EDITOR'S NOTE

This column reflects our commitment to provide you, the primary care physician, with information that will prove helpful in making informed decisions about the care of your patients who suffer from psychiatric disorders. We will highlight abstracts of high interest to you from our sister publication, *The Journal of Clinical Psychiatry*, and summarize pertinent articles from the general scientific literature. We hope that this section is clinically relevant to your practice and that it will encourage you to expand your horizons.

Efficient Identification of Adults With Depression and Dementia

Thibault JM, Steiner RW

Family physicians must determine which patients to screen for depression and dementia as well as how those patients should be screened. Mental health questionnaires can be helpful in this regard. Questionnaires are administered to all patients, regardless of risk status, in practice-based screening, whereas questionnaires are administered only when depression or dementia is suspected in case-finding screening. Although the 2002 U.S. Preventive Services Task Force report recommends screening adults for depression to improve detection and patient outcomes, it does not suggest the use of any particular screening instrument. A good strategy for detecting major depressive episodes in primary care settings includes serial or sequential testing with the Patient Health Questionnaire-2 and the Patient Health Questionnaire-9. The Patient Health Questionnaire-2 consists of 2 questions that assess the presence of anhedonia and dysphoria. If a patient answers "yes" to either question, the more specific Patient Health Questionnaire-9 is administered to evaluate the severity of depressive symptoms and to determine the presence of major depressive episode. The Patient Health Questionnaire-9 can be used to monitor treatment response and symptom severity as well. The 2003 U.S. Preventive Services Task Force report does not recommend for or against routine screening for dementia in older adults. The report does assert, however, that cognitive function should be assessed when impairment is suspected by such tools as the Folstein Mini-Mental State Examination and the Functional Activities Questionnaire. In primary care settings, the Clock Drawing Test has also been shown to be useful.

(Am Fam Physician 2004;70:1101–1110)

Adult Outcome of Child and Adolescent Attention-Deficit/Hyperactivity Disorder in a Primary Care Setting

McCormick LH

Background: The objective of this study was to determine the adult status of children and adolescents previously diagnosed with attention-deficit/hyperactivity disorder (ADHD). ***Method:*** From a consecutive sample, a case series from a primary care, private physician, office-based practice was evaluated. Eligible participants included 77 adults previously diagnosed with ADHD as children and adolescents by DSM-III and IV criteria. Of those, 73 were available for interviews; parents and significant others were also interviewed. The same criteria used originally were employed in the adult follow-up analysis. Rates of ADHD, other psychiatric disorders, and educational attainment were the main outcome measures. ***Results:*** Only 4 (5.5%) of 73 subjects had retained ADHD into adulthood; 69 (94.5%) did not have adult ADHD. Most of the cohort had achieved positive educational attainment, and the majority exhibited no disabling psychopathology. ***Conclusion:*** Adult follow-up of children and adolescents diagnosed with ADHD indicates that adult ADHD is rare in primary care. The data imply that clinicians who concentrate on the evaluation and management of children and adolescents with ADHD can have the greatest impact on the disorder.

(South Med J 2004;97:823–826)

A Double-Blind Comparison of Escitalopram and Venlafaxine Extended Release in the Treatment of Major Depressive Disorder

Bielski RJ, Ventura D, Chang C-C

Background: Escitalopram is the most selective serotonin reuptake inhibitor (SRI) antidepressant available. Venlafaxine is a nonselective SRI that also inhibits noradrenergic reuptake. This study compared escitalopram and venlafaxine extended release (XR) in depressed outpatients at the highest doses recommended in the United States. ***Method:*** In this randomized trial, patients (diagnosis of DSM-IV–defined major depressive disorder; baseline Hamilton Rating Scale for Depression score of ≥ 20) received 1 week of single-blind placebo treatment, followed by 8 weeks of double-blind, fixed-dose treatment with either escitalopram or venlafaxine XR (rapidly titrated to 20 mg/day and 225 mg/day,

