Adverse psychological effects of corticosteroids in children and adolescents

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Children and adolescents treated with oral, inhaled, and intravenous corticosteroids (CS) may experience adverse psychological side effects (APSE), including psychotic symptoms. These can occur at any point during treatment, including withdrawal. In this paper the literature on these effects in children and adults is reviewed. From the evidence available, it is not possible to give reliable estimates for incidence or prevalence of APSE, nor clear risk factors. Some evidence is reported to suggest that oral dexamethasone treatment may carry a higher risk of APSE than other CS, but this requires further investigation. There is evidence from the adult literature that higher CS doses increase the risk of APSE. However, the dose response effect is not straightforward or predictable for individuals or groups. This is likely to be a reflection of the complex effects of CS on the central nervous system and the probable interplay between individual susceptibility, disease factors, and external environmental stressors in the emergence of APSE. More research is required to further our understanding of the adverse effects of these clinically valuable agents.

Corticosteroids (CS) are used in the treatment of a wide variety of conditions in children and adolescents including asthma, rheumatic diseases, and central nervous system tumours. Since their introduction in the 1950s, CS have been associated with adverse psychological side effects (APSE), ranging from psychotic symptoms to mild changes in mood and cognition, in addition to their well known physical side effects. This is perhaps not surprising given the long recognised association between excessive endogenous CS levels and altered mood and behaviour. Rates of psychiatric disturbance (predominantly depression and anxiety) in adults with Cushing disease are between 57% and 78%, while children with this disorder show rates of 44%, with compulsive behaviours predominating.

Most research on APSE of CS treatment has been in adult populations with a focus on dramatic behavioural reactions (often vaguely described as “steroid psychosis”) reported in case series and case reports. In addition to case reports (table 1), the child and adolescent research includes a number of controlled prospective trials (table 2) providing information on less severe APSE, such as depressive symptoms and mild cognitive effects. Clinical trials of CS in adults and children have sometimes recorded APSE alongside other side effects, although they are often poorly described and defined.

This review is based on a literature search of published articles on this topic, prioritising research involving CS preparations in common current usage. We will give an overview of the varied APSE attributed to CS in children and adolescents, discuss possible risk factors and mechanisms, consider the clinical implications, and make recommendations for future research. Evidence from the adult literature will be drawn on where relevant.

SEVERE ADVERSE PSYCHOLOGICAL EFFECTS INCLUDING PSYCHOSIS

Prevalence and presenting features

Severe APSE, often referred to as “steroid psychosis”, are estimated to occur in 5–6% of adult patients. Equivalent figures are not yet available for paediatric populations. Rates of 25–60% for “psychiatric disturbance” from early paediatric studies cannot reliably be extrapolated, as “psychiatric disturbance” was generally poorly defined and the studies largely involved treatment with cortisone and ACTH. Historically, there was a view that severe APSE, especially psychotic symptoms, did not occur in children.

We identified 16 case reports of severe APSE in children and adolescents, over half of which included psychotic symptoms (table 1). Such APSE have also been reported in one case series of children treated with pulsed intravenous methylprednisolone (table 2), and in one, as yet unpublished, prospective trial in children with acute lymphoblastic leukaemia (ALL), both of which are discussed later.

Reviewing this data, severe APSE in children and adolescents usually emerge within days of onset of treatment. As in adults, affective/mood symptoms (emotional lability, grandiosity, pressured speech, suicidality, irritability) are the most common, sometimes accompanied by psychotic symptoms (perseveratory delusions, auditory hallucinations). There can be periods of altered conscious level and disorientation, and symptoms may vary within the episode. Duration varies widely between a few days, remitting on cessation/reduction of the CS dose, to a small minority persisting after discontinuation, also in keeping with adult research findings.

