Evidence Mounts on Pediatric Anxiety Disorders

BY MARY ELLEN SCHNEIDER
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NEW YORK — When treating first-time, uncomplicated cases of anxiety in children and adolescents, it's usually best to start with a 6- to 12-week trial of psychosocial treatment, Dr. Moira Rynn said at a psychopharmacology update sponsored by the American Academy of Child and Adolescent Psychiatry.

If the child does not respond to cognitive-behavioral therapy (CBT), consider adding a selective serotonin reuptake inhibitor (SSRI) at that point, said Dr. Rynn, deputy director of the division of child and adolescent psychiatry at Columbia University, New York.

The evidence base for medication treatment in children and adolescents has grown dramatically over the last decade, Dr. Rynn said, with randomized controlled trial data supporting the use of SSRIs for obsessive-compulsive disorder, generalized anxiety disorder, separation anxiety disorder, and social anxiety disorder.

There is also strong evidence for the efficacy of psychosocial treatment. Multiple studies that show cognitive-behavior therapy works for children with anxiety.

For example, in a 1994 study of 47 children aged 9-13 years who had anxiety disorders, the benefit of a 16-session course of CBT was compared with being on a waiting list. More than 60% of the children who received CBT were found to be without a diagnosis at the posttest and were within normal limits on many measures at the 1-year follow-up point, compared with less than 10% among the group on the waiting list (J. Consult. Clin. Psychol. 1994;62:100-10). A follow-up study by the same group of researchers found similar results, with about 50% of children being without a diagnosis after CBT (J. Consult. Clin. Psychol. 1997;65:366-80).

Other studies have examined the benefits of adding a family component to CBT. For example, researchers at Griffith University in Nathan, Australia, randomly assigned 79 children aged 7-14 years with separation anxiety, overanxious disorder, or social phobia to receive CBT or CBT plus family management, or to be on a waiting list. Almost 70% of the children who were in the CBT groups did not meet diagnostic criteria for an anxiety disorder, compared with 26% of the children on the waiting list.

At the 12-month follow-up, CBT combined with family management performed better than CBT alone. About 70% of the children in the CBT-only group did not meet criteria for an anxiety disorder, compared with 96% in the CBT plus family management group (J. Consult. Clin. Psychol. 1996;64:333-42).

With strong evidence to support the use of both medication and CBT, providers have wondered whether a combined approach from the outset would have the greatest benefit for patients. Researchers are beginning to address that question, Dr. Rynn said. The Pediatric OCD Treatment Study (POTS) team, of which Dr. Rynn was a member, assessed the efficacy of sertraline (Zoloft), CBT, and combination therapy among 112 children aged 7-17 years. The project was a multisite, placebo-controlled, double-blind study.

During the first phase, patients were randomized to receive sertraline, CBT, combination therapy, or placebo for 12 weeks. The results of the intent-to-treat random regression analyses showed that all the active treatments were significantly more effective than placebo and that combination therapy outperformed either of the single active treatments.

The results with treatments using CBT alone and sertraline alone were not significantly different from one another (JAMA 2004;292:1969-76).

Another study compared the use of imipramine plus CBT with placebo plus CBT among adolescents who refused to attend school. Sixty-three students were randomly assigned to the two groups and 47 students completed the study. The mean attendance rate in the final week of the study was about 70% in the imipramine plus CBT group, compared with about 28% in the placebo plus CBT group. Depression and anxiety rating scales decreased in both groups but decreased significantly faster in the imipramine plus CBT group (J. Am. Acad. Child. Adolesc. Psychiatry 2002;41:111-2).

Researchers also have recently completed the Child/Adolescent Anxiety Multimodal Treatment Study, which examined the efficacy of sertraline with CBT alone, combination treatment, and placebo. The analysis of that data is almost complete, said Dr. Rynn, who participated in the research. Dr. Rynn disclosed that she received research support from AstraZeneca Pharmaceuticals LP, Forest Laboratories Inc., Neuropharm Group PLC, Pfizer Inc., and Wyeth. ■

Track Lipids, Glucose With Atypical Antipsychotic Use

BY MARY ELLEN SCHNEIDER
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NEW YORK — Taking baseline measurements of fasting blood glucose, lipids, weight, and waist circumference and monitoring those measures are essential to the early identification of metabolic complications in patients taking atypical antipsychotics, Dr. Harold E. Carlson said.

But Dr. Carlson, head of endocrinology at Stony Brook University, New York, said it also makes sense to consider alternative drug choices in patients at high risk for metabolic complications.

Consider alternative drugs for high-risk patients or those with treatment-emergent diabetes mellitus.

DR. CARLSON

"If you have a choice, pick a different drug to begin with," Dr. Carlson said at a psychopharmacology update, sponsored by the American Academy of Child and Adolescent Psychiatry.

Data are not reliable enough to create a firm ranking of the relative metabolic risks of the atypical antipsychotics, but the available information suggests that the two worst offenders are clozapine (Clozaril) and olanzapine (Zyprexa), followed by risperidone (Risperdal) and quetiapine (Seroquel), followed by aripiprazole (Abilify) and ziprasidone (Geodon), he said.

It is possible to stay on top of these potential problems through close monitoring, Dr. Carlson said. For diabetes, obtain fasting blood glucose in all patients at baseline, at 3 months, and every 6 months after that. Fasting blood sugar should be monitored more frequently—monthly or quarterly—in high-risk patients, he said.

Patients at risk for diabetes include patients taking olanzapine or clozapine.

When feasible, consider alternative drug choices for high-risk patients or those with treatment-emergent diabetes mellitus, he said. Keep in mind that the diabetes may remit when the antipsychotic is stopped or changed, he said.

For lipid monitoring, obtain a fasting lipid panel at baseline, at 3 months, and then every 6 months for all patients. Obtain a fasting lipid panel quarterly for high-risk patients. High-risk patients include those with a high body mass index (BMI) or rapid weight gain on the drug, family or personal history of hyperlipidemia or coronary heart disease, and individuals receiving clozapine or olanzapine.

If lipid problems emerge, consider switching to a lower-risk antipsychotic or keep the patient on the drug and treat the lipid problem. Dr. Carlson disclosed financial relationships with several pharmaceutical companies, including Eli Lilly & Co.; Janssen L.P.; Otsuka America Pharmaceutical Inc.; Bristol-Myers Squibb Co.; Cephalon Inc.; McNeil Pediatrics, a division of McNeil-PPC Inc.; and Shire U.S. Inc. ■