(*Continued*)

Topic 6: Psychologic Issues Particularly Related to Adherence to Medical Therapy and Management of Mood Disorders in Heart Transplant Recipients	
2010 Prior Guideline Recommendation	2023 Guideline Update Recommendation
Class IIa, Level of Evidence C.	
Depressive symptoms should be regularly evaluated during follow-up of HT recipients. This can best be done by user friendly, validated screening instruments. All patients with elevated scores should be referred to specialized treatment. Class I, Level of Evidence C	Given their impact on post-transplant survival, depressive symptoms should be regularly evaluated before and during long-term follow-up of HT recipients. This can best be done by user-friendly, validated screening instruments (e.g., PHQ-9, PHQ-9 modified for teens). **Class I, Level of Evidence B**
Each HT team should include a psychologist/psychiatrist who is qualified to detect and treat depression and mood disorders. Multidisciplinary treatment teams are better prepared to address psychosocial risk factors for poor outcomes after HT. Class I, Level of Evidence C	All patients with elevated screening scores should be referred for specialized evaluation, assessment, and potential treatment. Each HT team should include a psychologist/psychiatrist who is qualified to detect and treat mood disorders. Patients with psychosocial problems or difficulty coping could be referred to appropriate mental and behavioral health services. **Class I, Level of Evidence C**
New Recommendations	Patients at risk should be monitored closely for presence of delirium immediately post-transplant by means of validated screening tools. **Class I, Level of Evidence C**
New Recommendations	Management for acute delirium should include treatment with antipsychotic medications, as per program protocol. Nonpharmaceutical interventions can include sleep protocols, mobilization, and cognition stimulation. **Class I, Level of Evidence C**
New Recommendations	Pediatric and adolescent HT patients are at greater risk of mental health comorbidities related to the psychological and physical changes associated with puberty. This may be further complicated by changing parent-child and peer relationships. Pediatric HT programs should have access to psychiatric services, with consideration to integrating child psychiatry into the pediatric transplant team. Screening for depression and mood disorders should be routine practice, before, during and after transplantation with attention to the family unit and referral to a psychologist or social worker for routine follow up and support. Pediatric HT programs should have specialized services in place to support the child and family through the transplant trajectory and transition to adult services. **Class IIa, Level of Evidence C**
Serotonin reuptake inhibitors, particularly citalopram, and new-generation antidepressants (mirtazapine) may be the best choice for HT recipients because they have no significant impact on blood pressure, heart rate, rhythm, or conduction intervals. Class I, Level of Evidence B.	Continuing approval without change
Agents that interact with the metabolism of CYA and TAC via the CYP450 system (e.g., fluvoxamine, nefazodone) should be avoided because they may alter CNI levels. Class I, Level of Evidence B.	Continuing approval without change
Tricyclic antidepressants (e.g., imipramine, desipramine, amitriptyline, and clomipramine) are associated with cardiovascular toxicity (conduction delay, orthostatic hypotension, and anticholinergic effects) and may lower seizure thresholds, and therefore, their use should be restricted to HT recipients with severe	Tricyclic antidepressants (e.g., imipramine, desipramine, amitriptyline, and clomipramine) are associated with cardiovascular toxicity (conduction delay, orthostatic hypotension, and anticholinergic effects) and may lower seizure thresholds, and therefore, their use should be restricted to HT recipients with severe

(*continued on next page*)