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Connecting Primary Care with Child Psychiatry

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Clinical Conversations
March 22, 2016
Depression in Pediatric Primary Care

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Objectives

- Review diagnostic criteria of depressive disorders
- Review TADS data
- Discuss criteria for starting/stopping medications and referring to specialized psychiatric treatment
- Review medication treatment options for depressive disorders

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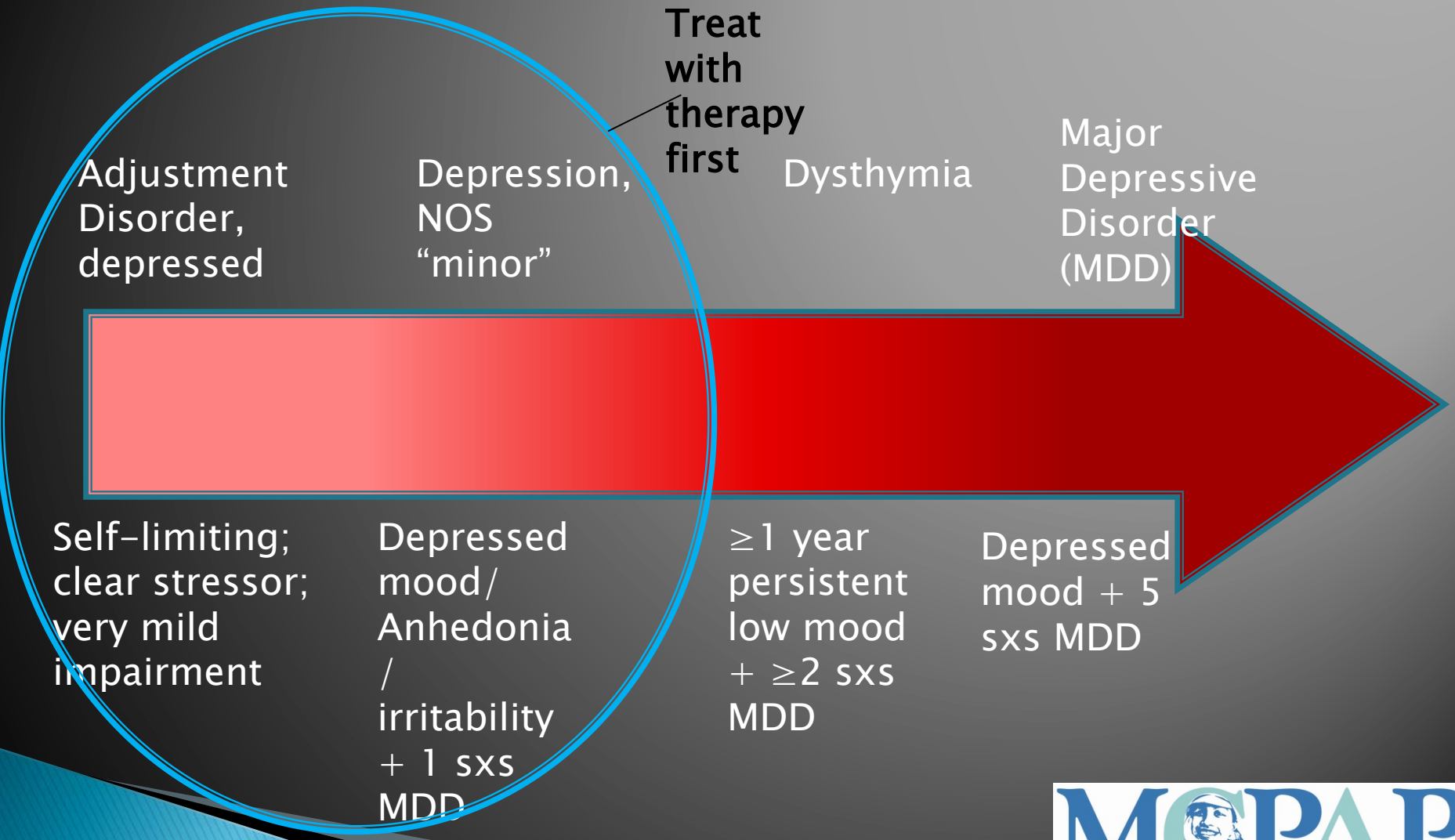
Depressive Disorders: Diagnosis

