

**Commentary** Serious bacterial infections among infants hospitalized with bronchiolitis are uncommon. This study, not surprisingly, shows that serious bacterial infections among infants treated for bronchiolitis in primary care settings is at least as unlikely. Notably, however, the infants with bronchiolitis were more ill-appearing than those without bronchiolitis; yet they were only half as likely to be evaluated for sepsis and receive parenteral antibiotics, suggesting that the clinical diagnosis of a viral infection primarily predicts the physician's management and comfort level. In contrast, infants hospitalized with bronchiolitis infection still frequently receive antibiotics and other therapies not recommended for bronchiolitis,<sup>1,2</sup> despite laboratory confirmation of respiratory syncytial virus. This difference in the management of bronchiolitis in the hospital and office setting may have important implications clinically and economically. The practitioner's close relationship to the family and readily available follow-up may be major factors in diminishing unnecessary therapies and laboratory analyses. The economic importance of these potential cost savings in office-based care of bronchiolitis is emphasized by the significantly greater proportion of the bronchiolitis burden that results from office visits compared with hospitalization or emergency department visits, an estimated 24- to 8-fold, respectively.<sup>3</sup> However, the infants with bronchiolitis in this study compared with those without bronchiolitis were significantly more likely to undergo chest radiography, oxygen saturation measurements, respiratory syncytial virus testing, to become hospitalized, and to require more follow-up visits. Thus do infants diagnosed with bronchiolitis in office settings actually have fewer total therapies, diagnostic procedures, and costs than infants with fever without bronchiolitis? That question remains to be answered.

Caroline Breese Hall, MD  
University of Rochester  
Rochester, New York

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## Combination of cognitive behavioral therapy and sertraline is more effective than monotherapy for pediatric anxiety disorders

Walkup JT, Albano AM, Piacentini J, Birmaher B, Compton SN, Sherrill JT, et al. Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *N Engl J Med* 2008;359:2753-66.

**Question** Among children and adolescents with anxiety disorders, what is the relative and combined efficacy of cognitive behavioral therapy and selective serotonin-reuptake inhibitors?

**Design** Randomized, controlled trial.

**Setting** Six mental health treatment centers in the United States.

**Participants** A total of 488 children (age 7 to 17 years) who had a primary diagnosis of separation anxiety disorder, generalized anxiety disorder, or social phobia.

**Intervention** Fourteen sessions of cognitive behavioral therapy (CBT), sertraline (at a dose of up to 200 mg per day), a combination of sertraline and CBT, or a placebo drug for 12 weeks in a 2:2:2:1 ratio.

**Outcomes** Categorical and dimensional ratings of anxiety severity and impairment at baseline and at weeks 4, 8, and 12.

**Main Results** The percentages of children who were rated as very much or much improved on the Clinician Global Impression-Improvement scale were 80.7% for combination therapy ( $P < .001$ ), 59.7% for CBT ( $P < .001$ ), and 54.9% for sertraline ( $P < .001$ ); all therapies were superior to placebo (23.7%). Combination therapy was superior to both monotherapies ( $P < .001$ , number needed to treat [NNT] = 5 for combination therapy over CBT; NNT = 4 for combination therapy over sertraline). Results on the Pediatric Anxiety Rating Scale documented a similar magnitude and pattern of response; combination therapy had a greater response than CBT, which was equivalent to sertraline, and all therapies were superior to placebo. Adverse events, including suicidal and homicidal ideation, were no more frequent in the sertraline group than in the placebo group. No child attempted suicide. There was less insomnia, fatigue, sedation, and restlessness associated with CBT than with sertraline.

**Conclusions** Both CBT and sertraline reduced the severity of anxiety in children with anxiety disorders; a combination of the 2 therapies had a superior response rate.

