

08 - Specific issues

Specific issues

570 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 5 ■ ■ If none of these factors explains the continued depressive symptoms and the young person does not have adverse effects, consider increasing the dose. Reassess every 4 weeks.^{3,31} This recommendation is largely based on evidence from adult depression trials, which have demonstrated small but significant improvements in depression symptoms with higher doses of SSRIs,⁴⁴ as there has been only limited research on this topic in children and adolescents.⁴⁵ ■ ■ If adverse effects develop, consider reducing the dose to the highest tolerated dose. ■ ■ If partial or non-response after 8 weeks of the maximum recommended (or highest tolerated) therapeutic dose of an SSRI, consider the medication changes outlined earlier.³¹ Maintenance phase Continue medication for 6–12 months after remission to reduce the risk of relapse. Consider a longer maintenance phase if depressive episodes were recurrent or chronic.^{3,4,6,31} Again, this recommendation is largely based on evidence from adult depression trials, in addition to very limited research in children and adolescents.^{46,47} Discontinuation phase Discontinuation may be considered after the maintenance phase. This is best undertaken during a period of low stress. Taper medications slowly and hyperbolically (see Chapter 3) to minimise the risk of discontinuation symptoms.^{3,4,6,31} Specific issues ■ ■ Age The evidence base for these recommendations is stronger for adolescents than for children, so caution should be higher when considering prescribing for children. There has been no research investigating antidepressant medication use in pre-school children, and medications are not recommended for this age group.^{4,22} ■ ■ Suicidality Antidepressant medication has been linked to an increased risk of suicidality in young people, which led to warnings issued by the US FDA, the European Medicines Agency and the UK MHRA in 2003–2005. Subsequent meta-analyses have also found evidence of this association with reported suicidality,^{11,22,48} particularly for venlafaxine,^{16,23} as well as a link with aggression.⁴⁹ A meta-analysis of reported suicidal thoughts or attempts in depression trials found a pooled absolute rate in antidepressant-treated young people of 3% and in those receiving placebo of 2%, giving a number needed to harm (NNH) of 112 (note these rates are low, probably because those with high risk of suicidality were often excluded from trials).⁵⁰ Concern has also been expressed about emergent suicidality with escitalopram.⁵¹ To date, there has been no link between antidepressant use and completed suicides, but extreme care should be exercised. Untreated depression is a significant risk factor for suicidality. After the FDA warning on antidepressant use in children and adolescents, antidepressant use declined, untreated depression increased and suicide rates increased.^{52,53} Given the risks of untreated depression, including completed suicide and impaired functioning, and that many more patients benefit from SSRIs than those who experience these serious adverse events, it is thought that the benefits of antidepressants, particularly fluoxetine, are

Revision #1

Created 2026-01-04 20:16:32 UTC by Omar Ayman

Updated 2026-01-04 20:16:32 UTC by Omar Ayman