- Depressed/irritable mood & 5 sxs of:
  - **S**leep – ↓or ↑
  - **I**nterest in activities ↓
  - **G**uilt ↑
  - **E**nergy ↓
  - **C**oncentration ↓
  - **A**ppetite – ↓or ↑
  - ~~**P**sychomotor agitation/retardation~~
  - **S**uicidal thoughts

Depressive Disorders Continuum



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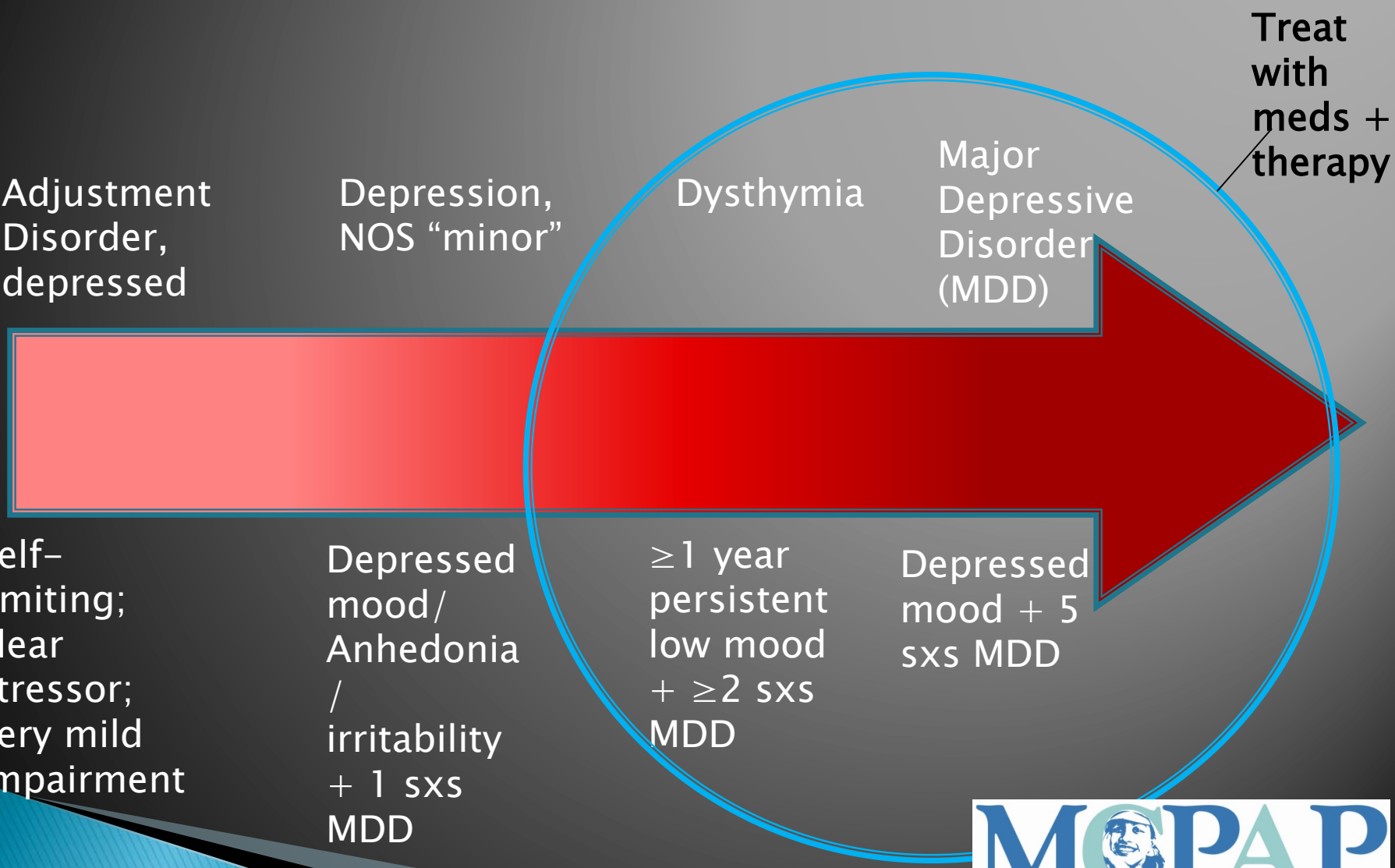
Depressive Disorders Continuum