respectively, in accordance with prescribing information). The primary efficacy variable was change from baseline to week 8 in Montgomery-Asberg Depression Rating Scale (MADRS) total score. Data were collected from May to December 2002. ***Results:*** Mean baseline MADRS scores for the escitalopram (N = 97) and venlafaxine XR (N = 98) groups were 30.7 and 30.0, respectively. There were no significant differences in measures of efficacy between the 2 antidepressants. Mean changes from baseline to endpoint in MADRS total score for escitalopram and venlafaxine XR were –15.9 and –13.6, respectively. Remission (MADRS score of ≤ 10) rates at endpoint were 41.2% for escitalopram and 36.7% for venlafaxine XR. Response (≥ 50% reduction from baseline MADRS score) rates for the escitalopram and venlafaxine XR groups were 58.8% and 48.0%, respectively. Tolerability measures favored escitalopram over venlafaxine XR treatment. The venlafaxine XR group had a higher incidence than the escitalopram group of treatment-emergent adverse events (85.0% vs. 68.4%) and discontinuation due to adverse events (16.0% vs. 4.1%; $p < .01$). ***Conclusion:*** Results of this study indicate that, when titrated rapidly to their maximum recommended doses, escitalopram is at least as effective as venlafaxine XR and significantly better tolerated. These results do not support the hypothesis that nonselective SRIs have greater efficacy than selective SRIs.

(J Clin Psychiatry 2004;65:1190–1196)

Ethnic and Regional Differences in Primary Care Visits for Attention-Deficit/Hyperactivity Disorder

Stevens J, Harman JS, Kelleher KJ

The authors examined the ethnic and regional differences in primary care visits for children in regard to the frequency of attention-deficit/hyperactivity disorder (ADHD) diagnoses, other mental health diagnoses, and stimulant prescriptions. Six years of U.S. data (1995–2000) from the National Hospital Ambulatory Medical Care Survey and the National Ambulatory Medical Care Survey were analyzed. It was found that an ADHD diagnosis and/or a stimulant prescription were less likely to be recorded during visits by Hispanic-American youths relative to visits by white-American youths. Stimulant prescriptions were given more frequently for visits of children with ADHD in the south and the west than in the northeast. No ethnic differences were found in the likelihood of receiving a psychotropic medication once an ADHD diagnosis was given or receiving a mental health diagnosis other than ADHD. In primary mental health care, ethnic disparities appear to exist for ADHD and not for other mental disorders pooled together.

(J Dev Behav Pediatr 2004;25:318–325)

Cognitive-Behavior Therapy, Sertraline, and Their Combination for Children and Adolescents With Obsessive-Compulsive Disorder: The Pediatric OCD Treatment Study (POTS) Randomized Controlled Trial

The Pediatric OCD Treatment Study (POTS) Team

Background: The efficacy of short-term obsessive-compulsive disorder (OCD)–specific cognitive-behavior therapy (CBT) or medical management with selective serotonin reuptake inhibitors (SSRIs) in children and adolescents is supported by the empirical literature. Yet, little is known about their relative and combined efficacy. The objective of this study was to evaluate the efficacy of CBT alone and medical management with the SSRI sertraline alone, or CBT and sertraline combined, as initial treatment for children and adolescents with OCD. ***Method:*** Participants were recruited from the Pediatric OCD Treatment Study between September 1997 and December 2002. This balanced, masked, randomized, controlled trial was conducted in 3 U.S. academic centers and enrolled 112 patients aged 7 through 17 years with a primary DSM-IV diagnosis of OCD and a Children's Yale-Brown Obsessive-Compulsive Scale (CYBOCS) score of ≥ 16. Participants were randomly assigned to receive CBT alone, sertraline alone, combined CBT and sertraline, or pill placebo for 12 weeks. Main outcome measures were defined as change in CYBOCS score over 12 weeks as rated by an independent evaluator masked to treatment status and rate of clinical remission defined as a CYBOCS score of ≤ 10. ***Results:*** Of 112 patients, 97 (87%) completed the full 12 weeks of treatment. Intent-to-treat random regression analyses indicated a statistically significant advantage for CBT alone ($p = .003$), sertraline alone ($p = .007$), and combined treatment ($p = .001$) when compared with placebo. Combined treatment also proved superior to CBT alone ($p = .008$) and to sertraline alone ($p = .006$), which did not differ from each other. Site differences did not emerge for combined treatment but did for CBT and sertraline alone, suggesting that combined treatment is less susceptible to setting-specific variations. The clinical remission rates were as follows: combined treatment, 53.6% (95% CI = 36% to 70%); CBT alone, 39.3% (95% CI = 24% to 58%); sertraline alone, 21.4% (95% CI = 10% to 40%); and placebo, 3.6% (95% CI = 0% to 19%). The remission rate for combined treatment did not differ from that for CBT alone ($p = .42$) but did differ from sertraline alone ($p = .03$) and from placebo ($p < .001$). CBT alone did differ from placebo ($p = .002$) but not from sertraline alone ($p = .24$). Sertraline alone did not differ from placebo ($p = .10$). The 3 active treatments proved acceptable and well tolerated. There was no evidence of treatment-emergent harm to self or to others. ***Conclusion:*** Children and adolescents with OCD should begin treatment with the combination of CBT plus an SSRI or CBT alone.

