FDA again reviews antidepressants

Janice Hopkins Tanne *New York*

The US Food and Drug Administration is considering tougher warnings about antidepressant drugs in children. The drugs have been linked to almost double the risk of suicide.

The FDA will hold public meetings on the subject in mid-September. Labelling changes and other regulatory actions are possible. The data are not "black and white," said Dr Thomas Laughren, team leader of psychiatric drug products at the FDA.

In addition, a front page *New York Times* article headlined "Boy's Murder Case Entangled in Fight Over Antidepressants" noted the FDA's examination of antidepressants in children and adolescents and said the drugs were the subject of a national debate. The article said the drugs might cause aggressive and violent behaviour (*New York Times* 23 Aug 2004:A1). Only fluoxetine is approved for treating depression in children in the United Kingdom and the United States.

The boy in the murder case, Christopher Pittman, came from a troubled family. When his parents broke up, he said he might kill himself, and he was admitted to hospital and began treatment with paroxetine for a few days.

He was then treated with sertraline and sent to live with his grandparents in a small town in South Carolina in 2001. At first, Christopher, then aged 12,

managed well. But a few weeks later he got into an argument on a school bus and then with his grandparents. That night he shot dead his grandparents, set their house on fire, and stole money and their car.

According to the *New York Times*, Christopher will be tried as an adult. If convicted, he could be jailed for life. His lawyers say he committed the murders because of sertraline.

Use of antidepressant drugs in children and teenagers is controversial both in the United Kingdom and in the United States.

The FDA began reviewing studies of antidepressant use in children in 2003, and the US controversy erupted in late 2003 when British authorities warned doctors that the newer antidepressants, particularly selective serotonin reuptake inhibitors, might increase the risk of suicidal thoughts and actions in children and teenagers.

In March 2004 the FDA cautioned doctors to monitor all patients closely for risk of suicide, especially when they began taking antidepressants or changed dosage. Doctors were warned about the high risk in patients with bipolar depression or a family history of bipolar disorder. The FDA also asked companies to add warning statements, which they did.

The FDA asked suicide

As the FDA again reviews antidepressants in children, Christopher Pittman, who took sertraline and paroxetine, faces trial for murder

experts from Columbia University in New York to review the studies of almost 4000 children and teenagers. They came to conclusions similar to those reached by the FDA's experts: the drugs increased suicidal thoughts and behaviours. No children in the review committed suicide.

Earlier this month, the *BMJ* and others reported that the FDA had suppressed documents showing that Dr Andrew Mosholder, an expert with the FDA's Office of Drug Safety, found that

children taking antidepressants were almost twice as likely to become suicidal as children taking placebo (7 August, p 307).

In an FDA "talk paper" of 20 August, the agency has said it will post on its website additional summaries of paediatric efficacy studies from drugs used in depression in paediatric patients. □

For further information see www.fda.gov/bbs/topics/ANSWERS/2004/ANS01306.html

NICE sets out guidelines for hypertension

Karen Hébert *London*

Combination drug treatment should be used to treat hypertension, recommends the National Institute for Clinical Excellence (NICE) in its latest guidelines on the diagnosis and management in primary care of essential hypertension in adults.

Previously patients would be given one antihypertensive drug, and if this failed to control their blood pressure adequately they would be taken off that drug and

given an antihypertensive from another class.

However, after a review of the evidence base, the guidelines now recommend that patients be given a combination of antihypertensive drugs. Treatment should begin with a low dose diuretic of the thiazide type. β blockers should be added as a second line of treatment, with a dihydropyridine calcium channel blocker being added as a third. In patients at a high risk of new onset diabetes, the second line treatment should be an angiotensin converting enzyme inhibitor, with a β blocker being added only as a fourth line.

Dr Wendy Ross, a GP and member of the guideline development group, said, "Treating hypertension is the bread and

butter work of general practice. GPs should pay attention to these guidelines because NICE has thoroughly reviewed the best evidence available to create this gold standard. We are not starting from scratch but aiming to improve the accuracy of diagnosis and quality of care for people with hypertension."

She indicated the potential benefits: "Better control will result in fewer strokes and heart attacks. And although it may seem that your initial workload will increase as a GP, ultimately you will see a long term decrease in your workload."

In addition GPs are advised to assess cardiovascular risk in patients with blood pressure persisting at 140/90 mm Hg or

higher. Tests should include urine dipstick analysis, blood tests, and a 12 lead electrocardiogram.

Intervention is recommended for people with blood pressures of 160/100 mm Hg or more. Treatment should also be offered to patients with a cardiovascular risk of 20% or more.

"The aim of this guideline is to decrease morbidity and mortality resulting from cardiovascular diseases such as stroke, chronic renal failure, and coronary heart disease for which hypertension is a significant risk factor," said Andrew Dillon, NICE's chief executive. □

The guidelines on hypertension are available at www.nice.org.uk