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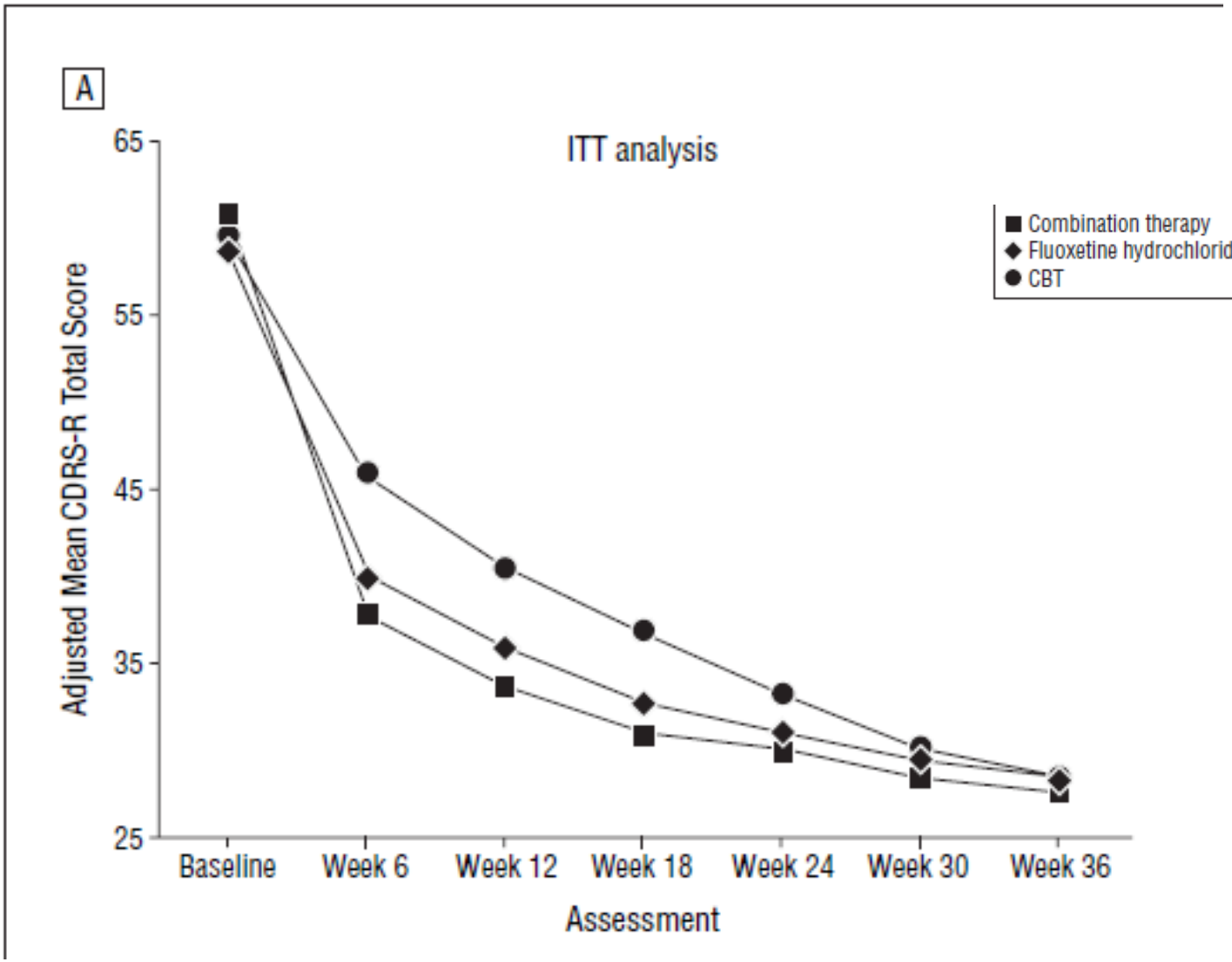
Depressive Disorders

