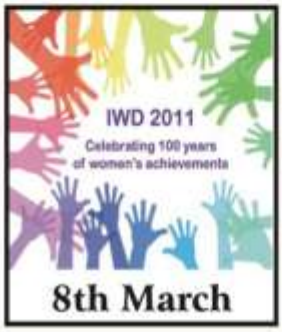
CHIEF EDITOR DR. SYED MUBIN AKHTAR

KARACHI PSYCHIATRIC HOSPITAL

MARCH BULLETIN 2011



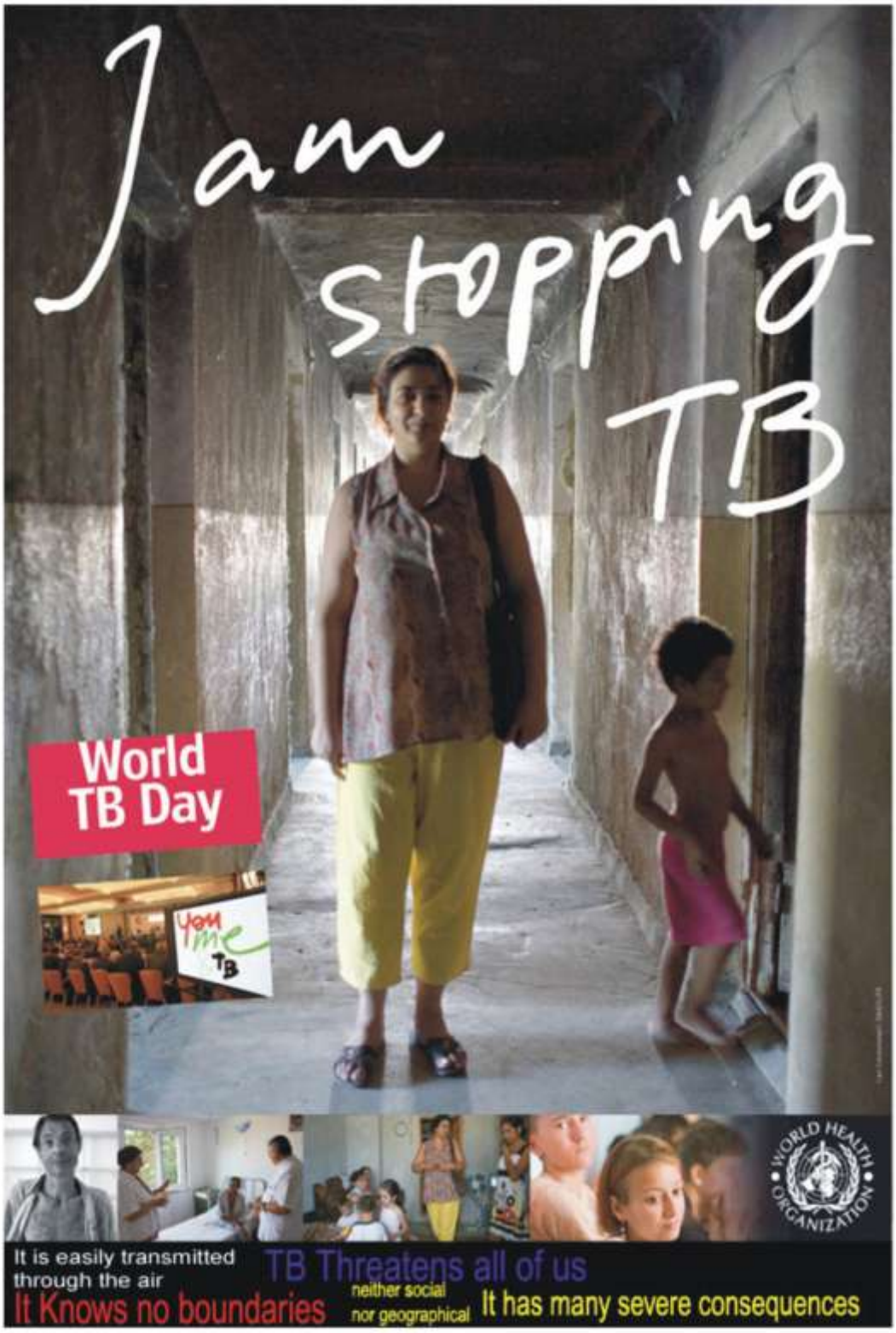
8th March

22nd March

24th March

26th March

PURPLE DAY FOR EPILEPSY 2011


I am stopping TB
World TB Day
WORLD HEALTH ORGANIZATION
It is easily transmitted through the air
It Knows no boundaries
TB Threatens all of us
neither social nor geographical
It has many severe consequences

KARACHI PSYCHIATRIC HOSPITAL

Vol. 34 Issue No.III March , 2011 Regd. No. SS -237

MONTHLY BULLETIN

(Psychiatric Research Article)

