La depressione nei giovani: sfide diagnostiche e terapeutiche

Lucio Ghio
Dipartimento di Salute Mentale e Dipendenze
ASL3 Genova

1. Aspetti epidemiologici
2. Sfide diagnostiche
3. Sfide terapeutiche

1. Aspetti epidemiologici
2. Sfide diagnostiche
3. Sfide terapeutiche

Guidelines on mental health promotive and preventive interventions for adolescents

World Health Organization

50% di tutti i disturbi psichici insorgono prima dei 14 anni

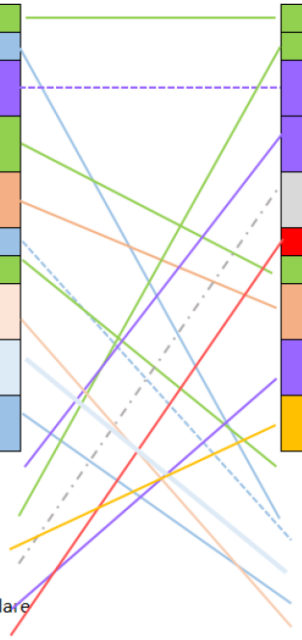
Fino al 20% dei bambini e adolescenti (0-19 anni) presenta un disturbo neuropsichico

Suicidio seconda causa di morte in adolescenza (in Europa)

Confronto tra le prime dieci cause di morte

N	Rate	%	1969
2088	12,9	19,8	1 Accidenti di trasporto
831	5,1	7,9	2 Polmonite
796	4,9	7,6	3 Tumori maligni del tessuto linfatico, ematopoietico e tessuti correlati
474	2,9	4,5	4 Annegamento e sommersione accidentali
403	2,5	3,8	5 Malformazioni congenite dell'apparato circolatorio
327	2,0	3,1	6 Malattie infettive intestinali
296	1,8	2,8	7 Cadute
221	1,4	2,1	8 Altre anemie emolitiche ereditarie
177	1,1	1,7	9 Malattie del rene e dell'uretere
161	1,0	1,5	10 Altre infezioni acute delle basse vie respiratorie
135	0,8	1,3	17 Tumori maligni dell'encefalo e del sistema nervoso
126	0,8	1,2	18 Suicidi
119	0,7	1,1	20 Epilessia
100	0,6	0,9	23 Mal definite
91	0,6	0,9	26 Tumori maligni di osso e cartilagine articolare
44	0,3	0,4	35 Altre malattie metaboliche

2019	N	Rate	%
1 Accidenti di trasporto	206	2,0	18,8
2 Suicidi	78	0,8	7,1
3 Tumori maligni del tessuto linfatico, ematopoietico e tessuti correlati	72	0,7	6,6
4 Tumori maligni dell'encefalo e del sistema nervoso	71	0,7	6,5
5 Mal definite	44	0,4	4,0
6 Altre malattie metaboliche	39	0,4	3,6
7 Annegamento e sommersione accidentali	35	0,3	3,2
8 Malformazioni congenite dell'apparato circolatorio	23	0,2	2,1
9 Tumori maligni di osso e cartilagine articolare	22	0,2	2,0
10 Epilessia	20	0,2	1,8
13 Cadute	18	0,2	1,6
24 Polmonite	5	0,05	0,5
29 Malattie infettive intestinali	2	0,02	0,2
30 Malattie del rene e dell'uretere	2	0,02	0,2
36 Altre infezioni acute delle basse vie respiratorie	1	0,01	0,1
40 Altre anemie emolitiche ereditarie	0	-	-



(World Psychiatry 2023;22:275–285)

Prevalence and trends of common mental disorders from 2007-2009 to 2019-2022: results from the Netherlands Mental Health Survey and Incidence Studies (NEMESIS), including comparison of prevalence rates before vs. during the COVID-19 pandemic

Margreet ten Have[1], Marlous Tuithof[1], Saskia van Dorsselaer[1], Frederiek Schouten[1], Annemarie I. Luik[1,2], Ron de Graaf[1]

[1]Netherlands Institute of Mental Health and Addiction (Trimbos Institute), Utrecht, The Netherlands; [2]Department of Epidemiology, Erasmus MC University Medical Center, Rotterdam, The Netherlands

Table 5 Trends in prevalence rates of 12-month DSM-IV disorders in people aged 18-64 years (N=11,615), based on NEMESIS-2 (2007-2009) and NEMESIS-3 (2019-2022), in weighted percentages, odds ratios (ORs) or adjusted odds ratios (aORs), and 95% confidence intervals (CIs)

	NEMESIS-2		NEMESIS-3		Unadjusted model	Adjusted model
	%	95% CI	%	95% CI	OR (95% CI)	aOR (95% CI)
Mood disorders	6.0	5.3-6.8	10.8	9.7-11.9	**1.89 (1.59-2.24)**	**2.04 (1.71-2.42)**
Anxiety disorders	10.1	9.2-11.0	15.6	14.3-16.9	**1.64 (1.44-1.87)**	**1.76 (1.56-1.99)**
Substance use disorders	5.5	4.5-6.5	7.1	6.1-8.2	**1.32 (1.04-1.68)**	1.27 (0.99-1.63)
Any mental disorder	17.4	16.0-18.7	26.1	24.2-28.0	**1.68 (1.48-1.90)**	**1.78 (1.59-2.00)**

Data were weighted to be representative of the adult population in the particular study period. Unadjusted model: OR and p not controlled for socio-demographic differences between the studies. Adjusted model: aOR and p controlled for socio-demographic differences (sex, age, education, living situation, employment status, urbanicity) between the studies. Significant values of OR or aOR (<0.05) are highlighted in bold prints.

Prevalence and trends of common mental disorders from 2007-2009 to 2019-2022: results from the Netherlands Mental Health Survey and Incidence Studies (NEMESIS), including comparison of prevalence rates before vs. during the COVID-19 pandemic

Margreet ten Have[1], Marlous Tuithof[1], Saskia van Dorsselaer[1], Frederiek Schouten[1], Annemarie I. Luik[1,2], Ron de Graaf[1]

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Table 3 Association between socio-demographic characteristics and 12-month DSM-5 disorders among people aged 18-75 years, based on NEMESIS-3 (2019-2022; N=6,194), in weighted percentages, adjusted odds ratios (aORs) and 95% confidence intervals (CIs), controlled for sex and age

	Mood disorders		Anxiety disorders		Substance use disorders		ADHD		Any mental disorder	
	%	aOR (95% CI)	%	aOR (95% CI)	%	aOR (95% CI)	%	aOR (95% CI)	%	aOR (95% CI)
Sex										
Men	8.1	1	11.0	1	9.5	1	3.7	1	24.0	1
Women	11.5	**1.50 (1.21-1.86)**	19.4	**1.97 (1.66-2.34)**	4.8	**0.48 (0.38-0.60)**	2.7	**0.73 (0.55-0.96)**	27.8	**1.24 (1.07-1.44)**
Age at interview (years)										
18-24	13.3	**3.04 (1.91-4.83)**	19.9	**2.68 (2.00-3.57)**	15.8	**7.17 (4.45-11.57)**	3.7	**3.67 (1.78-7.59)**	39.6	**4.09 (3.16-5.28)**
25-34	13.1	**2.97 (2.01-4.37)**	19.8	**2.62 (2.05-3.36)**	12.6	**5.56 (3.65-8.48)**	3.9	**3.86 (1.92-7.76)**	35.2	**3.37 (2.76-4.11)**
35-44	11.1	**2.41 (1.46-3.96)**	17.5	**2.20 (1.72-2.83)**	7.4	**3.13 (1.75-5.59)**	5.5	**5.66 (2.68-11.95)**	27.7	**2.35 (1.76-3.14)**
45-54	9.5	**2.05 (1.48-2.85)**	13.3	**1.61 (1.24-2.09)**	4.1	**1.65 (1.05-2.58)**	2.9	**2.90 (1.31-6.41)**	21.8	**1.72 (1.39-2.14)**
55-64	7.9	**1.67 (1.05-2.66)**	13.8	**1.68 (1.31-2.16)**	3.3	1.30 (0.78-2.15)	2.5	**2.44 (1.14-5.20)**	21.4	**1.68 (1.34-2.12)**
65-75	4.9	1	8.7	1	2.6	1	1.0	1	13.9	1
p for linearity		**<0.001**		**<0.001**		**<0.001**		**<0.001**		**<0.001**
Education										

Adolescent health brief

Journal of Adolescent Health 70 (2022) 496–499

Prevalence of Depression Among Adolescents in the U.S. From 2009 to 2019: Analysis of Trends by Sex, Race/Ethnicity, and Income

Michael Daly, Ph.D. *

Department of Psychology, Maynooth University, Co. Kildare, Ireland

Article history: Received June 24, 2021; Accepted August 26, 2021
Keywords: Major depressive disorder; Mood disorders; Depression; Prevalence trends; Sociodemographic characteristics

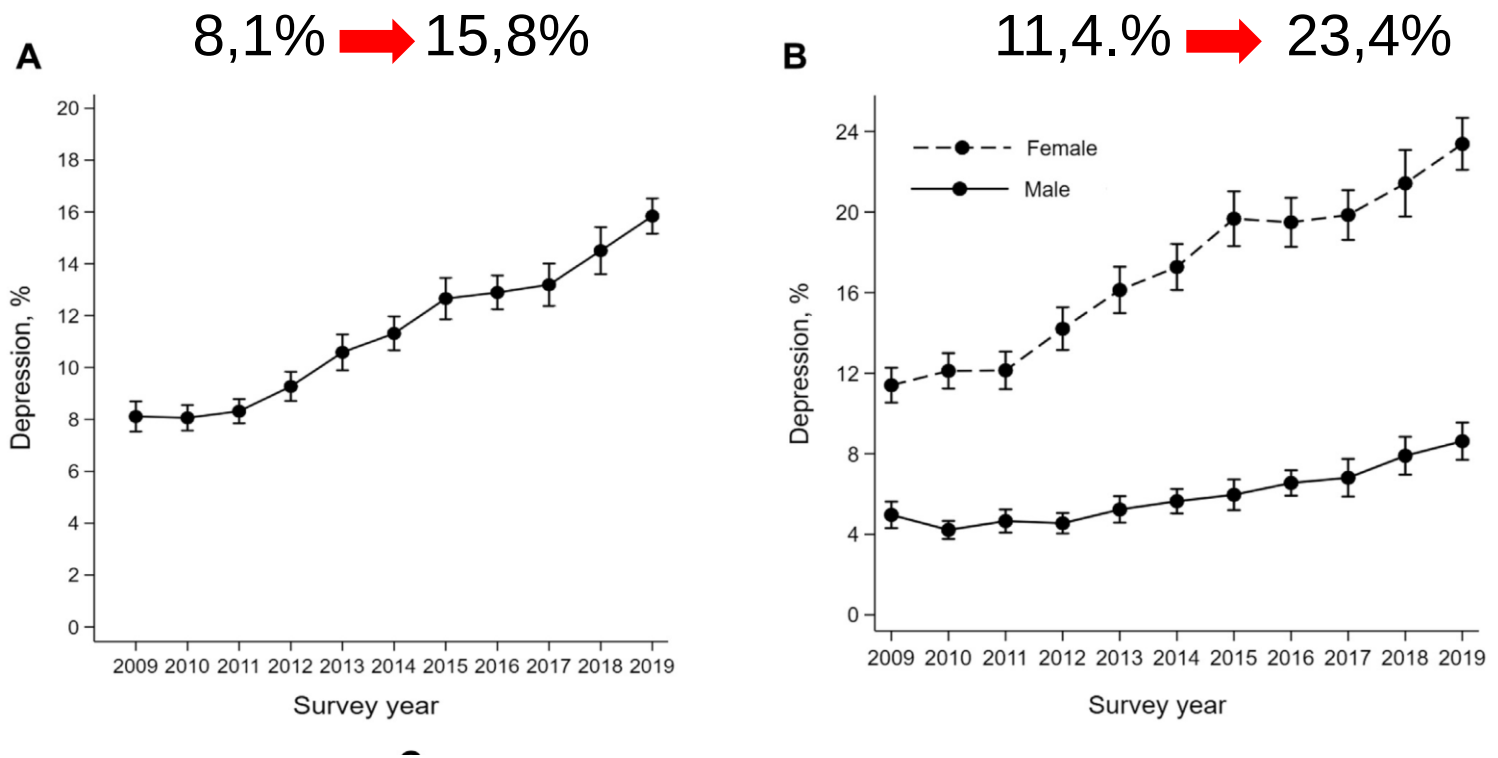


Figure 1. Trends in the prevalence of past-year MDE from 2009 to 2019 in the (A) overall NSDUH sample, for (B) males and females, and (C) nonblack and black race/ethnicity groups. Note: NSDUH graphs are derived from logistic regression analysis of 167,783 participants. 95% confidence intervals are presented.

Possibili cause

- Individualizzazione della societá
- Aumento delle aspettative di rendimento scolastico
- Pressione ad eccellere
- Incertezza rispetto alla stabilitá lavorativa e relazionale
- Diffusione e aumento dell’uso dei social media
- Aumento del bullismo
- Aumento dei disturbi del sonno

JAMA Pediatrics | Original Investigation

Global Prevalence of Depressive and Anxiety Symptoms in Children and Adolescents During COVID-19

A Meta-analysis

Nicole Racine, PhD, RPsych; Brae Anne McArthur, PhD, RPsych; Jessica E. Cooke, MSc; Rachel Eirich, BA; Jenney Zhu, BA; Sheri Madigan, PhD, RPsych

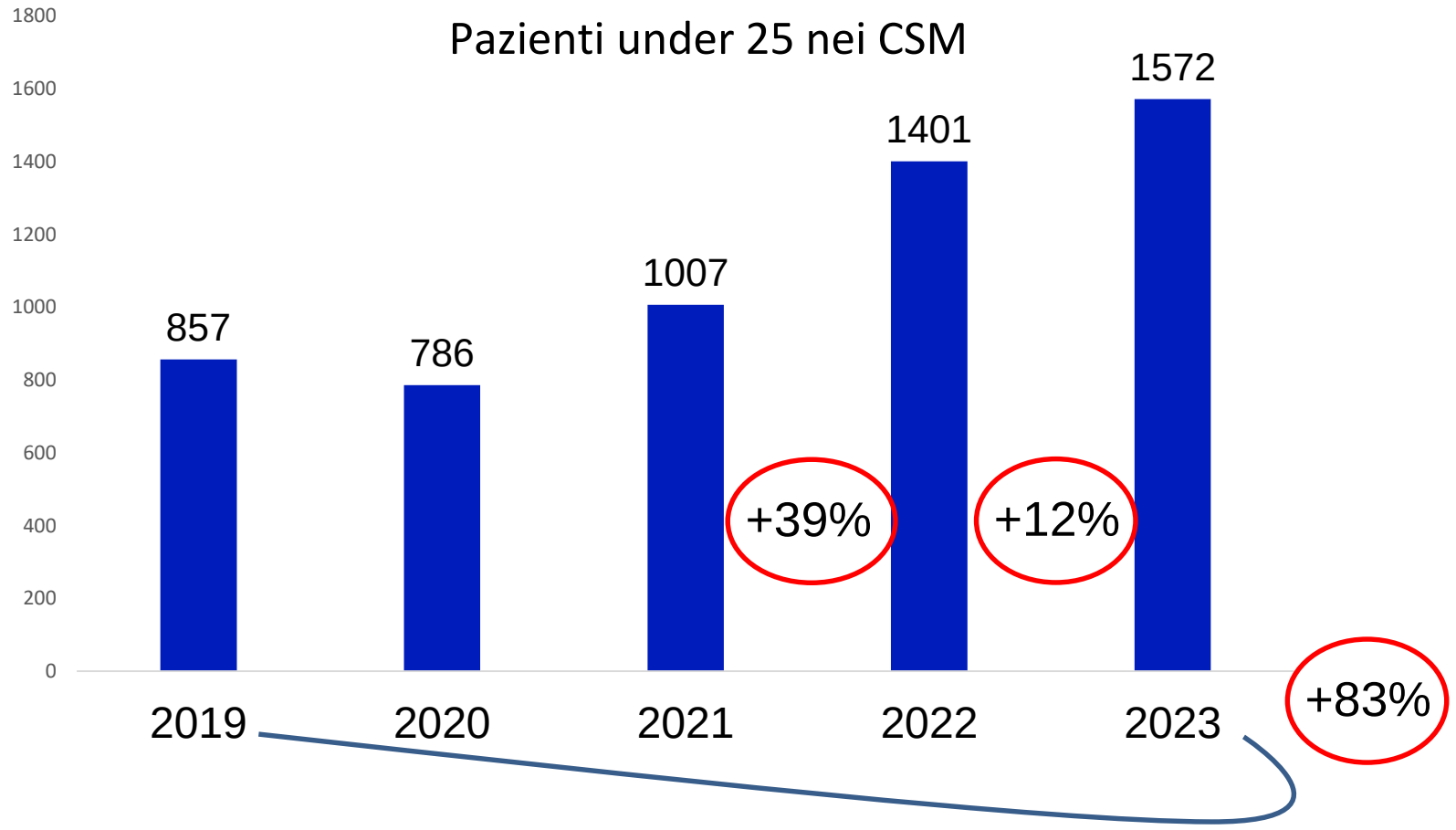
Dopo la pandemia, a livello mondiale:

- 1/4 dei giovani ha esperito sintomi depressivi severi
- 1/5 dei giovani ha esperito sintomatologia ansiosa severa

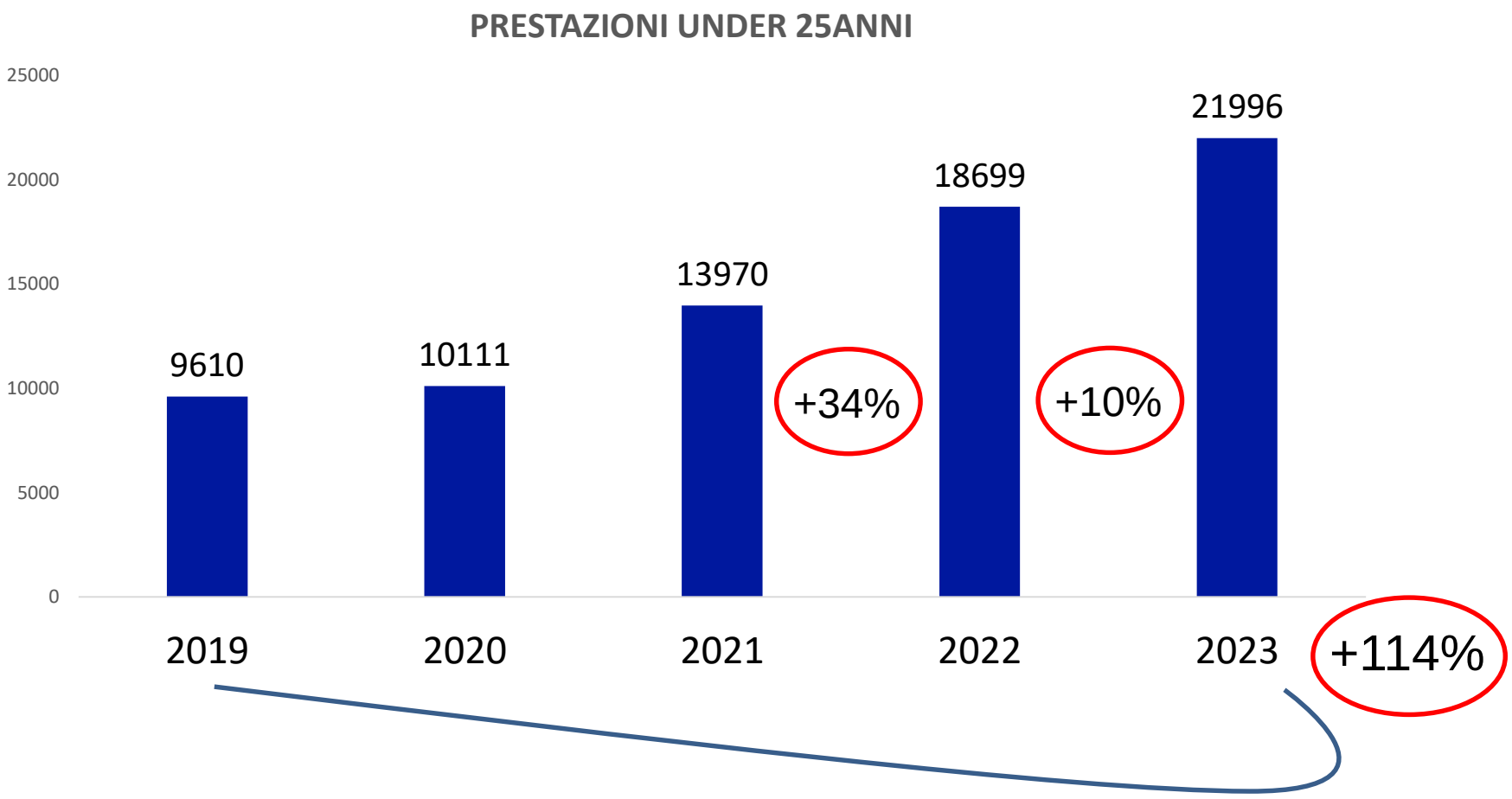
I dati nella pratica

DSMeD ASL3 Genova

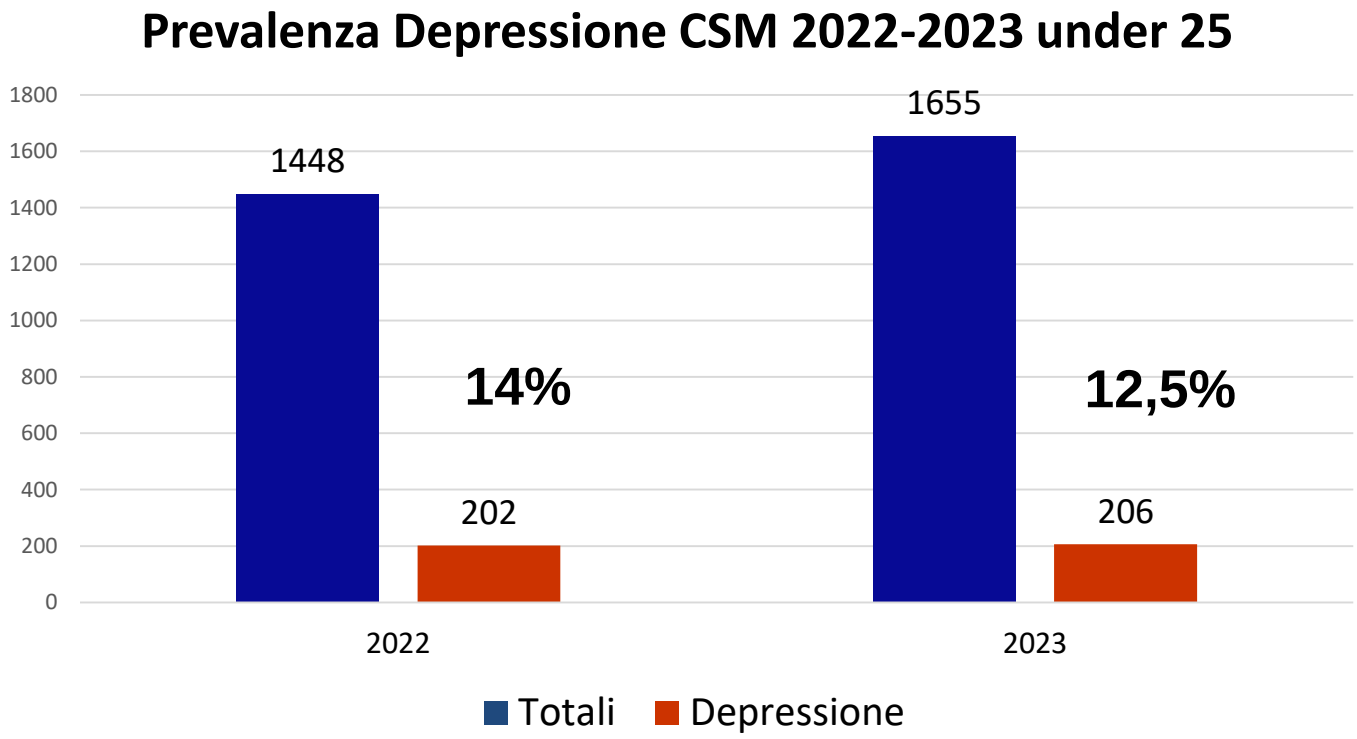
Aumento marcato delle richieste di cura nei giovani



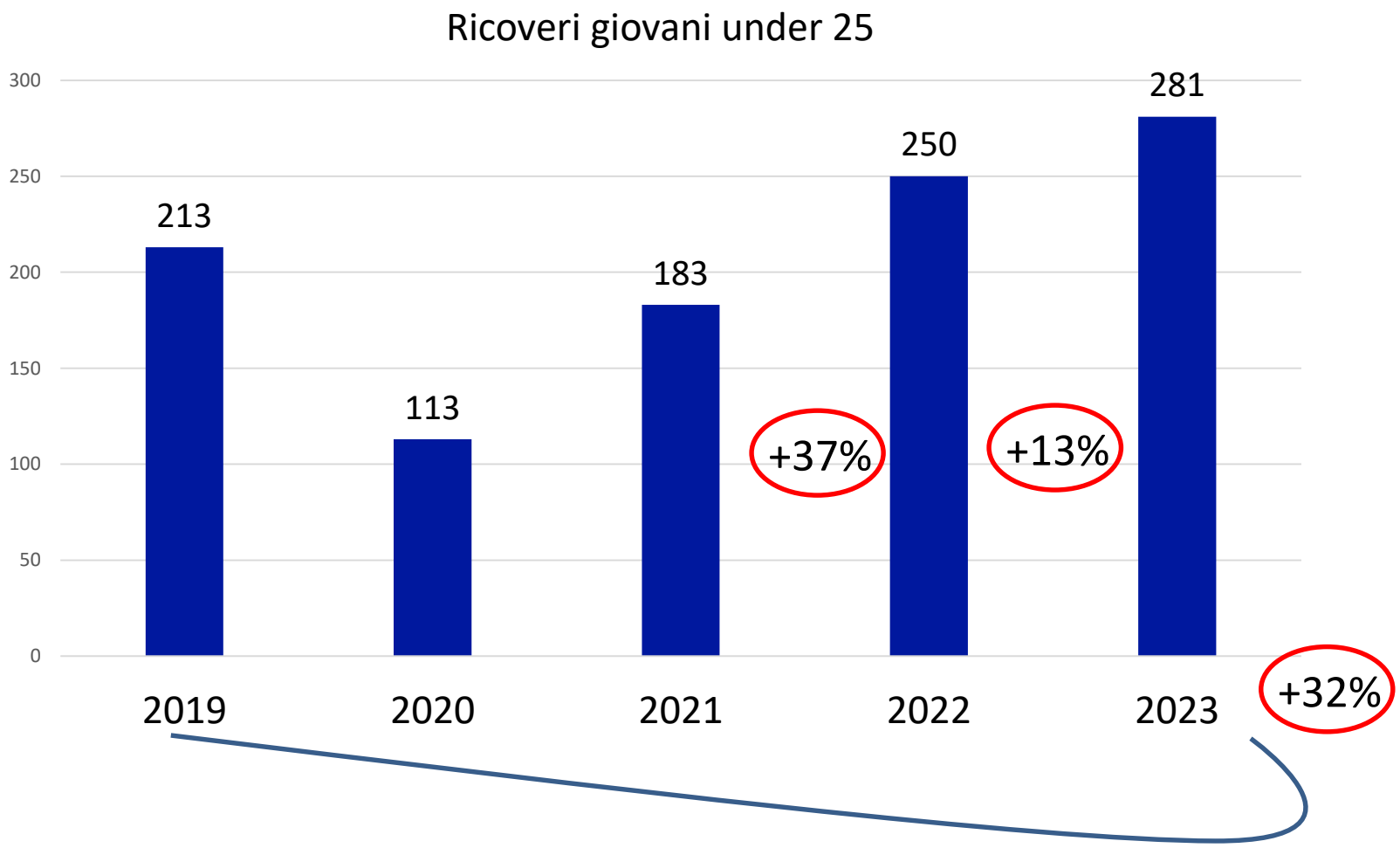
Aumento marcato dell'intensità dell'assistenza nei giovani



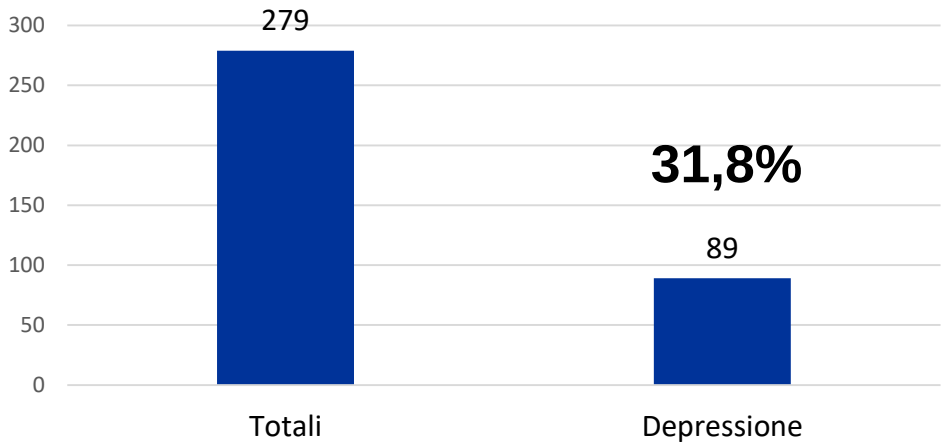
Prevalenza Depressione CSM



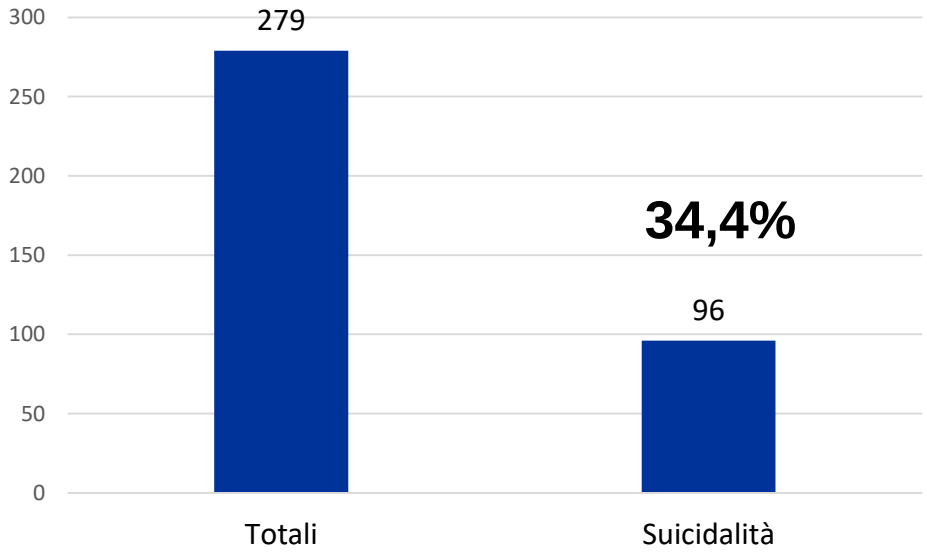
Aumento dei ricoveri nei giovani



Depressione alla dimissione under 25



TS/Idee di Suicidio/Autolesionismo



Tentativo di suicidio (eta media: 22,3); F:M = 2:1	
Diagnosi	
Depressione	**46,6%**
Disturbo Borderline	**33,3%**
Abuso di sostanze	**33,3%**
DCA	13,3%
Disturbo della condotta	13,3%
Disturbo bipolare	6,6%

Key points

La prevalenza annuale di depressione aumenta dal 2% in etá infantile al 20% in tarda adolescenza con un rapporto F:M = 2:1

Piú del 40% dei giovani che soffrono di depressione ha idee di suicidio e il 10% tenta il suicidio

Il disturbo tende a una remissione entro 1 anno ma il 40% presenta un episodio ricorrente in etá adulta

