

### PAL Press

Summer 2011

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Wyoming

Department

of Health

### We are Ready to Help!

The child psychiatrists working with the Partnership Access Line (PAL) are available to collaborate with you any time you wish, Monday through Friday between 9AM and 6PM. As always, consultation services are available at <u>no cost</u> to you or your patients since the program is being provided to you by the Wyoming Department of Health. If you haven't yet had a chance, give us a try at 877-501-PALS (7257), or check us out on our website, **www.wyomingPAL.org**!

## "Do You Ever Recommend Melatonin for Childhood Insomnia?"

Yes I do, for selected cases that do not respond to good sleep hygiene interventions. For instance, if a child has a television in their bedroom I would not expect a medication like melatonin to be of any help. (For a list of tips on sleep hygiene, check out our care guide at www.wyomingPAL.org.)

Melatonin blood levels normally rise every evening, which is associated with the onset of circadian rhythm sleepiness. Oral administration of about 0.3mg melatonin has been shown to create blood levels roughly equivalent this normal physiologic surge. Trials of giving melatonin as a treatment for sleep problems associated with childhood neurodevelopmental disorders, blindness, autism or ADHD have shown it can be effective. My experience is that this is a rather hit or miss phenomenon, that there are some children for whom this seems clearly effective as a sleep aide and others for whom there is no benefit at all.

There are no clear dosing guidelines for melatonin. The limited research that has been done in children has used doses in the range of 1-5mg taken an hour or so before bedtime, and I recommend staying within that dosing range. Manufacture of melatonin supplements is not FDA regulated or monitored, so we should warn parents there may be product variations in strength, purity and efficacy. The long term safety of melatonin supplements is also not well researched. Reports of impacts on seizure threshold, hormone balance, and concern about use during pregnancy

are some cause for caution. As with all sleep aides, I avoid combining this with other CNS depressants. The good news is that as a sleep aid, melatonin does not appear to create tolerance or addiction.

- Robert Hilt, MD, FAAP (PAL psychiatrist)

#### Free CME II Events

- Casper -September 24,
- Jackson -January 21, 2012

See page 4 for more details

# "Which SSRI Should I Start with for a Medication Naïve Depressed Adolescent?"

We have the most research evidence to support the use of fluoxetine (Prozac) in treating adolescent depression, in addition to its having an FDA approval. Sertraline (Zoloft), citalopram (Celexa), and escitalopram (Lexapro, the racemic isomer of citalopram) are next in line with evidence to support their use.

The long half life of fluoxetine (4-6 days) makes it a good choice if remembering to take doses is an issue, due to a lower chance of seeing any discontinuation side effects. Discontinuation side effects (flu like symptoms, nausea, dizziness, sensory disturbances, insomnia, imbalance, and hyperarousal) might happen if an SSRI is stopped abruptly or if a dose is missed. If the patient is non-compliant and these symptoms are experienced, it may affect future compliance. The down side is that if there are direct side effects from the medicine, they may take longer to subside once the medication is discontinued.

Family member experiences with a given SSRI are also an important consideration. Theoretically there may be some biological basis behind a familial response to a medication, though simply hearing a medication is "bad" can create a

negative experience. I generally find it best to take family experiences into account when selecting a medicine.

Medication interactions are another consideration. For instance since fluoxetine is a CYP2D6 selective inhibitor, it can interact with atomoxetine (Strattera – which is metabolized by CYP2D6) and increase its plasma levels. Citalopram and escitalopram tend to have less medication interactions and thus may be preferred in the setting of using other medications.

Fluoxetine, sertraline, citalopram and escitalopram are all available in both liquid and tablet forms. I usually recommend starting with very low doses of SSRI for at least the first 3-7 days to minimize side effects, which might involve either taking just half of the smallest available tablet, or taking a similar dosage using the liquid form. At the start of administering any SSRI close monitoring should occur, and the family should be asked to help watch for the worrisome rare but potential side effects of agitation, manic like symptoms, or suicidal thoughts.

-Kari Hancock, MD (PAL psychiatrist)

### "Do You Use Lamotrigine (Lamictal) to Treat Bipolar Disorder in Children?"

I do, but I think its role in treatment is unique. Lamotrigine has been reported in a few, limited open label studies to be an effective adjunctive treatment for adolescent bipolar disorder. With adults, lamotrigine is more clearly shown to be an effective "maintenance" medication, particularly for bipolar depression, but it is not terribly effective for acutely treating depression or mania. It takes weeks to months for lamotrigine to start working, so quick results should not be expected. I personally consider prescribing lamotrigine to treat adolescent bipolar depression, or for maintenance bipolar therapy where side effects to more commonly used moods stabilizers (anti-convulsants, lithium, and antipsychotic medications) have been a problem.

