Summary

Objective
Herein, a concise review is presented on the current and most promising antidepressant pharmacological agents for management of depression.

Materials and methods
A PubMed search (1966 - February 2012) was performed using the following keywords or their combination: “depression”; “major depressive disorder”; “antidepressants”; “novel antidepressant targets”; “monoamine”; “novel antidepressants”. Additional literature sources, including most authoritative and updated edited books or pamphlets were examined accordingly.

Results
All relevant literature sources written in English were evaluated giving priority to RCTs and meta-analyses. At present, the pharmacological management of depression appears characterized by a wide variety of different augmentation or switching approaches (Fig. 1). Nonetheless, response rates remain substantially unsatisfactory, thus prompting for the development of novel agents with different mechanisms of action.

Conclusions
Shifting the interest for novel antidepressant drugs beyond the monoaminergic modulation represents (Tables I-III) an intriguing opportunity to enhance response rates of depression, although other issues, including revision of current nosological boundaries, should also be considered.

Key words
Monoamines • Antidepressant drugs • Novel targets

Introduction
Depression is one of the most prevalent psychiatric disorders, and has unfavourable prognosis with considerable suicide risk. Its lifetime prevalence rate in the United States is estimated to be 16.6%, affecting over 30 million people, with more than 80% of these individuals experiencing recurrent episodes. Nonetheless, despite the clinical and social relevance of the phenomenon, depression still faces considerable unsatisfactory response rates, thus soliciting the exploration of novel therapeutic targets to develop more effective interventions.

Concerning the pharmacological treatment of depression, currently the cornerstone of clinical management, numerous agents from different classes have been proposed since the 1950s, when the mood-enhancing properties of two anti-tuberculosis agents, isoniazid and iproniazid, and imipramine, also a tricyclic compound were serendipitously observed. Unfortunately, at that time the number of people diagnosed with “depression” who would benefit from these “new” agents was very low, so that the development of antidepressants was not the high priority of pharmaceutical companies. The situation changed in 1988, when the introduction of fluoxetine, a selective serotonin reuptake inhibitor (SSRI) approved for the treatment of major depressive disorder (MDD), alternatively generically labelled as “depression”, marked the beginning of a “golden era” of the pharmacological treatment of the disorder. In fact, although not as effective as the previously introduced tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAO-Is), the SS- RIs and the latter introduced classes of antidepressants, still ensured substantial remission rates compared to placebo while providing a better tolerability profile (although not completely devoid of side-effects), thus contributing to the widespread pharmacological management of depression. Nonetheless, the need for higher response rates for the antidepressant treatment solicited the introduction of novel compounds as well the implementation of enhanced augmentation or switching strategies for currently available drugs.

In this review, the prominent pharmacological opportunities for the treatment of depression are briefly outlined, focusing on novel non-monoaminergic compounds.
Materials and methods

Considered sources included all PubMed results written in English (updated to February 2012) systematically retrieved using the following keywords or their combination: “depression”; “major depressive disorder”; “antidepressants”; “novel antidepressant targets”; “monoamine”; “novel antidepressants”. Additional literature sources, including most authoritative and updated edited books or pamphlets were evaluated accordingly.

Results

Two hundred and eighty nine randomized clinical trials (RCTs) or meta-analyses were assessed, while non-controlled studies were used only when controlled data unavailable. Finally, studies performed in humans were prioritized, while pre-clinical or animal investigations have been cited only in the absence of corresponding evidence in human samples.