CONTENTS

قول رسول اللہ ﷺ

حضرت ابوہریرہؓ فرماتے ہیں کہ رسول اللہ ﷺ نے ارشاد فرمایا: جو شخص دوسروں پر فخر کرنے کے لئے مالدار بننے کے لئے، نام ونمود کے لئے دنیا طلب کرے اگرچہ حلال طریقے سے ہو، وہ اللہ تعالیٰ کے سامنے اس حالت میں حاضر ہوگا کہ اللہ تعالیٰ اس سے سخت ناراض ہوں گے۔ اور جو شخص دنیا حلال طریقے سے اس لئے حاصل کرے تاکہ اس کو دوسروں سے سوال نہ کرنا پڑے اور اپنے گھر والوں کے لئے روزی حاصل کرسکے اور اپنے پڑوسی کے ساتھ احسان کرسکے تو وہ قیامت کے دن اللہ تعالیٰ سے اس حال میں ملے گا کہ اس کا چہرہ چودھویں رات کے چاند کی طرح چمکتا ہوا ہوگا۔ (بیہقی)

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NOT ALL "SIDE EFFECTS" OF TRICYCLIC ANTIDEPRESSANTS ARE TRUE SIDE EFFECTS

Syed Thiwan, MD & Colleagues - Clin Gastroenterol Hepatol 2009 April

Objectives: Patients with functional gastrointestinal (GI) disorders treated with tricyclic antidepressants may report non-GI symptoms. It is unclear whether these symptoms are side effects of the medication or reflect a general behavioral tendency to report symptoms. This study 1) evaluated whether a checklist of symptoms reported by patients prior to taking desipramine increased in number or worsened in severity after being on a tricyclic antidepressant (desipramine), and 2) assessed baseline factors that predispose patients to report symptoms.

Methods: Female patients in the drug arm of a multi-center NIH treatment trial for functional bowel disorders completed a 15 item symptom questionnaire at baseline before randomization and at 2 weeks after starting Desipramine (n=81), or placebo (n=40) and at study completion 12 weeks later. Patients were asked on each occasion if they experienced any of 15 Symptoms and its level of severity and frequency, and the results were compared.

Results: A total of 57 patients in the desipramine arm who completed the questionnaire at both week 0 and week 2 comprised the study sample. Certain symptoms reported as side effects: dizziness, dry mouth/thirstiness, lightheadedness, feeling jittery or tremors and flushing not only were reported more often but also worsened at week 2 indicating a drug effect. Conversely, other symptoms that were also reported as side effects: feeling tired in AM, nausea, blurred vision, headaches, decreased appetite, and trouble sleeping either did not change in severity or showed improvement at week 2 (tiredness). All these symptoms except trouble sleeping were reported less often at Week 2 than at baseline. Psychological distress but not desipramine level significantly correlated with symptom reporting.

Conclusions: The majority of symptoms often attributed to side effects of desipramine were present prior to treatment, and only a few related to its anticholinergic effects worsened 2 weeks after beginning treatment, suggesting that most symptoms considered as side effects were not related to drug per se. Clinicians should consider that "Side effects" may relate more to psychological distress than to drug effects.

Editor's notes: The practice of telling the patient in advance all the expected side effects probably promotes this effect.

www.ncbi.nlm.nih.gov/pmc/articles/pmc2702777

POST DISASTER COURSE OF ALCOHOL USE DISORDERS IN SYSTEMATICALLY STUDIED SURVIVORS OF 10 DISASTERS

Carol S. North, MD, MPE & Colleagues

rch Gen Psychiatry - October 4, 2010

Context: Although several studies have suggested that alcohol use may increase after disasters, it is unclear whether any apparent postdisaster increases regularly translate into new cases of alcohol use disorders.

Objective: To determine the relationship of predisaster and postdisaster prevalence of alcohol use disorders and to examine the incidence of alcohol use disorders in relation to disasters.

Design: Data from 10 disasters, studied within the first few postdisaster months and at 1 to 3 years postdisaster, were merged and examined.

Participants: Six hundred ninety-seven directly exposed survivors of 10 disasters.

Measures: The Diagnostic Interview Schedule for DSM-III-R provided lifetime diagnoses of alcohol abuse and dependence, and onset and recency questions allowed a determination of whether the disorder had been present either prior to or following the event, or both.

Results: While the postdisaster prevalence of alcohol use disorders was 19%, only 0.3% of the sample developed an acute new postdisaster alcohol use disorder. Most of those in recovery, however, consumed alcohol after the disaster (83%) and coped with their emotions by drinking alcohol (22%). Those with a postdisaster alcohol use disorder were more than 4 times as likely as those without to cope with their disaster-related emotions by drinking alcohol (40% vs 9%).

Conclusions: The vast majority of postdisaster alcohol use disorders represented the continuation or recurrence of preexisting problems. Findings suggest that those in recovery as well as those who drink to cope with their emotions represent groups warranting potential concern for postdisaster mental health intervention. Further research is needed to clarify the clinical significance of changes in alcohol use after disasters.

http://archpsyc.ama-assn.org/cgi/content/abstract/archgenpsychiatry.2010.131v1

INTEGRATING TOBACCO CESSATION INTO MENTAL HEALTH CARE FOR POST TRAUMATIC STRESS DISORDER: A RANDOMIZED CONTROLLED TRIAL

McFall M, et al _ JAMA 2010

Among military veterans, adding smoking cessation treatment to regular care of posttraumatic stress disorder (PTSD) increased quit rates, a randomized trial showed.