Since lamotrigine is not approved for treating mood disorders in children, dosing guidelines and uses are extrapolated from adult data and from dosing guidelines in pediatric seizure disorders. For adolescents, my recommendation would be 25mg/day for 2 weeks, then 50 mg/day for 2 weeks, then

100mg/day for 1 week. After this, dose increases if necessary are in range of 50mg per week up to maximum of 200 mg/day. In the presence of valproate, these doses should be reduced by half.

Use of lamotrigine in pediatric bipolar has been limited by the risk of potentially lethal rashes (Steven Johnson syndrome and toxic epidermal necrolysis), which tend to occur in the first few months of use. The risk of rash is higher in children <16 years old, and in patients also taking valproate (Depakote, Depakene, valproic acid). Conservative dosing such as described above reduces the incidence of serious rashes. I discontinue lamotrigine or at least do a dose decrease if no other explanation for a rash is found. I refer any child with a serious rash, especially involving mucous membranes, to the emergency room for evaluation. Lamotrigine, like other anticonvulsants, also has a black-box warning regarding increased risk of suicide, so this is another aspect to include in your informed consent.

- David Camenisch, MD, MPH (PAL psychiatrist)

Summer 2011 Page 3

### "What Do You Advise for Tantrums or Meltdowns?"

What I recommend depends on what is causing them, which I generally divide into two causes: The first cause of meltdowns is when a child's abilities to cope and communicate are overwhelmed. A child who is afraid, frustrated, or distressed may not be able to communicate these feelings verbally, and may act out as their form of communication instead. Meltdowns can occur in any child, but children with developmental disabilities, language disorders, and autism spectrum disorders are especially vulnerable. For this cause, I advise the parent try to identify and label the child's emotional state, like saying, "You feel really scared right now" and then respond to or otherwise address their fear. When we get it right, the child feels understood and the buildup toward a meltdown goes away. We can then reduce future meltdowns by decreasing a child's exposure to situations that trigger them and teaching children how to cope with distress.

The second reason children engage in tantrums or meltdowns is because it is working for them. It may not be working perfectly, but a meltdown that achieves a desired result is functional. Behaviors that work well are likely to be repeated and even escalated if the result is not obtained as quickly as before.

Take the example of child who wants but is denied a toy in the department store. Frustrated and sad, they begin to cry or if frustrated and mad, they begin to yell. Nothing happens at first, so they get louder. Perhaps they grab onto the toy, or refuse to get off the floor. Finally, in moment of understandable weakness, the parent relents and the wish is granted. Like magic, the tantrum is over. The child gets the toy. But the child also stumbles on a very useful strategy: Cry, beg, or scream and I get what I want and, if it isn't working, try harder. Moreover, as we've learned from behavioral therapy, the most effective way of maintaining a behavior is to randomly reinforce it with intermittent rewards. Rewards can be attention, a desired activity, a desired toy, or even escape from a distressing or unpleasant situation. Thus, a parent who withstands the onslaught of a child's temper, then gives in when the tantrum is simply too loud or too long to be ignored, has just reinforced the very behavior they worked so hard to eradicate.

The key in this situation is to identify triggers of behavior (in this case, the frustration of not getting a desired object) and reinforcements (getting the toy), and changing them. Positive attention for positive behaviors (praise and attention for the child who does not tantrum when he or she doesn't get the toy) and withdrawal of attention for negative behaviors (ignoring the tantrums) is most likely to change the behavior over time.

-A. A. Golombek, MD (PAL psychiatrist)



Partnership Access Line Mental Health Consultation Outreach For children





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### **Upcoming Free CME II Events**

Casper - September 24, 2011

Jackson - January 21, 2012

Earn 4 hours of Category II CME Credits through Seattle Children's Hospital.

Call Amy Barragan to Register at 509.534.4688

We hope to see you there!



Partnership Access Line Mental Health Consultation Outreach For children



The Partnership Access Line (PAL) is a State-funded Psychiatric consultation service, operated through Seattle Children's Hospital. If you are a primary care provider and would like to consult on your child or adolescent patients' mental health, please call the PAL Program at (877) 501-PALS (7257).