Difficulties in diagnosis and confounding factors

CS are often prescribed in response to a deterioration in the underlying condition, raising
difficult to distinguish from CS induced APSE. Other often acutely unwell and had CNS symptoms which were pointing out that SLE patients in the quoted studies were erythematous (SLE) are more prone to severe APSE, popularly held view that adults with systemic lupus than CS treatment per se. Indeed, Halper has questioned the this deterioration, as part of an acute confusional state, rather causative role is as follows: APSE appeared shortly after the commencement of CS treatment, resolved swiftly on dose re-exposure to the CS. Some case reports were complicated the possibility that psychiatric symptoms are secondary to this deterioration, as part of an acute confusional state, rather than CS treatment per se. Indeed, Halper has questioned the popularly held view that adults with systemic lupus erythematosus (SLE) are more prone to severe APSE, pointing out that SLE patients in the quoted studies were often acutely unwell and had CNS symptoms which were difficult to distinguish from CS induced APSE. Other authors, reviewing severe APSE in adult cancer patients, propose that medical complications and narcotic analgesics play an important contributory role. From the case reports of severe APSE in children and adolescents reviewed here, evidence supporting CS playing a causative role is as follows: APSE appeared shortly after the commencement of CS treatment, resolved swiftly on dose reduction or cessation of CS treatment (dose reduction/cessation was in response to APSE rather than improvement in condition). and reappeared on dose increase; physical examination and/or laboratory tests excluded deteriorating medical condition or concomitant medication toxicity as confounding factors; and stereotyped APSE appeared on re-exposure to the CS. Some case reports were complicated

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age</th>
<th>Sex</th>
<th>Ethnicity</th>
<th>Diagnosis</th>
<th>CS type + dose</th>
<th>Clinical presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ducore, 1983</td>
<td>15</td>
<td>M</td>
<td>White</td>
<td>ALL</td>
<td>Prednisolone oral 90 mg/day + intermittent IV hydrocortisone as part of chemotherapy protocol</td>
<td>Initially anxiety and fear of dying proceeding to frank psychosis with delusions of granularity, persecutory delusions, disinhibited behaviour, fluctuating levels of alertness, intermittent disorientation</td>
</tr>
<tr>
<td>Lewis, 1983</td>
<td>5.5</td>
<td>F</td>
<td>N/K</td>
<td>Asthma</td>
<td>Budesonide inhaled 100 μg twice daily</td>
<td>Disinhibition, regressive behaviour, apathy, incontinence, “frankly psychic’’ behaviour</td>
</tr>
<tr>
<td>Meyboom, 1988</td>
<td>9</td>
<td>M</td>
<td>N/K</td>
<td>Asthma</td>
<td>Budesonide inhaled 100 μg twice daily added to nasal beclomethasone</td>
<td>Hyperactive behaviour, impaired psychomotor activity and strongly increased appetite</td>
</tr>
<tr>
<td>Connett, 1991</td>
<td>2.5</td>
<td>M</td>
<td>N/K</td>
<td>Asthma</td>
<td>Budesonide (inhaled via spacer and mask) 400 μg twice daily</td>
<td>Severe temper tantrums, “miserable and uncooperative”</td>
</tr>
<tr>
<td>Connett, 1991</td>
<td>3</td>
<td>M</td>
<td>N/K</td>
<td>Asthma</td>
<td>Budesonide as above</td>
<td>Insomnia, screaming, aggression</td>
</tr>
<tr>
<td>Connett, 1991</td>
<td>2</td>
<td>M</td>
<td>N/K</td>
<td>Asthma</td>
<td>Budesonide as above</td>
<td>Hyperactive, undisciplined, insomnia</td>
</tr>
<tr>
<td>Connett, 1991</td>
<td>2.5</td>
<td>M</td>
<td>N/K</td>
<td>Asthma</td>
<td>Budesonide as above, but thrice daily</td>
<td>Secondary enuresis, aggression and violence towards sister, insomnia</td>
</tr>
<tr>
<td>Watanabe, 1994</td>
<td>17</td>
<td>F</td>
<td>N/K</td>
<td>ALL</td>
<td>Dexamethasone 15 mg/day for 3/52, then dose tapered for 5/52 as part of chemotherapy protocol</td>
<td>Symptoms emerged during tapering: psychomotor agitation, marked insomnia, euphoria, disinhibition, pressured speech, labile affect, flight of ideas</td>
</tr>
<tr>
<td>Watanabe, 1994</td>
<td>13</td>
<td>F</td>
<td>N/K</td>
<td>ALL</td>
<td>Dexamethasone 15 mg/day for 3/52, then dose tapered for 1/52 as part of chemotherapy protocol</td>
<td>Symptoms emerged during tapering: hypochondriasis and fear of dying, panic symptoms, sadness, separation anxiety</td>
</tr>
<tr>
<td>Turkta, 1997</td>
<td>14</td>
<td>M</td>
<td>N/K</td>
<td>Asthma</td>
<td>Beclomethasone inhaled 1500 μg/day</td>
<td>Insomnia, visual and auditory hallucinations, pressured speech, labile affect, decreased attention and memory</td>
</tr>
<tr>
<td>Dawson, 1998</td>
<td>8</td>
<td>F</td>
<td>Black</td>
<td>Asthma</td>
<td>Prednisolone oral 20 mg twice daily for 5 days</td>
<td>Hyperactivity, aggression, insomnia progressing to emotional lability, visual hallucinations, pressured speech, episodic crying spells</td>
</tr>
<tr>
<td>Beshay, 1998</td>
<td>12</td>
<td>M</td>
<td>White</td>
<td>Ulcerative colitis Long term oral prednisolone Rx up to 60 mg/day</td>
<td>Recurrent episodes of irritability, insomnia, agitation, physical aggression, auditory hallucinations, depressive symptoms, social withdrawal</td>
<td></td>
</tr>
<tr>
<td>Kramer, 1999</td>
<td>14</td>
<td>F</td>
<td>Black African American</td>
<td>ALL</td>
<td>Dexamethasone oral 24 mg/day for 21/7, then 10/7 taper</td>
<td>Symptoms during tapering: fluctuating presentation with disinorientation, auditory and visual hallucinations, grandiose delusions, suicidality</td>
</tr>
<tr>
<td>Ingram, 2003</td>
<td>2</td>
<td>M</td>
<td>White</td>
<td>ALL, BMT, GVHD</td>
<td>Methylpred 2 mg/kg/day in 3 divided doses</td>
<td>Irritable, visual hallucinations, crying, head banging</td>
</tr>
</tbody>
</table>