Compared with usual care, integrated cessation treatment resulted in a doubling of the number of patients who remained abstinent for 12 months (8.9% versus 4.5%; OR 2.26, 95% CI 1.30 to 3.91), according to Miles McFall, PhD, of the Veterans Affairs Puget Sound Health Care System in Seattle, and colleagues.

Psychiatric status was not adversely affected by the intervention; in fact, PTSD severity improved by 10% in both the treatment and control groups.

This multisite trial, with the advantages of large sample size and enhanced external validity, represents a significant advance in the evidence base on the effectiveness of treating tobacco dependence in smokers with mental disorders and integration of tobacco treatment services into mental health care settings.

The study represents a major step forward on the path to abating the previously overlooked epidemic of tobacco dependence that has plagued persons with mental illness.

Patients with mental illness are often excluded from clinical trials of smoking cessation, and studies have shown that most smokers with mental illness do not receive treatment to help them quit.

PTSD in particular is strongly associated with smoking and unsuccessful quit attempts, highlighting the need for more effective ways to deliver smoking cessation treatment, according to McFall and his colleagues.

They randomized 943 smokers with military-related PTSD to either integrated smoking cessation treatment or usual care at 10 VA medical centers.

The intervention was delivered by the patients' mental health providers, mostly at scheduled PTSD visits. It involved five weekly core sessions focusing on tobacco use education, behavioral skills for quitting, setting a quit date, and relapse prevention. The core sessions were followed by three follow-up visits and monthly booster sessions to reinforce the intervention.

Usual care consisted of referral to specialized smoking cessation clinics at each center.

The mean age was 54 in both groups. Patients in both groups reported that they started smoking at an average age of 17.

In addition to PTSD, nearly half of the participants had current major depression.

Prolonged abstinence of 12 months, the primary outcome, was significantly improved with integrated care, as confirmed by exhaled carbon monoxide, urinary cotinine levels, or both.

Both seven- and 30-day abstinence rates were higher with integrated care throughout

the study as well.

The 39.1% of the treatment effect could be explained by the greater number of counseling sessions attended in the intervention group (median 8 versus 1) and amount of cessation medication used.

Although the proportion of patients taking cessation medications was similar in both groups, patients in the intervention group used the drugs longer (median 104 versus 68.5 days).

The finding suggests that other factors are contributing to the effectiveness of the intervention, according to the researchers, including "qualitative aspects of the therapeutic relationship, such as mental health clinicians' ability to motivate patients and skill in managing the dynamic interplay between psychiatric distress and smoking urges."

Between baseline and 18 months, there were no between-group differences in PTSD or depressive symptoms, with improvement in PTSD severity in both groups.

There was no difference in PTSD symptoms between quitters and nonquitters, although depression was slightly worsened in the patients who did not quit.

The percentage of patients who had serious adverse events possibly related to the study -- psychiatric or medical hospitalizations or life-threatening or potentially jeopardizing psychiatric or medical conditions not resulting in hospitalization -- was small (2% in each group).

McFall and his colleagues noted that the study was limited by the selected sample -- mostly older male Vietnam-era veterans with chronic PTSD and co-occurring depression -- and by the collection of outcome data by staff members who were not blinded to treatment group.

http://www.medpagetoday.com/Psychiatry/Depression/23789

TIME TO RELAPSE AFTER 6 AND 12 MONTHS' TREATMENT OF GENERALIZED ANXIETY DISORDER WITH VENLAFAXINE EXTENDED RELEASE

Karl Rickels, MD & Colleagues - Arch Gen Psychiatry. 2010

Context: Generalized anxiety disorder (GAD) is a chronic disorder in need of reliable data to guide long-term treatment.

Objectives: To assess the benefits of 6 and 12 months' treatment of GAD with venlafaxine hydrochloride extended release (XR) in patients who improved after 6 months' open-label venlafaxine XR treatment.

Design: After 6 months' open-label venlafaxine XR treatment, improved patients were randomized to venlafaxine XR or placebo for 6 months. All venlafaxine XR patients still in the study at 12 months were randomized to receive venlafaxine XR or placebo, and all placebo patients continued taking placebo for another 6 months.

Setting: One urban site (5 locations).

Patients: Of 268 patients with a diagnosis of GAD entering the open-label venlafaxine XR treatment phase, 158 (59.0%) completed 6 months, and 136 (50.7%) entered relapse phase 2 (6-12 months). Fifty-nine (43.4%) of 136 patients entered phase 3 (12-18 months).

Intervention: Six months' open-label treatment with venlafaxine XR, followed by double-blind venlafaxine XR or placebo for 2 relapse phases, each lasting 6 months.

Main Outcome Measures: Time to relapse while receiving venlafaxine XR or placebo after 6 and after 12 months of treatment. Relapse was strictly defined to safeguard against assigning patients with venlafaxine XR discontinuation symptoms or temporary anxiety increase as relapse.

Results: For objective 1, relapse rates in phase 2 (months 6-12) were 9.8% on venlafaxine XR and 53.7% on placebo ($P < .001$). For objective 2, relapse rates after 12 months on placebo (32.4%) were lower than after 6 months on venlafaxine XR (53.7%) ($P < .03$).