The monoamine hypothesis of depression and beyond

Since its first conceptualization, the “monoamine hypothesis of depression” largely influenced the development of novel antidepressant drugs and prescribing attitudes of clinicians toward MDD. This hypothesis essentially focuses on increasing the levels and synaptic effects of three monoamines, namely dopamine (DA), norepinephrine (NE) and the indole amine 5-hydroxytryptamine (5-HT) or serotonin, to induce an antidepressant response. Within the past decades, this hypothesis has undergone extensive revision, leading to the observation that such synaptic modifications would be due to blockade of monoamine transporters, including the dopamine transporter (DAT), the norepinephrine transporter (NET) and the serotonin transporter (SERT). However, monoamine levels can increase rapidly following blockade of these transporters, much earlier than onset of clinical action, if ever. The neurotransmitter receptor sensitivity hypothesis of depression can explain this lag phase, and is also in agreement with the neurotransmitter receptor hypothesis focusing on the abnormal up-regulation of receptors during the course of depression. Nonetheless, it is likely that modifications in receptor number and/or sensitivity following antidepressant treatment require alterations in gene expression, transcription, translation and production of various neurotrophic factors as the brain derived neurotrophic factor (BDNF). Thus, in addition to modulating monoamine and receptor levels, the final common pathway of all antidepressants should involve the regulation of various trophic factors, rather than just the monoamine balance.

As a major implication, this possibility has suggested that other antidepressant targets should be explored.

The need for novel antidepressant drugs: the increasingly crowded antidepressant scenario

Both pharmacological and clinical considerations concerning the efficacy, safety, tolerability and costs influence compliance and outcome of the depressed patient, soliciting novel antidepressant interventions.

The need for an anticipated onset of action

A lag phase of at least 3-4 weeks prior to the onset of an antidepressant effect is commonly seen with current antidepressant drugs, in contrast with an almost immediate increase in monoamine extracellular levels evident just few hours initiation of therapy. At least two types of 5-HT auto-receptors are present on the serotonergic neuron. Activation of 5-HT1A receptors, present in the somatodendritic area, reduces neuronal firing, resulting in less serotonin release from the axon terminal. On the other hand, activation of 5-HT1B receptors causes direct inhibition of serotonin release. 5-HT1A is also related to control of serotonergic release through a large feedback loop from terminal to the cell body region. It is likely that these auto-restraining processes counteract the initial effect of SSRIs as well as other classes of antidepressant drugs that primarily act by serotonergic modulation, and chronic administration of these agents is reported to desensitize both presynaptic and postsynaptic 5-HT1A receptors.

Similarly, complex pre- and post-synaptic modulations concern norepinephrinergic modulation. The alpha-2 norepinephrinergic auto-receptors, located both on axon terminals and cell bodies, establish an effective self-regulation system similar to that in serotonergic neurons, which is also believed to become supersensitive during depression, while the beta-adrenoceptors are located post-synaptically. Up-regulation of these receptors has been observed in the course of depression, whereas down-regulation of these latter has been related to antidepressant activity. Nonetheless, despite the discovery of the mechanisms held to be responsible, overcoming the lag phase of antidepressant drugs remains an unaddressed need.