N/K, not known.
by features such as multiple concomitant medications and significant deterioration in physical health. Nevertheless, in the majority, features such as stereotyped symptoms on CS re-exposure, suggested that CS treatment was contributory, if not singly responsible, for the APSE.

**Is there a dose-response relation?**

Several case series of adult patients show an increasing incidence of severe APSE with increasing CS dose. The Boston Collaborative Drug Surveillance Programme, a multicentre prospective case series, recorded acute psychiatric reactions in 1.3% of patients receiving ≤40 mg oral prednisolone/day, 4.6% of patients receiving 41–80 mg, and 18.4% of patients receiving ≥80 mg. However, data from this and other adult case series suggest that it is not a straightforward dose-response effect, in that there was no predictable relation between the timing, severity, or duration of APSE and the timing, dosage, and duration of CS treatment. Previous reviewers have suggested that “disease related factors” may be important in the pathogenesis of severe APSE. A prospective double blind study of normal adult volunteers prescribed 80 mg oral prednisolone/day for five days reported no severe APSE, which would appear to suggest that the high CS doses, confounding factors such as publication bias, and methodological flaws and the specificity of treatment and underlying disorders in this trial demand caution in extrapolation of its results. However, taken together with the case reports involving inhaled CS, the data are too limited to draw conclusions about an association with CS withdrawal.

