Balance SSRI Benefits With Risks for Children

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WASHINGTON — It is important to balance risks with benefits when considering a selective serotonin reuptake inhibitor to treat a child or adolescent, several experts said at the annual meeting of the American Academy of Child and Adolescent Psychiatry.

Among other things, session participants discussed the Food and Drug Administration's requirement of a black box warning alerting prescribers and patients to the risk of suicidal behavior with antidepressants in children and adolescents.

"I think this is very important. This is not a contraindication. This [warning] box is not telling clinicians that they can't use these drugs. What it's saying is that if a clinician is considering using an antidepressant in a child or adolescent, they need to consider the risk and balance that against the clinical need," said Thomas Laughren, M.D., of the FDA's division of neuropharmacological drug products, Rockville, Md.

Selective serotonin reuptake inhibitors (SSRIs) do appear to work better than placebo in the short-term therapy of depression in children and adolescents, said Neal Ryan, M.D., of the Western Psychiatric Institute and Clinic in Pittsburgh. This is probably true in general, though fluoxetine is the only one with an indication for children.

Combining an SSRI with cognitive-behavioral therapy (CBT) might even be more effective, according to recent findings. In the Treatment for Adolescents with Depression Study (TADS), SSRIs combined with CBT showed the best results for treating depression. The results also suggested that pharmacotherapy is more effective than psychotherapy alone, but this finding needs to be duplicated in other studies, Dr. Ryan said.

For clinicians, the real problem is how

Depression Does Not Predict Mortality

Depressive symptoms are not independent predictors of mortality, according to data from a national sample of 3,617 adults.

The findings of previous studies of associations between depressive symptoms and mortality have been inconsistent, and few of these studies have used population-based samples, said Susan A. Everson-Rose, Ph.D., of Rush University Medical Center, Chicago, and her colleagues (Psychosom. Med. 2004;66:823-30).

The study included noninstitutionalized adults aged 25 years and older who were participating in an ongoing, longitudinal study called Americans' Changing Lives.

A total of 542 deaths occurred during 7.5 years of follow-up. Each increase of 1 standard unit on the Center for Epidemiological Studies Depression scale (CES-D) predicted a 21% increase in death from any cause after age, race, and gender were adjusted for. However, no excess risk of mortality was associated with CES-D scores in a fully adjusted model that included demographics, education, income, behavioral risk factors, and three indicators of health status (hypertension, functional impairment, and life-threatening conditions).

The physical complaints of patients with depression often resemble symptoms of other health problems, and distinguishing between clinical depression and poor physical health can be difficult.

Patients with scores in the highest quintile on the CES-D had an 85% greater risk of death from any cause, compared with participants with the lowest CES-D scores, but no other quintiles showed an increased mortality risk, the investigators said.

Depressive symptoms were not significantly associated with mortality risk in a healthy subgroup of 2,833 adults (with 306 deaths) who reported good or excellent health at baseline. In addition, depressive symptoms were not associated with increased mortality risk in patients without functional impairments at baseline.

Although depressive symptoms were associated with greater physical impairment over time, the CES-D does not measure clinical depression, which has been studied as a possible link to mortality and cardiovascular health, the investigators noted.

—Heidi Splete