Conclusions: Treatment of GAD with an antidepressant should be continued for at least 12 months. Preliminary data demonstrate that improved patients who relapse while off their antianxiety medication after at least 6 months of treatment will again most likely respond to a second course of treatment with the same medication.

Archpsyc.ama-assn.org/cgi/content/abstract/67/12/1274

A RANDOMIZED ADD-ON TRIAL OF AN N-METHYL-D-ASPARTATE ANTAGONIST IN TREATMENT-RESISTANT BIPOLAR DEPRESSION

Diazgranados N, et al _ Arch Gen Psych 2010

The anesthetic ketamine (sometimes illicitly used as a recreational drug) produced rapid alleviation of severe depression in patients with treatment-resistant bipolar illness in a small clinic trial.

In an 18-patient randomized trial, a single infusion of intravenous ketamine knocked 10 points off Montgomery-Asberg Depression Rating Scale (MADRS) scores in 40 minutes compared with a placebo treatment.

The difference between ketamine and placebo groups in mean MADRS scores grew to more than 13 points on the second day after the ketamine infusion.

This is the first article detailing the rapid antidepressant effects of a single infusion of an NMDA N-methyl-D-aspartateantagonist in patients with treatment-resistant bipolar depression.

In an earlier randomized trial of ketamine in patients with severe unipolar depression that also found rapid and pronounced benefits.

Numerous other researchers have reported similar findings in case reports and in small, uncontrolled series.

Conventional antidepressants all require several weeks of treatment before effects are apparent. Adherence can suffer in the meantime, as patients lose interest in taking a drug that doesn't seem to be working.

Nevertheless, even though ketamine is an approved prescription drug, it does not appear to have caught on clinically -- perhaps because its label includes a boxed warning for "vivid imagery, hallucinations, or emergence delirium" when used as an anesthetic. This effect has led to the illicit use of ketamine as a "rave" party drug, dubbed "Special K."

Quasi-psychedelic reactions were not uncommon in the new study. It was indicated that at least 10% of participants reported "feeling woozy or loopy" or having "odd sensations," as well as more mundane effects such as drowsiness, cognitive impairment, nausea, blurred vision, and headache.

On the other hand, given the severe and disabling depression seen in study participants, such effects -- which Zarate and colleagues described as nonserious -- may be a small price to pay.

The patients had failed to respond to a mean of seven previous antidepressant drugs, and 55% had not responded to electroconvulsive therapy.

The toll of this protracted and refractory illness on the subjects was evident, in that two-thirds of participants were on psychiatric disability and nearly all were unemployed.

Patients in the study remained on bipolar illness medications including lithium or valproate. They were hospitalized for an average of nine weeks prior to starting the randomized treatment, during which their responses to these mood stabilizers were assessed and stability of depression symptoms could be monitored in a relatively controlled setting.

MADRS scores averaged about 31 in the

treatment group and 33 in the control group at the start of the randomized treatment phase.

Just 40 minutes after a ketamine infusion of 0.5 mg/kg -- the standard anesthetic dose is 1 to 4.5 mg/kg -- mean MADRS scores in the active treatment group dropped to 18, whereas scores in the placebo group declined to 28.

Scores in the ketamine group remained stable through the second day after infusion, then returned to near baseline levels (not significantly different from the placebo group) by day seven.

Very similar patterns were seen in scores on the standard Hamilton and Beck depression evaluations.

The onset of significant relief was even faster in this sample than in the earlier trial with unipolar depressed patients -- in which relief took 110 minutes. This discrepancy may reflect concomitant treatment with lithium or valproate, and the more severe depression in the current study's sample.

Several limitations to their study were cited . One of the most important may be the hallucinogenic side effects ofketamine, which might have clued patients to whether they had received the active drug as opposed to placebo.

A significant number of placebo patients experienced similar adverse effects, and there was no apparent relationship between adverse effects and treatment efficacy in the ketamine group. Nevertheless conceded that blinding could have been compromised, potentially confounding the results.

Future studies using ketamine will have to address the limitation of blinding and may include an active comparator with central nervous system effects.

Also noted that the trial was small and that their patients were very severely depressed -- with a mean duration of illness of nearly 30 years -- which is not representative of most patients with bipolar depression.

In addition, they emphasized that it is still unknown whether the improvements in symptoms of severe depression seen with ketamine can be maintained -- or if so, how.

It is currently what would be the first large trial of ketamine for treating depression. The 164-patient study in unipolar depression, which began recruitment in 2004, is expected to be completed in 2014, according to its listing on Clinicaltrials.gov.

http://www.medpagetoday.com/21499

ANTIDEPRESSANT MEDICATION USE AND FUTURE RISK OF CARDIOVASCULAR DISEASE: THE SCOTTISH HEALTH SURVEY

Hamer M, et al _ Eur Heart J 2010

Growing concern that patients taking tricyclic antidepressants are at increased risk for cardiovascular disease has been proven out in a large European study.

In a prospective cohort study that included 14,784 adults, those using tricyclics had a 35% increased cardiovascular risk after adjustment for potential confounders including symptoms of depression and anxiety, which are known risk factors for cardiovascular disease (HR 1.35, 95% CI 1.03 to 1.77).

In contrast, the use of selective serotonin reuptake inhibitors (SSRIs) was not associated with an elevated risk (HR 1.11, 95% CI 0.77 to 1.60).

