td></td><td>• Lithium levels
• Side effects/ signs of toxicity</td><td>• Weekly until stable
• At every appointment and after each dose change</td></tr>
<tr><td>6. Ongoing monitoring requirements to be undertaken by primary care</td><td>Monitoring</td><td>Frequency</td></tr>
<tr><td></td><td>• Lithium levels</td><td>• 3 monthly for the first year. After the first year monitor levels every 6 months or every 3 months for patients in the following groups:
Older people; those taking medicines which interact with lithium; at risk of impaired renal or thyroid function; raised calcium levels, have poor symptom control; have poor adherence or whose last lithium level was 0.8mmol/L or higher.

Monitoring should be carried out weekly after dose change, until similar readings are obtained at the same dose - as per specialist advice.</td></tr>
<tr><td></td><td>• U&Es (including calcium and eGFR), TFTs, weight/BMI</td><td>• 6 monthly or more frequently if impaired renal or thyroid function</td></tr>
<tr><td></td><td>• FBC, plasma lipid & glucose profile, BP, plus ECG if indicated</td><td>• Yearly</td></tr>
<tr><td></td><td>• Side effects/signs of toxicity</td><td>• At every appointment and after each dose change</td></tr>
<tr><td>7. Action(s) to be taken by primary care if abnormal result(s)</td><td colspan="2">• Contact specialist or PCLS if levels are not within the usual target for that patient (see table below)
• Refer to hospital urgently if signs of lithium toxicity
<table>
<tr><th>Plasma lithium level</th><th>Action to be taken</th></tr>
<tr><td>Levels < 0.4mmol/L – level in keeping with that agreed with specialist team and patient is well</td><td>Continue treatment. Monitor level every 3-6 months.</td></tr>
<tr><td>Level <0.4 mmol/L and lower than the range specified by the specialist OR if the patient is unwell</td><td>If lower than level specified by specialist team, review adherence, consider other factors e.g. drug interactions, excess fluid intake and re-check level.

If patient is unwell, re-check level and refer to mental health team (PCLS)</td></tr>
<tr><td>Level 0.4-0.6mmol/L and level in keeping with that agreed with specialist team and patient is well</td><td>Continue treatment. Monitor level every 3-6 months.</td></tr>
<tr><td>Level 0.4-0.6mmol/L and lower than the range specified by the specialist OR if the patient is unwell</td><td>If lower than level specified by specialist team, review adherence, consider other factors e.g. drug interactions, excess fluid intake and re-check level.

If patient is unwell, re-check level and refer to mental health team (PCLS)</td></tr>
</table></td></tr>
</table>

	Level 0.6-0.8mmol/L and level in keeping with that agreed with specialist team and patient is well	Continue treatment. Monitor level every 3-6 months.
	Level 0.8-1.0mmol/L with no signs of toxicity	If level specified by specialist, continue treatment, monitor plasma level every 3-6 months. If level is higher than target, check for drug interactions, factors effecting fluid and sodium balance, timing of level, dehydration or brand change and re-check level. Consult specialist team if still elevated as dose reduction may be indicated.
	Level >1.0mmol/L with no signs of toxicity	If level is higher than target, check for drug interactions, factors effecting fluid and sodium balance, timing of level, dehydration or brand change and re-check level. Consult specialist team if still elevated as dose reduction may be indicated.
	Levels >0.8mmol/L with signs of toxicity	**Stop lithium immediately, refer to hospital.**

8. Cautions and contraindications

Please note this does not replace the Summary of Product Characteristics (SPC) and should be read in conjunction with it.

Cautions

- Cardiac disease; diuretic treatment; elderly; epilepsy (may lower seizure threshold); myasthenia gravis; psoriasis (risk of exacerbation); QT interval prolongation; review dose or hold as necessary in diarrhoea/vomiting; review dose as necessary in intercurrent infection (especially if sweating profusely); renal impairment; surgery

Contraindications

- History of sensitivity to lithium or excipients
- Addison's disease; cardiac disease associated with rhythm disorder; cardiac insufficiency; dehydration; family history of Brugada syndrome; low sodium diets; personal history of Brugada syndrome; untreated hypothyroidism

9. Significant medicine and food interactions and management

For a comprehensive list, consult the BNF or Summary of Product Characteristics (SPC)

- ACE inhibitors and angiotensin II receptor antagonists – can lead to increased lithium levels due to reduced secretion of lithium via their effect on renal blood flow. Avoid combined use but if unavoidable monitor lithium levels closely.
- Diuretics (including herbal diuretics), especially thiazides e.g. bendroflumethazide – cause increased lithium levels due to reduced excretion. Avoid thiazide diuretics and monitor closely lithium levels and U&Es if loop diuretics e.g. furosemide are prescribed.
- Non-Steroidal Anti-Inflammatory drugs (NSAIDs) and COX II inhibitors – increase lithium levels due to effects on renal blood flow and can occur within a few days. Advise patient to check when buying over the counter pain relief/cold remedies. Paracetamol is safe to use.
- Metronidazole, tetracycline, co-trimoxazole, trimethoprim – Increased risk of lithium toxicity due to reduced lithium clearance. Symptoms of lithium toxicity may occur with co-trimoxazole and trimethoprim even at normal lithium levels. Avoid concurrent use where possible.

