THE JOURNAL

September, 2016

Quote of the Month

“Spread love everywhere you go. Let no one ever come to you without leaving happier.”

Mother Teresa

Created By: Tanvir Iqbal MD

1901 N DUPONT HIGHWAY NEW CASTLE DE 19720

IN THIS ISSUE:

"Resident Well-being" I.e. Surprise baby shower

By: Sahar Zaidi PGY-1

Guest Post: Case Scenario

Neil Kaye M.D.

Board Certified General Psychiatrist and Forensic Psychiatrist

Guest Post: **Thrombocytopenia with Antipsychotics**

Angel King, PharmD

DPC pharmacist

"Resident Well-being" I.e. Surprise baby shower

By: Sahar Zaidi PGY-1

DPC emphasizes on resident camaraderie and morale which are essential to create a friendly work environment. It is well known that being a parent is one of the toughest jobs. On Sept 21, 2016 we celebrated the parenthood of three wonderful residents Dr. Abdel, Dr. Sanju George and Dr. Lee Berman who will soon be proud parents.

To maintain the work-life balance, it's imperative to have a support system as family members who can help. All residents actively participated in the event. Special thanks to Dr. Chang and Dr. Krautter for the beautiful arrangement. We would love to thank Dr. Trimzi, Ms. Young, and other faculty members for being part of the celebrations.

Expectant Fathers

Left to Right: Dr. George, Dr. Berman and Dr. Abdel

Dr. Trimzi (Residency Program Director) and Dr. Mian with proud fathers to be.

DPC Faculty celebrating baby shower

Left to Right: Dr. Luther, Ms. Young, Dr. Berman, Dr. Trimzi, Dr. Abdel, Dr. George, Dr. Mian, Dr. Shrestha, Dr. Donohue and Dr. Mishra

Residents and faculty having fun time

Case Scenario Discussion

By: Neil Kaye, M.D.

My patient is a 25-year old woman who is being abused by her husband. One night, after being beaten she called. I advised her to leave and to call the police. She refused. She is not being physically prevented from leaving; she just isn't emotionally ready to take that step, despite acknowledging cognitively that it is necessary, reasonable, and the correct thing to do.

Do I have any duty to take any action?

This is a common scenario, and one worthy of thought in advance of having to actually field such a call in the real world. It is a good example of the type of "consultation" questions psychiatrists ask of their forensic colleagues.

On the surface, this sounds like a pretty typical battered wife case. The medical-legal question appears to be a rather simple question of breaching confidentiality. Confidentiality is the physician's duty to keep secret what is disclosed to them secret. Psychiatry has long held that confidentiality is a critical element of the doctor-patient relationship and a necessity for treatment. In the modern age of the Internet, social networking, and reality TV, some have begun to question this assertion, yet it does remain a cornerstone of the profession and part of the AMA and APA Ethical Codes.

Reluctance to leave an abuser is quite common. People frequently are in abusive relationships and refuse to get out of them, often feeling helpless to do so. Ordinarily, they have a right to stay. Therapeutically we try to give them the courage to leave. Sometimes we succeed, but often we do not.

Generally, you discharge your duty to the patient by doing what was already done: giving her the best advice you can about getting out of the situation. But if she's not willing to take it, you probably don't have a duty to go further. Indeed, so doing could be counterproductive. If she is not ready to turn against her abuser, she will likely deny to the police that she was beaten and refuse to testify against her husband. They will let him go, and he will beat her again in revenge for telling you about the abuse. And, since you too have now betrayed her, she won't return to treatment, cutting her links with perhaps the only person who can someday help her leave. So, to continue to work to get her to the point where she can leave on her own is not unreasonable.

Most clinicians and experts alike agree that reporting would be a breach of confidentiality. However, it is also clear that the likelihood of being sued is essentially zero, and that even if you were sued, the plaintiff's chance of winning is similarly almost

zero. Although clinicians worry about breach of confidentiality suits, they are among the rarest in all of medicine. Most experts agree that the defense of "doing the right thing" and "trying to save a life and to protect a person" is a pretty hard defense for a plaintiff to crack in a malpractice case.

