TuftsMedicine
Integrated Network

Treating Depression in Adolescents and Children: A Guide for Family Medicine and Pediatrics

Dr. Neha Sharma Tufts Medical Center
Child/Adolescent Psychiatry Fellowship Director
Director of Gen CAP Clinic,
Live Recorded Session 3/16/2023

Reminders for today's CME Program

- **Welcome!**
- Please put your questions in the Q&A box during the Zoom presentation and we will try to answer live or will address at the end of the presentation.
- Today's presentation and medication guides will be available on the TMIN website and in the TUSM eeds learning platform.
- Today's session will be recorded, and CME credit may be obtained for this live session or clinicians may also receive credit for listening to the recorded lecture.

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Treating Depression in Adolescents and Children: A Guide for Family Medicine and Pediatrics

Neha Sharma, DO

March 16, 2023 – 12:15PM – 1:00PM

Virtual Live Course

Jointly provided by Tufts University School of Medicine
Office of Continuing Education (TUSM OCE)
and Tufts Medicine Integrated Network

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Activity Goal and Learner Objectives/Outcomes

Activity Goal: The goal of this activity is to increase knowledge, awareness, and comfort with evidence-based treatment of depression in primary care.

Learner Objectives - At the conclusion of the activity, learners will be able to:

- Diagnose and prescribe treatment, including pharmacotherapy, for their primary care patients with depression.
- Identify two first line antidepressant medications.
- Employ the skills identified in this program to better meet the needs of patients with depression.
- Identify times when psychiatric referral or consultation is needed.

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Commercial Support

No commercial support.

Exhibitors

Exhibitors will not be present.

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TMIN Team HOPEFUL

- Initiated by Tufts Medicine Integrated Network (TMIN) North Region Council

- “Innovation Team” of physicians, social workers and administrators came together to identify gaps in behavioral health (BH) resources and support so Tufts Medicine can easily **connect adults and children to solutions** they need to lead ***hopeful, fulfilling lives unburdened by mental health and substance use disorders***

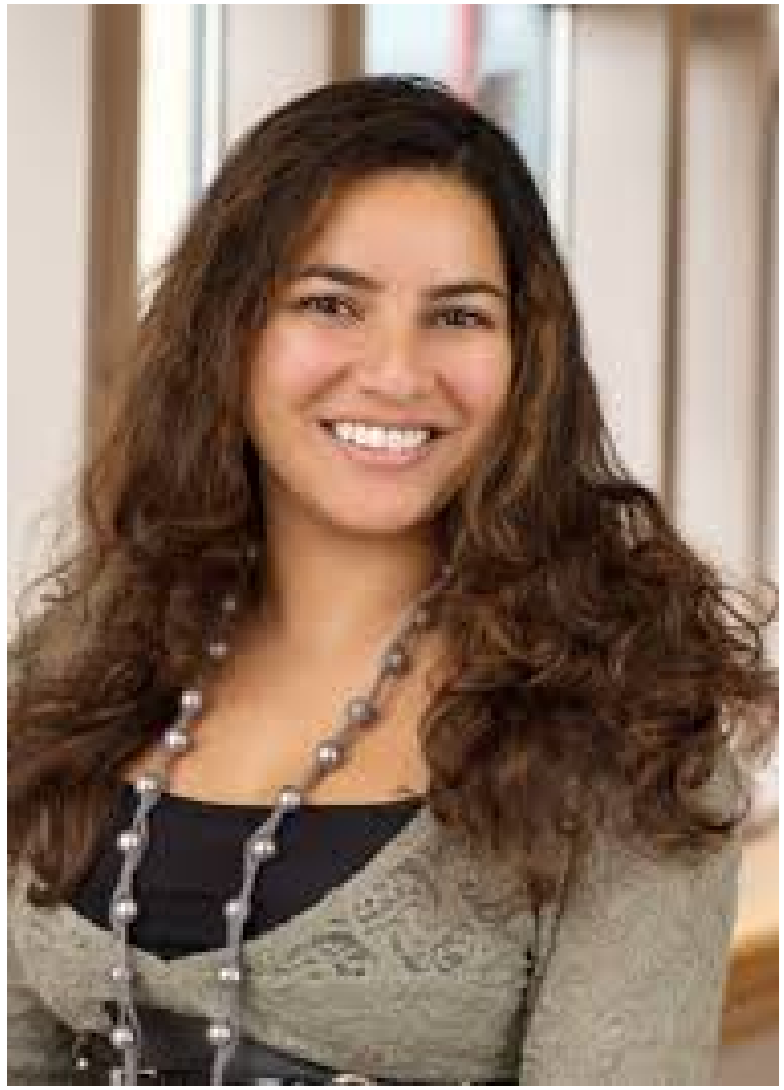
- One of the identified gaps was psycho-pharm education for Primary Care Clinicians

