Adolescents with prodromal psychosis had better outcomes with antidepresants than antipsychotics.

BY DIANA MAHONEY
New England Bureau

Atlanta — Adolescents with prodromal psychosis are more likely to receive antidepresants than antipsychotics, according to Dr. Brian Cornblatt, director of the RAP program at Columbia University.

"It seems that the antidepresants are more tolerated and have some kind of protective effect," said Dr. Cornblatt.

The RAP program began in 1997 and typically serves adolescents between the ages of 12 and 18 who fall somewhere on the prodromal psychosis continuum and have been referred to the stand-alone RAP clinic for treatment.

The objective of the research arm of the RAP program is to gain insight into the natural history and developmental course of psychotic disorders, as well as to understand the effects of different medications at different phases of the illness using a naturalistic vs. randomized control format.

"Our researchers treat patients as they would if they were in private practice with respect to selecting drug and behavior therapy. We give them no input; there's no ideation of our hypotheses. When they prescribe medication, it's based on the symptoms being displayed, not the notion of prevention," Dr. Cornblatt said.

To date, 152 patients at a mean age of 15 years have completed the baseline research procedures and have been divided into three subgroups:

- Clinical high-risk negative patients, who meet prodromal criteria but have only exhibited nonspecific negative symptoms, such as anhedonia and lack of affect.
- Clinical high-risk positive patients, who have attenuated positive prodromal symptoms (delusions and hallucinations, as well as disorganized thoughts and speech).
- Clinical high-risk “slip” patients, who position themselves into first-episode psychosis,” Dr. Cornblatt explained.

The adherence/conversion data come from a sample of 30 clinical high-risk positive patients who had at least one follow-up and available adherence rates. Although no significant differences were found in baseline symptoms, 22 of the patients were prescribed antidepresants, 11 received monotherapy with second-generation antipsychotics (either olanzapine or risperidone), and 17 received combination therapy of antidepresants and antipsychotics.

"For purposes of reporting outcome, the two groups that received antipsychotic medications were combined because we didn't find any difference between the baseline characteristics or outcome between combination [and] monotherapy," Dr. Cornblatt said.

During the follow-up period, investigators found that 13 of the 50 patients developed psychoses. Of the 13 who converted, 12 were receiving antipsychotic medications.

"In other words, nearly half the patients being treated with antipsychotics converted, compared with 1 out of 22 patients on antidepresants," Dr. Cornblatt noted.

The only major difference that was noted between these two groups, other than the class of medication they received, was noncompliance to medication. Approximately 64% of adolescents prescribed antipsychotics were noncompliant, compared with 18% of those prescribed antidepresants alone.

In general, the females in the study were more compliant with medication, and the older boys were the least compliant, suggesting that the earlier therapy is introduced, the more successful it might be," Dr. Cornblatt said.

The low conversion rate in this study among those adolescents who stayed on their antidepressant medication and the high conversion rate among those who were medication noncompliant generate several hypotheses.

"It’s possible that the negative symptoms set up some sort of biologic vulnerability, and antidepresants directly affects these underlying negative components," Dr. Cornblatt said.

It’s also possible that, although noncompliance doesn’t cause positive symptoms, it could act as a trigger that makes them worse or more likely to progress to psychosis,” she said.

Although the outcome data from this investigation are "obviously not the final word because the study was not randomized, it does make the case that treating prodromal individuals with antidepresants does not cause any damage and might have some kind of positive effect," she said.

"And it also points to medication noncompliance as a possible stressor, and one that we might be able to deal with," Dr. Cornblatt noted.

Symptoms of Pediatric Delirium Often Overlooked, Mistreated

BY JANE SALOUDO MacNeil
Southwest Bureau

Santa Ana Pueblo, N.M. — Pediatric delirium is rarely discussed in the medical literature and hardly ever diagnosed in practice, but Dr. Susan Beckett-Turkel contends that children can be as vulnerable as elderly patients.

"I think when we say that children don’t get delirium, it is because it is very rarely diagnosed by pediatricians, and most consultation-liaison psychiatrists don’t bump into it," Dr. Turkel said at the annual meeting of the American Psychiatric Association.

"While the second-generation antipsychotics may have a positive effect in treating symptoms, if adolescents won’t stay on them, the drugs cannot possibly be effective," said Dr. Cornblatt, director of the RAP program.

"On the other hand, it seems that the antidepresants are more tolerated and have some kind of protective effect, though exactly what that may be is not yet clear," she said.

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"And it also points to medication noncompliance as a possible stressor, and one that we might be able to deal with," Dr. Cornblatt noted.

As many adult diagnostic techniques cannot be used with very young children, she suggested asking pediatric hospital patients where they are.

"If they tell you they are at home or at school, you can tell they are disoriented," she said. "They don’t have the same specificity you get from an adult.

Sometimes a child will talk to someone who is not there, she said. Mood changes, irritability, and sleep changes also are clues.

"The interruption may not be picked up, but we get the consult because they are not sleeping," she said. "They nap a little while, and wake up really cranky."

Dr. Turkel described her approach to delirium treatment as multifaceted. Physicians treat the underlying condition, she said, but also look for sedating and anticholinergic medications that may be playing a role.

She said she closely follows the child’s family advising parents that their job is to tell where children are each time they wake up irritable and confused . "You tell them … You are in the hospital, you are sick, and mommy is here." That is often enough to calm them down," she said.

Positioning the children near a window can help them distinguish day from night, she added.

If these interventions do not work, Dr. Turkel said she gives the child a small dose of an atypical antipsychotic or sedative.

Benzodiazepines and anticholinergic agents should be avoided, she said, as they can make delirium worse and even precipitate delirium.