L'etá di esordio precoce è un fattore di rischio per depressione ricorrente e peggiori outcomes

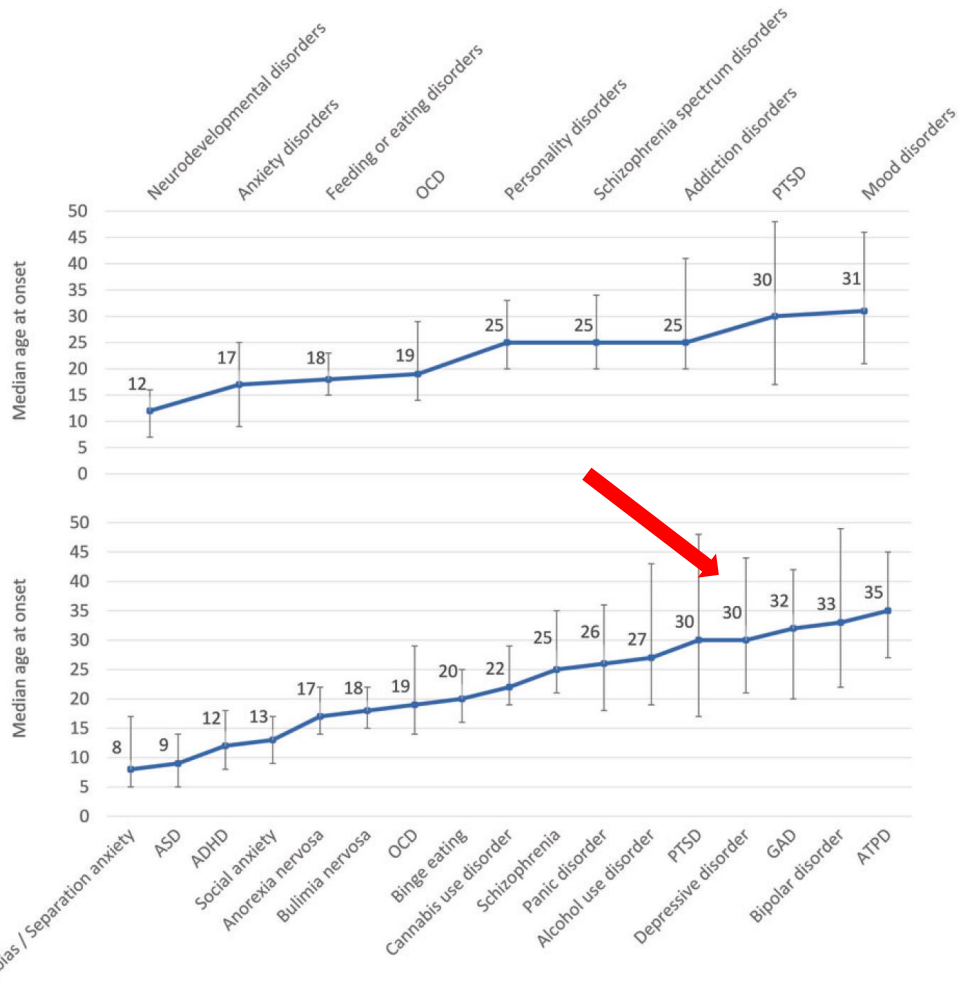
(Kessler and Walters, 1998; Costello et al., 2002 e 2005)

Molecular Psychiatry (2022) 27:281–295
https://doi.org/10.1038/s41380-021-01161-7

REVIEW ARTICLE

Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies

Marco Solmi[1,2,3] · Joaquim Radua[3,4,5] · Miriam Olivola[3] · Enrico Croce[6] · Livia Soardo[7] · Gonzalo Salazar de Pablo[3,8,9] · Jae Il Shin[10] · James B. Kirkbride[11] · Peter Jones[12,13] · Jae Han Kim[14] · Jong Yeob Kim[14] · Andrè F. Carvalho[15] · Mary V. Seeman[16] · Christoph U. Correll[17,18,19,20] · Paolo Fusar-Poli[3,7,21,22]



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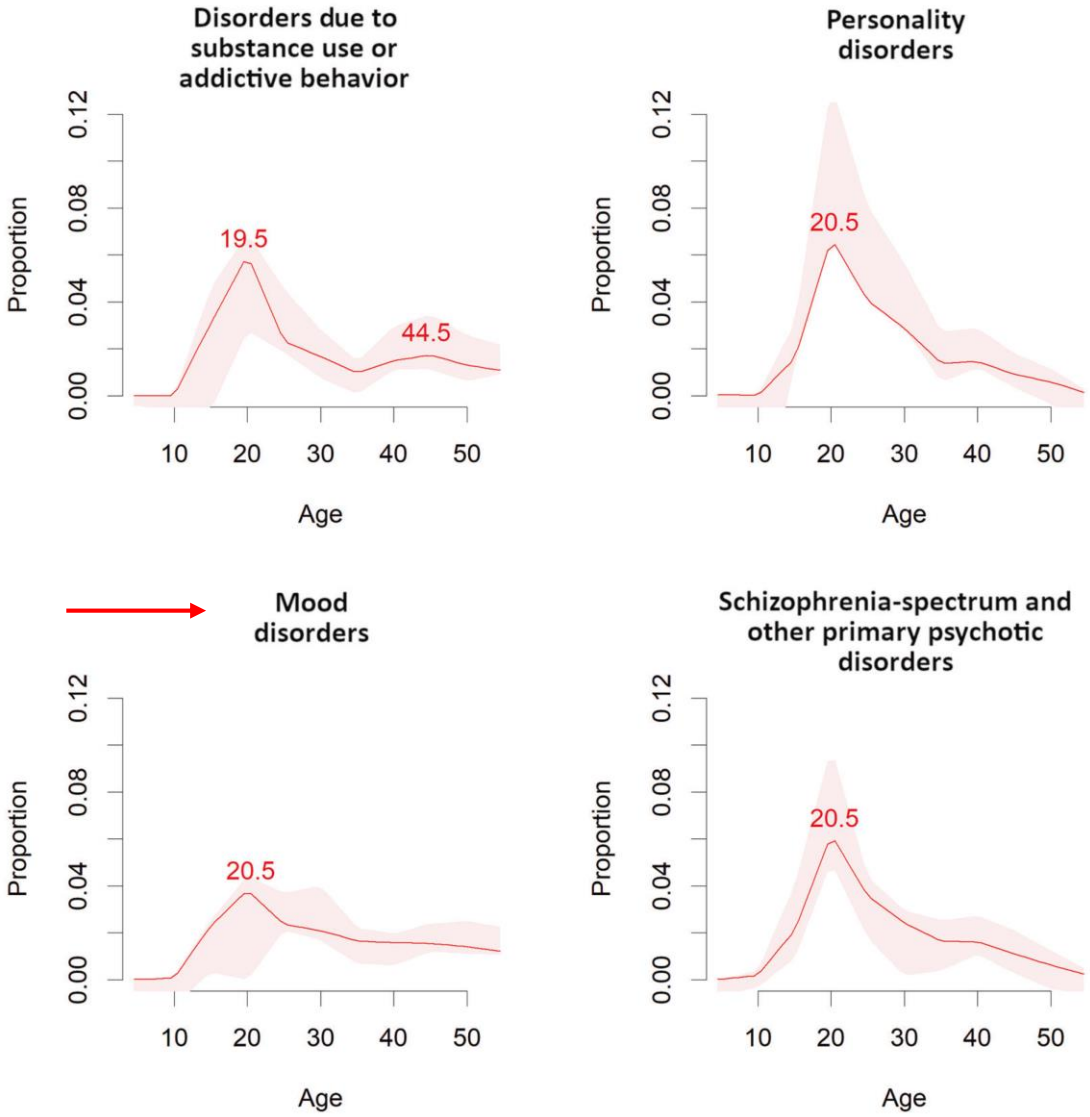


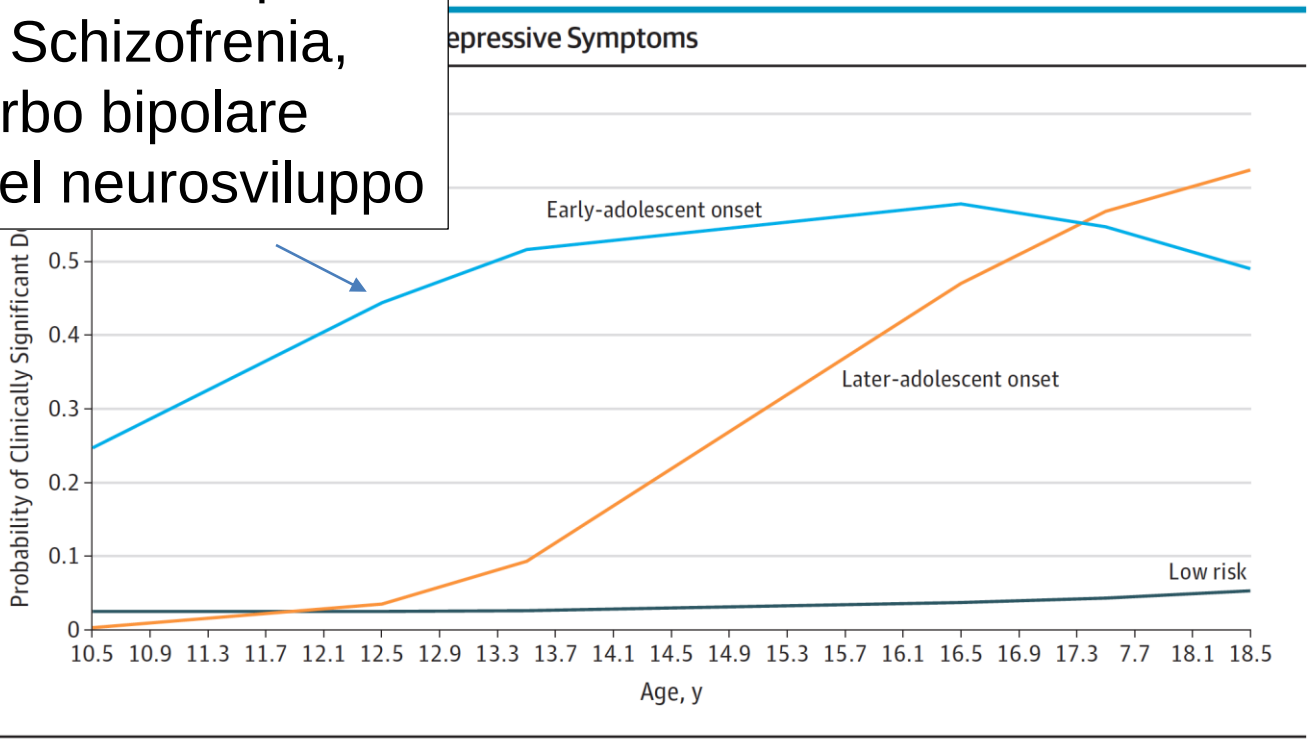
JAMA Psychiatry | Original Investigation

JAMA Psychiatry. 2019;76(3):306-313. doi:10.1001/jamapsychiatry.2018.3338
Published online October 14, 2018.

Characterizing Developmental Trajectories and the Role of Neuropsychiatric Genetic Risk Variants in Early-Onset Depression

Frances Rice, PhD; Lucy Riglin, PhD; Ajay K. Thapar, PhD, MD; Jon Heron, PhD; Richard Anney, PhD;

Alta frequenza di evoluzione eterotipica:
ADHD, Schizofrenia,
Disturbo bipolare
Disturbi del neurosviluppo



Heterogeneity in long-term trajectories of depressive symptoms: Patterns, predictors and outcomes

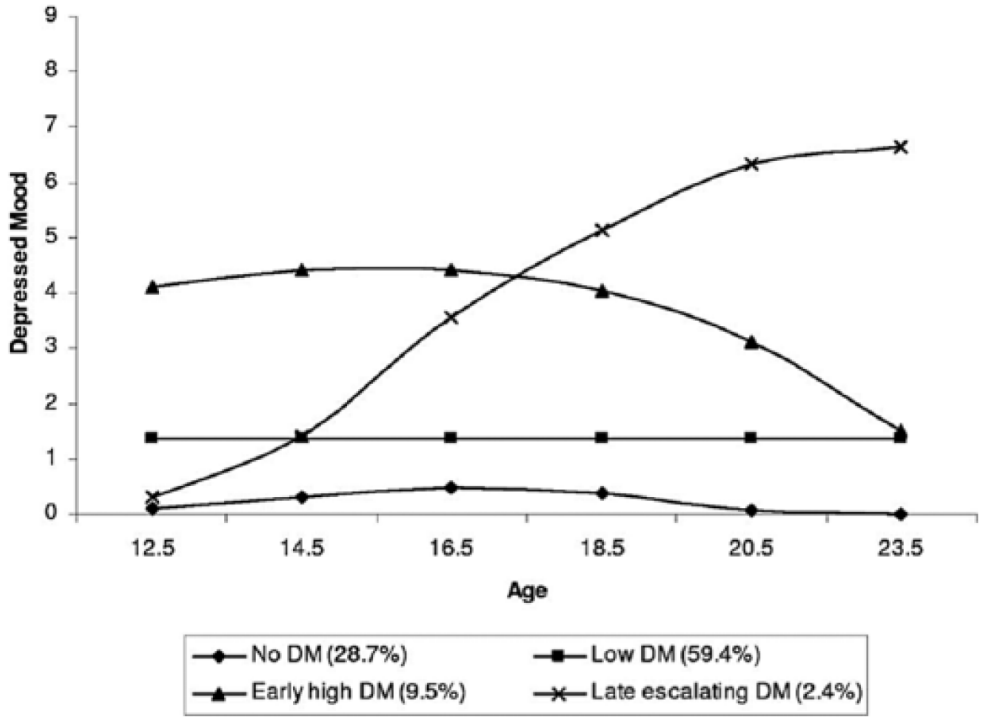
J Affect Disord. 2016

Katherine L. Musliner[1,2], **Trine Munk-Olsen**[1], **William W. Eaton**[2], and **Peter P. Zandi**[2]

[1]National Centre for Register-based research, University of Aarhus, Aarhus Denmark

[2]Johns Hopkins Bloomberg School of Public Health, Department of Mental Health, Baltimore MD USA

Figure 3. Example of depressive symptom trajectories calculated by a semi-parametric group-based method.



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Highlights

- Long-term trajectories of depressive symptoms are heterogeneous, with most studies identifying either 3 or 4 distinct trajectory patterns.
- Patterns of depression trajectories vary primarily in terms of severity (mild, moderate, severe) and stability (stable, increasing, decreasing).
- Overall, stable depressive symptoms over time appear to be more common than unstable depressive symptoms, regardless of severity.
- Most people follow a trajectory characterized by minimal depressive symptoms, but a notable minority (somewhere between 2 and 15%) experience persistent high depressive symptoms over long periods of time.
- Predictors of membership in a trajectory class characterized by higher depressive symptoms include female gender, younger age, low income/ education, non-white race, and stressful life events.
- Trajectories characterized by high symptoms are associated with poor psychiatric and psychosocial outcomes.