Meet Dr. Neha Sharma

- Program Director of the Child and Adolescent Psychiatry Fellowship Program at Tufts Medicine
- Specializes in anxiety and mood disorders and cultural psychiatry with focus on family systems
- Inaugural co-chair of Diversity, Equity, and Inclusion Subcommittee for Tufts GME
- Associate Professor and Course Director – Introduction to Clinical Psychiatry at TUSM
- Co-editor/lead author of book: Suicide in Diverse Youth – A Case Based Guidebook

Training:

- Bachelor of Neuroscience and Cell Biology, Rutgers University
- Medical School: New York College of Osteopathic Medicine of NYIT
- General Psychiatry Residency: Rutgers University
- Fellowship in Child and Adolescent Psychiatry, Tufts Medical Center



Treating Adolescent and Pediatric Depression: A Guide for Primary Care

Dr. Neha Sharma, the speaker for this ACCME accredited CME program, has no relevant financial or other disclosures to report.

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4. Identify times when psychiatric referral or consultation is needed.

Treating Adolescent and Pediatric Depression: A Guide for Primary Care

Case: Amy

- 15-year-old teenage girl whose has not been able to go to school for one week due to severe fatigue and difficulty sleeping.
- There is increased irritability that has made relationships more challenging.
- PHQ-9: 14, including hopelessness, SI (suicidal ideation).
- Relevant history: Patient had a breakup with her boyfriend a month ago which has also resulted in loss of a few friends.

What would you do next?

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Should you Treat or Refer to Psychiatry?

Refer to Psychiatry if:

- Depression is severe
- Significant suicidal ideation and self-injurious behavior
- Inability to function
- Patient has a history of bipolar disorder
- There is a co-morbidity of Autism Spectrum Disorder
- There is acute psychosis
- There is active severe substance use disorder

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How to start Treatment?

Establish a treatment alliance

- Empathic statements
- Reassurance

Encourage basic lifestyle improvements

- Encourage engaging with family and friends
- Encourage not giving up on extra curricular activities
- Encourage regular sleep and diet
- Reframe the sick role for patient and family/significant others

Lab Work

- Pregnancy test if biologically female
- Check for hypothyroidism
- Urine toxicology

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Should you Refer to Therapy?

- Therapy alone may treat mild depression / anxiety
- Therapy is the standard treatment for mild, moderate, and severe anxiety
- Combination therapy & medications usually indicated for moderate and severe depression
- Meds should be considered if the patient is in moderate or severe depression and/or if patient is unable to engage in therapy due to severity of illness

First Line Antidepressants

- Sertraline (Zoloft): 12.5 mg daily, increase to 25 mg after 2 weeks if tolerated
- Fluoxetine (Prozac): 5 mg daily, increase to 10 mg after 2 weeks if tolerated
- Escitalopram (Lexapro): Start 5 mg daily, increase to 10 mg after 2 weeks if tolerated
- Citalopram (Celexa): 5 mg daily, increase to 10 mg after 2 weeks if tolerated

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Back to Amy's Case: 15-year-old teenage girl who has not been able to go to school for one week due to severe fatigue and difficulty sleeping. There is increased irritability that has made relationships more challenging.