Some previous studies have suggested that any association between the use of antidepressants and risk of cardiovascular disease can be attributed to depression, not the drugs. Hamer and colleagues disagreed.

On the basis of our findings, the association between antidepressant use and cardiovascular disease risk is partly independent of psychiatric symptoms which suggests that there may be some characteristic of tricyclic antidepressants that is raising cardiovascular disease risk.

However, they also noted that the 35% increase might be explained by confounding by unidentified risk factors.

To investigate the issue, the researchers analyzed data from the nationally representative Scottish Health Survey, which is conducted among the country's adults every three to five years and includes information on demographics, lifestyle, and medical and medication history. Participants' mean age was 53, and more than half were women.

Tricyclic antidepressants were being used by 2.2%, SSRIs by 2%, and other antidepressants such as monoamine oxidase inhibitors by 0.7%.

Overall, antidepressant users were more commonly women, older, smokers, and sedentary. They also were more likely to report psychological distress and to have had a psychiatric inpatient stay.The average follow-up was eight years, during which time there were 1,434 cardiovascular events among the study participants. Events included cardiovascular death, MI, coronary surgery, stroke, and heart failure. A total of 26.2% of the events were fatal. Over the course of the study, a total of 1,238 participants died, 375 from cardiovascular disease.

In an unadjusted model, the use of tricyclic antidepressants was associated with cardiovascular death (HR 2.23, 95% CI 1.39 to 3.60), but after adjustment for variables this was no longer significant.

Further analysis showed that both tricyclic and SSRI users had a higher risk of stroke in age- and sex-adjusted models:

- Tricyclics, HR 2.23 (95% CI 0.85 to 6.39)

" SSRIs, HR 3.32 (95% CI 1.20 to 9.18)

But the researchers cautioned that the findings on risk of stroke should be interpreted with caution.

They pointed out that there were only 78 events and the association with SSRIs was weakened after multivariate adjustment (HR 2.46, 95% CI 0.87 to 6.96).

Possible reasons why tricyclic antidepressants might contribute to cardiovascular risk include their propensity to cause weight gain and their association with potentially cardiotoxic effects such as reduced heart rate variability and prolongation of the QT interval.

Limitations of the study include its observational design and the lack of information on drug dosages or compliance. But strengths include the large sample and detailed information about medical history, hospitalizations, and potential confounders.

http://www.medpagetoday.com/tbprint.cfm?tbid=23662

INTEGRATING NEUROBIOLOGICAL MARKERS OF DEPRESSION

Tim Hahn, PhD & others - Arch Gen Psychiatry

Context: Although psychiatric disorders are, to date, diagnosed on the basis of behavioral symptoms and course of illness, the interest in **neurobiological** markers of psychiatric disorders has grown substantially in recent years. However, current classification approaches are mainly based on data from a single biomarker, making it difficult to predict disorders characterized by complex patterns of symptoms.

Objective: To integrate neuroimaging data associated with multiple symptom-related neural processes and demonstrate their utility in the context of depression by deriving a predictive model of brain activation.

Design: Two groups of participants underwent functional magnetic resonance imaging during 3 tasks probing neural processes relevant to depression.

Setting: Participants were recruited from the local population by use of advertisements; participants with depression were inpatients from the Department of Psychiatry, Psychosomatics, and Psychotherapy at the University of Wuerzburg, Wuerzburg, Germany.

Participants: We matched a sample of 30 medicated, unselected patients with depression by age, sex, smoking status, and handedness with 30 healthy volunteers.

Main Outcome Measure: Accuracy of single-subject classification based on whole-brain patterns of neural responses from all 3 tasks.

Results: Integrating data associated with emotional and affective processing substantially increases classification accuracy compared with single classifiers. The predictive model identifies a combination of neural responses to neutral faces, large rewards, and safety cues as nonredundant predictors of depression. Regions of the brain associated with overall classification comprise a complex pattern of areas involved in emotional processing and the analysis of stimulus features.

Conclusions: Our method of **integrating** neuroimaging data associated with multiple, symptom-related neural processes can provide a highly accurate algorithm for classification. The integrated biomarker model shows that data associated with both emotional and reward processing are essential for a highly accurate classification of depression. In the future, large-scale studies will need to be conducted to determine the practical applicability of our algorithm as a biomarker-based diagnostic aid.

http://archpsyc.ama-assn.org/cgi/content/full/archgenpsychiatry.2010.178

ANTIDEPRESSANT MONOTHERAPY VS SEQUENTIAL PHARMACOTHERAPY AND MINDFULNESS-BASED COGNITIVE THERAPY, OR PLACEBO, FOR RELAPSE PROPHYLAXIS IN RECURRENT DEPRESSION

Segal ZV, et al _ Arch Gen Psych 2010

For patients who achieve an unstable remission after depression -- one dotted with depressive symptoms -- mindfulness-based cognitive therapy may prevent relapse just as well as maintenance antidepressant therapy.

Both treatments were equivalent and were associated with similar reductions in relapse compared with placebo.

For those unwilling or unable to tolerate maintenance antidepressant treatment, mindfulness-based cognitive therapy offers equal protection from relapse

Relapse after recovery from depression is common, and the current therapy to prevent relapse is maintenance antidepressants. Medication adherence, however, tends to be an issue.

