Hepatic dosing quick reference

Psychiatric meds by Child-Pugh class. The LOT rule, drugs to avoid, and when a mild LFT bump matters. Reviewed against current guidelines as of June 8, 2026.

Three things matter most. First, pick a glucuronidated benzo (lorazepam, oxazepam, or temazepam) if a benzo is needed, because those bypass phase I. Second, watch valproate, duloxetine, and nefazodone. They cause real hepatotoxicity and aren't worth the risk in most patients with liver disease. Third, don't panic over mild transaminase bumps on SSRIs or low-dose lamotrigine. The trajectory and the clinical picture matter more than the single number.

Child-Pugh scoring

Variable	1 point	2 points	3 points
Total bilirubin	Below 2 mg/dL	2 to 3 mg/dL	Above 3 mg/dL
Serum albumin	Above 3.5 g/dL	2.8 to 3.5 g/dL	Below 2.8 g/dL
INR	Below 1.7	1.7 to 2.3	Above 2.3
Ascites	None	Mild, diuretic-responsive	Moderate to severe
Hepatic encephalopathy	None	Grade 1 to 2	Grade 3 to 4

Class A: 5 to 6 points (compensated). Class B: 7 to 9 points (significant decompensation). Class C: 10 to 15 points (advanced).

Main hepatic-adjusted psychiatric drugs

Drug	Child-Pugh A	Child-Pugh B	Child-Pugh C	Notes
Valproate	Avoid	Avoid	Contraindicated	Boxed hepatotoxicity. Idiosyncratic fatal hepatitis, especially under 2 and with polytherapy.
Duloxetine	Use caution	Avoid	Avoid	Label: don't use in chronic liver disease or heavy alcohol use.
Nefazodone	Avoid	Avoid	Contraindicated	Boxed warning for fatal hepatic failure. Rarely appropriate now.
Atomoxetine	Standard	Reduce 50 percent	Reduce to 25 percent	Boxed warning for severe liver injury.
Naltrexone	Standard	Use caution	Avoid	Contraindicated in acute hepatitis or hepatic failure.
Disulfiram	Use caution	Avoid	Contraindicated	Check LFTs at baseline, 2 weeks, then periodically.
Sertraline	Standard	Reduce dose, longer intervals	Avoid or extreme caution	First-line SSRI in mild to moderate hepatic disease.
Fluoxetine	Standard	Reduce, extend interval	Reduce further	Long half-life makes adjustment slow and hard to reverse.
Citalopram	Max 20 mg	Max 20 mg	Avoid or lowest dose	QT plus reduced clearance.
Escitalopram	Standard	Max 10 mg	Max 10 mg	Cleaner than citalopram at higher doses.

Paroxetine	Reduce starting dose	Reduce further	Avoid	Anticholinergic and discontinuation issues are separate concerns.
Bupropion	Reduce	Max 75 mg daily	Avoid	Seizure threshold matters more with accumulation.
Mirtazapine	Standard	Reduce about 30 percent	Reduce further	Generally well tolerated.
Venlafaxine	Reduce 50 percent	Reduce 50 percent	Reduce further	BP monitoring regardless.
Desvenlafaxine	Standard	Max 100 mg	Max 100 mg	Doesn't need heavy CYP handling.
TCAs (nortriptyline, amitriptyline, imipramine)	Reduce 25 to 50 percent	Reduce 50 percent	Avoid	Anticholinergic and QT compound the metabolism issue.
Lamotrigine	Reduce 25 percent	Reduce 50 percent	Reduce 75 percent	Rash risk separate; go slow regardless.
Carbamazepine	Use caution	Avoid	Contraindicated	Hepatotoxicity plus complex interactions.
Quetiapine	Reduce start	Reduce further	Reduce further	Sedation compounds encephalopathy risk.
Aripiprazole	Usually no adjustment	Usually no adjustment	Consider lower dose	Unusually forgiving in liver disease.
Olanzapine	Usually no adjustment	Reduce start	Use caution	Metabolic side effects are the bigger concern.
Clozapine	Reduce start	Reduce further	Avoid	Agranulocytosis monitoring already high; hepatotoxicity signal exists.
Lithium	Standard	Standard	Standard	Renal, not hepatic. Watch fluid shifts, ascites diuretics, dehydration.

The LOT rule: benzos in liver disease

Lorazepam, oxazepam, and temazepam are conjugated via glucuronidation, which is preserved even in advanced cirrhosis. Diazepam, chlordiazepoxide, clonazepam, alprazolam, and midazolam rely on CYP3A4 and accumulate to dangerous levels. Lorazepam is the workhorse in liver disease. For alcohol withdrawal in cirrhotic patients, a lorazepam-based protocol is safer than chlordiazepoxide-based.

What to do about mild LFT bumps

- Less than 3x ULN, asymptomatic, normal bilirubin and INR: monitor, do not stop. Recheck in 2 to 4 weeks.
- 3 to 5x ULN, asymptomatic, normal synthetic function: recheck in a week. Consider dose reduction. Look for other causes.
- Above 5x ULN, or any symptoms (jaundice, RUQ pain, malaise), or synthetic dysfunction: stop the drug and work up.
- Bilirubin elevation with transaminitis (Hy's law): stop and refer to hepatology. Predicts serious injury.
- Valproate is the exception to the calm rule. Any hepatic sign or symptom on valproate, especially early, deserves prompt attention. Ammonia can rise independently of LFTs.

Not medical advice.