- Assess seriousness of Suicidal Ideation (SI), trigger being reactive or planned, history of suicidal behaviors, and differentiate from Self Injurious Behavior (SIB).
- Provide lifestyle advice - especially, increase in the usual activities without exhausting the adolescent.
- Assess for sleep hygiene and suggest appropriate sleep agent to facilitate improved sleep (Melatonin 1-3 mg PO at 6-7PM).
- Assess for substance use and encourage limited use while in depressive episode.
- Start sertraline (Zoloft) HCl 12.5 mg PO daily, increase to 25 mg after 2 weeks if tolerated and then to 50 mg.

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How to choose antidepressants based on symptom profile?

- Comorbid anxiety: Sertraline (Zoloft) or other SSRI
- Comorbid ADHD: Bupropion (Wellbutrin) (only if anxiety and eating disorder are not a comorbidity - very rare)
- Comorbid pain (ex. If co-morbidity is juvenile RA): Duloxetine (Cymbalta)

If no improvement at 2 weeks - Increase dose:

Maximum doses of first line antidepressants:

- Sertraline: Up to 150 mg daily
- Escitalopram (Lexapro): Up to 20 mg daily
- Bupropion: 150 mg daily

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Improvement at 2 weeks? If YES:

- Continue medication
- See patient in 4 weeks, then periodically
- Plan to continue medication for at least 6-12 months

If NO adequate improvement at 8-12 weeks, even with optimal dosing:

Option 1:	Option 2:
• Augment with another medication • Add bupropion (Wellbutrin) to an SSRI or add an SSRI to bupropion (only if anxiety and eating disorder are not a comorbidity) • Add aripiprazole (Abilify)	• Switch to a different medication (if not even a little response, or can't tolerate first medication) • Switch to a different SSRI

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Back to Amy

- Sertraline (Zoloft) increased fatigue despite improvement in mood
- Cross taper sertraline and fluoxetine (Prozac):
- Reduce sertraline from 50 mg to 25 mg and start fluoxetine 5 mg PO daily. 2 weeks later, discontinue sertraline and increase fluoxetine to 10 mg PO daily. Then, reassess.

More advanced options

- Treatment resistant depression (no response to 2-3 AD trials)
- Consult BH specialist
- More elaborate augmentation (dependent on co-morbidities)
- Aripiprazole (Abilify), Risperidone (Risperdal), Lurasidone (Latuda)

Amy

- Mood improved on fluoxetine
- Residual occasional insomnia, melatonin is ineffective. Consider low dosage of trazodone (25 mg)

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Questions/Resources

For more information:

Neha.Sharma@tuftsmedicine.org

TMIN's Abbreviated Pediatric Depression Medication Chart

AACAP.org

Treating Adolescent and Pediatric Depression: A Guide for Primary Care

Evidence-Based References

1. Martin A, Bloch M, and Volkmar FR. “Depressive Disorders” Lewis’s Child and Adolescent Psychiatry: A Comprehensive Textbook. 5th Ed. Philadelphia, PA: Lippincott Williams & Wilkins, 2017. 473-482.
2. Martin A, Bloch M, and Volkmar FR. “Bipolar Disorder” Lewis’s Child and Adolescent Psychiatry: A Comprehensive Textbook. 5th Ed. Philadelphia, PA: Lippincott Williams & Wilkins, 2007. 483-499.
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4. Nooner K, Roy A., and Pine D. “Neurobiology of Early-onset Anxiety Disorders” Pediatric Psychopharmacology. 139-146.
5. “Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorder.” Journal of American Academy of Children and Adolescent Psychiatry.59:10, February 2020. 1107–1124.
6. Walter HJ and eds. “Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Major and Persistent Depressive Disorder.” Journal of American Academy of Children and Adolescent Psychiatry.46:2, October 2022. 267-283.

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