Mindfulness-based cognitive therapy may be an alternative, the researchers said. The group-based regimen helps train patients to disengage from depressogenic thinking, and puts an emphasis on daily practice of health-enhancing behaviors such as meditation or yoga.

Yet little data on its efficacy exists. So the researchers conducted a randomized trial of 166 patients ages 18 to 65 at two outpatient clinics in Canada who met criteria for major depressive disorder, and focused on the 84 who achieved remission. These patients were assigned to one of the three groups: antidepressant maintenance therapy, mindfulness-based cognitive therapy, or placebo.

Patients who received cognitive therapy discontinued their antidepressants and attended eight weekly group sessions.

During their acute treatment phase, about half (51%) of patients were classified as unstable remitters, while the rest were stable.

These unstable remitters had higher depression scores, spent more days in the acute treatment phase, and spent more days in remission than those who were stable (P=0.03, P=0.02, and P=0.03, respectively).

Thus there was a significant interaction between quality of acute-phase remission and subsequent prevention of relapse in randomized patients (P=0.03).

The findings indicated that the quality of remission achieved during the acute phase interacted with the type of prevention treatment patients received to determine relapse outcomes during the subsequent maintenance phase.

So they assessed treatment effects among the unstable group. They found that all of these treated patients -- whether they had mindfulness-based therapy or antidepressant therapy -- had a reduction in relapse risk compared with placebo, which didn't differ significantly between the two groups.

Relapse rates were 27% for antidepressant maintenance therapy, 28% for mindfulness therapy, and 71% for placebo.

Individually, mindfulness therapy was

associated with a 74% reduced risk of relapse (95% CI 0.09 to 0.79, P=0.01), and antidepressant therapy was associated with a 76% reduced risk (95% CI 0.07 to 0.89, P=0.03).

For patients whose acute-phase remission was marked by periodic symptom flurries, discontinuing antidepressants and receiving [cognitive therapy], or continuing with antidepressants significantly lowered relapse/recurrence risk compared with discontinuation to placebo.

They said the results are "in accord with previous reports" that time in remission or the presence of residual symptoms are associated with "poorer acute- and maintenance-phase outcomes" and that reduction of this risk "with targeted treatment is beneficial."

Surprisingly, for patients whose acute-phase remission was stable, there was no differential effect on survival between the treatments studied.

The study was limited because its power was lessened when the cohort was divided into stable and unstable remitters, and the authors noted that further study is needed.

http://www.medpagetoday.com/Psychiatry/Depression/23798

ASSOCIATION BETWEEN BIPOLAR SPECTRUM FEATURES AND TREATMENT OUTCOMES IN OUTPATIENTS WITH MAJOR DEPRESSIVE DISORDER

Perlis R, et al _ Arch Gen Psychiatry 2010

The presence of a psychotic symptom in a patient with major depression does not necessarily signal underlying bipolar disorder or presage resistance to treatment with antidepressants.

Among more than 4,000 patients who sought treatment for major depression, 30% reported experiencing one psychotic feature and 38.1% had at least one recent manic or hypo manic symptom.

Review articles and continuing medical education programs frequently assert that unrecognized bipolarity is a substantial contributor to apparent treatment-resistant major depressive disorder.

Among the disease characteristics that have been proposed as suggestive of underlying bipolar disorder in depressed patients are early age at symptom onset, more frequent recurrences, shorter episodes, and family history of bipolar disorder.

The importance of identifying true bipolarity in a patient presenting in a depressive state lies in the choice of treatment, since some bipolar patients appear to worsen with antidepressant therapy.

To address what they termed the "challenging clinical problem" of distinguishing between major depression and bipolar disorder in a depressed patient, Perlis and colleagues analyzed data from the STAR*D study, a multicenter trial that evaluated several strategies for managing resistant depression.

STAR*D was intended to reflect routine clinical practice, so structured interviews were not used for detection of symptoms of bipolarity.

Rather, more simple symptom screens were used, with questions about potentially psychotic events and beliefs such as thoughts of being plotted against, spied on, and seeing or hearing things.

In addition, patients were questioned about manic-like symptoms such as not needing sleep and impulsive actions.

A total of 16.2% of 4,041 patients reported having both manic and psychotic symptoms.

The researchers then looked at whether the disease features commonly thought to reflect underlying bipolar disorder were associated with failure to reach remission with antidepressant treatment.

Certain features were significantly associated with lack of remission, including irritability, psychomotor symptoms, and hyperphagia.

However, other important features were not associated with poor outcome:

- Family history of bipolar disorder, HR 0.96 (95% CI 0.82 to 1.12)
- Presence of manic symptoms, HR 1.02 (95% CI 0.93 to 1.12)
- Brief episode duration, HR 1.10 (95% CI 1 to 1.22)

Further statistical analysis confirmed that features suggestive of bipolarity were only weakly and inconsistently correlated with

treatment resistance.

The results indicate that putative bipolar spectrum features are common in this general clinical population presenting for treatment with major depressive disorder.

There were limitations to their analysis, such as the exclusion from STAR*D of patients with overt bipolar disorder and the investigators' use of simple diagnostic tools, which could have resulted in bias toward the null.