J Affect Disord. 2013

Heterogeneous trajectories of depressive symptoms: Adolescent predictors and adult outcomes

Ilya Yaroslavsky[a], **Jeremy W. Pettit**[b,*], **Peter M. Lewinsohn**[c], **John R. Seeley**[c], and **Robert E. Roberts**[d]

Le traiettorie con alto carico sintomatologico in adolescenza hanno peggiori outcomes psicosociali e psichiatrici a 30 anni

Adult outcomes

Education level	Coping skills	SAS family	No. of lifetime ANX episodes
Income	Dysfunctional attitudes	SAS social/leisure	No. of lifetime SUD episodes
Marital status	Self-esteem	SAS work	No. of lifetime MDD episodes

Fattori predittivi di traiettorie con alto carico sintomatologico in adolescenza

Genere femminile
Familiarità per depressione
Eventi stressanti precoci
Basso livello socioeconomico

Problemi relazionali con i pari
Problemi relazionali in famiglia
Bassa autostima
Solitudine
Ruminazione
Scarse capacità di coping
Abuso di sostanze (Alcool)

Characterising depression trajectories in young people at high familial risk of depression

Bryony Weavers [a,b,*], Lucy Riglin [a,b], Joanna Martin [a,b], Richard Anney [b], Stephan Collishaw [a,b], Jon Heron [c], Ajay Thapar [a,b], Anita Thapar [a,b], Frances Rice [a,b]

Familiaritá

Rischio 4 volte maggiore di Depressione maggiore

Rischio 7 volte maggiore di Distimia

Rischio 3 volte maggiore di suicidalitá

Maggiore frequenza di ricoveri psichiatrici (40% versus 1%)

Journal of Affective Disorders 337 (2023) 66–74

Transdiagnostic risk of mental disorders in offspring of affected parents: a meta-analysis of family high-risk and registry studies

Rudolf Uher[1,2], Barbara Pavlova[1,2], Joaquim Radua[3], Umberto Provenzani[4], Sara Najafi[1,2], Lydia Fortea[3], Maria Ortuño[3], Anna Nazarova[1,2], Nader Perroud[5,6], Lena Palaniyappan[7-9], Katharina Domschke[10], Samuele Cortese[11-14], Paul D. Arnold[15], Jehannine C. Austin[16], Michael M. Vanyukov[17], Myrna M. Weissman[18-20], Allan H. Young[21], Manon H.J. Hillegers[22], Andrea Danese[23,24], Merete Nordentoft[25,26], Robin M. Murray[27], Paolo Fusar-Poli[4,28,29]

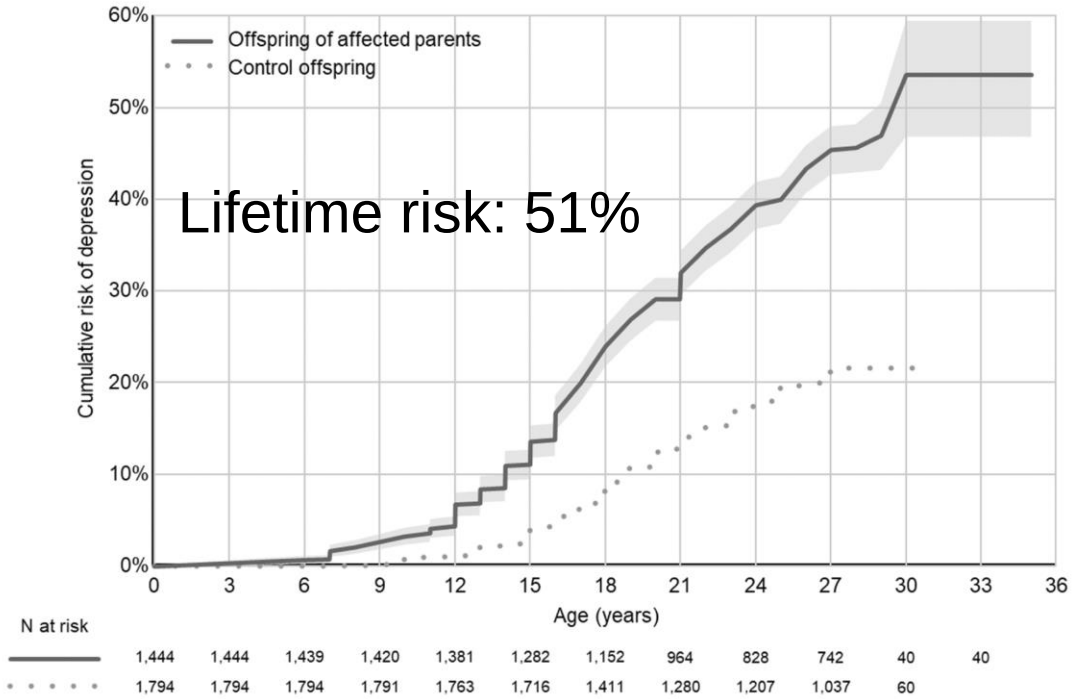


Figure 4 Meta-analytic Kaplan-Meier curve summarizing the cumulative incidence of DSM/ICD depressive disorders in offspring of parents affected with those disorders (n=5) and control offspring (n=6). The shade in the curve represents 95% CI.

(World Psychiatry 2023;22:433–448)

REVIEW ARTICLE OPEN

Molecular Psychiatry (2023) 28:141–153

Dissecting early life stress-induced adolescent depression through epigenomic approach

Shinichiro Ochi [1,2] and Yogesh Dwivedi [1]✉

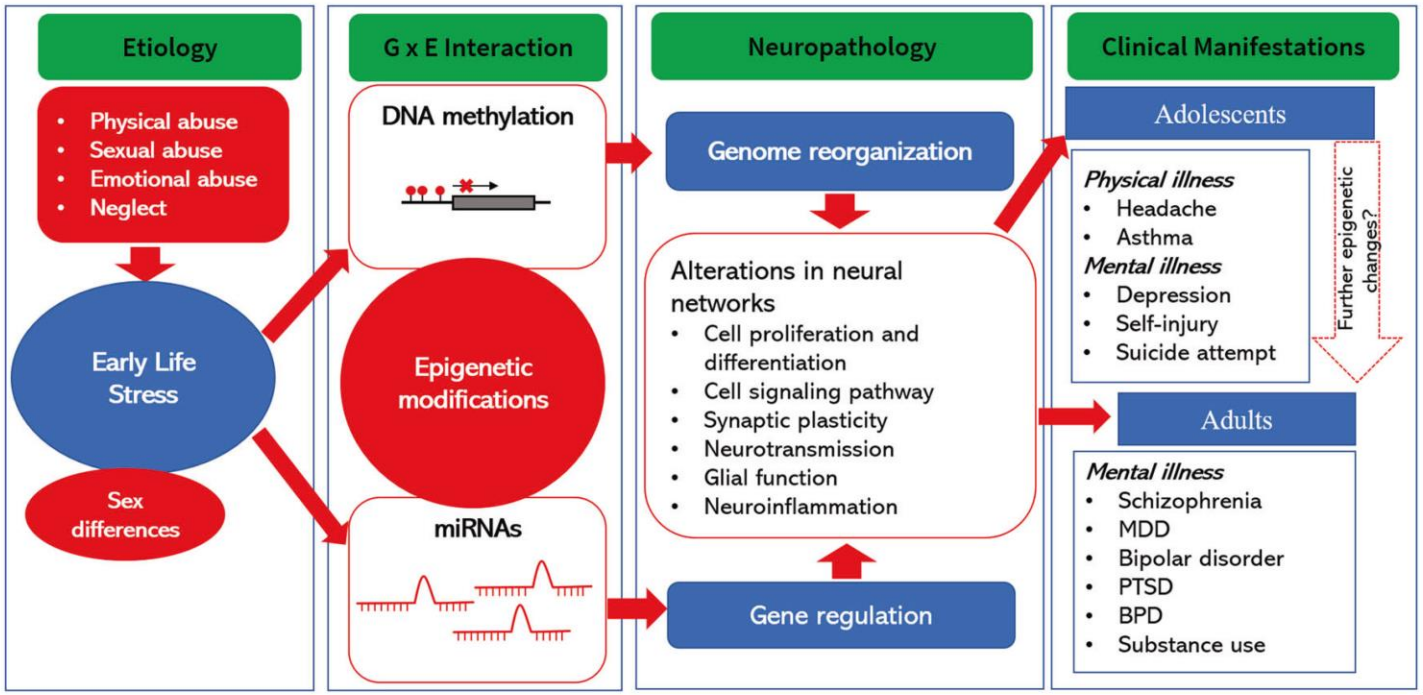


Fig. 1 Early life stress mediated epigenetic modifications as regulators of neuropsychiatric disorders in adolescence. Early life stress such as physical abuse, sexual abuse, emotional abuse, and neglect leads to epigenetic modifications such as DNA methylation and abnormal microRNA expression, which causes genome reorganization and alterations in gene regulation in a sex-dependent manner. These changes may affect neural networks leading to aberrant cell proliferation, synaptic plasticity, neurotransmission, and neuroinflammation. This may lead to physical and mental illnesses in adolescents and adulthood. Clinical manifestations in adolescents can cause further epigenetic modifications and affect neuropsychiatric disorders in adulthood. G × E gene and environmental, MDD major depressive disorder, miRNA microRNA, PTSD posttraumatic stress disorder, BPD borderline personality disorder.

From “online brains” to “online lives”: understanding the individualized impacts of Internet use across psychological, cognitive and social dimensions

Joseph Firth[1,2], John Torous[3], José Francisco López-Gil[4,5], Jake Linardon[6], Alyssa Milton[7,8], Jeffrey Lambert[9], Lee Smith[10], Ivan Jarić[11,12], Hannah Fabian[1], Davy Vancampfort[13,14], Henry Onyeaka[15], Felipe B. Schuch[16,17,18], Josh A. Firth[19,20]

Nel 2023 il 50% degli adolescenti si descrive sempre online rispetto al 24% del 2015

Esisterebbe una finestra di maggiore sensibilitá agli effetti negativi dell’iperutilizzo (11-13 per le ragazze e 14-15 per i ragazzi)

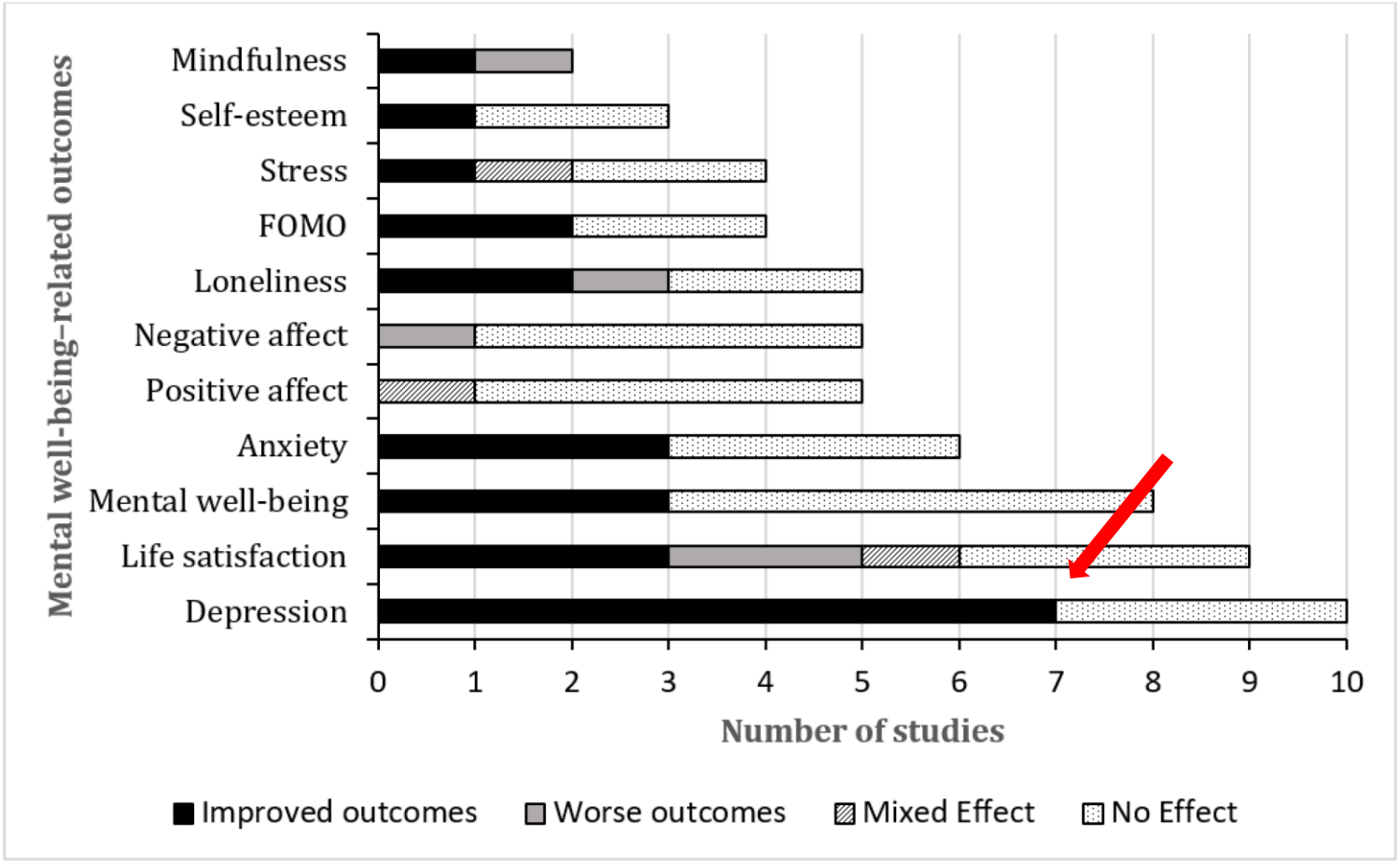
Cyberbullismo, gambling, addiction, FOMO

Esistono dati discordanti rispetto a una correlazione diretta tra tempo online e depressione

The Impact of Social Media Use Interventions on Mental Well-Being: Systematic Review

(J Med Internet Res 2023;25:e44922)

Ruth Plackett, PhD; Alexandra Blyth, MSc; Patricia Schartau, MBBS, MRCGP, PhD



BJPsych Open (2023)
9, e152, 1–12. doi: 10.1192/bjo.2023.523

A scoping review of social media in child, adolescents and young adults: research findings in depression, anxiety and other clinical challenges

Donald M. Hilty, Dorothy Stubbe, Alastair J. McKean, Pamela E. Hoffman, Isheeta Zalpuri, Myo T. Myint, Shashank V. Joshi, Murat Pakyurek and Su-Ting T. Li

Background

Social media and other technologies are reshaping communication and health.

Aims

This review addresses the relationship between social media use, behavioural hea
for youth aged <25 y

Method

A scoping review of
explored research st
depression and anxi
engagement and qua
being.

Results

Out of 2820 potential
criteria. The foci were clinical depression and anxiety disorders ($n = 78$), clinical challenges (e.g. suicidal ideation, cyberbullying) ($n = 34$) and psychological well-being ($n = 28$). Most studies focused on Facebook, Twitter, Instagram and YouTube. Few studies are longitudinal in design ($n = 26$), had comparison groups ($n = 27$), were randomised controlled trials ($n = 3$) or used structured assessments ($n = 4$). Few focused on different youth and sociodemographic populations, particularly for low-income, equity-seeking and deserving populations. Studies examined association ($n = 120$; 85.7%), mediating ($n = 16$; 11.4%) and causal ($n = 4$; 2.9%) relationships. Prospective, longitudinal studies of depression and anxiety appear to indicate that shorter use (≤3 h/day) and purposeful engagement is associated with better mood and psychological well-being. Depression may predict social media use and reduce perception of support. Findings
to engage youth.

nes from func-
erse youth and
intervention and
parison designs
d. Health systems
oment challenges.