Large prospective case series in paediatric populations are lacking. In the prospective controlled trials to date there have been no reports of severe APSE. This could be explained by the fact that the only trials with large samples involved low dose CS treatment schedules (table 2). In the published case reports of severe APSE where the treatment was oral CS, all doses were of ≥40 mg of prednisolone or prednisolone equivalent/day. While this might support APSE occurring at higher CS doses, confounding factors such as publication bias may represent withdrawal reactions. APSE in children when the MP dose was increased. In over half these cases, APSE appeared ≥24 hours after the infusion and so may represent withdrawal reactions. APSE were picked up by parent/child or clinician reports, not standardised assessment schedules. Some appeared after several non-eventful infusions and others, as complicated by the fact that a proportion of children were taking oral CS concomitantly. Researchers were not blind; however, a causative role of MP in the behavioural reactions was potentially supported by a proportion showing stereotyped recurrences following subsequent pulses and by significant improvements in some children when the MP dose was decreased or the time interval between infusions was increased.

Methodological flaws and the specificity of treatment and underlying disorders in this trial demand caution in extrapolation of its results. However, taken together with the case reports of symptoms appearing on tapering of dexamethasone, it suggests that children and adolescents, like adults, are vulnerable to APSE on withdrawal from CS treatment.

**MINOR/MODERATE MOOD AND BEHAVIOURAL EFFECTS AND ADVERSE COGNITIVE EFFECTS**

Less dramatic CS related APSE have generally received little attention in the adult literature. One difficulty is detangling these APSE from the “normal” responses of stress and anxiety provoked by the underlying illness for which CS are prescribed. The designs of controlled prospective trials in children and adolescents (table 2) have attempted to address this issue. In some the child acted as their own control, the dexamethasone group. Cessation of steroids lead to rapid resolution of symptoms. Most patients on dexamethasone with severe problems were switched to prednisolone with no reported significant recurrence of behavioural problems. However, clinicians were not blind to steroid allocation. Importantly, there was a significant reduction of isolated CNS relapse of ALL in the dexamethasone group (unpublished data, personal communication).

In three case reports, adolescent girls developed psychotic reactions during the tapering phase of dexamethasone treatment, but did not experience APSE on high dose prednisolone (up to 90 mg/day), either before or after dexamethasone treatment. However, one of the girls had shown no APSE to a similar previous course of dexamethasone, again raising the possibility that “disease related factors” are also required for development of severe APSE. There is therefore some evidence that dexamethasone may be more associated with severe APSE than prednisolone in children and adolescents, but further research is required to clarify this.

**ADVERSE PSYCHOLOGICAL EFFECTS APPEARING ON WITHDRAWAL OF CORTICOSTEROIDS**

“Psychological dependency” on CS due to their euphoric effects is widely recognised both anecdotally and in published literature. It is now clear, however, that both flord and milder APSE can occur during tapering or after cessation of CS treatment. Mood and affect changes are most common in adults, followed by delirium and psychotic states. Previous reviewers have concluded that a significant proportion of the reported suicidal behaviour associated with CS treatment in adults occurs during withdrawal. Cs related suicidal ideation has been reported in children and adolescents, but the data are too limited to draw conclusions about an association with CS withdrawal.

In a large prospective case series of children with acute rheumatic diseases receiving pulsed intravenous methylprednisolone (MP), 10% experienced “neuropsychiatric” reactions, ranging from “hyperactivity” to “psychosis” (table 2). In over half these cases, APSE appeared ≥24 hours after the infusion and so may represent withdrawal reactions. APSE were picked up by parent/child or clinician reports, not standardised assessment schedules. Some appeared after several non-eventful infusions and others, as complicated by the fact that a proportion of children were taking oral CS concomitantly. Researchers were not blind; however, a causative role of MP in the behavioural reactions was potentially supported by a proportion showing stereotyped recurrences following subsequent pulses and by significant improvements in some children when the MP dose was decreased or the time interval between infusions was increased.

Methodological flaws and the specificity of treatment and underlying disorders in this trial demand caution in extrapolation of its results. However, taken together with the case reports of symptoms appearing on tapering of dexamethasone, it suggests that children and adolescents, like adults, are vulnerable to APSE on withdrawal from CS treatment.