It was emphasized that resistance to antidepressant therapy certainly should warrant further consideration of the diagnosis of depression, but "considered as a whole, our results cast doubt on the frequent assertion that unrecognized bipolar disorder is widespread in clinical practice and particularly in treatment-resistant major depressive disorder."

http://www.medpagetoday.com/tbprint.cfm?tbid=23770

10 FACTS ABOUT TUBERCULOSIS

Fact 1: Tuberculosis (TB) is contagious and spreads through the air. If not treated, each person with active TB can infect on average 10 to 15 people a year.

Fact 2: More than two billion people, equal to one third of the world's total population, are infected with TB bacilli, the microbes that cause TB. One in every 10 of those people will become sick with active TB in his or her lifetime. People living with HIV are at a much greater risk.

Fact 3: A total of 1.7 million people died from TB in 2009 (including 380 000 people with HIV), equal to about 4700 deaths a day. TB is a disease of poverty, affecting mostly young adults in their most productive years. The vast majority of TB deaths are in the developing world, with more than half occurring in Asia.

Fact 4: TB is a leading killer among people living with HIV, who have weakened immune systems.

Fact 5: There were 9.4 million new TB cases in 2009, of which 80% were in just 22 countries. Per capita, the global TB incidence rate is falling, but the rate of decline is very slow - less than 1%.

Fact 6: TB is a worldwide pandemic. Among the 15 countries with the highest estimated TB incidence rates, 13 are in Africa, while a third of all new cases are in India and China.

Fact 6: TB is a worldwide pandemic. Among the 15 countries with the highest estimated TB incidence rates, 13 are in Africa, while a third of all new cases are in India and China.

Fact 7: Multidrug-resistant TB (MDR-TB) is a form of TB that does not respond to the standard treatments using first-line drugs. MDR-TB is present in virtually all countries surveyed by WHO and its partners.

Fact 8: There were an estimated 440 000 new MDR-TB cases in 2008 with three countries accounting for over 50% of all cases globally: China, India and the Russian Federation. Extensively drug-resistant TB (XDR-TB) occurs when resistance to second-line drugs develops. It is extremely difficult to treat and cases have been confirmed in more than 58 countries.

Fact 9: The world is on track to achieve two TB targets set for 2015:

"The Millennium Development Goal, which aims to halt and reverse global incidence (in comparison with 1990); and

"The Stop TB Partnership target of halving deaths from TB (also in comparison with 1990).

Fact 10: 41 million TB patients have been successfully treated in DOTS programmes and up to 6 million lives saved since 1995. 5 million more lives could be saved between now and 2015 by fully funding and implementing The Global Plan to Stop TB 2011-2015

MAJOR DEPRESSIVE DISORDER WITH SUBTHRESHOLD BIPOLARITY IN THE NATIONAL COMORBIDITY SURVEY REPLICATION

Angst J, et al - Am J Psychiatry 2010

A high proportion of people with major depression may actually have a "hidden" form of bipolar disorder, according to a population-based study.

Interviews with a nationally-representative sample of more than 9,000 people suggest that nearly 40% of people with a history of major depressive disorder report periods of hypomania that just miss the threshold for a bipolar diagnosis.

The group with subthreshold hypomania appeared to fall between pure depression and bipolar disorder for clinical severity.

Since such patients might benefit from the addition of a mood stabilizer after response to antidepressants, the researchers supported a proposed broadening of the criteria for bipolar disorder.

Subthreshold mania hasn't made it into the current edition of the Diagnostic and Statistical Manual of Mental Diseases (DSM-IV), but changes are being debated as the psychiatric "bible" undergoes revision for its fifth edition, expected in 2013.

A diagnostic specifier for subthreshold bipolarity might fit well in the diagnostic category of major depression.

Such an expansion of the bipolar concept would likely lead to important changes in the treatment of patients who are undiagnosed or misdiagnosed despite elevated morbidity and mortality rates.

Regardless, if there is such a substantial group of patients with hidden bipolarity, careful evaluation of a history of hypomanic symptoms and a family history of mania would be critical.

The group analyzed results from the nationally-representative National Comorbidity Survey Replication (NCS-R) -- a nationally representative face-to-face household survey of the prevalence and correlates of a wide range of DSM-IV mental disorders.

For the study, responses were analyzed from 9,282 people surveyed between February 2001 and April 2003.

Overall, 5.4% of the NCS-R respondents met criteria for major depressive disorder alone over the prior 12 months, jumping to 10.2% for lifetime prevalence.

Together, the bipolar spectrum conditions were nearly as common as major depression alone.

The lifetime prevalence of major depression with subthreshold hypomania in the NCS-R respondents was 6.7% and 2.2% over the prior 12 months.

Bipolar I disorder – major depressive disorder with mania -- affected 0.3% of the respondents over the prior 12 months and 0.7% over their lifetime.

Bipolar II disorder -- major depressive disorder with hypomania – affected 0.8% of the respondents over the prior 12 months, with a 1.6% lifetime prevalence.

Treatment for mood disorders was no more likely for those with subthreshold hypomania than for those with depression alone.