10. Adverse effects and management

Include details of incidence, identification, importance and management.

Adverse Effect	Action to be taken if detected
• Weight gain, hand tremor, mild memory impairment, hypothyroidism	• Monitor and refer to specialist if needed. (propranolol may be used to treat tremor)
• Tremor, polyuria, thirst, diarrhoea, indigestion/heartburn, feeling dulled mentally, drowsiness, metallic taste in mouth	• These are common side effects which may be dose related and indicate a raised lithium level: Check lithium level and renal function test promptly. If lithium level is elevated, seek advice from **Specialist** with the view to reduce the dose and recheck level after 5-7 days. Supportive measures: reversal of

	• Coarse tremor, blurred vision, muscle weakness, ataxia, slurred speech, vomiting, severe diarrhoea, severe polyuria, confusion, seizures	dehydration/electrolyte imbalance. • These are signs of lithium toxicity. Arrange for an urgent lithium level and renal function test, stop lithium until the results are known and consider referral for urgent medical review.

11. Advice to patients and carers

The specialist will counsel the patient with regard to the benefits and risks of treatment and will provide the patient with any relevant information and advice, including patient information leaflets on individual medicines.

- Each patient will be provided with written information on lithium before treatment starts and will be provided with a purple lithium therapy pack where they can keep a record of all their blood tests and treatment. Some patients may prefer to keep this electronically and a free app is available on Apple iPhone and Android. https://www.bipolaruk.org/news/new-app-now-available-for-monitoring-lithium-use
- Women of child bearing age will be given advice about the need for adequate contraception and the risks to the unborn child if they become pregnant whilst taking lithium.
- Patients will be told that it may take 6 months to a year for the full benefits of taking lithium to become apparent.
- Patients will be advised that they shouldn't stop lithium abruptly and that if lithium is stopped it will be done over at least 4 weeks but preferably longer to reduce the risk of relapse.
- In order to avoid developing lithium toxicity, patients should be encouraged to maintain a good intake of fluids and to avoid sudden changes in dietary salt intake (e.g. low salt diet, slimming diet). A lack of salt can result in lithium toxicity. Other circumstances predisposing to lithium toxicity include febrile illness, sweating (e.g. hot weather, after exercise), vomiting, diarrhoea and certain drug interactions. Patients must be regularly reminded of the causes and signs of lithium toxicity and what to do if toxicity is suspected.
- Patients should be told that if they forget to take a dose of lithium they must never 'double up' the next dose.
- Patients who accidentally ingest a single additional daily dose should be advised to omit their next dose, then continue normal therapy and consult their prescriber if they develop any new side effects. Patients who accidentally ingest more than an additional single daily dose, or who are showing signs of lithium toxicity should be assessed in hospital
- Patients will be told to look out for the signs or symptoms suggestive of hypothyroidism such as constipation, depression, intolerance to cold, lethargy and fatigue

12. Pregnancy and breast feeding

It is the responsibility of the specialist to provide advice on the need for contraception to male and female patients on initiation and at each review but the ongoing responsibility for providing this advice rests with both the GP and the specialist.

- Lithium should be avoided in pregnancy as there is a possible increase in risk of cardiac defects (Ebstein's anomaly).
- Women should be advised to speak to their mental health team about alternative treatments if they are planning a pregnancy as the maximum period of risk to the foetus is 2-6 weeks after conception, i.e. often before the woman is aware that she is pregnant. Slow discontinuation is advised as an abrupt discontinuation may worsen the risk of relapse.
- Lithium readily crosses into breast milk with levels being 40-50% of the maternal plasma concentration. Breast feeding is not usually recommended.

13. Specialist contact information

AWP Primary Care Liaison Service Teams (Adults)

BaNES	01225 371480	South Gloucestershire	0117 378 7960
Bristol	0117 919 5670	South Wiltshire	01722 820372
North Somerset	01934 836406	Swindon	01793 835787
North Wiltshire	01380 737840		

Other Specialist Contact Information

- Click or tap here to enter text.