**Are certain CS more likely to cause severe APSE?**

Halper flags up the lack of systematic studies in adults or children addressing this issue. APSE account for 9% of all adverse reactions for dexamethasone, compared to 6% for prednisolone, which are likely to have produced higher systemic CS levels. APSE ceased either on cessation of the inhaled CS or switching to an alternative inhaled CS.

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Table 2  Trials and case series

<table>
<thead>
<tr>
<th>Reference</th>
<th>n/age in years</th>
<th>Design</th>
<th>Disease</th>
<th>Drug/daily dose</th>
<th>Standardised tests used</th>
<th>Main findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>De La Riva, 1957</td>
<td>34/4–14</td>
<td>Open Case series</td>
<td>Various</td>
<td>ACTH/cortisone</td>
<td>None</td>
<td>61% of sample had psychiatric SE. 59% “depressive”, 41% “euphoric”. Depressed group had usually shown euphoric symptoms first</td>
<td>No standardised tests used. Little detail given about nature of psychiatric SE</td>
</tr>
<tr>
<td>Harris, 1986</td>
<td>16/4–16</td>
<td>Prospective Child as own control Repeated measures</td>
<td>ALL (14) Lymphoma (2)</td>
<td>Prednisolone (pred) 40–60 mg/day oral for 4/52 every 4/12</td>
<td>CSI CDI SHSQ</td>
<td>Night-waking increased on pred (NS). Irritability, tearfulness, argumentativeness, mild depressive symptoms and tiredness increased when on pred</td>
<td>CDI is for use in children over 8 y of age, excluding 6 of their sample. Not blinded</td>
</tr>
<tr>
<td>Suess, 1986</td>
<td>120/9–18</td>
<td>Prospective Comparison Single blind</td>
<td>Asthma</td>
<td>Non-asomatic controls v theophylline only v theophylline + pred (all doses 16 mg/day)</td>
<td>BVRT WMS</td>
<td>Increased delayed memory recall in steroid groups at 6-8 h. No significant difference between groups at 22–24 h or 46–48 h post-dose</td>
<td>No steroid alone group so 7 differences due to steroid-theophylline interaction</td>
</tr>
<tr>
<td>Bender, 1988</td>
<td>27/8–16</td>
<td>Prospective Comparison HD v LD</td>
<td>Asthma</td>
<td>Prednisolone (oral) 3.3 mg/day (low dose, LD) v 62 mg/day (high dose, HD)</td>
<td>CDI, CMAS, CPT, DRT, SRT, ultrasonic motion detector for hyperactivity, static steadiness tester for fine motor control</td>
<td>HD: decreased memory, increased anxiety + depressive symptoms. No differences in impulsiveness, hyperactivity, motor unsteadiness</td>
<td>No information gathered from parents/carers. Children not asked re other psychiatric Sx</td>
</tr>
<tr>
<td>Bender, 1991</td>
<td>32/8–16</td>
<td>Prospective Comparison HD v LD</td>
<td>Asthma</td>
<td>Prednisolone (oral) 7 mg/day (LD) v 62 mg/day (HD)</td>
<td>PPVT, CGAS, FGAS, CDI, CMAS, CPT, SRT, ultrasonic motion detector for hyperactivity, static steadiness tester for fine motor control</td>
<td>Confirmed above results. No predisposing factors identified.</td>
<td>Children not asked re other psychiatric Sx. ? Atypical sample in terms of social class</td>
</tr>
<tr>
<td>Nall 1992</td>
<td>19/7–15</td>
<td>Prospective Child as own control</td>
<td>Asthma</td>
<td>Prednisolone (oral) 1–2 mg/kg/day on or off</td>
<td>WRAT-R BRP-2</td>
<td>No difference in cognitive tests or behaviour scale score</td>
<td>Researchers not blind</td>
</tr>
<tr>
<td>Drigan, 1992</td>
<td>38/2.5–8.8</td>
<td>Prospective Comparison Repeated measures</td>
<td>ALL</td>
<td>Chemo + pred (oral) 40 mg/m²/day (Ch=LD) v chemo + pred 120 mg/m²/day (Ch+HB) v chemo alone</td>
<td>Conners Parent-Teacher Hyperkinesis Index (amended) administered to parents only</td>
<td>Adverse changes in attention/hyperactivity, emotionality, sleep disturbance, depressed mood, listlessness &amp; peer relations in Ch-LD and Ch-HD v Ch alone No differences in behaviours between Ch-HD and LD groups</td>
<td>Small matched sample size may have limited ability to detect difference between LD and HD groups</td>
</tr>
<tr>
<td>Bender, 1998</td>
<td>102/6–17</td>
<td>Prospective Double-blind controlled multi-centre</td>
<td>Asthma</td>
<td>Beclomethasone (inh) 2–50 μg qds placebo v theophylline-placebo inhaler</td>
<td>CBCL, WISC-R, W-J, SCWT, WCST, TT, BRVRT, SDLT, RAVLT</td>
<td>No significant differences in cognitive tests or behaviour between groups</td>
<td>Sample did not include children under 6 who may be most vulnerable to APSE from inhaled steroids</td>
</tr>
<tr>
<td>Klein-Gitelman, 1998</td>
<td>213/1–18</td>
<td>Case series</td>
<td>Acute rheumatic disease</td>
<td>Intermittent pulsed IV methylprednisolone 30 mg/kg</td>
<td>None</td>
<td>10% of sample had adverse psychological SE, including psychosis. Majority appeared post pulse and ceased within 48 h</td>
<td>Case series rather than controlled study</td>
</tr>
<tr>
<td>Salido, 1999</td>
<td>10/ages not known</td>
<td>Prospective Child as own control</td>
<td>Steroid sensitive idiopathic nephritic syndrome</td>
<td>“High dose” prednisolone therapy (oral)</td>
<td>CBCL</td>
<td>Anxious, depressive and aggressive behavioural changes at doses of &gt;1 mg/kg/48 h</td>
<td>Small sample Not blinded</td>
</tr>
</tbody>
</table>

