SSRIs for Depression in Teens and Children

SSRIs, 5 HT Selective							**Side Effects**: May attenuate over several weeks. In general, any SSRI may cause: nausea, anxiety, agitation anorexia, tremor, somnolence, sweating, dry mouth, headache, dizziness, diarrhea, constipation, or sexual dysfunction		
Medication (generic)	**Trade Name**	**Initial Dose**	**Incre-mental dose changes**	**Maximum Daily Dose**	**FDA Approved for Teen/Child Depression**	**RCT shows efficacy in Depression in Teens & Children**	**Anticholinergic Side Effects**	**Sedating Effect**	**Comments**
Fluoxetine	Prozac	10 mg QD/QOD	10 – 20 mg	60 mg	**Yes**	**Yes**	+, esp nausea, sexual dysfunction, anorexia	+	stimulating
Escitalopram	Lexapro	5 mg QD/QOD	5 mg	20 mg	**Yes**	**Yes**	+	+	
Sertraline	Zoloft	25 mg QD/QOD	12.5 – 25 mg	200 mg	No	**Yes**	0, esp diarrhea & male sexual dysfunction	+	FDA Approved for Teen OCD
Citalopram	Celexa	10 mg QD/QOD	10 mg	60 mg	No	**Yes**	+	+	

Psychotherapy should be strongly encouraged for all pts on SSRIs, especially if not responding adequately to maximum dose of medication.

Changing medication: Consider when maximum dose is been reached and maintained for 4-6 wks without response in target sx or if major side effects occur.

Maintaining medication: Continue for 6 – 12 months follow cessation of sx; some teens may need ≥ 2 yrs of meds to prevent relapse. See pts monthly once stabilized. Evaluate target sx, adverse reactions, and med adherence at each visit. Obtain teen and parent sx checklists q 3 months.

Stopping medication: Taper slowly, 1 – 2 weeks between each dose reduction, decrementing dose as follows for each drug: Fluoxetine, 10 mg; Sertraline, 25 mg; Citalopram, 10 mg; Escitalopram, 5 mg.

The "Black Box" Warning: In 2004, the FDA reviewed reports of 23 clinical trials involving more than 4,400 children and adolescents prescribed any of nine antidepressants for treatment of major depression, anxiety, or obsessive-compulsive disorder. Outcomes are summarized here: 1. No suicides occurred in any of these trials. 2. Suicidality (suicidal intention) and suicide attempts: Pts treated with anti depressants spontaneously reported suicidality and suicide than pts on placebo (4 vs. 2 out of 100). Such thoughts were not increased among pts with pre existing suicidality. 3. In 17 trials measuring suicidality, medication did not increase pre existing suicidality, or induce new suicidality in those teens without prior suicidal ideation. All studies showed a reduction in suicidality with tx. 4. Nine medications were examined, but the FDA applied the labeling changes to all antidepressant medications because of concern that if the warning applied only to the newer antidepressants, doctors and pt might falsely assume that older antidepressants such as tricyclic antidepressants have a more favorable risk-benefit ratio.

AACAP Statement: "Pediatric depression is a real illness, with neurobiological underpinnings. Effective treatments are available. Although antidepressant treatment carries risks, untreated depression has potentially greater risks, and treatment is effective, especially when started early. Depression is a serious illness, sometimes episodic and often chronic, when it occurs in childhood. In addition to the human suffering that occurs because of depression, symptoms can and do interfere with academic learning, peer relationships, and family interactions, often derailing normal development." AACAP

Patients of all ages started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

Data from: GLAD-PC Toolkit and www.RxFiles.ca, L Regier and B Jensen, Queens University, Canada