14. Additional

- Lithium plasma levels should be measured 12 hours post-dose

information For example, process for when Specialist or GP changes roles; specific issues related to patient age/ capacity/ specific monitoring.	• Lithium treatment is usually continued long term and should not be stopped abruptly. Intermittent treatment with lithium may worsen the natural course of bipolar illness.
15. References	• Summary of Product Characteristics for Priadel 400mg Prolonged Release Tablets via https://mhraproducts4853.blob.core.windows.net/docs/1d564e9014ea5648ce688944e51fbfc004e96ef2 • Summary of Product Characteristics for Priadel 520mg/5ml liquid via https://mhraproducts4853.blob.core.windows.net/docs/b56feb47a555dcf1efe66021baccb01590d2307f • Summary of Product Characteristics for (Li-Liquid 1018mg/5ml Oral Syrup) via https://www.medicines.org.uk/emc • BNF online (Lithium Carbonate and Lithium Citrate) via https://bnf.nice.org.uk/ • NICE Clinical Guideline (Bipolar disorder: assessment and management CG185) via https://www.nice.org.uk/guidance • NICE Clinical Guideline (Depression in adults: recognition and management CG90) via https://www.nice.org.uk/guidance • Patient Safety Alert: Safer lithium therapy. NPSA/2009/PSA005 December 2009. Available at: https://www.sps.nhs.uk/articles/npsa-alert-safer-lithium-therapy-2009 • Avon and Wiltshire Mental Health Partnership NHS Trust - Med07 Procedure for the prescribing, and monitoring of lithium in AWP, December 2010. Available internally in AWP at: http://ourspace/Skills/MedicinesPharmacy/Medicines-procedures/Med07.doc [Accessed 18 November 2020]. • Avon and Wiltshire Mental Health Partnership NHS Trust – MG18 Prescribing Guidance for Mental Health Prescribers and GPs in Perinatal Mental Health, March 2019. Available internally in AWP at: http://ourspace/Skills/MedicinesPharmacy/Medicines-procedures/MG18.doc [Accessed 18 November 2020]. • Bazire, S (2016) Psychotropic Drug Directory Norwich: Lloyd-Reinhold Publications Ltd • Taylor D, Paton C and Kapur S. (2018). The Maudsley prescribing guidelines in psychiatry 13th edition. Oxford: Wiley-Blackwell.
16. To be read in conjunction with the following documents	• NHS England: Responsibility for Prescribing Between Primary & Secondary/ Tertiary Care. Ref 07573, Version 1.0, Published January 2018. Accessed via: https://www.england.nhs.uk/publication/responsibility-for-prescribing-between-primary-and-secondary-tertiary-care/ • Click or tap here to enter text.

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Shared Care Agreement template adapted by Ellen Brennan-Rist from Appendix 5 of Shared Care Guidance – A Standard Approach for RMOC Consultation (SPS Website). Template approved by AWP, BSW and BNSSG September 2020, Version 1.2

Appendix 1: Summary of Lithium Pathway & Monitoring

Initiation within AWP

Baseline

Check cautions and contraindications

AWP lithium checklist

Patient discussion and education

- U&Es and calcium
- FBC
- TFTs
- Weight/BMI
- BP & pulse
- ECG, if indicated

Target Level

Aim for lowest effective level

Adults: usual target **0.6 to 0.8mmol/L** but in some instances levels up to 1.0mmol/L may be needed

Elderly patients (>65): monitor more closely, may develop symptoms of lithium toxicity at standard therapeutic levels. Response may be seen at low levels, **0.4mmol/L** with target optimal level adjusted as per clinical response

Initial Monitoring

Plasma levels **12 hours post dose** initially 5-7 days after starting or changing dose/ brand, then weekly levels until stable (two similar results at the same dose)

Be clear who is reviewing results

Shared Care Request

After 3 months and once dose is stable, GP may be requested to take over prescribing and monitoring

Include: indication, brand name, preparation, target level

Monitoring and Review in Primary Care

Renal Function

Check 6-monthly or 3-monthly if high risk group:

But **test more frequently**, assess trend and seek advice from renal specialist and psychiatrist **if**:

Urea and creatinine levels become elevated
or eGFR falls over 2 or more tests
or eGFR between 25-30ml/min/1.73m^2
or eGFR falls by 5ml/min/1.73m^2 or more annually

Plasma Lithium Level Monitoring

12 hours post dose **every 3 months** for the first year then 6 monthly thereafter unless in a high risk group.

Level outside target range? See section 4

Additional plasma level check if: signs of toxicity, side effects, relapse of mental illness, fluid/sodium balance affected by medication or physical health

High Risk Group:
Over 65 year
Impaired renal/thyroid function
Raised calcium
Poor symptoms control/adherence
Plasma level above 0.8mmol/L
Target level above 0.8mmol/L

Other Monitoring

6-monthly (or 3-monthly if high risk group):

U&Es
Calcium
TFTs
Weight/BMI

Every year:

LFTs
FBC
Lipids
Glucose
BP
ECG, if indicated

High-risk drug interactions

High risk of **raised plasma levels**:

- Non-steroidal anti-inflammatory drugs (NSAIDs, including OTC medicines)
- Angiotensin-converting enzyme (ACE) inhibitors
- Angiotensin II receptor antagonists
- Thiazide and loop diuretics

Avoid or introduce extra plasma level monitoring

See BNF for full interactions list

Side effects

Review regularly:

Tremor
Polyuria and/or thirst
Diarrhoea
Indigestion/heartburn
Drowsiness
Metallic taste

Check plasma level if side-effect(s) persistent

Signs of toxicty

Coarse tremor, seizures, blurred vision, slurred speech, muscle weakness, ataxia, nausea/vomiting, diarrhoea, severe polyuria, confusion

Elderly patients can suffer with toxicity even at levels within normal range.

Stop lithium, check level, and urgently refer to hospital