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Life Events, Medical Comorbidity, and Somatic Symptoms in Pediatric Mood Disorders

Three of the articles in this section of Focus on Childhood and Adolescent Mental Health are on topics about bipolar disorder in youth, including treatment, negative life events, and medical comorbidity. The fourth article examines symptom presentation and somatic symptoms in depressed children and adolescents.

A 4-week multicenter, double-blind, randomized, placebo-controlled trial was conducted to assess the efficacy and safety of aripiprazole in the treatment of children and adolescents aged 10 to 17 years with a diagnosis of bipolar I disorder, manic or mixed episode, with or without psychotic features. In the study, 296 youths were randomly assigned to aripiprazole 10 mg/d (n=98), aripiprazole 30 mg/d (n=99), or placebo (n=99). Findling and colleagues found that both aripiprazole 10 mg and 30 mg were significantly superior to placebo on the primary efficacy endpoint of change from baseline to week 4 on the Young Mania Rating Scale (YMRS) total score. Response rates ($\geq 50\%$ reduction from baseline YMRS total score) at week 4 were 44.8% in the aripiprazole 10-mg group, 63.6% in the aripiprazole 30-mg group, and 26.1% in the placebo group. The most common treatment-emergent adverse event was extrapyramidal disorder: 12.2% in the aripiprazole 10-mg group, 27.3% in the aripiprazole 30-mg group, and 3.1% in the placebo group. This study adds to the growing evidence base for the efficacy of atypical antipsychotics in the acute treatment of bipolar I disorder, mixed or manic episode, in youths aged 10 to 17 years old.

In the largest study to date, Romero and colleagues examined negative life events among children and adolescents with bipolar spectrum disorders and their relationship to demographic characteristics and comorbid disorders. In the study, 446 youths with bipolar spectrum disorders and their parents completed the Life Events Checklist for the year prior to the evaluation. It was found that demographic factors of older age, lower socioeconomic status, nonwhite race, and living with nonintact family were associated with a greater number of total negative life events. Those youth with comorbid attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and anxiety disorders had a higher rate of negative life events than those youths without these comorbidities. Interestingly, a comparison group of youth with depressive and anxiety disorders had similar rates of negative life events to those of youth with bipolar disorder. Both groups of mood-disordered youths had more negative life events than a healthy comparison group. Since exposure to negative life events may worsen the course of bipolar illness, the authors stress the importance of early identification of the illness in order to prevent and/or ameliorate negative life events. However, the authors recognize the importance of conducting follow-up studies of this sample to determine the role of stressful life events in the course and outcome of bipolar disorder in youth.

Are rates of medical comorbidity higher in youth with bipolar disorder than in those youth diagnosed with other psychiatric illnesses? Evans-Lacko and colleagues examined the number and type of medical comorbidities in 832 youth diagnosed with bipolar disorder compared to 21,493 youth with other types of psychiatric disorders from a national database of privately insured families. The mean age of the youth with bipolar disorder in the sample was 14.7 years (range, 6 to 18 years) and 55% were male. Seventy-three percent of the youth with bipolar

disorder were being treated for chronic medical conditions. Compared to youth diagnosed with other psychiatric disorders, youth with bipolar disorder were more likely to have multiple (≥ 2) chronic medical conditions (36% vs 8%). The types of medical conditions that were significantly more common in youth with bipolar disorder were as follows: cardiology (odds ratio [OR] = 1.9), gastrointestinal/hepatic (OR = 1.5), neurologic (OR = 1.5), musculoskeletal (OR = 1.2), female reproductive (OR = 1.9), and respiratory (OR = 1.2). Youth with bipolar disorder were also found to have more adverse effects from treatment than youths with other psychiatric disorders. The findings from this study demonstrate the need to assess medical conditions when evaluating and treating youth with bipolar disorder.

Baji and colleagues examined whether symptoms of major depressive disorder vary as a function of age and sex in youth. In this study, 559 Hungarian children and adolescents with a mean age of 11.7 years were enrolled in a study of childhood-onset depression. Linear increases in age were found for the following symptoms: depressed mood,

hypersomnia, fatigue, psychomotor retardation, thoughts of death, and suicidal ideation. Girls were significantly more likely than boys to exhibit depressed mood, anhedonia, insomnia, hypersomnia, psychomotor retardation, thoughts of death, and somatic complaints, whereas boys were more likely to have psychomotor agitation. No age-by-sex interaction was found. The rate of somatic complaints averaged 37% across all age groups, with no specific age trends. Although somatic symptoms are not a diagnostic criteria for major depressive disorder, given the high rates of somatic symptoms in this sample, the authors suggest that somatic complaints be considered an associated symptom of depression in children and adolescents.

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doi:10.4088/JCP.09f05642gre
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