The need for more effective antidepressants: beyond the SSRIs

The SSRIs are still the most commonly prescribed antidepressant drugs. Nonetheless, their efficacy has highly debated, especially for most severe cases of depression, which have favoured the use of serotonin norepinephrine...
FIGURE 1.
Switching and augmentation of strategies are part of routine psychopharmacological practice of the treatment of depression, especially for less responsive cases. Other optimizations include the development of novel formulations of older medications to enhance tolerability and compliance (e.g. controlled release formulation of trazodone with milder anti-alpha-1 effect is waiting approval for a new high-dose, 300-450 mg once-daily formulation; similarly, desvenlafaxine, the main metabolite of venlafaxine, under-metabolized by the kidney, appears to have the antidepressant effects of its parent compound with a more favourable pharmacokinetic profile) 30 31. More selective serotonergic antidepressants are also being considered, including the following: Lu AA21004, a SSRI with anti-nausea and anti-anxiety 5-HT3 antagonism plus 5-HT1A action 32, gepirone ER and PRX 00023 as 5-HT1A partial agonist 33, gepirone ER and PRX 00023 as 5-HT1A partial agonist 34 35, VPI 013 or OPC 14523 acting as a sigma-1/5-HT1A partial agonist 36, TGW-00-AD/AA as 5-HT1A agonist and 5-HT2A antagonist, TGBA-01-AD as SRI/5-HT2/5-HT1A/5-HT1D modulator, elzasonam as 5-HT1B/D antagonist 37 and agonelmatine acting as 5-HT2C and weak 5-HT2B antagonist and MT1/MT2 melatonergic agonist 38. Additional 5-HT1A/5-HT1B modulation could be provided by non-antidepressant augmentation strategies, including the following: the beta-blocker pindolol acting as 5-HT1A partial agonist and the thyroid hormone triiodothyronine (T3) modulating 5-HT1B receptors 37 as well as some triptans providing 5-HT1A and/or 5-HT1D and/or 5-HT1F agonist effects. Many more agents, including 5-HT2C/5-HT2A blockers, lithium and atypical antipsychotics are under consideration 31. Le strategie di passaggio o di aggiunta sono parte delle prassi psicofarmacologica antidepressiva, specie nei casi meno responsivi. Altre strategie di ottimizzazione riguardano lo sviluppo di nuove formulazioni di vecchi farmaci allo scopo di aumentarne la tollerabilità e quindi l’aderenza al trattamento (es. formulazioni a rilascio controllato di trazodone, con minor effetto anti-alfa1 e in attesa dell’approvazione per la nuova formulazione a dosaggio elevato, 300-450 mg una volta al giorno; parimenti, la desvenlafaxina, il principale metabolita della venlafaxina, sotto-metabolizzata dal rene, pare mantenere lo stesso effetto antidepressivo del farmaco sorgente ma con un profilo farmacocinetico più favorevole) 50 51. Altri farmaci selettivi serotoninergici sono ugualmente oggetto di considerazione, inclusi i seguenti: Lu AA21004, un SSRI con attività anti-nausea ed anti-anxia legate all’antagonismo 5-HT3 più azione 5-HT1A 52, vilazodone o SB 659746A attivo quale SRI parziale agonista 5-HT1A 53, gepirona a rilascio esteso e PRX 00023 quali parziali agonisti 5-HT1A 54 55, VPI 013 o OPC 14523 agente quale parziale agonista sigma-1/5-HT1A 56, TGW-00-AD/AA come 5-HT1A agonista e 5-HT2A antagonista, TGBA-01-AD quale modulatore SRI/5-HT2/5-HT1A/5-HT1D, elzasonam come 5-HT1B/D antagonista 37 ed agonelmatina agente come antagonista 5-HT2C e blando bloccante 5-HT2B nonché come agonista melatoninergico MT1/MT2 38. L’ulteriore modulazione 5-HT1A/5-HT1B potrebbe essere fornita inoltre da strategie di “augmentation” con farmaci non antidepressivi, tra cui i seguenti: il beta-bloccante pindololo che agisce come parziale agonista 5-HT1A e l’ormone tiroidico Triiodotironina (T3) che modula i recettori 5-HT1B 57 come pure alcuni triptani che forniscono effetti di agonismo 5-HT1A e/o 5-HT1D e/o 5-HT1F. Molti altri agenti, inclusi i bloccanti 5-HT2C/5-HT2A, litio e antipsicotici atipici sono anch’essi considerati 31.

reuptake inhibitors (SNRIs) such as duloxetine and venlafaxine, characterized by a more comprehensive pharmacological profile and higher antidepressant efficacy in most cases 34. Efficacy and tolerability concerns have partially shifted prescribing patterns towards novel pharmacological agents, including the norepinephrine selective serotonin antagonists (NaSSA) mirtazapine, or dopaminergic modulators such as the norepinephrine dopamine reuptake inhibitor (NDRI) bupropion. These aim to enhance the anhedonic, cognitive, metabolic and sexual profile of depression frequently seen as part of disease or as SSRIs-induced effects 35. Additional strategies to enhance the efficacy of current antidepressant drugs include targeting specific monoamine receptors or “tweaking” the posology of current drugs (Fig. 1).

