THE JOURNAL

August, 2017

- **We wish all our DPC Residency graduates**

good Luck on the board exam next month.

- **DPC Residents conducted a survey study to determine the relationship between residents' perception of the preparations that Didactic lectures provided towards the PRITE exams and their self-reported results.**
- **The presentation will be discussed in the APA meeting 2018!**

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Aricept (Drug information)

Abdel, PGY-3

Review of Up to date lists the following indications:

1. Alz dementia (FDA approved) The effectiveness of aricept as a treatment for Alzheimer's Disease is demonstrated by the results of randomized, double-blind, placebo-controlled clinical investigations in patients with mild to moderate Alzheimer's Disease, and in patients with severe Alzheimer's Disease.

2. Dementia associated with Parkinson disease (**off label):** start 5 mg PO Q daily then increase to 10 mg PO Q daily.

3. Lewy Body Dementia **(off label):**

Does food or timing of administration affect absorption?

Neither food nor timing of administration affects absorption.

Watch for:

1. QTC prolongation and arrhythmia

3. GI side effects (most common). Patients with less than 55 kg can commonly have more GI side effects.

4. NMS: rare cases of NMS have been reported in patient using Aricept.

5. Rhabdomyolysis: rare cases have been reported in patients using Aricept.

6. Use with caution in patients with peptic ulcer, COPD and seizure (cholinomimetics may lead to seizure occurrence)

7. Use with caution in patients with BPH as cholinomimetics can worsen outflow in patients with pre-existing predisposing conditions (i.e. bladder outflow obstructions)

Reference:

1-Up to date

2**https://www.accessdata.fda.gov/drugsatfda_docs/label/2006/020690s026,021720s003lbl.pdf**

First Episode Psychosis:

Neil S Kaye, MD, DLFAPA

Psychosis may be defined as an inability to distinguish reality. It includes grossly impaired reality testing, and commonly delusions (fixed, false beliefs held despite obvious evidence to the contrary and not sanctioned by the person's culture/religion) and/or hallucinations (false sensory perceptions in any of the 5 sensory modalities.) Psychosis involves both perceptual and cognitive disruptions. However, psychosis is only a symptom and not an illness. In the USA, approximately 100,000 young people experience psychosis each year. As many as 3% of people will have an episode at some point in their lives.

Early or first-episode psychosis (FEP) refers to when a person first shows signs of beginning to lose contact with reality. While it is easy to identify psychosis when it presents as hallucinations and/or delusions. FEP often presents as "thought disorganization" or in some cases grossly disorganized behavior. Thought disorganization or fragmentation is often difficult to characterize and can easily missed or misdiagnosed.

While schizophrenia is the prototypical thought disorder, and is relatively easy to diagnose, FEP is more challenging, especially in the absence of primary or first rank symptoms (Schneider 1887-1967) such as hallucinations and/or delusions. Building on Bleuler's (1857-1939) concepts, I would suggest remembering the 6 A's of thought disorder: Associations (loose); Affect (abnormal); Autism (lack of ability to/interest in relating to others); Ambivalence; Accessory symptoms (hallucinations/delusions) and; Affect (blunted/flat.)

FEP generally comes on gradually with non-specific alterations in thoughts, perceptions, and even mood in some cases. These changes may be difficult to distinguish from normal adolescence. The affected individual may not realize or be aware of the changes and observations from family can be especially helpful. Professional evaluation is highly recommended.

Early warning signs before psychosis include:

- A worrisome drop in grades or job performance
- Trouble thinking clearly or concentrating
- Suspiciousness or uneasiness with others
- A decline in self-care or personal hygiene
- Spending a lot more time alone than usual

Early warning signs of psychosis include:

- Strong, inappropriate emotions or having no feelings at all
- Hearing, seeing, tasting or believing things that others don't
- Persistent, unusual thoughts or beliefs that can't be set aside regardless of what others believe
- Strong and inappropriate emotions or no emotions at all
- Withdrawing from family or friends
- A sudden decline in self-care

- Trouble thinking clearly or concentration

The cause of psychosis is worthy of evaluation, including understanding the patient's genetic risk factors, trauma history, substance use pattern, physical illness and injury, and personal and familial mental health history. Many street drugs including marijuana and PCP/Ketamine are known to "unmask" a schizophrenia-like psychotic presentation and are commonly used and too often presumed to be safe by high school and college students.
Regardless of etiology, most cases of FEP are approached similarly: Treatment includes case management; family support and education; patient support and education; psychotherapy; medication management; peer support; and supported education/employment.