However, a significant minority of experts see this situation differently, and feel that intervention and breaching confidentiality is appropriate in some circumstances. These are discussed below:

It would be relevant if you thought she was committable according to the laws of your state. If so, you could call the police to initiate an involuntary hospitalization. A "Tarasoff" approach could also be invoked and allow reporting if you believed the woman was trying to get herself killed as a way out of the abuse. This would be akin to "suicide by cop" and would represent and unusual use of the duty to protect doctrine.

It is also possible that your calling the police might get her to leave him, although based on the current literature, this appears to be less likely. Calling the police does help to create a record, which could be helpful in future litigation should she ask for a restraining order; pressing charges can be part of that process, if/when she decides to leave.

One must always consider the patient's welfare as well as other variables. If reporting is not a mandatory requirement, the therapist's duty is to act in the best interest of the patient. If the threat to the patient is real, apparent, and the patient takes no action to protect herself, the therapist-patient relationship requires the therapist to protect the patient from imminent harm. In this instance, imminent harm, including potential homicide cannot be ruled out and so breaching confidentiality could be considered appropriate and justified.

So, there is no unequivocal "right answer" to the scenario presented.

Some, but not all States have case law and/or regulations that address this issue. Pennsylvania requires a therapist to report confirmed incidents of domestic violence (1). Maryland is the only state that has addressed this in detail (2). Their regulations, as promulgated by DHSS are worth considering:

Intimate Partner Abuse & Sexual Assault –To protect patient confidentiality, Maryland does not have mandatory reporting laws for domestic violence or sexual assault. You may not report suspected or confirmed domestic violence or sexual assault

unless the adult victim consents or if disclosure is required or authorized by state law as follows:
• The case involves abuse of a child or vulnerable adult, report to Child Protective Service, Adult Protective Service or law enforcement.
• A health care provider must report to law enforcement if he or she treats a person for an injury caused by:
• a gunshot or moving vessel of any type.
• an auto accident or a lethal weapon only in the following counties: Allegany, Anne Arundel, Charles, Kent, Montgomery, Prince George's, Somerset, Talbot and Wicomico.

The Maryland regulations raise the possibility of consulting with Adult Protective Services in the state that would have jurisdiction for your patient to see whether or not they feel that a woman in a life-threatening situation who refuses to leave (along with all the typically accompanying cognitive distortions and rationalizations for staying) would meet their definition of an "impaired" or "vulnerable" adult and thus require reporting and intervention by APS.

As always, there are 50 different sets of State laws as well as Federal law. You should certainly be aware of your own State's laws and regulations regarding this issue.

A search of both the medical literature and case law failed to turn up even a single case where a clinician has ever been sued over either of these scenarios. If you did call the police, it is very unlikely that a breach of confidentiality claim could succeed, given the defense that she was in danger and you were acting to save her. An exception might (and I emphasize might) be, if the husband killed her as a result of your intervention, but I believe this would be very defensible.

1. 18 Pa. Cons. Stat. 5106
2. http://www.healthymaryland.org/documents/66090_DomVio_D_Confid.pdf

Thrombocytopenia with Antipsychotics

Angel King, PharmD

Antipsychotic agents can cause a number of hematologic effects, the most widely known of these being the potential for agranulocytosis by clozapine. However, all antipsychotic agents have the potential to cause this effect and other blood abnormalities such as leukopenia, neutropenia, and thrombocytopenia. Although there are no conclusive frequencies defined, there are several case reports that exist of antipsychotics (first and second generation) causing varying degrees of thrombocytopenia.

Normal platelet counts in adults are between 150,000 and 450,000. Thrombocytopenia is defined as a platelet count of less than 150,000 and is further categorized into mild (100-150,000), moderate (50-99,000), and severe (less than 50,000). The dangers of low platelet counts include bleeding or possibly life-threatening thrombosis. There are several mechanisms for decreased platelet count in the blood including bone marrow suppression (decreased production of platelets), antibody related destruction of platelets (immune response), consumption of platelets in clots, dilution of blood (from increased fluid load), or pooling of platelets in the spleen due to liver disease. Drug induced thrombocytopenia (DITP) is most often caused by an immune response where platelets are destroyed by antibodies. In addition to decreased platelet count, signs and symptoms of thrombocytopenia include bruising, bleeding, blood in stools, or decreased hemoglobin.