(JAMA 2004;292:1969–1976)

Risk of Fetal Exposure to Tricyclic Antidepressants

Wen SW, Walker M

Background: The objectives of this study were to (1) review the literature on the risk of fetal exposure to tricyclic antidepressants (TCAs) and (2) estimate the frequency of TCA exposure in pregnant women in the Canadian province of Saskatchewan, Canada. ***Method:*** MEDLINE was searched for English-language papers published from 1953 to 2003, using the key words *tricyclic antidepressants*, *amitriptyline*, *amoxapine*, *clomipramine*, *desipramine*, *doxepin*, *imipramine*, *lofepramine*, *maprotiline*, *nortriptyline*, *protriptyline*, and *trimipramine*. The search was restricted to human studies. Data from the outpatient prescription drug database of Saskatchewan, Canada, were analyzed to estimate potential exposure to TCAs during pregnancy. ***Results:*** The number of women of reproductive age (16 to 44 years) with at least 1 prescription of genotoxic TCAs was 3501 in 1977, 2959 in 1991, and 1330 in 1999. Corresponding figures for nongenotoxic TCAs were 3403, 4200, and 5493, respectively. On the basis of these figures, the rates of prescriptions given to women of reproductive age in any particular calendar year were 1.30% (95% CI = 1.25% to 1.35%) for genotoxic TCAs and 2.32% (95% CI = 2.25% to 2.39%) for nongenotoxic TCAs. ***Conclusions:*** There has been no apparent decline in

TCA prescriptions to women of reproductive age in recent years, and prescriptions are quite frequent. The frequent prescription of potentially toxic TCAs to pregnant women may be due to lack of adequate scientific evidence on the adverse effects of TCAs, increases in unplanned pregnancies in industrial countries, and conflicting needs to treat maternal diseases and to protect fetuses. Consultation with specialists in depression treatment may be helpful when treating pregnant women with TCAs. There is a need for large-scale epidemiologic studies to assess the potential adverse effects of TCA use in pregnancy on a broad spectrum of fetal and infant outcomes. Findings from such studies would have direct implication on the clinical treatment of depression in pregnancy with TCAs.

(J Obstet Gynaecol Can 2004;26:887–892)

Citalopram Treatment of Pediatric Recurrent Abdominal Pain and Comorbid Internalizing Disorders: An Exploratory Study

Campo JV, Perel J, Lucas A, et al.

Background: The authors assessed the potential tolerability, efficacy, and safety of citalopram in the treatment of functional pediatric recurrent abdominal pain and comorbid internalizing disorders. ***Method:*** 25 clinically referred children and adolescents with recurrent abdominal pain aged 7 to 18 years entered a 12-week, open-label, flexible-dose trial of citalopram. The Clinical Global Impression-Improvement (CGI-I) scale was the primary outcome measure; responders were defined by ratings of 1 (very much improved) or 2 (much improved). Secondary measures included parent and self-reports of abdominal pain, depression, anxiety, functional impairment, and other somatic symptoms. A standardized checklist was used to assess side effects. Data were analyzed by the last-observation-carried-forward procedure and an intent-to-treat format. ***Results:*** Responders included 21 subjects (84%) (CGI-I score ≤ 2). Citalopram was generally well tolerated. During the study, 4 subjects withdrew, 1 due to reported visual side effects. Compared with baseline, ratings of abdominal pain, depression, anxiety, functional impairment, and other somatic symptoms all improved significantly over the course of the study. ***Conclusions:*** Citalopram is a promising treatment for functional pediatric recurrent abdominal pain and should be studied further with a randomized, placebo-controlled clinical trial.

(J Am Acad Child Adolesc Psychiatry 2004;43:1234–1242)

Individuals With Type 2 Diabetes and Depressive Symptoms Exhibited Lower Adherence With Self-Care

Park H, Hong Y, Lee H, et al.

Background: The objective of this study was to determine whether poor self-care behaviors among patients with type 2 diabetes are associated with depressive symptoms. ***Method:*** Study subjects included 168 patients aged > 30 years with diabetes of 1 to 15 years' duration. The authors evaluated diabetes self-care behaviors and depressive symptoms using a self-reported questionnaire. The 5 categories of self-care evaluation included medication taking, self-monitoring of blood glucose, diet, exercise, and participation in patient education programs. The Centers for Epidemiologic Studies-Depression scales were used to evaluate depressive symptoms. The association between self-care behaviors and depressive symptoms was determined using multiple logistic regression analyses. ***Results:*** Higher depressive-symptom scores were associated with poor self-care behaviors, significantly with poor participation in education programs (odds ratio [OR] = 1.21, 95% CI = 1.06 to 1.38) and poor diet (OR = 1.11, 95% CI = 1.01 to 1.22), and marginally with poor medication taking (OR = 1.14, 95% CI = 1.00 to 1.31). Depressive symptoms were not significantly associated with either exercise or self-monitoring of blood glucose. ***Conclusions:*** These data suggest that adherence to self-care behaviors among diabetic patients would improve through the evaluation and control of depressive symptoms.