When “two is not enough”: triple reuptake inhibitors
Dual reuptake inhibitors offered clinicians effective and patient-oriented SSRIs alternatives, substantially reducing the need for TCAs or MAO-IIs and their unpleasant anti-cholinergic and anti-histaminergic side effects or even potentially life-threatening complications. Nonetheless, response rates did not increase to a satisfactory level, thus suggesting further strengthening of the antidepressant
Beyond monoamines: present and future directions

Depression has been conceptualized as the clinical expression of a broader “stress” condition underlined by immune and neuroendocrine imbalances, thus further shifting the interest for novel potential antidepressant targets beyond monoamines (Table II). This is confirmed by the recent clinical interest toward agomelatine, acting both as 5-HT2C antagonist and as a melatonergic (MT) type I and type II agonist, as well as increasing attention toward anti-oxidative stress modulators and pro-inflammatory cytokines. Rebalancing of an overactive hypothalamic-pituitary-adrenal pharmacological profile by concomitant administration of multiple antidepressants with different mechanisms of action or by the development of novel, triple reuptake inhibitors (TRIs) enhancing transmission of 5-HT, NE and DA at once. Remarkably, no TRI is currently available for prescription over the counter either in Europe neither in the US (Table I), and the expectations toward these novel agents still await clinical confirmation. What might be expected, however, is a reduced need for augmentation therapies and total number of daily medications, lower potential for pharmacokinetic interactions and, finally, better patient compliance.

**TABLE I.**
Sample triple reuptake inhibitors proposed for MDD. Esempio di triple del reuptake della serotonina proposte per MDD.

<table>
<thead>
<tr>
<th>Compound</th>
<th>Stage of development</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSK 372475</td>
<td>Phase II</td>
<td>Triple reuptake inhibitor (TRI)</td>
</tr>
<tr>
<td>Boehringer NS 2330 (Tesofensine)</td>
<td>Undetermined</td>
<td>TRI</td>
</tr>
<tr>
<td>DOV 216303</td>
<td>Phase II</td>
<td>TRI</td>
</tr>
<tr>
<td>NS 2360</td>
<td>Preclinical</td>
<td>TRI</td>
</tr>
<tr>
<td>Lu AA24530</td>
<td>Phase II</td>
<td>TRI and specific 5-HT2C, 5-HT3, 5-HT2A, alpha1 modulator</td>
</tr>
<tr>
<td>Lu AA37096</td>
<td>Phase I</td>
<td>TRI and specific 5-HT6 modulator</td>
</tr>
<tr>
<td>Lu AA34893</td>
<td>Phase II</td>
<td>TRI and specific 5-HT2A, alpha1 and 5-HT6 modulator</td>
</tr>
<tr>
<td>Sepracor SEP 225289</td>
<td>Phase II</td>
<td>TRI</td>
</tr>
<tr>
<td>DOV 21947</td>
<td>Phase II</td>
<td>TRI</td>
</tr>
<tr>
<td>JNJ 7925476</td>
<td>Undetermined</td>
<td>TRI</td>
</tr>
</tbody>
</table>

**Beyond monoamines: present and future directions**

Depression has been conceptualized as the clinical expression of a broader “stress” condition underlined by immune and neuroendocrine imbalances, thus further shifting the interest for novel potential antidepressant targets beyond monoamines (Table II). This is confirmed by the recent clinical interest toward agomelatine, acting both as 5-HT2C antagonist and as a melatonergic (MT) type I and type II agonist, as well as increasing attention toward anti-oxidative stress modulators and pro-inflammatory cytokines. Rebalancing of an overactive hypothalamic-pituitary-adrenal

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**TABLE II.**
Examples of novel HPA modulators being considered for MDD. Esempi di nuovi modulatori HPA considerati per MDD.