Of the antipsychotics, first generation agents have a stronger association with thrombocytopenia, but there are several case reports of second generation agents causing platelet levels to decrease as well. Most of the patients who experienced this reaction in the case reports had a previous history of immune thrombocytopenia (not drug induced) and the antipsychotic agent triggered a drug-induced immune thrombocytopenic event. Haloperidol has a causal association with isolated DITP through an immune response. Other case reports include quetiapine, olanzapine, risperidone, fluphenazine, chlorpromazine, and clozapine. However, other antipsychotics cannot be excluded. The frequency of thrombocytopenia as an adverse reaction is either listed as “less than 1%” or undefined. The severity of thrombocytopenic effects ranged from mild to severe, including death. In published case reports where antipsychotics were the suspected cause of the patient’s thrombocytopenia, the platelet levels dropped within a few days of initial administration of the drug and returned to normal within a few days after discontinuation of the suspected agent.

DITP accounts for 5-20% of all cases of thrombocytopenia. The most common drug induced causes of thrombocytopenia stem from heparin, quinine, sulfonamides, acetaminophen, ibuprofen, naproxen, ampicillin, vancomycin, and the antiplatelet agent class of glycoprotein IIb/IIIa inhibitors. In addition to case reports of antipsychotics causing thrombocytopenia, it is important to note that other drugs frequently used in psychiatry can also decrease platelets. Mirtazapine and carbamazepine have been associated with DITP while valproate can cause bone marrow suppression leading to decreased platelet count. Valproate has a 6-33% incidence of dose related thrombocytopenia. Since polypharmacy in psychiatry is so prevalent, using multiple agents that each have potential to cause thrombocytopenia on their own can have additive effects when used concomitantly.

In conclusion, thrombocytopenia is a potential adverse reaction of first and second generation antipsychotics. With the current knowledge we have of antipsychotic agents causing blood abnormalities, it is prudent to monitor blood counts for any potential reactions and identify and discontinue suspected agents if problems are detected.

References

Carrillo, J. A., Gonzalez, J. A., Gervasini, G., Lopez, R., Fernadez, M. A., & Nunez, G. M. (2004). Thrombocytopenia and fatality associated with olanzapine. *European Journal of Clinical Pharmacology, 60*, 295-296. Retrieved September 7, 2016.

Gardner, D. M., & Teehan, M. D. (2011). *Antipsychotics and their Side Effects*. New York, NY: Cambridge University Press.

George, J. N. , & Arnold, D. M. (2016). Approach to the adult with unexplained thrombocytopnia. In L. Leung (Ed.), *UpToDate*. Waltham, Mass.: UpToDate. Retrieved from www.uptodate.com

George, J. N. , & Arnold, D. M. (2016). Drug-induced immune thrombocytopenia. In L. Leung (Ed.), *UpToDate*. Waltham, Mass.: UpToDate. Retrieved from www.uptodate.com

Huynh, M., Chee, K., & Lau, D. H. (2005, July/August). Thrombotic Thrombocytopenic Purpura Associated with Quetiapine. *The Annals of Pharmacotherapy, 39*, 1346-1348.

Shankar, B. R., D.P.M., D.N.B. (2007, November/December). Quetiapine-Induced Leucopenia and Thrombocytopenia. *Psycosomatics, 48*(6), 530-531. Retrieved September 7, 2016, from http://psy.psychiatryonline.org

Stubner, S., Grohmann, R., Engel, R., Bandelow, B., Ludwig, W., Wagner, G., . . . Ruther, E. (2004). Blood Dyscrasias Induced by Psychotropic Drugs. *Pharmacopsychiatry, 37*(Suppl 1), S70-S78. Retrieved September 7, 2016.