

Question Culls Child's School Problems

BY PATRICE WENDLING
Chicago Bureau

CHICAGO — Physicians can screen for academic problems in school-age children by asking parents a simple question, Jeffrey P. Brosco, M.D., said at the annual meeting of the Society for Developmental and Behavioral Pediatrics.

Asking parents explicitly, "Do you have any concerns about how your child is learning in school?" was a more sensitive screener than the Pediatric Symptom Checklist (PSC), a new study showed.

Even specific questions about academic performance on the PSC were less sensitive than the single question.

Primary care medical providers typically rely on informal caregiver reports to screen for school academic problems. Many doctors ask parents, "How is your child doing in school?" only to get the response, "fine," said Dr. Brosco of the Mailman Center for Child Development at the University of Miami.

"We're particularly interested because we often see, as I'm sure many of you do, the 12- or the 13-year-old who has inattentive [attention-deficit hyperactivity disorder] or a reading disorder, and he or she has made it along for years barely getting by because they don't act out or create a lot of problems in school," Dr. Brosco said.

A total of 51 parent-child pairs, recruited from a university general pediatrics practice and a county hospital general pediatrics clinic in urban Miami, completed the PSC and a questionnaire that included 15 screening questions about school and general health. School information was obtained directly from the school.

The children's mean age was 9 years, 41% were male, and the majority of children were identified by their parents as African American or Hispanic. The primary languages at home were English, Spanish, and French or French Creole.

The question was drawn from Parents' Evaluation of Developmental Status (PEDS), a standardized, validated, and copyrighted screening test (www.pedstest.com).

Fifty-six percent of parents answered "yes," that they had concerns about how their child was learning at school. The sensitivity was 72.4% and specificity 52.2%.

Academic problems actually occurred in 21 children, defined as a cumulative grade point average in core subjects below 2.5.

Two other questions had similar sensitivity; asking parents whether they had concerns about a child's behavior in school (sensitivity 69%, specificity 56.5%), and asking parents whether a teacher had concerns about their child (sensitivity 74.1%, specificity 69.6%). A total PSC score of 26 or greater was not a sensitive measure of school academic problems (sensitivity 31%, specificity 86%).

There was no difference in responses by socioeconomic status, and the results were inconclusive as to the impact of the language spoken in the home. ■

Checklist Finds High Rates of Child PTSD

BY PATRICE WENDLING
Chicago Bureau

CHICAGO — Preliminary findings suggest that the Pediatric Symptom Checklist can identify high rates of posttraumatic stress disorder among children, but that results vary depending on whether a child or parent completes the checklist.

Based upon parental responses to the Pediatric Symptom Checklist (PSC), 25% of 72 children evaluated in a New York

City practice had positive screens for general psychosocial dysfunction. But when the children completed the youth-PSC, 33% had positive screens. This suggests that parents and children have very different perceptions of a child's level of distress, Deborah Steinbaum, M.D., said at the annual meeting of the Society for Developmental and Behavioral Pediatrics.

The sensitivity for detecting children with likely posttraumatic stress disorder (PTSD) was 58% for the youth-PSC and

33% for the parent-PSC. When the cutoff for a positive youth-PSC screen was lowered from 30 to 28—as has been done in some studies—the sensitivity of the screen rose to 83%, Dr. Steinbaum said. Specificity was about 70%.

"The parent-PSC didn't do so well because it identified fewer of the likely PTSD children than would have been identified by a coin toss," said Dr. Steinbaum of Mount Sinai Medical Center, New York. "A lot of the research [on] the

DEPRESSED PATIENTS NEED EMOTIONAL SYMPTOM RELIEF



Important Safety Information:

- Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders
- Patients started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior
- Cymbalta is not approved for use in pediatric patients

Cymbalta should not be used concomitantly with monoamine oxidase inhibitors (MAOIs) or thioridazine and not in patients with uncontrolled narrow-angle glaucoma.

Clinical worsening and suicide risk: All adult and pediatric patients being treated with an antidepressant for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially when initiating drug therapy and when increasing or decreasing the dose. A health professional should be

immediately notified if the depression is persistently worse or there are symptoms that are severe, sudden, or were not part of the patient's presentation. If discontinuing treatment, taper the medication.

Cymbalta should not be administered to patients with end-stage renal disease (requiring dialysis) or severe renal impairment (CrCl <30 mL/min); or any hepatic insufficiency.

Cymbalta should generally not be prescribed to patients with substantial alcohol use.

Most common adverse events (≥5% and at least twice placebo) in MDD clinical trials were: nausea, dry mouth, constipation, fatigue, decreased appetite, somnolence, and increased sweating. Most common adverse events in diabetic peripheral neuropathic pain (DPNP) clinical trials were: nausea, somnolence, dizziness, constipation, dry mouth, increased sweating, decreased appetite, and asthenia.