There is no "best" medication for FEP. Because many people with FEP will go on to eventually be diagnosed with schizophrenia and be on medication for a prolonged period of time, attention to potential long term side effects of TD and metabolic syndrome should be considered from the very first prescription.

The NIMH has created the RA1SE program for coordinated care of a person with FEP and all treaters should become familiar with these recommendations (see below.)

References:

https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/psychosis/first_episode_psychosis_information_guide/Pages/first_episode_psychosis_information_guide.aspx

Clinical Scenarios:

Abdel PGY-3

A patient with history of anxiety and depression is travelling to Africa. Which anti-malarial medications should be avoided?

The answer is mefloquine: it can cause various neuropsychiatric side effects even after it has been discontinued

It should be avoided for prophylaxis in patients with major psychiatric disorders

If psychiatric illness worsens, the drug should be discontinued and another alternative medication should be prescribed.

Reference: http://reference.medscape.com/drug/mefloquine-342689#5

Quick Facts: Does Ziprasidone have anxiolytic properties?

Yes, it is a potent 5HT1A agonist which might be helpful in treating anxiety.

Reference: APA guideline for treatment of depression, third edition. Page 40

Evaluating suicidality:

Once patient decides to take their own life, they could possibly view the psychiatrist more of an adversary than a colleague. We should always evaluate the risk factors for suicide even if the patient state they are no longer suicidal.

- Look for evidence in the nursing notes: How are they eating, and sleeping? How is their affect?
- Obtain collateral information from family. Patients inform their therapist around 18% of the time only of their suicidal intention and 60% to their spouse. The family should report to the psychiatrist if the patient is obtaining a will, buying a gun or saying goodbye in any way.
- We need to look at the actions of patients more than the words (i.e. patient writing suicidal note)

Reference: Phill Resnick M.D. Forensic Psychiatrist
http://www.mdedge.com/currentpsychiatry/article/143585/depression/evaluating-suicidality

Adjusting psychotropics in Renal impairment/part 1

Abdelaziz M.D.

PGY2

CKD complications include: loss of further of kidney function, cardiovascular shifts and unexpected toxicities.

Paliperidone *is primarily excreted as an unchanged drug in urine. Dosage modifications recommended.*

Ziprasidone: *It does not have a dosage modification recommendation by the manufacture but the risk of QTc prolongation and Arrythmias can occur secondary to renal impairment. Dosage should be used cautiously.*

Quetiapine: *studies showed no significant difference in pharmacokinetics in patients using quetiapine with renal impairment.*

Lurasidone: *Patient using lurasidone with mild, moderate and severe renal impairment was found to have a higher area under the curve compared to healthy patients. Dose modification is recommended.*

Escitalopram: *The package insert does not recommend dosage adjustments. However start slow and titrate slow as trials showed possible decrease in renal clearance in patients with mild-moderate renal impairment.*

Venlafaxine: *packet insert recommends dosage reduction of 50%. Similar recommendations for desvenlafaxine.*

Reference:

http://www.mdedge.com/currentpsychiatry/article/110902/schizophrenia-other-psychotic-disorders/when-adjust-dosing/page/0/2

Clinical Case Discussion MCQ

Abdelaziz

A 45-Year-old female develops acute dystonic reaction. The patient has been taking an antipsychotic orally but does not recall its name. The patient denies any prior history of dystonic reaction. Which of the following factors increases the risk for developing acute dystonic reactions due to antipsychotics?

A-Male gender

B-Second generation antipsychotic

C-Older ages

D-Lack of prior history of dystonic reactions

E-Oral preparations of medications

Answer A

Risk factors for acute **dystonic reactions due to antipsychotics:**

- High potency antipsychotics (i.e. Haloperidol)
- Higher doses and IM preparations
- Younger age(under 35)
- Prior history of dystonic reactions to neuroleptics
- Male gender

Reference: APA textbook of psychopharmacology, second edition Page 365