(J Clin Epidemiol 2004;57:978–984)

Risk Factors for Premenstrual Dysphoric Disorder in a Community Sample of Young Women: The Role of Traumatic Events and Posttraumatic Stress Disorder

Perkonigg A, Yonkers KA, Pfister H, et al.

Background: There is some evidence that the onset and course of premenstrual syndrome is related to stress; however, few studies have explored the role of traumatic events and posttraumatic stress disorder (PTSD) as risk factors for the development of premenstrual dysphoric disorder (PMDD). ***Method:*** A community cohort of 1488 women (aged 14–24 years at baseline) were prospectively and longitudinally evaluated up to 3 times over a period of about 42 months from 1995 to 1999. The DSM-IV version of the Munich-Composite International Diagnostic Interview was used to establish PMDD and PTSD diagnostic status; stressful life events and conditions were assessed with the Munich Events List and the Daily Hassles Scale. Prevalence and incidence of either threshold or subthreshold PMDD from baseline to the second follow-up were calculated. Risk factors, including prior comorbid mental disorders and traumatic events, were examined using logistic regression analysis. ***Results:*** The incidence of threshold PMDD was 3.0%. The most powerful predictors were subthreshold PMDD at baseline (OR = 11.0, 95% CI = 4.7 to 25.9). Traumatic events greatly increased the odds of developing PMDD at follow-up (OR = 4.2, 95% CI = 1.2 to 12.0). Other predictors were a history of anxiety disorder (OR = 2.5, 95% CI = 1.1 to 5.5) and elevated daily hassles scores (OR = 1.6, 95% CI = 1.1 to 2.3). Both were also associated with the risk of developing subthreshold PMDD, although the association was less robust. ***Conclusions:*** Traumatic events and preexisting anxiety disorders are risk factors for the development of PMDD. The underlying mechanisms are unknown, making further investigation necessary.

(J Clin Psychiatry 2004;65:1314–1322)

Pharmacotherapy of Pain in Depressed Older Adults

Unutzer J, Ferrell B, Lin EH, et al.

Background: The objective of this study was to examine pharmacotherapy for pain in a sample of 1801 older depressed primary care patients. ***Method:*** Cross-sectional survey data were collected from 1999 to 2001 in 18 primary care clinics belonging to 8 health care organizations in 5 states. Subjects included 1801 patients aged 60 and older who met diagnostic criteria for dysthymia or major depression. Outcome measures included diagnoses or treatment for chronic pain, functional impairment from pain, and use of over-the-counter and prescription analgesic medications. ***Results:*** Of the participants, 1416 (79%) re-

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ported functional impairment from pain in the previous month, and 1024 (57%) reported a diagnosis of or treatment for chronic pain during the previous 3 years. Of those patients with recent functional impairment from pain, 51% reported any analgesic use, ranging from 31% to 75% across the participating health care organizations. Opioid analgesic use varied from 5% to 34%. Analgesic use predictors included the degree of functional impairment from pain in the previous month and a history of chronic pain or arthritis. After adjusting for clinical and demographic covariates, differences in analgesic use across participating organizations remained significant. ***Conclusion:*** Most depressed older adults in the sample reported a history of chronic pain and recent functional impairment from pain, but almost half of those with functional impairment from pain did not report using analgesic medications. There were substantial variations in use of analgesics among participating organizations, suggesting that improvement in the quality of pain management among depressed older adults is warranted.

(J Am Geriatr Soc 2004;52:1916–1922)

Behavioral and Psychological Symptoms in Patients With Dementia as a Target for Pharmacotherapy With Risperidone

Rabinowitz J, Katz IR, De Deyn PP, et al.

