BETTER AVOID.

Risks: Venlafaxine is extensively metabolised in the liver, mainly via cytochrome P450 2D6. This pathway is clinically relevant for potential drug interactions and may be affected by genetic polymorphisms of CYP2D6 and CYP2C19. Rare cases of clinically apparent liver injury have been reported. Mild elevations of liver enzymes occur in fewer than 1 % of patients and are usually transient, not requiring dose adjustment or discontinuation.

Risk monitoring: Monitor ALT, AST, ALP, GGT, and bilirubin regularly, especially during the first months of therapy or if hepatic function worsens. Watch for jaundice, abdominal pain, rash, fever, or other symptoms of hepatic injury. In patients with impaired hepatic clearance, monitor for signs of drug accumulation, such as cardiovascular toxicity, confusion, gait instability, falls, or hyponatraemia. Consider genotyping for CYP2D6.

Dose adjustment: Use with caution in patients with hepatic impairment, as clearance is reduced, and plasma concentrations are increased. For Child–Pugh A or B, reduce the usual dose by approximately 50 %. For Child–Pugh C, avoid use or consider a greater reduction with close monitoring.

Recommendation:

Better to avoid venlafaxine in patients with severe hepatic impairment (Child–Pugh C). For mild to moderate hepatic impairment (Child–Pugh A or B), use approximately 50 % of the standard indication-specific dose with close monitoring. Discontinue immediately if hepatic injury or significant enzyme elevation occurs.