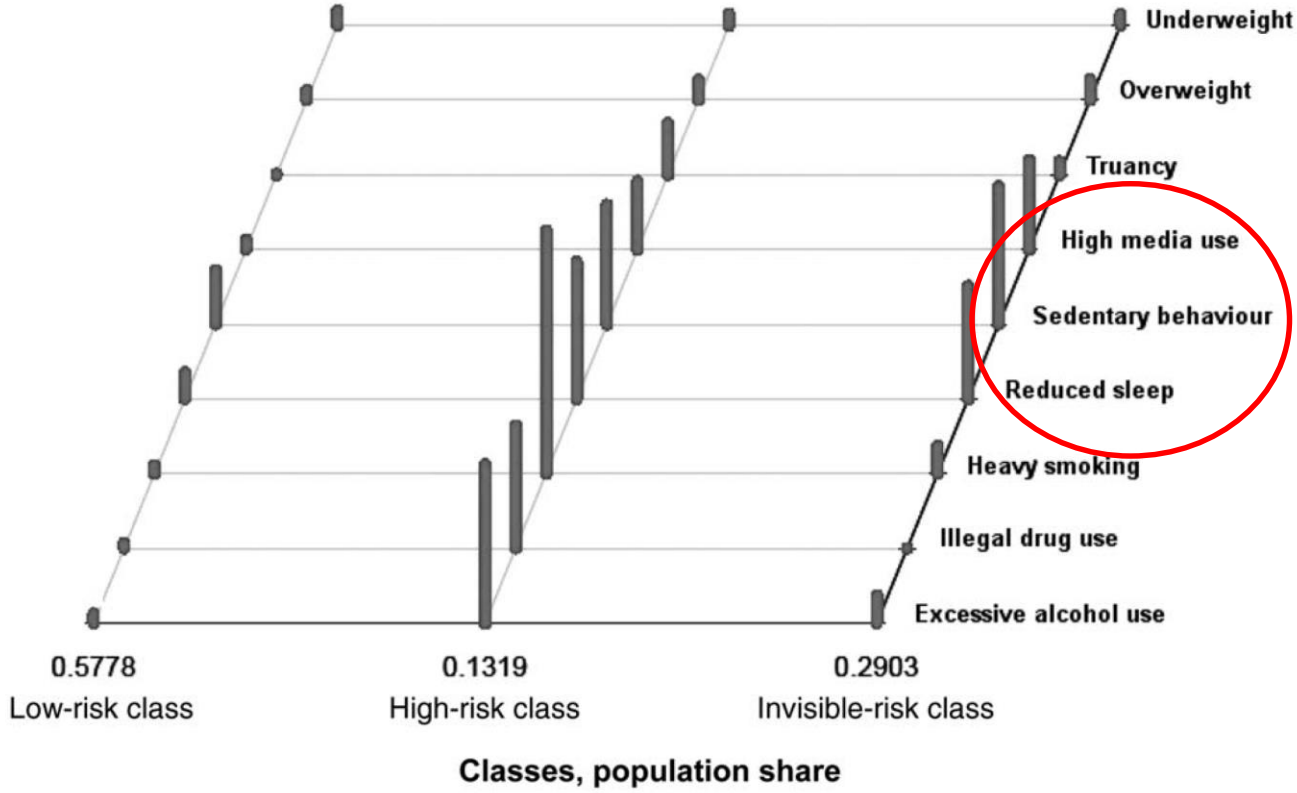
outh.

Un tempo di utilizzo < 3 ore e con uso attivo e diretto a uno scopo è associato a un umore migliore

RESEARCH REPORT

A newly identified group of adolescents at "invisible" risk for psychopathology and suicidal behavior: findings from the SEYLE study

Vladimir Carli[1], Christina W. Hoven[2,3], Camilla Wasserman[2,4], Flaminia Chiesa[1], Guia Guffanti[2], Marco Sarchiapone[4], Alan Apter[5], Judit Balazs[6], Romuald Brunner[7], Paul Corcoran[8], Doina Cosman[9], Christian Haring[10], Miriam Iosue[4], Michael Kaess[7], Jean Pierre Kahn[11], Helen Keeley[12], Vita Postuvan[13], Pilar Saiz[14], Airi Varnik[15], Danuta Wasserman[1]



RESEARCH REPORT

A newly identified group of adolescents at "invisible" risk for psychopathology and suicidal behavior: findings from the SEYLE study

Vladimir Carli[1], Christina W. Hoven[2,3], Camilla Wasserman[2,4], Flaminia Chiesa[1], Guia Guffanti[2], Marco Sarchiapone[4], Alan Apter[5], Judit Balazs[6], Romuald Brunner[7], Paul Corcoran[8], Doina Cosman[9], Christian Haring[10], Miriam Iosue[4], Michael Kaess[7], Jean Pierre Kahn[11], Helen Keeley[12], Vita Postuvan[13], Pilar Saiz[14], Airi Varnik[15], Danuta Wasserman[1]

Table 4 Psychiatric symptoms (%) by latent class risk groups

Psychiatric symptoms	Low-risk class, n=6,054 (M/F=2,557/3,497)	High-risk class, n=1,184 (M/F=622/562)	Invisible-risk class, n=1,796 (M/F=687/1,109)
Subthreshold depression**	29.4	34.0	33.2
Depression**	4.2	14.7	13.4
Subthreshold anxiety**	19.0	31.3	31.0
Anxiety**	2.5	9.2	8.0
Emotional symptoms*	5.8	9.0	11.6
Conduct problems*	6.4	23.2	11.5
Hyperactivity*	6.1	18.6	11.8
Peer problems***	2.3	3.0	5.0
Lack of prosocial behavior**	4.5	9.9	8.1
Non-suicidal self-injury*	5.5	22.3	12.4
Suicidal ideation**	27.1	44.0	42.2
Suicide attempter*	1.7	10.1	5.9

The Exposome Paradigm to Understand the Environmental Origins of Mental Disorders

INVITED REVIEW
Alpha Psychiatry 2021;22(4):171-176
DOI: 10.5152/alphapsychiatry.2021.21307

I fattori di rischio non sono fenotipo specifici

Interazione tra i fattori di rischio

Peso dei fattori di rischio

Key points

E’ importante conoscere quali adolescenti sono a maggior rischio di sviluppare traiettorie psicopatologiche gravi

La familiaritá è uno dei fattori di rischio piú rilevanti ed evidenzia la necessitá di sviluppare programmi di prevenzione precoce per i figli

I fattori di rischio ambientali non vanno studiati singolarmente ma nella loro interazione per individuare set di domini utili a clusterizzare le popolazioni a rischio

1. Aspetti epidemiologici
2. Sfide diagnostiche
3. Sfide terapeutiche

The clinical characterization of the adult patient with depression aimed at personalization of management

(World Psychiatry 2020;19:269–293)

Mario Maj[1], Dan J. Stein[2], Gordon Parker[3], Mark Zimmerman[4], Giovanni A. Fava[5], Marc De Hert[6,7], Koen Demyttenaere[8], Roger S. McIntyre[9], Thomas Widiger[10], Hans-Ulrich Wittchen[11,12]

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1. Symptom profile
2. Clinical subtypes
3. Severity
4. Neurocognition
5. Functioning and quality of life
6. Clinical staging
7. Personality traits
8. Antecedent and concomitant psychiatric conditions
9. Physical comorbidities
10. Family history
11. Early environmental exposures
12. Recent environmental exposures
13. Protective factors / Resilience
14. Dysfunctional cognitive schemas

Eterogeneitá clinica in relazione all'etá

0-3 ANNI

- **Pianto eccessivo**, irritabilità
- **Riduzione dell'appetito** e/o del peso corporeo, disturbi psicosomatici (vomito, diarrea, alopecia)
- **Disturbi del sonno** (riduzione, aumento, inversione del ritmo) alterazioni della motricità (inibizione, irrequietezza)
- **Ritardi psicomotori** (linguaggio, motricità, controllo degli sfinteri)
- **Assenza del sorriso facciale, scarso contatto visivo, scarsa mimica facciale**

Eterogeneitá clinica in relazione all'etá

3-5 ANNI

- Rallentamento psicomotorio, apatia, **riduzione di interesse per il gioco** (non si divertono nel giocare)
- Alterazioni del tono dell'umore (tristezza, irritabilità, appiattimento dell'affettività); il bambino apparire amimico, **eccessivamente capriccioso, scontroso, imbronciato**
- **Lamentele somatiche** (vomito, asma, dermatite, allergie, dolori addominali, cefalea, alopecia)
- **Dipendenza e ansia**
- **Difficoltà di socializzazione** con progressivo evitamento sociale
- Comportamenti **auto/eteroaggressivi**

Eterogeneitá clinica in relazione all'etá

6-11 ANNI

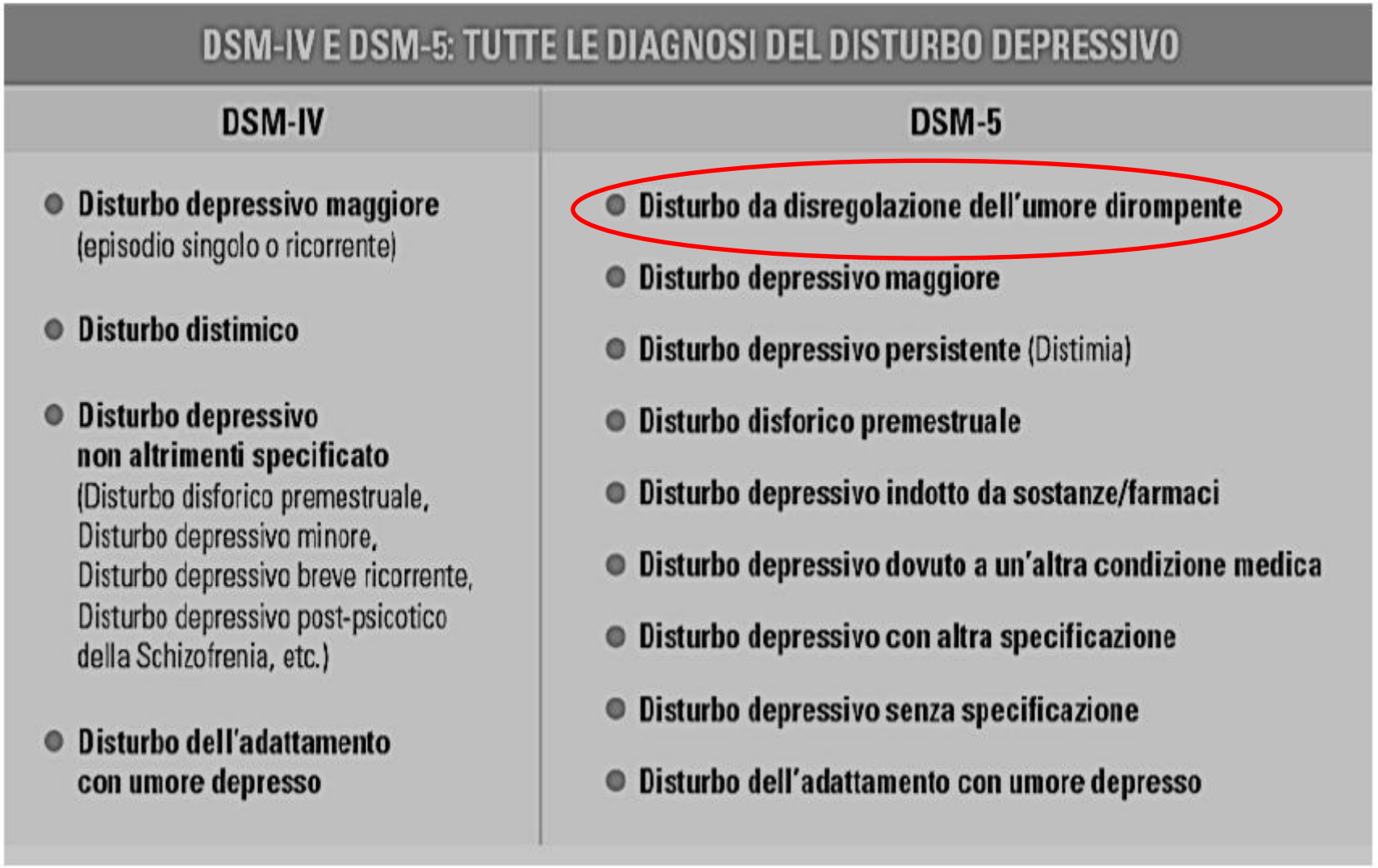
- **Tendenza ad esprimere l'umore depresso nei giochi, nei sogni e nei disegni**
- Difficoltà relazionali con i coetanei con **tendenza all'isolamento sociale**
- **Difficoltà scolastiche**: il rendimento scolastico può calare per difficoltà di concentrazione e facile stancabilità
- **Lamentele somatiche** (vomito, asma, dermatite, alopecia, dolori addominali, cefalea, dolori diffusi, etc)
- Problemi comportamentali: protesta, aggressività, oppositività
- **Pensieri di morte**, raramente idee di suicidio e tentativi di suicidio.

Eterogeneitá clinica in relazione all'etá

> 12 ANNI

- **Intense oscillazioni dell'umore/Anedonia**
- **Scarsa iniziativa**, perdita degli interessi, calo del rendimento scolastico
- Sentimenti di inferiorità e **bassa autostima**
- **Preoccupazioni per l'aspetto fisico**
- **Irritabilitá, ansia**
- Comportamenti antisociali e **abuso di sostanze**
- **Idee di suicidio e autolesionismo**
- **Sintomi psicotici**: deliri ed allucinazioni
- **Disturbi somatici** (cefalea, dolori diffusi, disturbi neurovegetativi)

Irritabilitá



Disturbo da disregolazione dell'umore dirompente

Il disturbo da disregolazione dell'umore dirompente è stato descritto per la prima volta all'interno del DSM-5 nella categoria dei disturbi depressivi. È **caratterizzato da scoppi di collera espressi verbalmente o da un punto di vista comportamentale e da un umore cronicamente irritabile o arrabbiato** (APA, 2013).

Il disturbo si distingue dal disturbo bipolare in quanto non sono presenti sintomi maniacali o ipomaniacali; la **caratteristica centrale è la condizione di irritabilità cronica che si manifesta con comportamenti rabbiosi o aggressivi**

Disturbo da disregolazione dell'umore dirompente

Incidenza
Il 2-5% degli accessi ai servizi di NPI è per un disturbo da disregolazione dell'umore dirompente.

Etá di esordio
6-18 aa

Decorso
L'evoluzione clinica sembrerebbe essere verso la depressione unipolare e la distimia piuttosto che verso un disturbo bipolare vero e proprio**.**

F1000Prime REPORTS

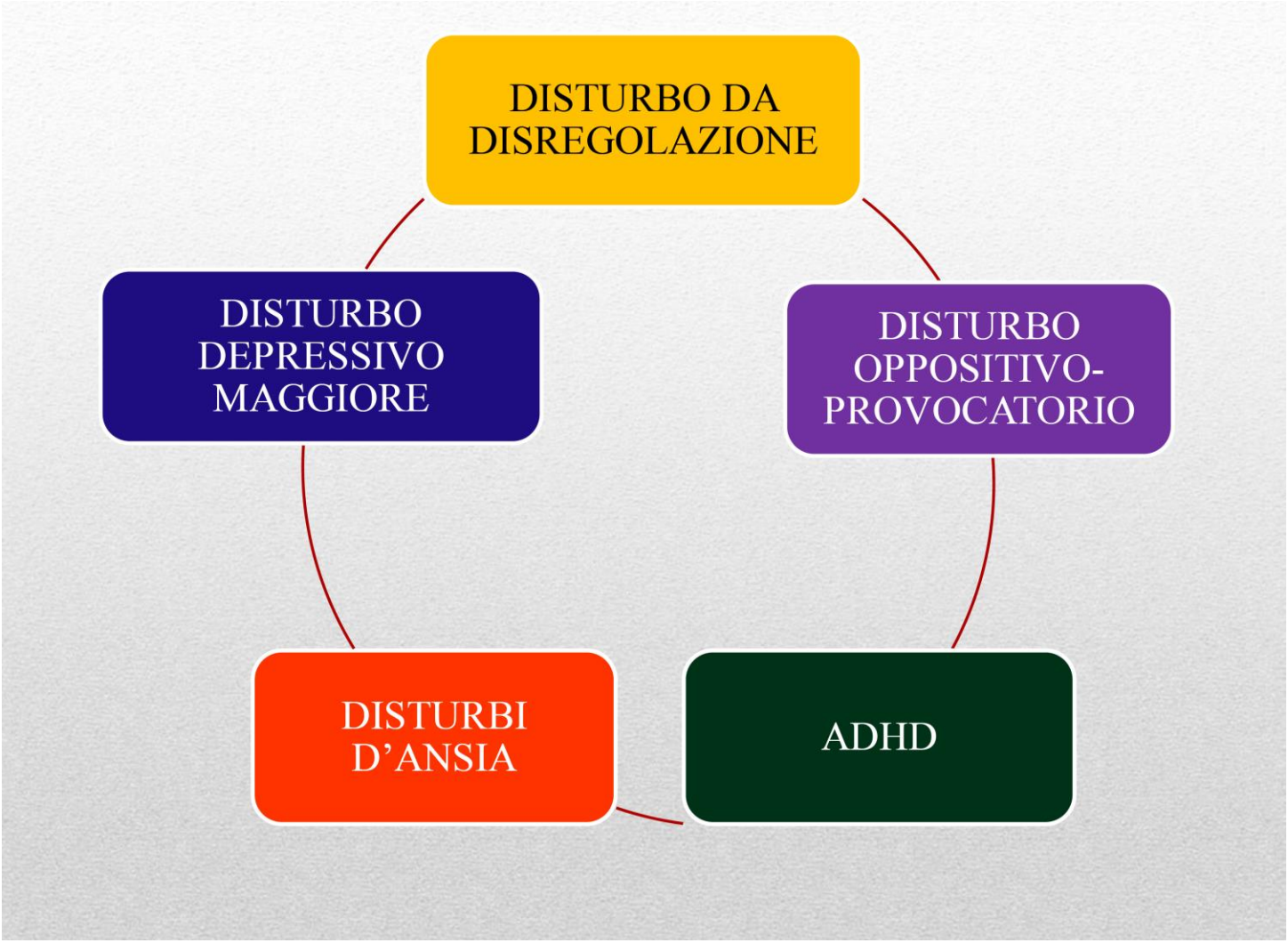
Published: 01 December 2014

Is bipolar always bipolar? Understanding the controversy on bipolar disorder in children

Yvonne Grimmer[1], Sarah Hohmann[1] and Luise Poustka[1,2]*

Con l'introduzione del Disturbo da Disregolazione dell'umore dirompente come nuova categoria, è stata sottolineata **la delimitazione tra irritabilità cronica e disturbo bipolare.**

Non ancora chiara la validitá di questa condizione e la sovrapposizione con altri disturbi come ADHD, Disturbo Oppositivo, Disturbi della condotta


DISTURBO DA DISREGOLAZIONE
DISTURBO OPPOSITIVO-PROVOCATORIO
ADHD
DISTURBI D'ANSIA
DISTURBO DEPRESSIVO MAGGIORE

Psychol Bull. 2014 May ; 140(3): 816–845. doi:10.1037/a0034733.

