تازه های درمان اختلال دوقطبی در کودکان و نوجوانان

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Fewer studies in pediatric, treatment often based adult studies.

However, response may differ between youth and adults.

The mainstay of treatment :pharmacotherapy.

Adjunctive psychotherapy generally: essential.

Prospective and retrospective studies found:

37% were never prescribe animanic medications

24% receive wrong medication of antidepressant monotherapy for mania with or without mixed features.

GENERAL PRINCIPLES OF PHARMACOTHERAPY

assessing patients prior to treatment

prescribing medications to age appropriate patients

using monotherapy, medication combinations, drugs may destabilize patients

monitoring patient progress, duration of an adequate drug trial

information for patients and families.

MANIA

The primary treatments:either as monotherapy or combination therapy, include:

- Second-generation antipsychotics
- Lithium

Psychotherapy always indicated as an adjuvant to pharmacotherapy

Initial drugs for mania

SGA : aripiprazole, asenapine, olanzapine, quetiapine, risperidone, or ziprasidone.

In10 randomized trials efficacy/tolerability established.

As an example, an eight-week open-label trial in youth with mania or mixed mania (n = 279), improvement was greater with risperidone, compared with either lithium or divalproex.

Remission with SGA : 25 to 70 percent of patients / response (eg, reduction of baseline symptoms ≥50 percent) in 50 to 90 percent.

Initial drugs

No head-to-head randomized trials have compared SGAs in youth with mania

Separate trials, the clinical effect of these drugs appears to be comparable.

The specific choice: depends on factors such as past response to medications, side effect profiles, comorbidities, potential drug-drug interactions, patient preference, and cost.

Initial drugs

If do not respond to with one SGA within 4-8 weeks of starting treatment, or do not tolerate the drug:

Tapering and discontinuing the failed medication over one to two weeks, and simultaneously starting and titrating up another SGA..)

Generally attempt 2-3 trials of AS before proceeding to next-step treatment.

Treatment resistant patients

Not respond to multiple (eg, two to three) trials of SGA

partially respond: add lithium to the antipsychotic.

little or no response :taper and discontinue the antipsychotic 1-2 weeks, and at the same time start lithium and titrate the dose up.

Treatment refractory patients

Refractory to monotherapy SGA and lithium: combining a SGA with lithium.

Aside from SGAs plus lithium, other combinations that may be useful include SGAs plus an antiepileptic (eg, divalproex or lamotrigine), lithium plus an antiepileptic (eg, divalproex, lamotrigine, or carbamazepine).

Divalproex: Generally do not use as monotherapy.

Lamotrigine:. However, randomized trials adults mania indicate is not effective.

CBZ: an open-label trial that randomly youth with hypomania or mania to CBZ, lithium or divalproex. Response was comparable with each drug.

CBZ: is often not combined with antipsychotics

FGAs: also cause extrapyramidal symptoms, generally not combined with SGAs.

ECT: used infrequently for adolescents and rarely for younger children.may be beneficial for severe, persistent, and significantly disabling pediatric mania that is refractory to pharmacotherapy, especially episodes with psychosis or catatonia.

Clozapine: Pediatric mania may be refractory to numerous (eg, 8 to 10), but it is typically not used due to concerns about side effects, including agranulocytosis, myocarditis, and seizures.

Nonstandard drugs that are possibly beneficial

Drugs that are possibly helpful for mania, but lack conclusive evidence due to small samples and/or mixed results, include the following:

Omega-3 fatty acids / Celecoxib / Ketamine / Topiramate.

Drugs with little to no benefit: Oxcarbazepine

MANIA WITH MIXED FEATURES

SGAs as first line therapy.

A review: improvement depressive symptoms in 36 to 60 percent of patients.

If does not respond to monotherapy switching to another SGA

If unresponsive to multiple (eg, two to three) trials of a SGA, subsequent treatment is similar to mania without mixed features.

ECT: USE prior to a trial of clozapine for mania with mixed features.

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MANIA WITH PSYCHOTIC FEATURES

SGAs: generally select risperidone or quetiapine, but reasonable alternatives include aripiprazole, olanzapine, or ziprasidone.

If does not respond to monotherapy switching to another SGA

Patients unresponsive multiple (eg, 2-3) trials SGA monotherapy, adding lithium .

Reasonable alternatives to lithium include adjunctive divalproex or lamotrigine.

ECT: USE prior to a trial of clozapine for mania with psychotic features.

Ketamine: An investigational drug for psychosis in patients with bipolar disorder

Hypomania: Despite clinical differences with mania, treatment are similar.

Subsyndromal symptoms: treated same medications that used to treat mania.

Rapid cycling: SGAs

Major depression : lurasidone monotherapy or an alternative SGAs (aripiprazole, olanzapine, quetiapine, and risperidone) plus a SSRI (except Citalopram / paroxetine). However, antidepressants should not used in bipolar major depression with mixed features (symptoms of mania/hypomania).

MAINTENANCE TREATMENT

Continuing the same treatment to prevent recurrences, unless the regimen is poorly tolerated.

There is no indication from head-to-head trials that any drug is superior for MT.

MAINTENANCE TREATMENT

patients with psychotic features who respond to combination treatment, such as a SGA plus lithium, continue both drugs for at least two to six months; combination treatment longer than six months is suggested for patients who were severely ill (eg, attempted suicide) during the index episode or patients whose prior history indicates the need for maintenance treatment with multiple medications.

Patients who remain stable on combination treatment can eventually attempt to gradually taper and discontinue lithium. Patients should subsequently maintain treatment with the SGA.

Duration: Following recovery from acute bipolar mood episodes, continue treatment for at least one to two years.

Although the duration of maintenance treatment varies among patients, some patients require maintenance treatment for many years, and some patients require it their entire lives. Factors to consider include prior response to medication discontinuation, how many years the patient has had bipolar disorder, and the lifetime number and severity of mood episodes. Maintenance treatment should last longer for patients with a more severe course of illness.

clinicians should first try to find better tolerated alternatives.

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If patients insist on stopping treatment, slowly tapering over a period of several months (at least four to six months) unless negative effects dictate a more rapid taper.

For patients who are taking multiple medications, slowly taper and discontinue one drug at a time. The first drug to be removed is generally the adjuvant; if both drugs are considered essential, the first drug to be stopped is the one most likely to cause side effects with long-term use.

During the process of tapering and discontinuing pharmacotherapy, clinicians should monitor patients regularly (eg, every two to four weeks) for prodromal symptoms of recurrence.

Patients and families should be educated about the symptoms of relapse and counseled to quickly seek clinical attention if they occur.

Adjunctive psychotherapy

Psychotherapy is nearly always indicated as an adjuvant to pharmacotherapy for pediatric bipolar disorder. If symptoms are not responding adequately to treatment, the frequency and/or intensity of psychotherapy is increased (multiple visits per week, intensive outpatient program, or partial hospitalization program). However, severe symptoms (eg, agitation, psychosis, or psychomotor retardation) may delay onset of psychotherapy.

First line: psychoeducation as adjunctive psychotherapy with pharmacotherapy

Second line: family therapy

Other options: dialectical behavior therapy, cognitive-behavioral therapy, interpersonal and social rhythm therapy, and motivational interviewing.

Thank
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