**Commentary** Anxiety disorders are relatively prevalent disorders (6% to 20%) in the pediatric age group. However, these disorders frequently go unrecognized by medical professionals, which is a critical concern because younger age of onset leads to increased rates of later anxiety disorders, depression, substance abuse, and educational underachievement. Once identified, treatment is essential to reduce both short- and long-term impairment. Earlier randomized controlled trials have demonstrated effectiveness of the individual treatments (antidepressant medications and CBT). This study is the first direct comparison of the 2 monotherapies, and the first to examine the combination of the 2 therapies. Both monotherapies (antidepressant treatment and CBT) demonstrated similar effectiveness, although CBT takes slightly longer (8 to 12 weeks), and the medications demonstrate quick improvements, with little continued improvement after 8 weeks. Combination treatment was very effective (80%) and was superior to both monotherapies. It appears unlikely that most children with severe and persistent anxiety disorders are receiving optimal evidence-based treatments in the community. The dissemination of clinical research to clinical practice

(both psychotherapy and psychopharmacology) remains a continued challenge and is a national priority.

Graham J. Emslie, MD  
University of Texas Southwestern Medical Center  
Dallas, Texas

## Parent-only interventions may be effective for weight loss in overweight children in rural areas

Janicke DM, Sallinen BJ, Perri MG, Lutes LD, Huerta M, Silverstein JH, et al. Comparison of parent-only vs family-based interventions for overweight children in underserved rural settings: Outcomes from project STORY. *Arch Pediatr Adolesc Med* 2008;162:1119-25.

**Question** Among overweight children in underserved rural settings, is a parent-only intervention as effective as a family-based intervention in terms of decreasing the child's standardized body mass index (BMI)?

**Design** A 3-arm randomized controlled clinical trial.

**Setting** Cooperative Extension Service offices in 4 underserved rural counties.

**Participants** Ninety-three overweight or obese children (ages 8-14 years) and their parent(s).

**Intervention** Families were randomized to (1) a behavioral family-based intervention, (2) a behavioral parent-only intervention, or (3) a wait-list control group.

**Outcome** Change in children's standardized BMI.

**Main Results** Seventy-one children completed posttreatment (month 4) and follow-up (month 10) assessments. At the month 4 assessment, children in the parent-only intervention demonstrated a greater decrease in BMI z-score (mean difference [MD] = 0.127; 95% confidence interval [CI] 0.027 to 0.226) than children in the control condition. No significant difference was found between the family-based intervention and the control condition (MD = 0.065; 95% CI, -0.027 to 0.158). At month 10 follow-up, children in the parent-only and family-based intervention groups demon-

strated greater decreases in BMI z-score from before treatment compared with those in the control group (MD = 0.115; 95% CI, 0.003 to 0.220; and MD = 0.136; 95% CI, 0.018 to 0.254, respectively). No difference was found in weight status change between the parent-only and family-based interventions at either assessment.

**Conclusions** A parent-only intervention may be a viable and effective alternative to family-based treatment of childhood overweight. Cooperative Extension Service offices have the potential to serve as effective venues for the dissemination of obesity-related health promotion programs.

**Commentary** Many more randomized control trials of interventions in real world settings are needed to inform clinical strategies for treatment of overweight children, something observational (epidemiologic) studies are less able to contribute. Unfortunately, a number of important design and implementation problems in this study prohibit making definitive conclusions regarding the comparative efficacy of the 2 treatments and the generalizability of the results. Key among these were randomizing participants before their enrollment in the study, biased dropout of participants after randomization, not using an intention-to-treat analysis, and randomizing as families but analyzing as individual children. However, there was some evidence that both treatments produced greater improvements in BMI z-scores than the waitlist when assessed 6 months after the end of the 4-month treatment period. Thus both of these approaches may be efficacious in real-world settings, but additional experimental studies are needed to determine the most effective approaches. Also, this study demonstrated the feasibility of using Cooperative Extension Service offices to deliver treatments to rural children and families—a high-risk group that has received little attention in past weight control research. This is one example of a creative community partnership that may help pediatricians provide treatment programs to a larger proportion of the at-risk population.

Thomas N. Robinson, MD, MPH  
Stanford University School of Medicine and  
Lucile Packard Children's Hospital  
Palo Alto, California