tive in some patients with hip pain. Many of my patients are referred by highly trained osteopathic physicians because osteopathic manipulative treatment (OMT) has failed to help these patients. To state that OMT works and is part of my everyday practice does not convey any new information to readers; it only emphasizes what is commonly known and performed by our readers.

I appreciate your comments indicating that allopathic physicians acknowledge that OMT works for low back pain. The article you cite in *The Physician and SportsMedicine* is a good sign. I am glad that after 100 years, allopathic physicians finally have become educated in the treatment of low back pain. Nonetheless, I do not think that most allopathic physicians are properly trained to examine and to treat a patient using osteopathic manipulative techniques for low back pain. As such, I cannot get excited about our allopathic counterparts accepting our osteopathic medical ways and means.

I apologize if I have insulted any physician with this article. Anterior hip pain in the adult is commonly evaluated by family physicians. Osteopathic medical examination and treatment does play a role. However, when these conventional osteopathic medical means fail, one must consider diagnoses other than musculoskeletal trauma.

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Update on treating depression in children

To the Editor:

The article by Mark Anthony Troxler, DO, and Stanley E. Grogg, DO, "Guide to family practitioners for the diagnosis and treatment of depression in children and adolescents," (*JAOA* 1997;97:280-285) contains some dated material that is important to correct. The authors appear to endorse the use of tricyclic antidepressants (TCAs) for the treatment of depression in children and adolescents. Although TCAs have a long record of use, they have been superseded largely in clinical practice

by selective serotonin reuptake inhibitors (SSRIs).

As the authors correctly point out, TCAs carry significant risks of cardiotoxicity. Within the past 1-1/2 years, reports of sudden death have been made in a number of children taking desipramine.¹ It is unclear whether these deaths represent a real increase in risk compared with other TCAs. The TCAs are also extremely toxic when taken in overdose.

Conversely, at the most, SSRIs pose minimal cardiotoxicity. Because of their selectivity, they are not anticholinergic or histaminergic as are TCAs. Major side effects associated with SSRIs include gastrointestinal (diarrhea) and sexual dysfunction. To my knowledge, no reports of death have been recorded with regard to overdose of an SSRI as a single agent.

Although, as the article mentions, no studies have demonstrated the superiority of antidepressant medications to placebo in treating adolescents, this may be because of several methodologic considerations:

- The studies that have been conducted have consisted of small populations; thus the results lacked sufficient statistical power to demonstrate the drug's effect.

- The placebo response rate in depressed children is 40% to 60%, creating a small available pool from which to draw study participants.

- In a number of studies, dosages may not have been adequate. Clinically, most physicians treating children and adolescents with depression think that antidepressants are helpful.

Another important issue is the length of time these medications need to be taken. Given that the average depression lasts at least 9 months, it is now standard practice to administer antidepressants for a minimum of 1 year. After one episode of major depression, there is roughly a 50% chance of having a second episode. After two episodes, the chance of further episodes is about 75% and after three episodes, 90% or more. The duration, severity, and frequency of episodes increase with time. Antidepressant treatment modifies the natural history of the disorder by blocking or at least modifying this pattern. Clinicians should consider major depressive disorder to be a chronic disease and after two or three episodes, treat it with long-term

antidepressant therapy to favorably modify morbidity and mortality.

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References

1. Werry JS, Biederman J, Thisted R, et al: Resolved: Cardiac arrhythmias make desipramine an unacceptable choice in children. *J Am Acad Child Adolesc Psychiatry* 1995;34:1239-1248.

Response

To the Editor:

I concur with Dr Magen's comments. New studies have indicated the efficacy and safety of the selective serotonin reuptake inhibitors. Thank you for your comments. ♦

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