Pharmacy Pearls

Antidepressant Management Algorithm for Pediatric PCPs for ages 12+

Adapted from: 2018 GLAD-PC Toolkit, Available at: gladpc.org

Assess Depression Severity

Mild Depressive Symptoms or Functional Impairment
PHQ-9 score of 5-9
Management:
- Active Support and monitoring[a] every 1-2 weeks for 6-8 weeks

Moderate Depressive Symptoms or Functional Impairment
PHQ-9 score of 10-19
Management:
- Care management referral **and**
- Consider BHI team consult **and/or**
- Referral for psychotherapy
- Assess need for pharmacotherapy

Severe Depressive Symptoms or Functional Impairment
PHQ-9 score of ≥20
Management:
- Initiate pharmacotherapy **and**
- Care management referral **and**
- Consult BHI team **and**
- Referral for psychotherapy

If Antidepressant Initiated

SSRIs are medication of choice.
- Choice may be based on: age, presenting symptoms, physical health status, other mental health comorbidities, safety and tolerability, patient/family history of medication response, patient preference, cost, and potential drug interactions
- **Fluoxetine** (ages 8+) and **escitalopram** (12+) are the only SSRIs with FDA labeling for children/adolescents; **citalopram** and **sertraline** have positive studies in adolescent depression; *Maximize dose before considering treatment failure*
- Set expectations about time to effect as well as side effects and that they diminish over time
- Counsel patients and caregivers on medication safety including: suicidality, common SSRI side effects, adult supervised administration, likely treatment duration, discontinuation symptoms with missed doses/cessation

Follow-up Assessment every 2 weeks

Assess response (PHQ-9), presenting symptoms or impairment, side effects, adherence, and suicide risk at each visit. Treatment goal is Remission (PHQ-9 of <5).

Good Response
After 6-8 wks; Reduction in PHQ-9 of ≥50%
Management:
- Continue therapy(s)
- Reassess Q4 weeks until remission

Remission and Maintenance:
- Continue medication for 12 months after remission then monitor monthly x 6 months
- Continue to monitor for 6 to 24 months whether or not referred for psychotherapy

Partial Response
After 6-8 wks; PHQ-9 improves, but <50%
Management:
1. Consider:
   - Care management referral **and**
   - Consider BHI team consult **and/or**
   - Pharmacotherapy, if not started **or**
   - Dose increase as tolerated to max. **or**
   - Adding psychotherapy if not started
2. Provide further education, review safety plan and continue ongoing monitoring

No Response
After 6-8 wks; No or minimal PHQ-9 reduction
Management:
1. Reassess diagnosis (e.g. bipolar)
2. Consider:
   - Care management referral **and**
   - Consider BHI team consult **and/or**
   - Pharmacotherapy, if not started **or**
   - Dose increase as tolerated to max. **or**
   - Medication change if on max. dose **or**
   - Adding psychotherapy if not started
3. Provide further education, review safety plan and continue ongoing monitoring

[a]Psychoeducation, sleep hygiene, supportive counseling, facilitate parental and patient self-management, refer for peer support, and regularly monitor for depressive symptoms and suicidality

Antidepressant Management Tables for Pediatric PCPs for ages 12+

1. Antidepressant Dosing and Side Effects

	Dosing for Ages 12+				SAFETY[2]	EFFICACY
SSRI Medication	**Starting Dose**	**Titration[1] Increments (mg)**	**Therapeutic Dose (mg)**	**Maximum Dose (mg)**	**Side Effects[3]** *evaluate each for drug interactions*	**RCT Evidence** ***FDA approved*
First-line Agents						
Fluoxetine	10 mg PO daily	10-20	20	60	Headaches, GI upset, insomnia, agitation, anxiety *Note:* long half-life minimizes risk of discontinuation syndrome with poor adherence	Y**
Second-line Agents						
Escitalopram	5 mg PO daily	5	10-20	20	Headaches, GI upset, insomnia	Y**
Third-line Agents						
Citalopram	10 mg PO daily	10	20	40	Headaches, GI upset, insomnia	Y
Sertraline	25 mg PO daily	12.5-25	100	200	Headaches, GI upset	Y

[1]**Optmizing the SSRI dose:** Full medication effects will not be observed until 4-6 weeks after initiation; however, *some* response should be observed at 2-3 weeks of a therapeutic dose. If no response at 2-3 weeks, the dose should be increased. Optimal dose is when significant improvement occurs in presenting symptoms, PHQ-9 score is <5 and side effects of medication are either absent or tolerable

[2]**Side effect evaluation:** If mild, wait 7 days to determine if transient. If they persist but are tolerable, continue on the dose. If side effects are moderate, reduce the dose or change the dosing schedule or drug. If side effects are severe, discontinue or change the medication as soon as possible.

[3]**Treatment Emergent Activation Syndrome (TEAS)** (common and tends to occur in early treatment phase; presents as agitation, dysphoria, or akathisia, with no striking mood changes) may occur with any SSRI, consult BHI team if concerns arise; often responds to dose reduction or slowed titration.

Other potential common side effects may include: dry mouth, sweating, irritability, disinhibition, agitation, jitteriness, appetite changes, or rash

More serious, less common side effects include: serotonin syndrome, akathisia, hypomania, or discontinuation syndrome

2. SSRI Switch Strategy

Cross tapering (gradually decreasing one agent while simultaneously increasing the other) should be considered when switching between SSRIs in children/adolescents.

	Cross Taper
Benefits	Minimizes discontinuation syndrome* and symptom relapse
Risks	Drug interactions, serotonin syndrome, adverse effects
Tapering/Starting Schedule	Typically accomplished over 1-4 weeks. Longer durations may be warranted if doses are high, return of depressive symptoms, symptoms of withdrawal or side effects **Consult BHI team or refer to GLAD-PC toolkit for suggested up and down taper schedules.**
Exceptions	**Fluoxetine,** due to its long half-life, stop fluoxetine and start the new SSRI 4-7 days after the last dose

*Discontinuation syndrome (occurs with prolonged use of >1 month after abrupt cessation, 1-7 days after stopping; presents as dizziness insomnia, nightmares, flu-like symptoms) is of more concern with **paroxetine,** which is not typically used in adolescents. Other factors that increase risk: shorter drug elimination half-life (<24 hours), higher antidepressant doses, prior history of discontinuation syndrome, etc.

3. Use of other agents

If a child/adolescent fails 2 SSRI trials at maximum tolerated doses, **consult BHI team** for additional management strategies.