Comorbidity of Anxiety and Depression in Children and Adolescents: 20 Years After

Colleen M. Cummings, **Nicole E. Caporino**, and **Philip C. Kendall**

Tra i giovani che presentano un quadro depressivo, i disturbi d'ansia sono quelli più presenti in comorbilità con una frequenza stimata che va dal 15% al 75%

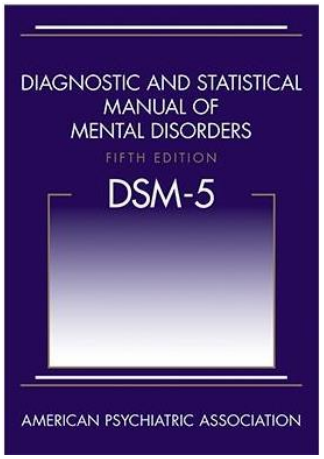
REVIEW

Comorbidity of bipolar and anxiety disorders: An overview of trends in research

Mamidipalli Sai Spoorthy, Subho Chakrabarti, Sandeep Grover *World J Psychiatr* 2019

Comorbidità tra disturbo bipolare e disturbi ansiosi in adolescenza varia tra il 15%-44%

Specificatori per i disturbi depressivi

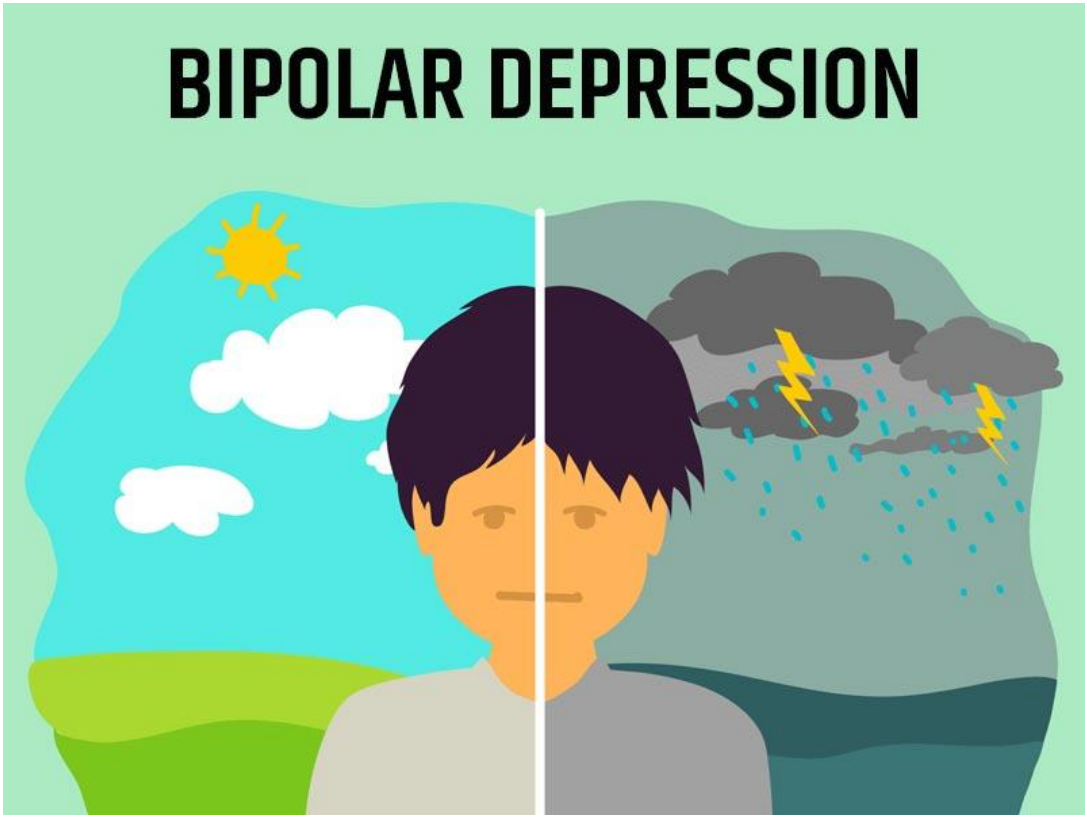


Con ansia
Con caratteristiche miste
Con caratteristiche melanconiche
Con caratteristiche atipiche
Con caratteristiche psicotiche
Con caratteristiche psicotiche congruenti all'umore
Con caratteristiche psicotiche non congruenti all'umore
Con esordio nel peripartum
Con andamento stagionale

Con ansia

L'ansia è definita come la presenza di almeno due dei seguenti sintomi nella maggior parte dei giorni di un episodio depressivo maggiore o di un disturbo depressivo persistente (distimia):

1. sentirsi nervosi e tesi;
2. Sentirsi insolitamente inquieti;
3. Difficoltà di concentrazione a causa della preoccupazione;
4. Paura che possa accadere qualcosa di terribile;
5. Sentire che l'individuo può perdere il controllo di se stesso.



Il 25% dei pazienti con una prima diagnosi di Depressione Maggiore sviluppa episodi ipo/maniacali in 5-10 anni

Schizophrenia Bulletin vol. 43 no. 4 pp. 737–744, 2017
doi:10.1093/schbul/sbw154
Advance Access publication November 21, 2016

Bipolar At-Risk Criteria: An Examination of Which Clinical Features Have Optimal Utility for Identifying Youth at Risk of Early Transition From Depression to Bipolar Disorders

Jan Scott*[,1,2], Steven Marwaha[3], Aswin Ratheesh[4,5], Iain Macmillan[6], Alison R. Yung[7,8], Richard Morriss[9], Ian B. Hickie[10], and Andreas Bechdolf[4,11,12]

Table 2. Prevalence and Performance of Each Putative Risk Factors for Bipolarity in Differentiating Between Cases With ET-BD and Controls With UP

	ET-BD (N = 50)	UP (N = 50)	OR (95% CI)	Clinical Rule in Accuracy (CUI+)	Clinical Rule Out Accuracy (CUI−)	Overall Clinical Utility[a]
Bipolar at-risk criteria[b]						
Cyclothymia	39	10	14.2 (5.4, 37.2)	Good	Good	Case finding and screening
Sub-threshold mania	26	3	16.9 (4.7, 61.8)	Moderate	Good	Screening
Family history of BD	12	2	7.6 (1.6, 35.9)	Poor	Good	Screening
Additional risk factors[c]						
Probable antidepressant-emergent elation	21	8	3.4 (1.2, 4.9)	Fair	Good	Screening
Atypical depression	25	4	11.5 (3.6, 36.7)	Fair	Good	Screening
Psychomotor retardation	6	2	2.6 (0.5, 13.6)	Poor	Moderate	—
Psychotic mood episode	6	1	6.7 (0.8, 57.7)	Poor	Moderate	—
Family history of other mood disorders and/or ASUD	22	14	2.0 (0.9, 4.64)	Fair	Moderate	—
Multi-generational family history of mood disorders	3	0	3.1 (0.3, 31.1)	Poor	Moderate	—

Comorbidità abuso di sostanze

- La grande diffusione di sostanze rende la comorbidità una regola e non un’eccezione
- Quadri clinici contaminati dalla presenza delle sostanze (“disorganizzatore nosografico”)

Complessità della diagnosi nei giovani

Il vissuto caotico che provano i giovani corrisponde spesso alla confusione diagnostica che prova il clinico

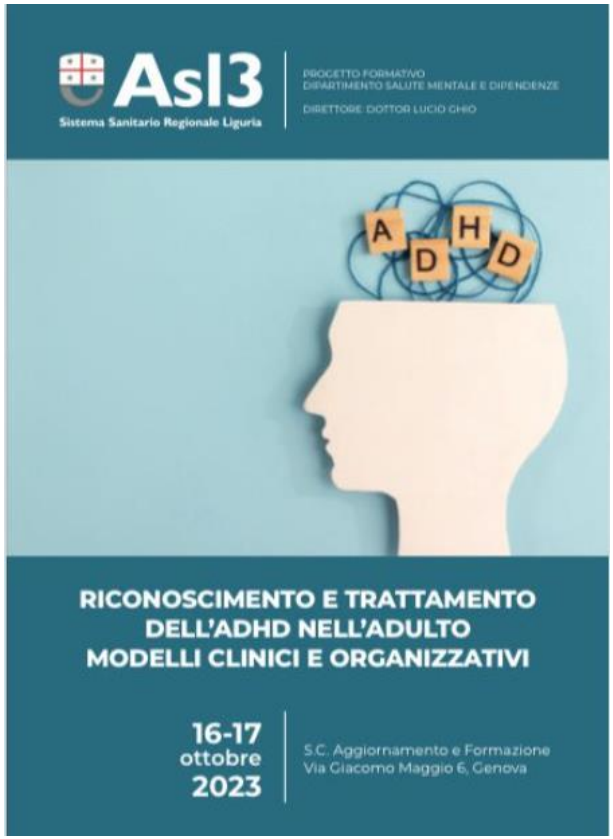
Depressione giovanile e comorbidità

Disturbi dell'apprendimento
Disturbi del comportamento
Disturbi dello spettro dell'autismo
ADHD
Disturbo Ossessivo compulsivo
Disturbi della nutrizione e dell'alimentazione
Disturbo depressivo persistente (distimia)
UHR

Depressione e ADHD

Un **disturbo depressivo maggiore** può manifestarsi con irritabilità, scarsa concentrazione, agitazione psicomotoria e difficoltà a portare a termine i compiti assegnati

Ragazzi con **ADHD** hanno spesso episodi depressivi o disforici di carattere transitorio, in seguito ad eventi sfavorevoli o come risultato di una persistente demoralizzazione per i problemi associati all‘ADHD



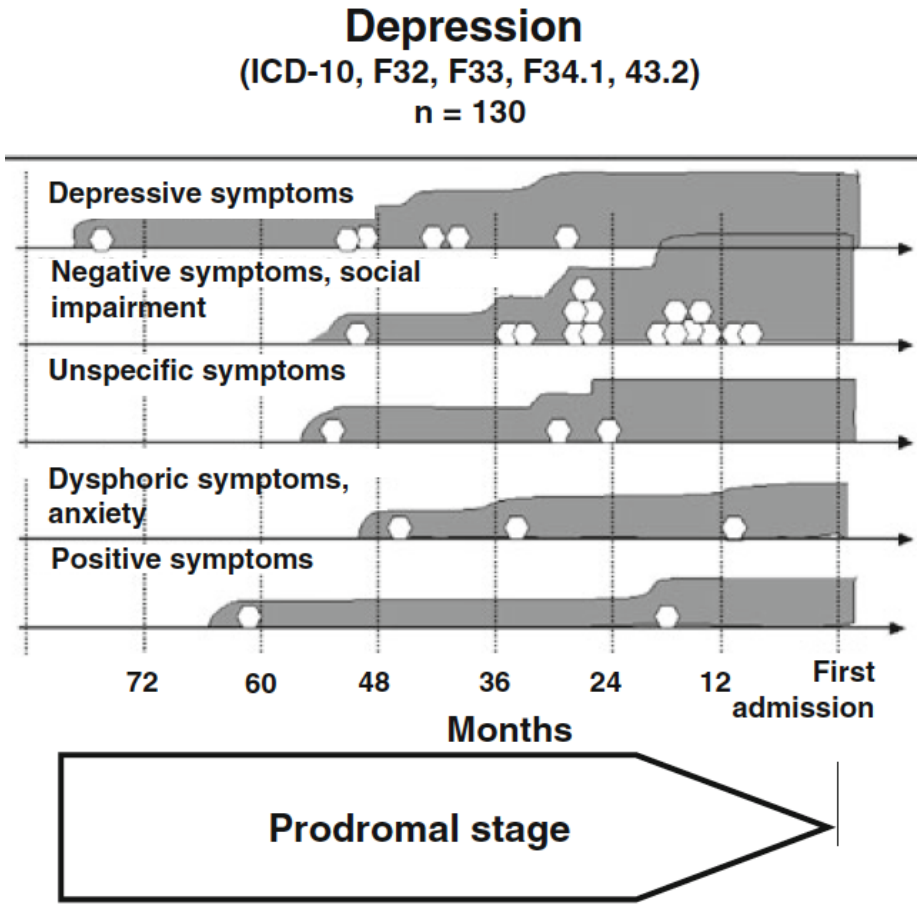
Linee di indirizzo 2024 per ADHD DSMD ASL 3 Genovese

Percorso di cura dei Disturbi dello Spettro Autistico nei Centri di Salute Mentale

Depressione ed esordi psicotici

ABC Schizophrenia study: an overview of results since 1996

H. Häfner · K. Maurer · W. an der Heiden



The clinical characterization of the adult patient with depression aimed at personalization of management

(World Psychiatry 2020;19:269–293)

Mario Maj[1], Dan J. Stein[2], Gordon Parker[3], Mark Zimmerman[4], Giovanni A. Fava[5], Marc De Hert[6,7], Koen Demyttenaere[8], Roger S. McIntyre[9], Thomas Widiger[10], Hans-Ulrich Wittchen[11,12]

Table 3 Clinical staging of depression

STAGE 1	Prodromal phase a. Aspecific symptoms (generalized anxiety, irritability, sleep disorders) with mild functional change or decline b. Subthreshold depressive symptoms
STAGE 2	First depressive episode
STAGE 3	Residual phase a. Aspecific symptoms (sleep disturbance, generalized anxiety, irritability, anorexia, impaired libido) b. Residual depressive symptoms (depressed mood, guilt, hopelessness) c. Dysthymia (mild chronic depressive syndrome)
STAGE 4	a. Recurrent depression b. Double depression (depressive episodes superimposed on dysthymia)
STAGE 5	Chronic depressive episode (i.e., episode lasting at least two years without interruptions)

This staging is a modification of that proposed by Cosci and Fava[132]

Journal of Affective Disorders 309 (2022) 123–130

Review article

Is subthreshold depression in adolescence clinically relevant?

Blake K. Noyes [a], Douglas P. Munoz [a,b,c,d], Sarosh Khalid-Khan [a,d,e], Elisa Brietzke [a,b,e], Linda Booij [d,f,g,h,*]

Table 2
Summary of results on similarities and differences between subthreshold depression and major depressive disorder in adolescents. * Indicates that there is a limited number of studies. For further detail and specific references, see main text.

