11 - Clinical guidance

Clinical guidance

Prescribing in children and adolescents CHAPTER 5 Bipolar disorder in children and adolescents Clinical guidance Before prescribing ■ ■Establish clinical diagnosis informed by structured instrument assessment if possible. Symptom checklists should be avoided, especially in primary care. Try to monitor symptom patterns prospectively with mood or sleep diaries. If in doubt, seek specialist advice early on. ■ ■Explain the diagnosis to the patient and family and invest time and effort in psycho education. This is likely to improve adherence and help children and adolescents and their families appreciate early warning signs of a relapse. Furthermore, there is evidence that such approaches reduce relapse rates, at least in adults.1 ■ ■Measure baseline symptoms of mania (e.g. Young Mania Rating Scale2 [YMRS] and the parent YMRS3), depression (e.g. Children's Depression Rating Scale4 [CDRS]) and impairment (e.g. Clinical Global Impression – BD version5). Use these to set clear and realistic treatment goals. ■ ■Measure baseline height, weight, waist and hip circumference, pulse, blood pressure and electrocardiogram (ECG) and obtain baseline bloods as appropriate (fasting blood glucose, HbA1c, fasting lipid profile, full blood count [FBC], urea and electrolytes [U&E], creatine kinase, LFTs, prolactin and thyroid function). What to prescribe ■ ■Tables 5.3, 5.4, 5.5 and 5.6 summarise medication use in bipolar mania and depression and acute mania. ■ ■For the treatment of mania and hypomania in children and adolescents, UK NICE guidelines suggest following the same recommendations as for adults – second- generation antipsychotics (SGAs) may be used as first-line treatment, and mood stabilisers (MS) can be added after a failure of two trials of SGAs.6 The difference in comparison with adult guidelines is that NICE recommends that SGAs should not be routinely offered for more than 12 weeks. This information should be shared with the child or adolescent and their family. ■ ■SGAs seem to show greater short-term efficacy (effect size [ES] = 0.65 compared with placebo) than MS (ES = 0.20 compared with placebo) in youth, according to a 2010 meta-analysis.7 ■ ■SGAs produce significantly greater weight gain (particularly olanzapine) and somnolence in children and adolescents compared with adults,7 although weight gain assessment is made complicated by normal growth at this time of life. ■ ■Valproate should be completely avoided in all adolescents. ■ ■Adherence to lithium cannot be assumed and blood level testing may be difficult in adolescents. ■ ■Overall, we recommend the use of SGAs as first line for the acute treatment of mania in children and adolescents (Tables 5.3 and 5.5). ■ ■It is helpful to document family history of response and non-response to pharmacological treatment as there is evidence to suggest that pharmacological response, at least for lithium, runs in families.8

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