

14. Dieckmann RA, Brownstein D, Gausche-Hill M. The pediatric assessment triangle: a novel approach for the rapid evaluation of children. *Pediatr Emerg Care* 2010;26:312-315.
15. Balamuth F, Fitzgerald J, Weiss SL. Shock. In: Sahw KN, Bachur RG, eds. *Fleisher and Ludwig's textbook of pediatric emergency medicine*. 7th edition. Philadelphia: Lippincott Williams & Wilkins; 2016. p. 55-67.
16. Brown SG, Stone SF, Fatovich DM, Burrows SA, Holdgate A, Celenza A, et al. Anaphylaxis: clinical patterns, mediator release, and severity. *J Allergy Clin Immunol* 2013;132:1141-9.
17. Tole JW, Lieberman P. Biphasic anaphylaxis: review of incidence, clinical predictors, and observation recommendation. *Immunol Allergy Clin North Am* 2007;27:309-26. viii.
18. Stark BJ, Sullivan TJ. Biphasic and protracted anaphylaxis. *J Allergy Clin Immunol* 1986;78:76-83.
19. Brady WJ Jr, Luber S, Joyce TP. Multiphasic anaphylaxis: report of a case with prehospital and emergency department considerations. *J Emerg Med* 1997;15:477-81.
20. Confino-Cohen R, Goldberg A. Allergen immunotherapy-induced biphasic systemic reactions: incidence, characteristics, and outcome: a prospective study. *Ann Allergy Asthma Immunol* 2010;104:73-8.
21. Scranton SE, Gonzalez EG, Waibel KH. Incidence and characteristics of biphasic reactions after allergen immunotherapy. *J Allergy Clin Immunol* 2009;123:493-8.
22. Ellis AK, Day JH. Incidence and characteristics of biphasic anaphylaxis: a prospective evaluation of 103 patients. *Ann Allergy Asthma Immunol* 2007;98:64-9.
23. Turner PJ, Gowland MH, Sharma V, Ierodiakonou D, Harper N, Garcez T, et al. Increase in anaphylaxis-related hospitalizations but no increase in fatalities: an analysis of United Kingdom national anaphylaxis data, 1992-2012. *J Allergy Clin Immunol* 2015;135:956-63.
24. Turner PJ, Campbell DE. Epidemiology of severe anaphylaxis: can we use population-based data to understand anaphylaxis? *Curr Opin Allergy Clin Immunol* 2016;16:441-50.
25. Sampson HA, Mendelson L, Rosen JP. Fatal and near-fatal anaphylactic reactions to food in children and adolescents. *N Engl J Med* 1992;327:380-4.
26. Russell S, Monroe K, Losek JD. Anaphylaxis management in the pediatric emergency department: opportunities for improvement. *Pediatr Emerg Care* 2010;26:71-6.

50 Years Ago in *THE JOURNAL OF PEDIATRICS*

Suicide among Adolescents with Chronic Illness: A Path Forward

Weinberg S. Suicidal Intent in Adolescence: A Hypothesis about the Role of Physical Illness. *J Pediatr* 1970;77:579-86.

Similar to 1970, suicides continue to be a major cause of death among adolescents with chronic illness. Weinberg describes 12 adolescents who had expressed suicide intent while hospitalized for a medical condition or were admitted after attempting suicide. Chronic illness was a significant contributing factor, and the authors felt that the suicide intent was due to concerns about impact of illness on their lives. These included factors such as the inability to obtain a job in the future and the pain of separation from an important person. Some adolescents viewed illness as an obstacle to success, blaming themselves for difficulty in underachieving, whereas in others, suicidal intent was linked to family discord. Weinberg described sex-related differences in these concerns.

Fifty years later, suicide continues to be a leading cause of death in adolescents, with significant sex differences. Although adolescent suicide attempts are twice as high in females, completed suicides are 3 times higher in males than in females.¹ Suicide intent and attempts continue to be common among adolescents with chronic illness. However, depression and mood disorders are now known to be significant and modifiable risk factors for all sexes.² Given the path from chronic illness to depression and mood disorders to suicide, pediatricians and pediatric subspecialists have instituted screening for depression, anxiety, and suicidal risk with tools such as the Patient Health Questionnaire-9 for depression and the Global Assessment of Disability-7 for anxiety. Unfortunately, connection to mental health services remains a challenge for all adolescents.¹ Many pediatric subspecialty groups now employ social workers and counselors in their subspecialty clinics to immediately connect adolescents with chronic illness with suspected co-occurring depression and mood disorders to needed assessments and services. Appropriate screening and provision of mental health resources to adolescents with chronic illness provide a much needed mechanism to reduce the number of attempted and completed suicides.

Sharon C. Enujioko, MD
Mary A. Ott, MD, MA
 University School of Medicine
 Indianapolis, Indiana

References

1. Shain B. Suicide and suicide attempts in adolescents. *Pediatrics* 2016;138:e20161420.
2. Greydanus D, Patel D, Pratt H. Suicide risk in adolescents with chronic illness. *Dev Med Child Neurol* 2010;52:1083-7.