See Appendix for list of test abbreviations.
RISK FACTORS FOR APSE

In adults, reports from earlier studies that female gender and a history of past psychiatric disturbance increased the risk of APSE, whether severe or “minor”, have been called into question by recent analysis, as have reports that certain underlying medical conditions predispose to CS induced APSE. Results from controlled prospective trials in children and adolescents suggest a slightly increased risk of APSE in girls, and younger children, but these are not conclusive. Regarding past psychiatric history, authors from one prospective trial attempted to explore individual and family psychosocial dysfunction as a risk factor for APSE. However, the methods used, together with the small differences observed, render their conclusions questionable. There was no history of past psychological disturbance in the majority of paediatric case reports, although in four the family histories were highly positive.

As to whether certain underlying medical conditions render children and adolescents more susceptible to CS related APSE, this is largely unanswered. Prospective studies merely reflect the CS treated conditions studied to date and extrapolation from case reports is again likely to be contaminated by publication bias. A history of adverse cutaneous reactions to other drugs was found to be predictive for all adverse effects to CS in the prospective case series involving pulsed intravenous MP.

POTENTIAL MECHANISMS UNDERLYING APSE

Through research on endogenous and exogenous CS in animals and humans we know that CS exert a bewilderingly large range of effects on the nervous system. They have varying effects on the neurotransmitters serotonin and dopamine, and adrenal steroid receptors are expressed in many different regions of the brain. On a molecular level, CS have both direct, rapid, non-genomic effects such as binding to receptors or altering membrane permeability, as well as indirect, genomically mediated effects such as repression of gene transcription. However, we are still some way from knowing which effects underlie specific APSE.

