MCPAP Clinical Conversations: Common Challenges in Using Psychiatric Medications to Treat Youth: Special Considerations and Monitoring

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Outline

- Presentation
  - Antidepressants: risk, benefits and special considerations
    - SSRI
    - Other antidepressants
    - Discontinuation syndrome, switch to mania, suicidality
  - Antipsychotics: use, side effects, monitoring
  - Mood stabilizers: lithium and lamotrigine
    - Side effects, caution, monitoring and special considerations
  - Stimulants: non responders and side effects
- Comments and Questions (15-20 mins)

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SSRI Risks/Benefits:

Risks:

- Agitation/activation
- Suicidal ideation
- Insomnia/somnolence
- GI (nausea, diarrhea)
- Headache
- Sexual dysfunction
- GI hemorrhage
- Drug interactions
- Sweating, tremor

Benefits:

- Effective for mood and anxiety disorders
- Well tolerated
- No labs
- Generally safe in overdose
- Many available as generic/inexpensive

Other Antidepressants

SNRI (Venlafaxine, Duloxetine)

Risk:

- Elevated diastolic BP at higher doses

Benefits:

- May work when other classes don't
- Some approved to also treat fibromyalgia/chronic pain in adults

Atypical (Bupropion)

Risks:

- Lowers seizure threshold in a dose-dependent fashion
- Insomnia
- Headache
- Loss of appetite/weight loss

Benefits:

- 3rd line for ADHD
- Fewer sexual side effects

Risk: SSRI Discontinuation Syndrome

Emerges when medication is stopped abruptly, more prevalent if short half life:

- Irritability /anxiety
- Tremor/ataxia
- Fatigue/insomnia
- Dizziness
- Headache
- Diarrhea/nausea/vomiting
- Paresthesia

Risk: Switch to Mania

Treatment with antidepressants for patients who have unrecognized bipolar disorder may result in worsening of symptoms, or a switch to a hypomanic or manic state.

The emergence of mania or hypomania can be reasonably attributed to antidepressant use in 10% to 25% of patients with bipolar disorder.

It is thought that TCA's and SNRI's have a higher risk of switch to mania than bupropion and SSRI's.

It is a short-term phenomenon, happening within 2 months of initiation of an antidepressant, however, some data suggests that using antidepressants in patients with bipolar disorder can produce long-term mood destabilization.

Risk: Suicide

The short-term risk of suicide may increase in patients when placed on an antidepressant.

The U.S. Food and Drug Administration issued a controversial black box warning re: increased suicidal ideation and behaviors in children, adolescents, and young adults (18 to 24 years of age) treated with antidepressants.

It is important to note the risk posed by untreated depression, in terms of morbidity and mortality, has always been far greater than the very small risk associated with antidepressant treatment.

Close follow up and monitoring is indicated in early treatment and when medications are discontinued to manage risk in children, adolescents, and young adults.

Risk: Suicide

A comprehensive review (JAMA 2007) of pediatric trials conducted 1988 - 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to youth with MDD and anxiety disorders:

- no completed suicides occurred among nearly 2,200 children treated with SSRI medications.
- however, about 4% experienced suicidal thinking or behavior.

Antidepressants Monitoring

Monitoring should be more frequent immediately after treatment onset and after changes in treatment.

Monitoring frequency depends on the individual patient, and should focus on:

- side effects
- effectiveness
- suicidality

Antipsychotic Use in Children and Adolescent

Many antipsychotics are prescribed “off-label”

Increasing use in younger children, disproportionately more frequently to males, those in foster care, and those on Medicaid

Additional research needs to be done to show safety and efficacy in youth for off label uses

Antipsychotics prescribed for children are usually prescribed by a psychiatrist, following the general rules: start low, go slow, and avoid polypharmacy whenever possible

FDA Indications for Second Generation Antipsychotics:

Mania in Bipolar Disorder

Approved by the FDA to treat youth with bipolar disorder (10-17 years):

- Risperidone (Risperdal)
- Aripiprazole (Abilify)
- Quetiapine (Seroquel)
- Olanzapine (Zyprexa)
- Asenapine (Saphris) – as of March 2015

Risperidone – Irritability associated with autistic disorder (5-16 years)

Aripiprazole – Irritability associated with autistic disorder (6-17 years)