Objective: To examine the effect of risperidone on specific behavioral and psychological symptoms of dementia (BPSD). ***Method:*** We conducted a post hoc exploratory analysis of an integrated database from 3 randomized, controlled trials of risperidone versus placebo in treating 1150 nursing home residents with BPSD. Changes in scores were measured for items on the Cohen-Mansfield Agitation Inventory (CMAI) and Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD). ***Results:*** On the CMAI, risperidone was significantly more effective in treating hitting ($p = .000$), hurt self or other ($p = .005$), cursing or verbal aggression ($p = .000$), repetitive sentences or questions ($p = .001$), scratching ($p = .041$), general restlessness ($p = .001$), grabbing onto people ($p = .028$), constant request for attention ($p = .041$), pacing and aimless wandering ($p = .013$), and performing repetitious mannerisms ($p = .045$). On the BEHAVE-AD, risperidone was significantly more effective in treating physical threats and/or violence ($p = .000$), verbal outbursts ($p = .000$), other anxieties ($p = .01$), agitation ($p = .000$), tearfulness ($p = .03$), and nonparanoid delusions ($p = .02$). ***Conclusions:*** The items from the BEHAVE-AD and CMAI that were improved with risperidone included psychotic, agitated, and aggressive symptoms. These data suggest that risperidone is more effective than placebo in treating a variety of symptoms associated with dementia.

(J Clin Psychiatry 2004;65:1329–1334)

Prevalence and Predictors of Depression Treatment in an International Primary Care Study

Simon GE, Fleck M, Lucas R, et al.

Background: This study evaluated the prevalence and predictors of depression treatment in a diverse cross-national sample of primary care patients. ***Method:*** A 2-stage screening process was used to identify 1117 patients with current depressive disorders at primary care facilities in 6 countries (Australia, Brazil, Israel, Russia, Spain, and the United States). All patients completed a structured diagnostic interview as well as measures of anxiety symptoms, alcohol use, chronic comorbid physical conditions, and perceived barriers to treatment at baseline. Primary care physicians were advised if the research interviews indicated probable depressive disorders in their patients. Three and 9 months later, participants reported all health services, including antidepressant medication and specialty mental health care, used in the preceding 3 months. ***Results:*** The proportion of patients receiving any antidepressant pharmacotherapy across the 6 sites ranged from a high of 38% in Seattle, Wash., to a low of 0% in St. Petersburg, Russia. The proportion receiving any specialty mental health care varied from a high of 29% in Melbourne, Australia, to a low of 3% in St. Petersburg, Russia. There was no consistent association between patient characteristics and receipt of either specialty mental health care or pharmacotherapy. The most commonly reported barrier to treatment for depression was out-of-pocket cost; the percentage of patients who reported this barrier ranged from 24% in Barcelona, Spain, to 75% in St. Petersburg, Russia. ***Conclusions:*** Physician notification and depression screening are not sufficient to prompt adequate treatment for depression. Probability of treatment may be more influenced by characteristics of health care systems than by the clinical characteristics of individual patients. Stigma may be a less important impediment to appropriate care than financial barriers.

(Am J Psychiatry 2004;161:1626–1634)

Depressive Symptoms and Inflammatory Bowel Disease in Children and Adolescents: A Cross-Sectional Study

Szigethy E, Levy-Warren A, Whitton S, et al.

Background: The authors assessed the rates of depressive symptoms in older children and adolescents with inflammatory bowel disease (IBD) and the associations between depressive symptoms and IBD characteristics. ***Method:*** Study participants included 102 youths aged 11 to 17 years with IBD seen consecutively in a gastroenterology clinic. The subjects were screened for depressive symptoms with the Children's Depression Inventory (CDI). Those subjects with CDI scores of ≥ 12 were evaluated for current psychiatric diagnoses using the Schedule for Affective Disorders and Schizophrenia for School Age Children-Present and Lifetime Version (K-SADS-PL). IBD type, duration, current severity, course, age at diagnosis, and steroid treatment were examined. ***Results:*** Of the total sample, 25 subjects (24.5%) had a CDI score of ≥ 12, consistent with clinically significant depressive symptoms. Of the qualified subjects, 19 of 25 participated in the K-SADS-PL semistructured interview and 16 of 19 met criteria for major or minor depressive disorder. Mean CDI scores positively correlated with age at IBD diagnosis but not with IBD type, course, or duration. Subjects with moderate/severe current IBD-related symptoms had significantly higher mean CDI scores than did those with inactive disease activity. Decreased appetite, fatigue, and anhedonia were selectively correlated with IBD disease severity. Subjects taking steroids were more likely to have CDI scores of ≥ 12; those with such scores were taking higher doses of steroids than those without clinically significant depressive symptoms (both p values $< .05$). ***Conclusion:*** These findings support the recommendation that adolescents with IBD in outpatient medical care settings, especially older adolescents and those taking steroids, should be screened for depression.

(J Pediatr Gastroenterol Nutr 2004;39:395–403)