SSRI medication in children, adolescents and young adults with PWS: A cautionary report

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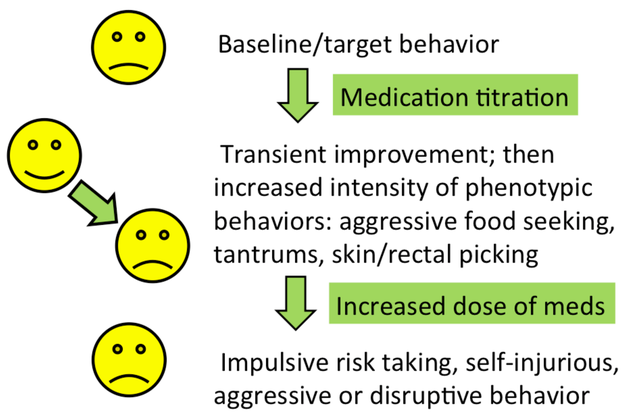
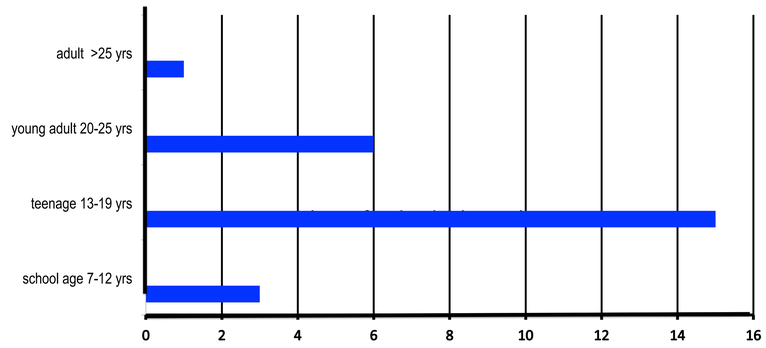
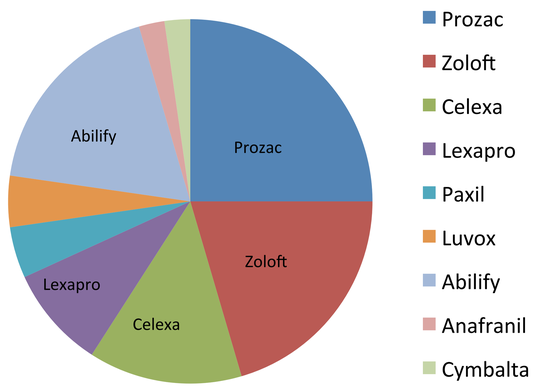
Paradigm of the frequent progression of mood and behavioral activation symptoms in PWS:



Distribution of Ages of PWS with Mood Activation:



Activating Agents:



Activating Agents: Dose Parameters

Agent	Typical Starting Dose	Typical Maximum Dose	PWS Case Activating Dose
Prozac	10-20 mg	80 mg	10 mg
Zoloft	25 mg	200 mg	25 mg
Celexa	10 mg	40 mg	5 mg
Lexapro	10 mg	20 mg	5 mg
Paxil	10 mg	50 mg	*
Luvox	20-25 mg	300 mg	25 mg
Anafranil	25 mg	200 mg	*
Cymbalta	20 mg	120 mg	*
Abilify	2.0 -2.5mg	30 mg	2.5 mg

*information not available

Observed Signs of Mood and Behavioral Activation:

Early:
Increased intensity of typical PWS behaviors such as perseveration, food seeking, irritability, tantrums and picking, including rectal picking.

Late:
Impulsive risk taking, self injury, aggression or disruption is out of character for the person. MBA has consisted of threatening to stab self or others with knife or scissors; repeatedly inserting fingers into a hornets nest to get stung; repeatedly inducing paper cuts on fingers; jumping out of a window, over a railing, or out of a moving vehicle; pulling the drivers wheel or gear shift when the vehicle is in motion; ingestions of light bulbs, rocks, beads, toys, or keys; paranoid or delusional thinking with inappropriate sexual behavior or allegations of sexual abuse; self biting, gouging, vaginal or rectal picking; biting the flesh of others and eating it; stealing and eating a pet guinea pig and bird.

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Background: Mood and behavioral activation is a known risk factor associated with the use of antidepressant medications of the selective serotonin reuptake inhibitor (SSRI) type. Among persons of all ages with PWS, the first indication of mood and behavioral activation is increased intensity of typical excessive/repetitive behaviors, including food acquisition, perseveration, tantrums and picking behaviors. As a result, prescribers not experienced with PWS often increase medication dose, mistaking early signs of mood activation as recurrence of target symptoms, which in turn exacerbates symptoms. More severe symptoms of mood and behavioral activation include impulsive suicidal, homicidal, self-injurious, or aggressive behaviors. In the extreme, mood and behavioral activation can be associated with psychosis. The treatment of choice for mood and behavioral activation is the discontinuation of the iatrogenic agent. Here, the serum half-life of these agents determines how fast the medication can be tapered safely, because abrupt discontinuation of SSRI's can precipitate a withdrawal syndrome that is characterized by mood instability. This presentation summarizes the authors' longitudinal clinical experience with treating symptoms of mood and behavioral activation on an outpatient and residential treatment setting, and elucidates a role for low dose SSRI treatment in some individuals with PWS.

Methods: This presentation is informed by literature review and the authors' longitudinal clinical experience in outpatient and residential treatment settings. Chart review informs the clinical data. The authors' collective experience includes both a referred population of individuals with PWS who experienced mood activation and mood activation observed in office practice despite careful low dose use.

Results: Among the 25 individuals with PWS (8 UPD; 9 DEL; 4 subtype undetermined; 1 atypical), ages 11-27 years, who displayed symptoms of mood activation associated with SSRI treatment, decreasing the medication resulted in improvement. However, very few individuals remained medication free. The majority of individuals (23/25) went onto require mood stabilizers and/or atypical antipsychotic medication to manage mood and behavior. In several cases, withdrawal emergent effects necessitated treatment with low doses of SSRI medication (equivalent of fluoxetine 5 mg or citalopram 10 mg). Neither age, gender, nor genetic subtype predicted mood activation, withdrawal emergent effects, or ongoing mood instability.

Discussion: Despite the growing awareness of mood activation associated with SSRI use as a problem in young patients and persons with developmental disabilities, the authors continue to see this phenomenon as a reason for psychiatric deterioration, crises and hospitalization in PWS. In addition, prescribing or recommending these mediations seems to be done without an adequate description of the behaviors associated with mood activation in PWS. Because behavioral changes can come on gradually and begin weeks or months after the initiation or an increase in dose, families commonly fail to connect the behavioral changes with the medications and may suffer many months of crisis before the association is made. The relationship is further masked by the symptoms being an increase in already present syndromic behaviors. Psychiatrists familiar only with the symptoms of mood activation in typicals do not necessarily seek out or identify symptoms of increased food seeking, increased rectal picking and increased perseverations as early signs of mood activation.

Clinical Recommendations: The authors are familiar with cases where low dose and even typical dosing of SSRI medications have had the desired benefits of reduced anxiety and irritability but we want to emphasize that recommendations to try such medications should always be accompanied by an extended discussion and description of the various presentations of mood activation both early and late in treatment. These discussions should be repeated every time the dose is increased and frequent and closely spaced follow-up visits are needed to identify early signs of mood activation