<table>
<thead>
<tr>
<th>Compound</th>
<th>Stage of development</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSK 561679</td>
<td>Phase II</td>
<td>Corticotropin releasing factor-1 receptor (CRF1) antagonist</td>
</tr>
<tr>
<td>GSK 586529</td>
<td>Phase I</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>ONO 233M</td>
<td>Preclinical</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>R121919</td>
<td>Phase I</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>CP316,311</td>
<td>Phase II</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>BMS 562086</td>
<td>Phase II</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>(Pexacerfont)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GW876008</td>
<td>Undetermined</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>SSR125543</td>
<td>Phase I</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>JNJ19567470; TS041</td>
<td>Preclinical</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>SSR126374</td>
<td>Preclinical</td>
<td>CRF1 antagonist</td>
</tr>
<tr>
<td>Schering Plough SCh 900635 (org34517)</td>
<td>Phase II</td>
<td>Glucocorticoid Receptor (GR) antagonist</td>
</tr>
<tr>
<td>Corcept Miliprestone</td>
<td>Phase III</td>
<td>GR II antagonist</td>
</tr>
<tr>
<td>Sanofi SSR 149415</td>
<td>Phase II</td>
<td>Vasopressin b1 antagonist</td>
</tr>
</tbody>
</table>
Since the introduction of newer antidepressant drugs in the past decade, there has been an increase in the diagnosis and treatment of MDD, perhaps in part related to the introduction of “treatments for the diagnosis”, “treatment-oriented observation bias” or Klerman’s “pharmacocentric view of the world” 47. Nonetheless, with the exception of agomelatine 38, yet still characterized by a substantial serotonergic activity eventually accounting for most of its antidepressant effects, innovative non-monoaminergic antidepressants are still lacking, and most of the needs for the treatment of major depression remain unmet, especially concerning residual symptomatology and the subsequent risk for recurrence and/or relapse.

Moreover, the antidepressants that already reached the market were produced in the early 1990s and subsequently redeveloped. There are several reasons why the field has been in a relative drought 48. The first problem that arose in the 1990s was the eagerness of industry to get their candidate antidepressants quickly to market at the expense of performing solid pivotal trials. A second problem persisting in the field is the inadequate dosing of the candidate compounds in clinical trials. A third difficulty is the limited period of patent protection, especially in the presence of financial drain exerted by generic medications. On one hand, industry has to be kept in check to ensure that novel medications are not sold at exorbitant prices, still making enough profits to ensure that their pipelines are not depleted. Additionally, the cost to bring an antidepressant to market is massive, and on occasion medications have to be discontinued due to unexpected adverse events even after they have become “blockbuster”.

Shifting the targets of novel antidepressant drugs toward the modulation of monoamine is therefore an ambitious goal from pharmacological, clinical and financial standpoints.

**Table III.** Examples of nonmonoaminergic, non-HPA-ergic modulators proposed for MDD 63-71. Esempi di non monoaminergici, non HPA-ergic modulatori proposto per la MDD 63-71.

<table>
<thead>
<tr>
<th>Compound</th>
<th>Stage of development</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPP</td>
<td>Undetermined</td>
<td>NMDA antagonist</td>
</tr>
<tr>
<td>Org 26576</td>
<td>Preclinical</td>
<td>Positive AMPA allosteric modulator</td>
</tr>
<tr>
<td>Enhancers of sleep and anxiety proposed as SSRI augmentation strategies for MDD</td>
<td></td>
<td>GABAAa stimulant</td>
</tr>
<tr>
<td>Enhancers of sexual impairment during course of MDD</td>
<td></td>
<td>GABAB antagonist</td>
</tr>
<tr>
<td>Amiheguron</td>
<td>Undetermined</td>
<td>Beta-3 antagonists</td>
</tr>
<tr>
<td>SA 4503</td>
<td>Undetermined</td>
<td>Sigma-1 agonist</td>
</tr>
<tr>
<td>SSR 411298</td>
<td>Undetermined</td>
<td>Fatty acids amide hydrolase derivate</td>
</tr>
<tr>
<td>Celecobix</td>
<td>Preclinical</td>
<td>Cyclooxygenase-2 (COX-2) inhibitor</td>
</tr>
</tbody>
</table>
Conclusions
The clinical management of depression remains a major concern for clinicians. In fact, despite the associated burden and a number of therapeutic options, including non-pharmacological interventions, response rates remain low. Therefore, shifting the interest on the development of novel antidepressants beyond monoaminergic modulation is attentively evaluated both by pre-clinical researchers and practitioners. Nonetheless, greater insights on the aetiology of depression are needed, along with more accurate nosological constructs to allow a more focused exploration of potential novel antidepressant targets, with a special attention to sub-threshold bipolarity as potential, insidious, responsible of “pseudo”-resistance in the pharmacological treatment of depression.

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