- Treatment for Adolescents with Depression Study (TADS)
- 439 teens ages 12-17
  - Teens in SSRI + therapy faster improvement than other groups
    - 73% combo vs. 62% meds only vs. 48% therapy only in first 12 weeks
  - Suicidal thoughts decreased most in combo group
  - At one year, all groups at same level of improvement and better than at study initiation

March JS, Silva S, Petrycki S, Curry J, Wells K, Fairbank J, et al. The Treatment for Adolescents With Depression Study (TADS): long-term effectiveness and safety outcomes. Arch Gen Psychiatry. 2007 Oct;64(10):1132-43.



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When to treat?

- **Functional decline**
  - Grades declining in school
    - Treat more readily with high school students
  - Withdrawing from extracurricular activities
  - Child says it is difficult to have fun/enjoy things
  - Decreased self-care
- **Aggressive behavior**
- **Suicidal thoughts**
  - Untreated depression is the greatest risk factor for suicide
- **Diagnosis of MDD or Dysthymia**

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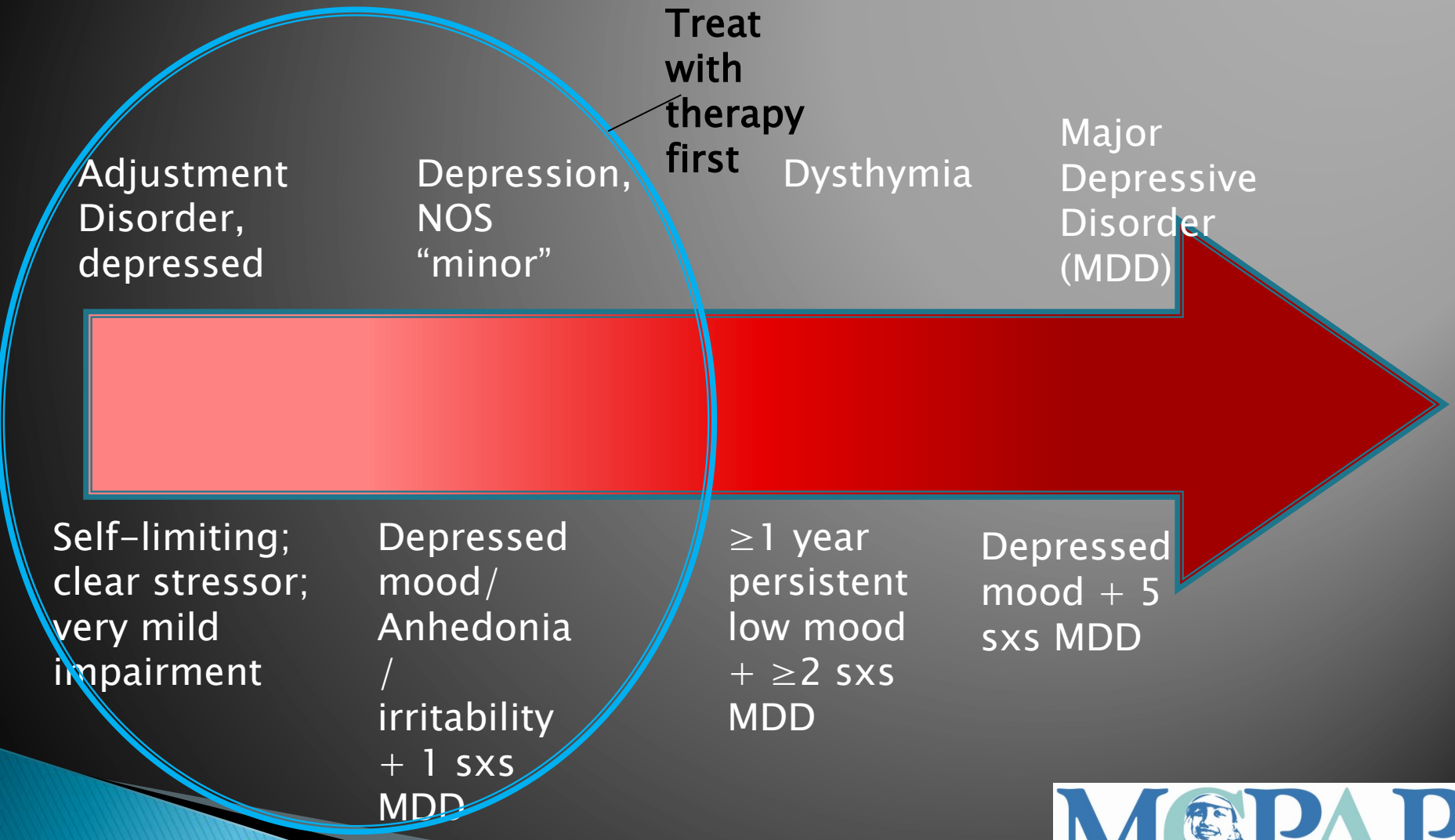
Depressive Disorders Continuum



