07 - After prescribing

After prescribing

Prescribing in children and adolescents CHAPTER 5 are approved for use in adults with treatment--resistant depression, but there is no substantial evidence in children and adolescents.31 With regard to ketamine, or its enantiomer esketamine, emerging evidence suggests that it may be effective and adequately tolerated in adolescents with treatment-resistant depression based on a small number of studies, including two small RCTs.36–38 Considering rTMS, initial evidence suggested that it may be effective, again based on a small number of studies and a small RCT, but a larger RCT found no evidence of effectiveness.39 Electroconvulsive therapy (ECT) has limited evidence of effectiveness in young people, although one randomised trial in adolescents showed good effect against both depression and suicide.40 Therefore, these treatments' unknown potential effects on the developing brain need to be considered carefully and weighed up against the risks of not attempting these treatments.41 Further research is greatly needed to inform clinical decisions.42 ■ ■NICE warns against prescribing paroxetine, venlafaxine, tricyclic antidepressants or St John's wort for depression in young people, because of potential adverse effects and interactions.4 Table 5.2 summarises medication treatment for depression in children and adolescents. After prescribing Acute phase ■ ■Monitor for adverse effects regularly, for example weekly for the first 4 weeks. Children and adolescents generally tolerate SSRIs well. Potential adverse effects include those experienced by adults, described in Chapter 3. Additionally, young people taking SSRIs have a small increased risk of suicidality and switch to mania, as well as activation effects (see 'Specific issues' later in this chapter). Therefore, risk of harm, mood and behaviour should be monitored closely and addressed.3,4,6,31 ■ ■After 4 weeks of SSRI treatment at a therapeutic dose, assess response including depression severity using the measures completed at baseline. Most therapeutic effects appear by 4 weeks.43 ■ ■If partial or non--response, consider the possibility of poor treatment adherence, inaccurate diagnosis, comorbidity or modifiable maintaining factors. Table 5.2 Summary of pharmacotherapy for depression in children and adolescents.3,4,6,31 Medication Starting dose Therapeutic dose range First line Fluoxetine 10mg/day 20–60mg/day Second line Sertraline Escitalopram Citalopram* 25–50mg/day - 5–10mg/day 10mg/day 50–200mg/day 10–20mg/day 20–40mg/day Subsequently Consider augmentation of antidepressant with second-generation antipsychotic or lithium.† Consider switching to an antidepressant from a different class, such as mirtazapine. *Caution advised in cardiac or hepatic disease. †No randomised controlled trials available in young people (but there is evidence from adult trials).

Revision #1
Created 2026-01-04 20:16:31 UTC by Omar Ayman
Updated 2026-01-04 20:16:31 UTC by Omar Ayman