	Major Depressive Disorder	Subthreshold Depression
Prevalence	5–19.4%	Up to 29.2%
More Prevalent in Females	Yes	Yes
Prevalence Peaks in Mid-Adolescence	Yes	Yes
Functional Impairment	Yes	Yes
Healthcare Usage	Equal levels	
Suicidal Ideation	Equal levels	
Rate of Any Psychiatric Disorders	Equal levels	
Heritability	30–40%	37%
Altered Grey Matter Volume	Yes	Yes*
Altered Resting State Connectivity and Task-Based Activation	Yes	Yes*
Benefit from Psychotherapy (CBT/IPT)	Yes	Yes*
Benefit from Pharmacotherapy (SSRIs)	Yes	Unknown*

Screening diagnostico

Un’offerta dedicata e integrata per i giovani

Asl 3
Sistema Sanitario Regione Liguria

LINEE DI INDIRIZZO 2024 PER FAVORIRE INTERVENTI INTEGRATI PER IL RICONOSCIMENTO E IL TRATTAMENTO PRECOCE DEI DISTURBI PSICHICI GRAVI IN ETA’ GIOVANILE (14-27 anni)

Screening diagnostico

- Sono consigliati i seguenti test di screening e approfondimento: Checklist ERIraos (intervista per l'individuazione precoce del disagio psichico giovanile); PQ-16 (Questionario Dei Sintomi Prodromici, autosomministrato) ; PID-5 (Personality Inventory for DSM-5, misurano i tratti di personalità non adattivi); GHQ-12 (Questionario sul Benessere Generale, autosomministrato); GAF (Global Assessment of Functioning); WAIS (Wechsler Adult Intelligence Scale); Vineland-II ABS (revisione delle Vineland Adaptive Behavior Scales)

Treating depression in young people

Guidance, resources and tools for assessment and management

Orygen
The National Centre of Excellence in Youth Mental Health

A comprehensive assessment involves asking questions about a range of aspects of a person's life including their:

- home and environment
- education and employment
- activities
- drugs and alcohol
- relationships and sexuality
- conduct difficulties and risk-taking
- anxiety and eating
- depression symptoms and suicide risk
- psychosis and mania symptoms
- strengths and supports.

Key points

La valutazione deve essere fatta in ambiente accogliente e friendly, coinvolgendo se possibile i genitori

E’ importante considerare l’atipicitá della presentazione clinica, le comorbiditá, l’eterotipia dell’evoluzione, ma anche l’impatto sul funzionamento di forme anche non gravi

E’ utile un assessment standardizzato

Una buona valutazione è utile per il trattamento, ma una valutazione eccessiva mette a rischio l’alleanza terapeutica

1. Aspetti epidemiologici
2. Sfide diagnostiche
3. Sfide terapeutiche

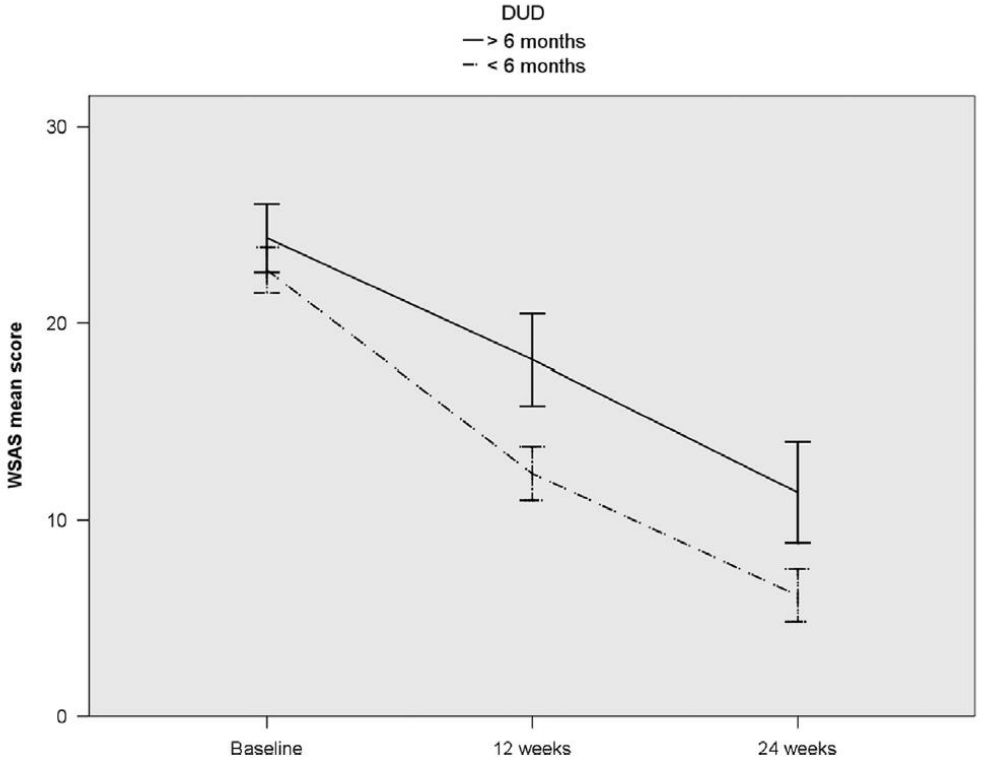
Brief report

Journal of Affective Disorders 175 (2015) 224–228

Duration of untreated depression influences clinical outcomes and disability

Lucio Ghio [a,*], Simona Gotelli [b], Alice Cervetti [a], Matteo Respino [a], Werner Natta [a], Maurizio Marcenaro [a], Gianluca Serafini [a], Marco Vaggi [b], Mario Amore [a], Martino Belvederi Murri [a]

[a] *Department of Neuroscience, Ophthalmology and Genetics, Psychiatry Section, University of Genoa, Italy*
[b] *Department of Mental Health, ASL3, Genoa, Italy*



Early intervention for depression in young people: a blind spot in mental health care

Christopher G Davey, Patrick D McGorry

Depression is a major contributor to disability across the lifespan. As a disorder that commonly has its onset in adolescence and early adulthood, and high recurrence and persistence, it is a prime candidate for early intervention. Most of the early intervention focus, however, has been confined to indicated prevention efforts. In this Personal View, we argue that early intervention for depression must expand beyond this narrow focus to include young people (aged 12–25 years old) who present with early episodes of full-threshold major depressive disorder. We discuss the development of enhanced primary care services for youth mental health, which allow young people improved access to evidence-based care. We argue that young people with severe and complex depression require particular attention: they are at high risk of lifelong disabling illness and need support to alleviate the early effects of their illnesses on their functional trajectories.

Lancet Psychiatry 2018

Published Online
November 27, 2018
http://dx.doi.org/10.1016/S2215-0366(18)30292-X

Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, VIC, Australia (C G Davey MD,

Prevenzione indicata

Interventi precoci per depressione lieve –moderata

Interventi precoci per depressione grave e complicata

Stepped care for depressive disorders

Depressione lieve/moderata

Watchful waiting

↓

Psicoeducazione sugli stili di vita
Gruppi CBT
Psicoterapia di supporto

↓

Step successivo se persistenza sintomi

FACT SHEET

FOR FAMILY, FRIENDS AND YOUNG PEOPLE

DEPRESSION AND YOUNG PEOPLE

WHAT ARE NORMAL FEELINGS AND WHAT IS DEPRESSION?

People use the word 'depression' in different ways. We all feel down from time to time. It's a part of being human. But it is important to know the difference between depression and sadness. Sadness is a feeling that lasts for only for a short time after a difficult experience, like following a break up or an argument with someone.

Depression is different because this feeling of sadness doesn't go away – it persists over time and seems to cast a dark cloud over life. Depression is a problem because it can inhibit the enjoyment of most things and stop people from taking part in activities that used to be easy to do. Depression can cause changes in thinking, how a young person responds to things, motivation and activity levels, sleep, and relationships. This may lead to significant difficulties that affect a young person's life, including difficulties with friends and family, poor performance at school or work, substance use or dependence, and in some young people, suicidal behaviour.

Journal of Adolescence 40 (2015) 83–92

Contents lists available at ScienceDirect

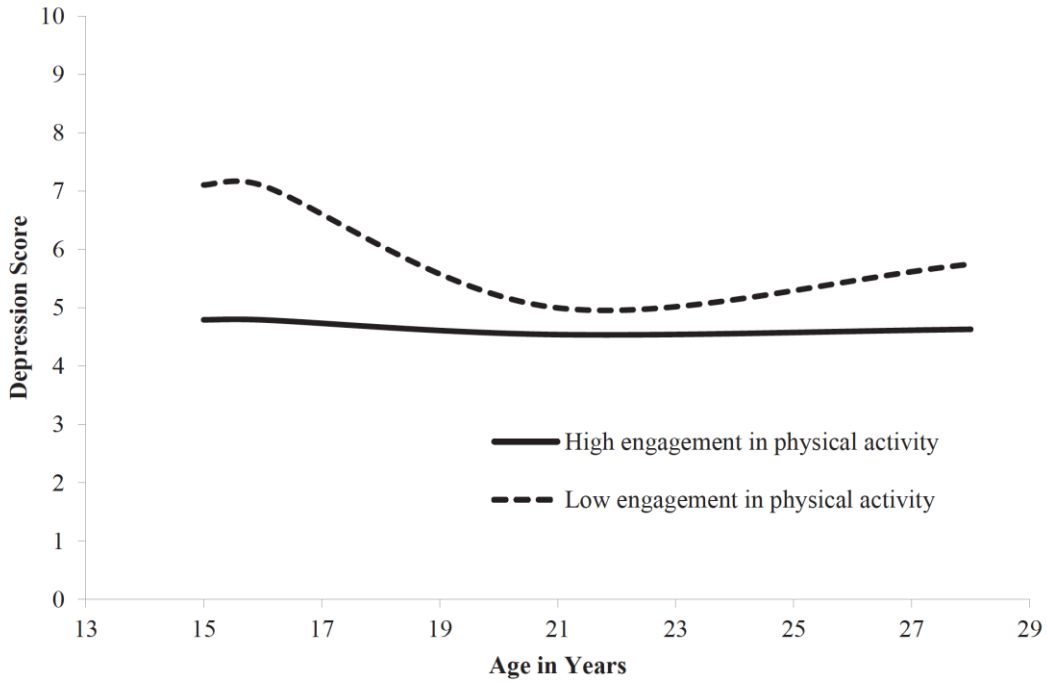
Journal of Adolescence

journal homepage: www.elsevier.com/locate/jado

The effect of physical activity on depression in adolescence and emerging adulthood: A growth-curve analysis☆

Meghan L. McPhie [1], Jennine S. Rawana*

Department of Psychology, York University, Toronto, ON M3J 1P3, Canada



(World Psychiatry 2020;19:360–380)

RESEARCH REPORT

A meta-review of "lifestyle psychiatry": the role of exercise, smoking, diet and sleep in the prevention and treatment of mental disorders

Joseph Firth[1,2], Marco Solmi[3], Robyn E. Wootton[4], Davy Vancampfort[5,6], Felipe B. Schuch[7], Erin Hoare[8], Simon Gilbody[9], John Torous[10], Scott B. Teasdale[11], Sarah E. Jackson[12], Lee Smith[13], Melissa Eaton[2], Felice N. Jacka[14], Nicola Veronese[15], Wolfgang Marx[14], Garcia Ashdown-Franks[16-18], Dan Siskind[19,20], Jerome Sarris[2,21], Simon Rosenbaum[11], André F. Carvalho[22,23], Brendon Stubbs[17,18]

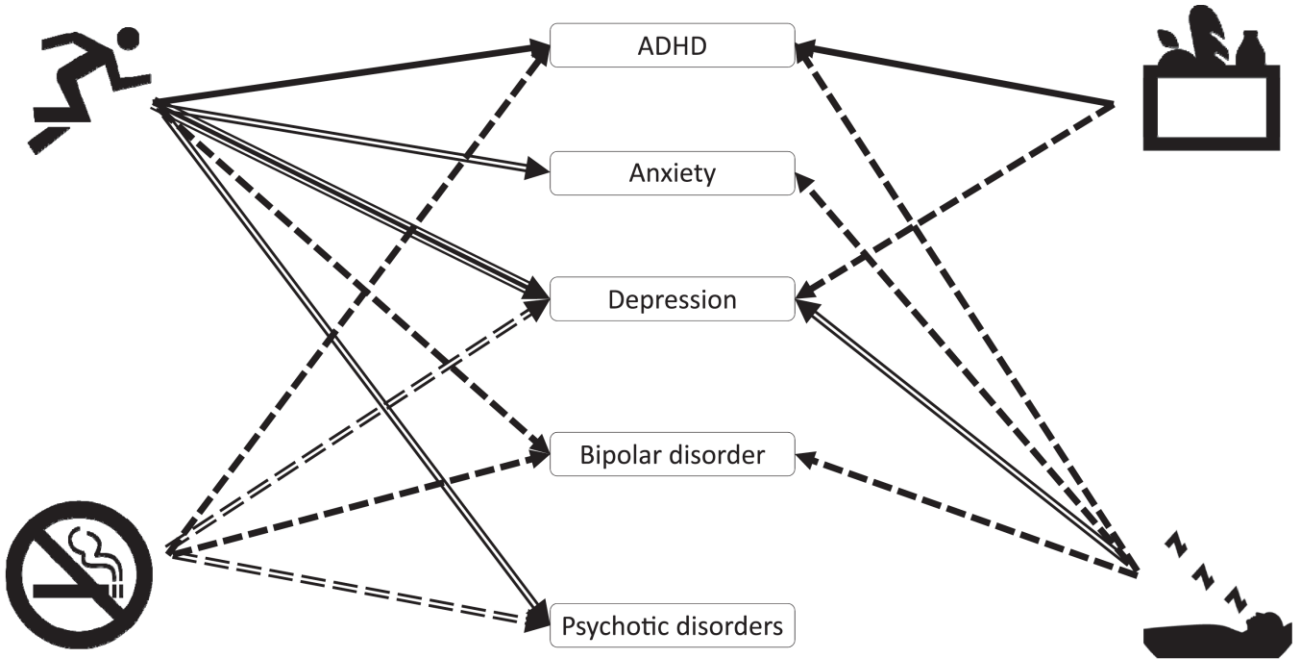


Figure 1 Lifestyle factors in the prevention and treatment of mental illness. The dashed line indicates evidence for protective benefit from either prospective meta-analyses (P-MAs) or Mendelian randomization studies (MRs). The double-dashed line indicates evidence for protective effects from both P-MAs and MRs. The solid line indicates evidence for efficacy in treatment of mental illness from MAs of randomized controlled trials (RCTs). The double solid line indicates convergent evidence from MRs or P-MAs with MAs of RCTs. The treble solid line indicates convergent evidence from all three (P-MAs + MRs + MAs of RCTs). ADHD – attention-deficit/hyperactivity disorder.