Side Effects of Antipsychotics

Weight gain (common)

Metabolic syndrome (hyperglycemia, hyperlipidemia)

Sedation (common)

Extrapyramidal symptoms, dystonic reactions, akathisia (probably most common)

Tardive dyskinesia (very uncommon)

Neuroleptic malignant syndrome (rare)

Orthostatic hypotension (monitor BP if symptomatic)

Hyperprolactinemia (mostly with risperidone, mostly clinically insignificant) – only worry if clinically significant gynecomastia or lactation – rare)

Monitoring Guidelines for Antipsychotics

	Baseline	3 months	6 months	Every 6 months	Annually
Medical History	X				X
BMI/Weight	X	X	X	X	
Blood Pressure	X	X	X	X	
Fasting glucose & HbA1C	X	X	X	X	
Fasting Lipids	X	X	X	X	
Fasting Insulin	X (not required)				X (not required)
TSH	X		X		X
Prolactin	Only if symptomatic – nipple discharge, gynecomastia				

Medication education

- Side effects, risks, & benefits
- Diet & exercise

Lithium: Indications

Bipolar Disorder: all phases and maintenance

Major Depressive Disorder: augmentation of antidepressants

Schizoaffective Disorder, Bipolar type: all phases and maintenance

Suicide: shown to reduce risk in patients with mood disorders (however, lethal in overdose, and suicide risk *increases* following discontinuation of the drug)

Lithium: Side Effects

Neuromuscular: dose related tremor, can affect hand writing. In toxicity: worsening tremor, ataxia

CNS: impaired concentration and memory, drowsiness and fatigue. In toxicity: dysarthria, coma

GI: nausea, diarrhea, dry mouth

Endocrine: weight gain, edema, up to 20% develop clinical hypothyrodism

Renal: polydipsia, polyurea, diabetes insipidus, interstitial nephritis/major renal impairment rare (5% develop renal insufficiency)

Cardiovascular: t wave flattening, bradycardia

Dermatology: acne, psoriasis, transient alopecia

Lithium: Prescribing Cautions

Pregnancy: Epstein's cardiac anomaly with first trimester use (0.1-0.7%, 20 X population rate)

- More recent studies show this risk may be significantly lower

Renal insufficiency

Cardiac conduction delay

Drug interactions: diuretics, NSAIDS

Pre-existing thyroid disease, psoriasis

Dehydration (eating disorders, post-op)

Lithium: Monitoring

Pre-test: renal function, thyroid function, HCG; Consider: ECG, electrolytes, CBC

Monitoring Q3-6 months: trough Li level (12 hr post dose), renal function, thyroid function

Annual PE and derm exam, review med lists including OTC, contraception plan

Overdose/toxicity management: lavage (not adsorbed to charcoal), IV fluids, dialysis, treat dysrhythmia

Lamotrigine

Indications: depressed phase of Bipolar Disorder, off label augmentation strategies

Inhibits release of glutamate

Well tolerated if titrated SLOWLY

Many drug interactions with other antiepileptic medications

Rash – mild to severe (Stevens – Johnson Syndrome)

Pregnancy registry gathering data

Lithium and Lamotrigine:

Open trials of lithium and lamotrigine show that these drugs may be effective in the treatment of depressive episodes

Stimulant Non Responders

Patient factors:

- Is the dx of ADHD accurate?
  - Many other dx can look like ADHD, including anxiety, PTSD, mood disorders, ASD, and rarely psychosis
- Are there unrecognized co-morbidities?
  - Anxiety, depression, bipolar disorder, conduct disorder, substance use
- Are side effects interfering?
- Is the pt adherent?

Medication factors:

- Is the pt under/overdosed?
- Does med wear off quickly (rebound)?

Family factors:

- Family stressors
- Undiagnosed ADHD in the family
- Ambivalence about meds

Stimulant Side Effects

Insomnia (common)

Decreased appetite, weight loss, abdominal pain (common)

Headache (common)

Mood lability, irritability, sadness, moodiness (uncommon)

Tics (motor and vocal) (1/3 improve, 1/3 say the same, 1/3 worsen)

Auditory/visual hallucinations (rare)

If there is a satisfactory response, it is important to try and manage these without having to discontinue the stimulant

Questions and Comments

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