There has been considerable focus on hippocampal damage as a potential mechanism underlying APSE. Functionally this model is attractive as the hippocampus, as part of the limbic system, is intimately involved in regulation of the emotions and emotional lability is a frequent feature of APSE. It also plays a major role in memory, particularly the formation of memory (episodic, declarative) found to be adversely affected in patients treated with CS, patients with Cushing disease, and normal human volunteers given CS. It is known to express high levels of adrenal steroid receptors and animal and human studies have shown a correlation between high levels of endogenous CS, hippocampal damage and atrophy, and cognitive dysfunction. The “cascade effect” further proposes that damage to the hippocampus adversely affects its ability to provide negative feedback on glucocorticoid levels to the hypothalamic-pituitary-adrenal (HPA) axis, leading to increased levels and hence more damage.

How reversible this damage is, is not yet clear, nor how it occurs. It may be mediated by increases in excitatory amino acids and serotonin, or it may also be attributable to glucocorticoids rendering hippocampal neurones more vulnerable to other insults such as ischaemia, through impaired neuronal glucose uptake. If exogenous CS render hippocampal neurones more vulnerable to insults, this could perhaps explain some cases of inter- and intra-patient variability with respect to APSE. That is, APSE might only arise if there is both exposure to CS and potential insults to hippocampal neurones arising from the disease process, which could represent the speculated “disease related factors”. However, while there have been studies linking endogenous CS with hippocampal atrophy in rats and primates, definitive links have not yet been found in humans. Human adult studies suggesting that “working memory” (generally considered a frontal lobe function) is more sensitive than declarative memory (hippocampal) to exogenous CS administration, also point to other areas of the brain being involved in APSE in addition to the hippocampus.

We also know that CS can improve cognitive functioning adversely affected by the underlying illness in both children and adults. Halper has proposed that there may be different CS dose-response curves for hippocampal damage versus beneficial anti-inflammatory (or other) effects in CS responsive illnesses associated with cognitive dysfunction. Studies involving cognitive testing of normal young adults whose cortisol levels have been pharmacologically manipulated also suggest that certain levels of CSs are necessary for learning and memory.

The picture is further complicated by the lack of knowledge regarding whether exogenous CS gain access to the same organs and cellular sites as are occupied by endogenous CSs. Studies in rats suggest that dexamethasone is more substantially taken up by the pituitary than other brain regions and may have little access to hippocampal neurones. Prednisolone is structurally more similar to cortisol and
corticosterone than dexamethasone and so might be expected to be more readily taken up, but systematic studies investigating this and, more generally, links between the pharmacokinetic properties of different CS, brain neurochemistry, and APSE are lacking.3

As well as speculated “disease related factors”, perhaps there are other factors which may contribute to the expression of APSE. While case reports generally document any abnormal laboratory test results, the level of detail is usually not sufficient to exclude other CS side effects such as hyperglycaemia as contributors to psychological disturbance. One case described a father and son showing very similar dramatic behavioural reactions to inhaled budesonide (the child’s episode predated the father’s by a year), raising the possibility of underlying genetic factors.45 An intriguing double blind case study of an adult patient requiring intermittent CS treatment for renal disease suggested that APSE only developed when CS treatment coincided with environmental stressors.46

Thus, while there is still a great deal of uncertainty, the current findings suggest that the emergence of APSE, whether severe or minor, is likely to involve an interplay between individual predisposing factors, disease related factors, environmental stresses, and the pharmacokinetic properties of the CS treatment.

CLINICAL IMPLICATIONS AND TREATMENT OF APSE

Because of their valuable therapeutic effects, CS are likely to continue to play an important role in the treatment of many conditions in children and adolescents. Paediatric clinicians, especially those from specialties where CS prescribing plays a major role, need to be alert to the possibility of APSE arising at any point during CS treatment, including withdrawal. Parents and children should be forewarned of these potential side effects in the same measured way that they are forewarned of the potentially serious physical side effects of CS. Proactive questioning about mood and behavioural symptoms is indicated, as stigma42 and difficulty in recognition (especially in younger children) may limit spontaneous reporting of psychological symptoms.

Current evidence suggests that, in the majority of cases, APSE respond to dose reduction, switching to an alternative CS preparation, or cessation of CS treatment. If symptoms worsen rather than improve on reduction/cessation, it may be that a withdrawal reaction has been triggered in addition. An adult case report suggested that reintroduction of low dose CS may be effective in these cases.47 Clearly it is also important to screen carefully for infection, toxicity from other drugs, or other metabolic disturbances which could be causative or additive to the psychological disturbance.