Stepped care for depressive disorders

Depressione moderata/grave

Almeno 3 mesi di psicoterapia EB
(CBT, IPT, terapia familiare breve)

Terapia combinata psicoterapia EB
+
Antidepressivo

Utilizzo di antipsicotici se depressione psicotica

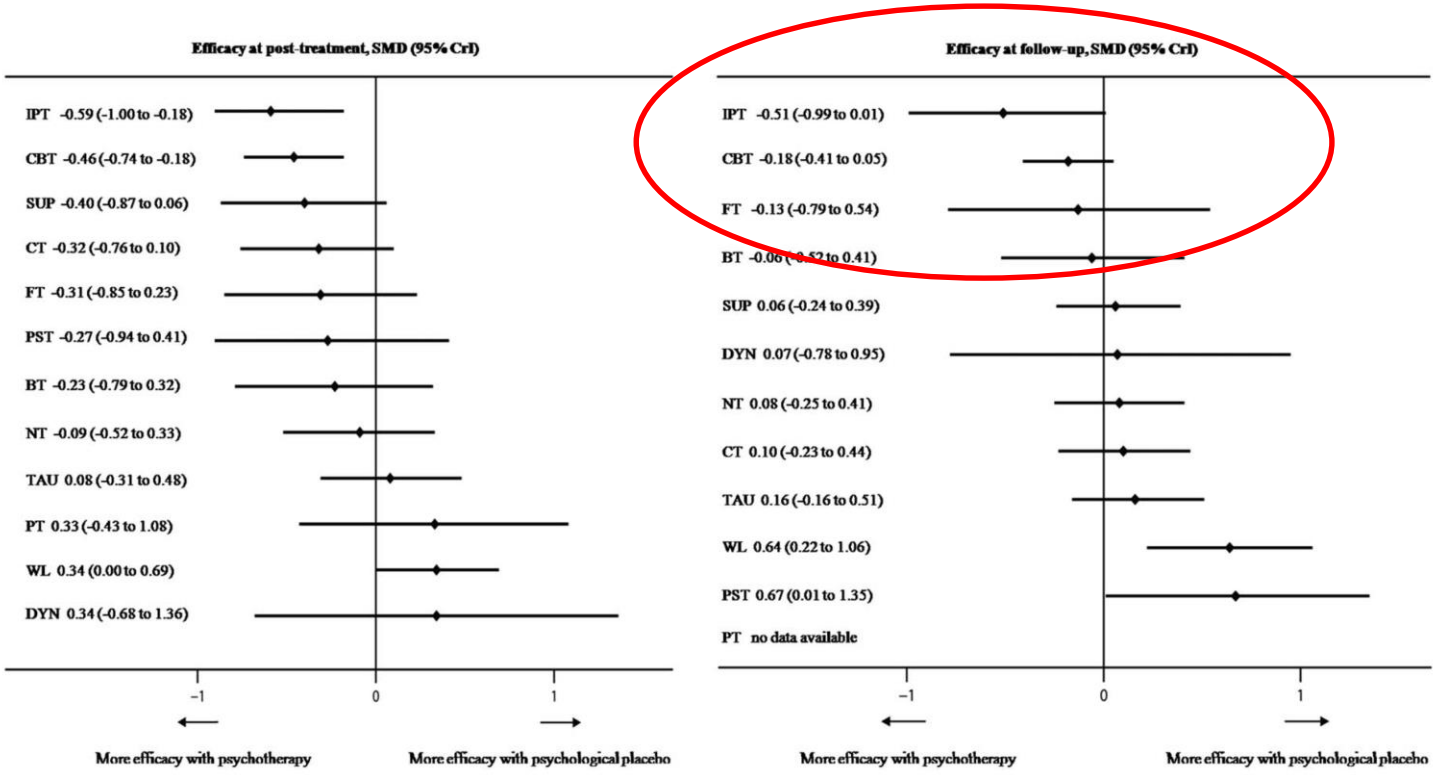
Valutazione ricovero se idee di suicidio

RESEARCH REPORT

(World Psychiatry 2015;14:207–222)

Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: a systematic review and network meta-analysis

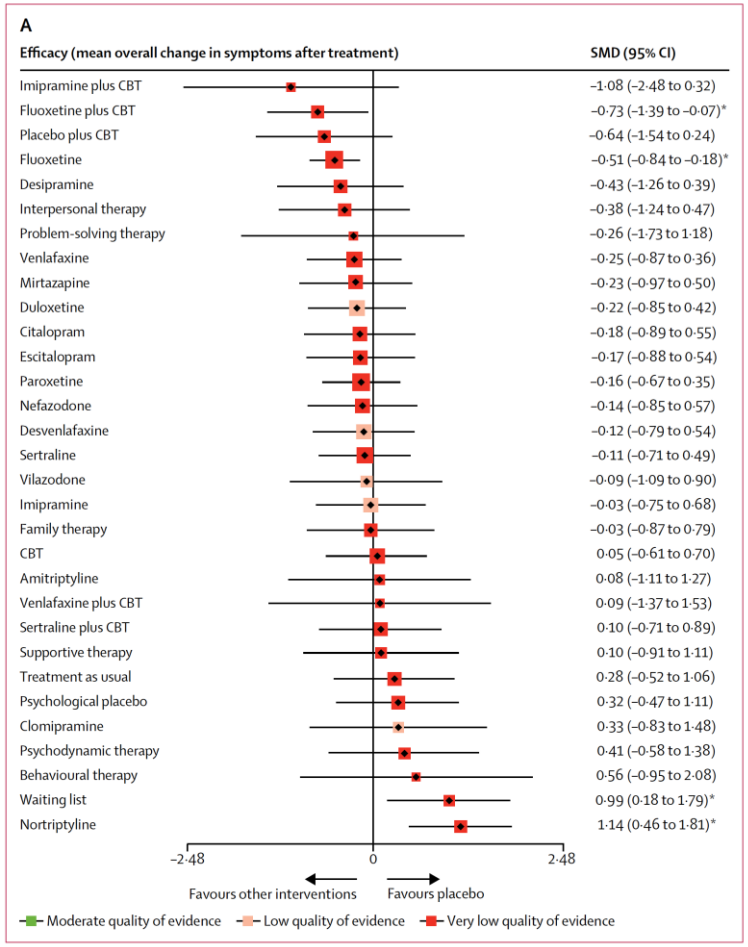
Xinyu Zhou[1], Sarah E. Hetrick[2], Pim Cuijpers[3], Bin Qin[1], Jürgen Barth[4], Craig J. Whittington[5], David Cohen[6], Cinzia Del Giovane[7], Yiyun Liu[1], Kurt D. Michael[8], Yuqing Zhang[1], John R. Weisz[9], Peng Xie[1]



Comparative efficacy and acceptability of antidepressants, psychotherapies, and their combination for acute treatment of children and adolescents with depressive disorder: a systematic review and network meta-analysis

Lancet Psychiatry 2020; 7: 581–601

Xinyu Zhou, Teng Teng*, Yuqing Zhang*, Cinzia Del Giovane, Toshi A Furukawa, John R Weisz, Xuemei Li, Pim Cuijpers, David Coghill, Yajie Xiang, Sarah E Hetrick, Stefan Leucht, Mengchang Qin, Jürgen Barth, Arun V Ravindran, Lining Yang, John Curry, Li Fan, Susan G Silva, Andrea Ciprianit, Peng Xie†*



Solo fluoxetina e fluoxetina + CBT sono superiori a placebo

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New generation antidepressants for depression in children and adolescents: a network meta-analysis (Review)

Hetrick SE, McKenzie JE, Bailey AP, Sharma V, Moller CI, Badcock PB, Cox GR, Merry SN, Meader N

Authors' conclusions

Overall, methodological shortcomings of the randomised trials make it difficult to interpret the findings with regard to the efficacy and safety of newer antidepressant medications. Findings suggest that most newer antidepressants may reduce depression symptoms in a small and unimportant way compared with placebo. Furthermore, there are likely to be small and unimportant differences in the reduction of depression symptoms between the majority of antidepressants. However, our findings reflect the average effects of the antidepressants, and given depression is a heterogeneous condition, some individuals may experience a greater response. Guideline developers and others making recommendations might therefore consider whether a recommendation for the use of newer generation antidepressants is warranted for some individuals in some circumstances. Our findings suggest sertraline, escitalopram, duloxetine, as well as fluoxetine (which is currently the only treatment recommended for first-line prescribing) could be considered as a first option.

Children and adolescents considered at risk of suicide were frequently excluded from trials, so that we cannot be confident about the effects of these medications for these individuals. If an antidepressant is being considered for an individual, this should be done in consultation with the child/adolescent and their family/caregivers and it remains critical to ensure close monitoring of treatment effects and suicide-related outcomes (combined suicidal ideation and suicide attempt) in those treated with newer generation antidepressants, given findings that some of these medications may be associated with greater odds of these events. Consideration of psychotherapy, particularly cognitive behavioural therapy, as per guideline recommendations, remains important.

FDA Black box warning per 9 antidepressivi nel 2004 per aumento della suicidalitá.
(citalopram, fluvoxamine, paroxetine, fluoxetine, sertraline, venlafaxine , mirtazapine, nefazodone bupropion)

JAMA Psychiatry | Original Investigation

JAMA Psychiatry. 2024;81(1):25-33.

Antidepressant Use and Risk of Manic Episodes in Children and Adolescents With Unipolar Depression

Suvi Virtanen, PhD; Tyra Lagerberg, PhD; Christine Takami Lageborn, MD; Ralf Kuja-Halkola, PhD; Isabell Brikell, PhD; Anthony A. Matthews, PhD; Paul Lichtenstein, PhD; Brian M. D'Onofrio, PhD; Mikael Landén, MD, PhD; Zheng Chang, PhD

Key Points

Question Do pediatric patients diagnosed with unipolar depression who receive antidepressant treatment have an increased incidence of mania/hypomania compared with patients not treated with antidepressants?

Findings In this cohort study including 43 677 children and adolescents diagnosed with unipolar depression, during a 12-week follow-up, patients treated with antidepressants did not have an increased incidence of mania/hypomania compared with patients who did not initiate antidepressant treatment. Hospitalizations, parental bipolar disorder, and use of antipsychotics and antiepileptics were the most important predictors of mania/hypomania by 12 weeks.

Meaning This study found no evidence of treatment-emergent mania/hypomania in children and adolescents with unipolar depression.

Major challenges in youth psychopathology: treatment-resistant depression. A narrative review

Giulia Menculini[1*], Gianmarco Cinesi[1], Francesca Scopetta[1], Matteo Cardelli[1], Guido Caramanico[1], Pierfrancesco Maria Balducci[1,2], Filippo De Giorgi[3], Patrizia Moretti[1] and Alfonso Tortorella[1]

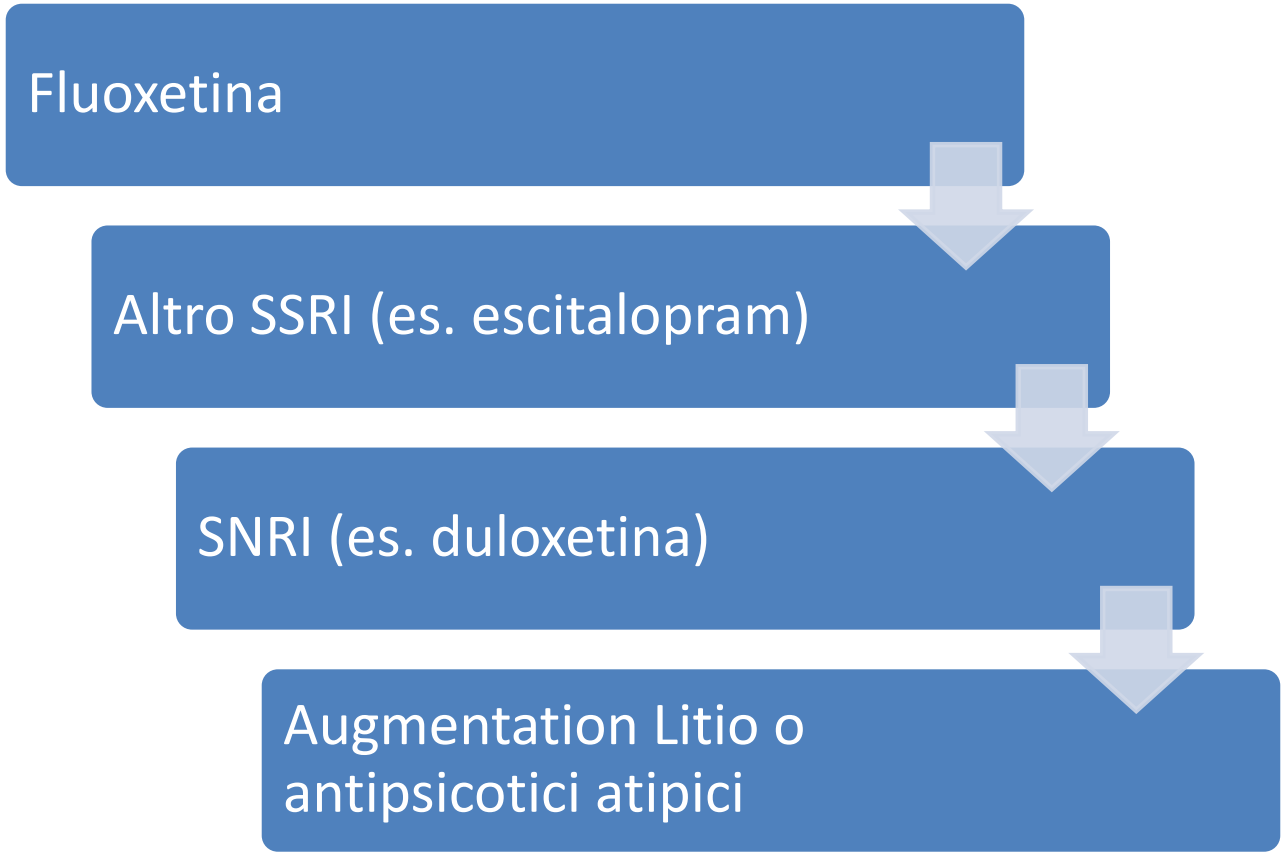
Frontiers in Psychiatry

TYPE Mini Review
PUBLISHED 11 July 2024

Circa il 40% dei giovani non risponde al trattamento con antidepressivi o con una psicoterapia EB

La depressione in adolescenza viene considerata resistente se non risponde a un trattamento per 2 mesi con un antidepressivo (fluoxetina-dose equivalente a 40mg/die) e/o a 16 sessioni di psicoterapia EB

Algoritmo terapia farmacologica



Systematic Review

A Systematic Review on Ketamine and Esketamine for Treatment-Resistant Depression and Suicidality in Adolescents: A New Hope?

Simone Pardossi *, Andrea Fagiolini, Simona Scheggi and Alessandro Cuomo

Ketamine and esketamine have both shown rapid and significant improvements in depressive symptoms in adolescents with TRD, as well as in improving symptoms and suicidal ideation in adolescents with MDD. Ketamine has been effective in populations of adolescents who had failed to respond to traditional antidepressants [58,59]. Additionally, its action is rapid, as seen in Dwyer's study, where a reduction in depressive symptoms was observed within 24 h [58]. Not only does it improve depressive symptoms as measured by the MADRS, but it also leads to improvements in specific anhedonic symptoms [59]. Regarding esketamine, it has shown efficacy in rapidly addressing suicidal ideation [33], with improvements in depressive symptoms as well. Notably, the NCT03185819 trial [60] underscores the potential of esketamine as a viable adjunctive treatment for TRD in adolescents, offering a non-intravenous route of administration that might be more practical and acceptable in clinical settings [60]. Delbello et al. also published the initial results from the clinical trial NCT03185819 concerning suicidal ideation, showing promising outcomes [66].

Schwartz *et al. Trials* (2023) 24:686
https://doi.org/10.1186/s13063-023-07631-3

Trials

STUDY PROTOCOL Open Access

The Study of Ketamine for Youth Depression (SKY-D): study protocol for a randomised controlled trial of low-dose ketamine for young people with major depressive disorder

Orli S. Schwartz[1,2,3*], Paul Amminger[2,3], Bernard T. Baune[1,4,5], Gillinder Bedi[2,3], Michael Berk[2,6], Sue M. Cotton[2,3], Rothanthi Daglas-Georgiou[2,3], Nick Glozier[7,8,9], Ben Harrison[1], Daniel F. Hermens[10], Emma Jennings[2,3], Jim Lagopoulos[10,11], Colleen Loo[12,13], Sumudu Mallawaarachchi[2,3], Donel Martin[13,14], Bethany Phelan[2,3], Nikki Read[2,3], Anthony Rodgers[15], Lianne Schmaal[2,3], Andrew A. Somogyi[16], Lily Thurston[2,3], Amber Weller[2,3,17] and Christopher G. Davey[1,2,3]

Discussion Results from this trial will be important in determining whether low-dose subcutaneous ketamine is an effective treatment for young people with moderate-to-severe MDD. This will be the largest randomised trial to investigate the effects of ketamine to treat depression in young people.

Key points

Il trattamento della depressione nel giovane è piú complesso e spesso meno efficace rispetto all'adulto

Nei casi gravi la terapia combinata appare la piú efficace, ma esistono pochi AD approvati per utilizzo < 18 aa

E' necessario monitorare il rischio di attivazione (suicidalitá, ipomania)

Programmi di sensibilizzazione e di health literacy

PROGETTO "#NOTALONE" (2021-2024)

GENOVARCHITETTURA
Università degli Studi di Genova
Dipartimento di Scienze per l'Architettura

Asl 3
Sistema Sanitario Regione Liguria

Progetto #chatsafe
in collaborazione con AIPP

Grazie per l’attenzione