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When to stop treatment?

- **Once child symptom free for ≥ 6-12 months**
  - Slow taper; decrease dose every two weeks
  - Continue taper as long as symptoms do not worsen
  - If symptoms worsen, go back to previous dose
  - I recommend tapering doses during summer/non-school times
    - School often exacerbates symptoms and can be confounding factor

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When to refer or consult to psychiatrist?

- Failure of ≥ 2 antidepressant trials
- Concern for bipolar disorder
- Psychotic symptoms
- Psychiatric hospitalization

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SSRIs: Antidepressants

- **Sertraline (Zoloft):**
  - FDA approved 6 y/o+
  - Preadolescents:
    - start at 12.5 mg and increase by 12.5 mg Q1-2 weeks.
    - At dose 25 mg—50 mg wait one month before further increases.
    - Max dose 150 mg/daily
  - Adolescents:
    - start 25 mg and increase by 12.5-25 mg Q1-2 weeks.
    - At dose 50 mg—75 mg wait one month before further increases.
    - Max dose 200 mg/daily.

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SSRIs: Antidepressants

- **Sertraline (Zoloft)**
- GI side effects more common than other SSRIs
  - Good for kids with constipation
- Preferred in younger kids due to smaller available doses
  - Also liquid preparation 20 mg/mL
- taper by 12.5-25 mg Q3-5 days to discontinue

SSRIs: Antidepressants

- **Fluoxetine (Prozac):**
  - FDA approved 7 y/o+
  - Preadolescents:
    - start at 5 mg and increase by 5 mg Q1-2 weeks.
    - At dose 10 mg—20 mg wait one month before further increases.
    - Max dose 40 mg/daily
  - Adolescents:
    - start 10 mg and increase by 5 mg Q1-2 weeks.
    - At dose 20 mg—30 mg wait one month before further increases.
    - Max dose 60 mg/daily

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SSRIs: Antidepressants

- **Fluoxetine (Prozac):**
  - Longer half-life and good for kids who frequently miss doses
    - If child sensitive to medication side effects, might want to avoid due to half-life
  - Comes in liquid 20 mg/5 mL
  - Taper by 5 mg Q-3-5 days to discontinue

SSRIs: Antidepressants

- **Escitalopram (Lexapro):**
  - FDA approved depression 7 y/o+
  - All ages:
    - start 2.5 -5 mg for 3 weeks then double dose
    - Wait three weeks before further increases
    - Max dose 20 mg/daily.
  - Akathisia/jitteriness more common
    - slow down titration or lower dose
  - Good for families wary of frequent dose changes
  - taper by 2.5-5 mg Q5 days to discontinue

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SSRIs: Antidepressants

- **General info for SSRIs:**
  - FDA black box warning of increased suicidality:
    - risk of suicidality was 2% with placebo and 4% with SSRIs (smaller differences in studies of anxiety). No suicides occurred in the studies.
  - Meta-analysis of MDD, OCD and non-OCD anxiety:
    - NNT 10, 6, and 3, respectively
    - Pooled number needed to harm: 143
  - The biggest risk factor for completed suicide is untreated depression.