There are examples from both adult and paediatric case reports of various psychoactive medications, for example, benzodiazepines, neuroleptics, and antidepressants, being used to treat APSE.48 49 50 51 Treatment outcomes are variable; for example, there are reports that tricyclic antidepressants can actually make symptoms worse.49 The mood stabiliser lithium has been used prophylactically.52 However, potential nephrotoxicity, the need for serum monitoring, and evidence that one episode of APSE does not necessarily predict future episodes, render this treatment questionable. Consultation with child and adolescent psychiatrists and paediatric pharmacists is recommended if psychoactive medications are being considered. One-to-one nursing with mental health trained staff and limiting stimuli and also have an important role in the management of cases of severe APSE and may lessen the need for psychoactive medication.

RECOMMENDATIONS FOR FUTURE RESEARCH

Authors of a recent review on CS use in the management of paediatric central nervous system (CNS) tumours comment that “the beneficial effects of relief of symptoms attributable to raised ICP (intracranial pressure) must be balanced by the frequently observed severe mood and behavioral changes” (our italics).49 No data were provided to support this statement, nor were any found in our literature search. This discrepancy between clinical recognition of CS related APSE and actual published data is not confined to CNS tumours, and must be addressed if we are to arrive at reliable estimates of incidence and gain a better understanding of risk factors.

Double blind design trials investigating CS related APSE are difficult, due to a number of factors including: risk of serious physical side effects, limited range of alternative treatment options, changes in physical appearance, and the likely need for large sample sizes to pick up severe APSE. Furthermore, comparison of mean scores can miss out dramatic individual variation within groups. Perhaps the most realistic way of increasing the available data on this important topic would be the inclusion, into large prospective clinical trials involving CS treatment, of standardised assessments by blinded mental health trained assessors for both “minor” and more severe APSE. Smaller qualitative studies may also have a role, particularly in getting a better picture of the functional impact of APSE. Assessments of APSE should always extend into the withdrawal period.

Further elucidation of the underlying mechanisms of APSE is likely to come from the complimentary field of research into the psychological effects of endogenous CS, from more detailed studies exploring the links between APSE, brain neurochemistry, and CS pharmacokinetics, and from research investigating mechanisms for all effects of CS, including therapeutic effects.46

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APPENDIX

BMT, Bone Marrow Transplant.
BRP-2, Behavior Rating Profile (Brown and Hammill, 1990).
BVRT, Benton Visual Retention Test (Benton, 1974).
BRVRT, Benton Revised Visual Retention Test.
CDI, Children’s Depression Inventory (Kovacs, 1978).
CGAS, Child Global Assessment Scale (Shaffer et al., 1983).
CMAS, revised Children’s Manifest Anxiety Scale (Reynolds and Richmond, 1985).
CPT, Continuous Performance Test (Rosvold et al., 1956).
CSI, Corticosteroid Symptom Inventory (Harris et al., 1986).
DRT, Delayed Responding Test (Bender et al., 1988).
FGAS, Family Global Assessment Scale (Mrazek et al., 1985).
GVHD, graft versus host disease.
PPVT, Peabody Picture Vocabulary Test (Dunn and Dunn, 1981).
RAYLT, Rey Auditory Verbal Learning Test.
SCWT, Stroop Color and Word Test.
SDIT, Serial Digit Learning Test.
SHSQ, Sleep Problems and Sleep Habits Questionnaire (Anders, 1980).
It was not possible to obtain complete references for all tests listed.

WISC-R, Weschler Intelligence Scale for Children–Revised.
WCST, Wisconsin Card Sorting Test.
SRT, Selective Reminding Test (Buschke, 1973).

References

52. Achenbach TM. Manual for the Child Behavior Checklist/4.1 and 1991 profile. Department of Psychiatry, University of Vermont, Burlington, VT.