SSRIs: Antidepressants

- **Common side effects:**
  - GI upset
  - headache
  - sedation
    - Move dose to evening
  - changes in sleep
    - Vivid dreams; move dose to morning
  - activation/agitation
    - ↑energy, ↓sleep, irritability, racing thoughts
  - Decreased libido
- Less common side effects
  - Easy bruising/bleeding; diarrhea

Other Antidepressants

- **Wellbutrin (bupropion):**
  - FDA approved 11 y/o+ (depression and ADHD)
  - If SR preparation:
    - start 100 mg daily and increase by 100 mg every 2-3 weeks as needed
    - Dose above 100 mg divide BID; second dose no later than 4 PM
    - Max dose 400 mg daily
  - If XL preparation
    - 150 mg daily for one month; increase by 150 mg daily each month as needed
    - Max doses 450 mg daily

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Other Antidepressants

- **Wellbutrin (bupropion):**
  - More weight neutral
    - Can decrease appetite and avoid if low appetite or history of eating disorder
  - Good for kids who have concentration issues with depression or co-morbid ADHD
  - Higher seizure risk than other antidepressants
  - Can elevate blood pressure

Other Antidepressants

- **Venlefaxine (Effexor) ER:**
  - FDA approved 7 y/o+
    - Start 37.5 mg daily and increase by 37.5 mg every week
    - Once at 75 mg to 112.5 mg daily, wait one month before further increases
    - Max dose 225 mg
  - High risk of discontinuation syndrome (numbness, tingling, akathisia)
    - Taper by 37.5 mg q1-2 weeks to discontinue
  - More efficacy in treatment resistant depression but higher risk of side effects

Other Antidepressants

- **Duloxetine (Cymbalta):**
  - FDA approved 7 y/o+
    - Start 20 mg daily and increase by 20 mg every 2-4 weeks
    - Max dose 60 mg daily
    - Taper by 20 mg q1-2 weeks to discontinue
  - Great for kids with many somatic complaints or nerve pain
  - Lower risk of discontinuation syndrome

Treating co-morbid symptoms

- **Insomnia**
  - Melatonin up to 9 mg QHS
  - Clonidine 0.05 – 0.1 mg QHS
  - Trazodone
    - Start 25 mg QHS and increase by 12.5-25 mg each night as needed
  - Mirtazapine 7.5 mg – 15 mg QHS
    - Also can cause ↑ appetite and weight gain
- **Anxiety or agitation**
  - Hydroxyzine 25 mg TID PRN
  - Avoid benzodiazepines if possible

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Case example

- 16 y/o female with history of anxiety and depression. She was previously tried on citalopram without improvement. PCP then started paroxetine as patient's father had success with this medication. Paxil initially helpful but lately patient has felt more depressed and periods of increased anxiety. Has been missing school 1-2 times per week partly due to mood issues and partly due to oppositional behavior. Patient also has history of bulimia but has not engaged in purging behaviors recently. Patient has a therapist but recently had a disagreement with therapist and refuses to see therapist.

Things to consider

- Using medication with positive effect in family member is generally a good plan
- Paroxetine less effective in children/adolescents than adults
  - Has greater risk of discontinuation syndrome
  - More drug-drug interactions
- Given behavioral issues and failure of two antidepressants, consider referral to psych for consult
- Would be reasonable to try third antidepressant
  - Fluoxetine has efficacy with purging behaviors

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Case example

- 12 y/o M feeling more depressed, low energy withdrawn, decreased concentration, middle insomnia for 6 months. Grades declining in school and in danger of failing a class (normally A/B student). No suicidal thoughts. Seeing therapist for past month. Father with anxiety, sister with OCD both improved with fluoxetine. Recent stressors: parents divorced, sister with worsening OCD (targeted at patient).

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Things to consider

- Using medication with positive effect in family member is generally a good plan
- Given his risk of failing and main symptoms of ↓energy, ↓concentration, failing a class
  - Consider Wellbutrin XL
- Therapy important due to significant psychosocial stressors

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