However, the subthreshold hypomania group showed greater rates of comorbidity than the depression alone group for the following (P<0.05 for all):

- Anxiety (72.2% versus 52.6%)
- Substance use disorders (35.3% versus 18.0%)
- Behavioral problems (41.1% versus 19.2%)

Suicide attempts were reported by 41% of those with major depression and subthreshold hypomania, which fell between the 50% of those with bipolar II and the 31% of those with major depression alone.

Age at first onset showed the same pattern as did number of episodes of depression.

These differences in clinical characteristics "underscore the heterogeneity of major depression and support the notion that a critical reappraisal of diagnostic criteria for mood disorders is warranted.

Even more convincing, they suggested, was that family history of mania was as common for those with subthreshold hypomania as for those with mania or hypomania (76.0% versus 70.4% and 67.8%, respectively).

The findings provide the first comparisons of the prevalence and clinical correlates of bipolar II disorder, major depression with subthreshold hypomania, and major depression alone in a nationally representative U.S. sample.

However, the researchers noted that the data were based on self-report in the lay-administered NCS-R survey, and precluded collection of information on the full spectrum of expression of bipolar disorder proposed in recent studies.

The definition of subthreshold bipolar disorder -- which required a major depressive episode diagnosis and a "yes" answer to either of the mania screening questions that encompassed a discrete period of increased energy, activity, and euphoria or irritability not related to impairment in daily activities -- was more restrictive than the definitions proposed by clinical researchers.

The study may have underestimated the prevalence of bipolar spectrum disorder in the population.

http://www.medpagetoday.com/21687

MAINTENANCE TREATMENT OF DEPRESSION IN OLD AGE

A Randomized, Double-blind, Placebo-Controlled Evaluation of the Efficacy and Safety of Donepezil Combined with Antidepressant Pharmacotherapy

Charles F. Reynolds III, MD & Colleagues_ Arch Gen Psychiatry. 2011

Context: Cognitive impairment in late-life depression is a core feature of the illness.

Objective To test whether donepezil hydrochloride and antidepressant therapy is superior to placebo and antidepressant therapy in improving cognitive performance and instrumental activities of daily living and in reducing recurrences of depression over 2 years of maintenance treatment.

Design: Randomized, double-blind, placebo-controlled maintenance trial.

Setting: University clinic.

Participants: One hundred thirty older adults aged 65 years and older with recently remitted major depression.

Interventions: Random assignment to maintenance antidepressant pharmacotherapy and donepezil or to maintenance antidepressant pharmacotherapy and placebo.

Main Outcome Measures: Global neuropsychological performance, cognitive instrumental activities of daily living, and recurrent depression.

Results: Donepezil and antidepressant therapy temporarily improved global cognition (treatment x time interaction, F2,126 = 3.78; P = .03), but effect sizes were small (Cohen d = 0.27, group difference at 1 year). A marginal benefit to cognitive instrumental activities of daily living was also observed (treatment x time interaction, F2,137 = 2.94; P = .06). The donepezil group was more likely than the placebo group to experience recurrent major depression (35% [95% confidence interval {CI}, 24%-46%] vs 19% [95% CI, 9%-29%], respectively; log-rank 2 = 3.97; P = .05; hazard ratio = 2.09 [95% CI, 1.00-4.41]). Post hoc subgroup analyses showed that of 57 participants with mild cognitive impairment, 3 of 30 participants (10% [95% CI, 0%-21%]) receiving donepezil and 9 of 27 participants (33% [95% CI, 16%-51%]) receiving placebo had a conversion to dementia over 2 years (Fisher exact test, P = .05). The mild cognitive impairment subgroup had recurrence rates of major depression of 44% with donepezil vs 12% with placebo (likelihood ratio = 4.91; P = .03). The subgroup with normal cognition (n = 73) showed no benefit with donepezil and no increase in recurrence of major depression.

Conclusions: Whether a cholinesterase inhibitor should be used as augmentation in the maintenance treatment of late-life depression depends on a careful weighing of risks and benefits in those with mild cognitive impairment. In cognitively intact patients, donepezil appears to have no clear benefit for preventing progression to mild cognitive impairment or dementia or for preventing recurrence of depression.

http://archpsyc.ama-assn.org/cgi/content/abstract/68/1/51?

PROBLEM-SOLVING THERAPY AND SUPPORTIVE THERAPY IN OLDER ADULTS WITH MAJOR DEPRESSION AND EXECUTIVE DYSFUNCTION

George S. Alexopoulos, MD & Colleagues _ Arch Gen Psychiatry- 2011

Effect on Disability

Context: Older patients with depression and executive dysfunction represent a population with significant disability and a high likelihood of failing pharmacotherapy.

Objectives: To examine whether problem-solving therapy (PST) reduces disability more than does supportive therapy (ST) in older patients with depression and executive dysfunction and whether this effect is mediated by improvement in depressive symptoms.

Design: Randomized controlled trial.

Setting: Weill Cornell Medical College and University of California at San Francisco.

Participants: Adults (aged >59 years) with major depression and executive dysfunction recruited between December 2002 and November 2007 and followed up for 36 weeks.

Intervention: Twelve sessions of PST modified for older depressed adults with executive impairment or ST.

Main Outcome Measure: Disability as quantified using the 12-item World Health Organization Disability Assessment Schedule II.

Results: Of 653 individuals referred to this study, 221 met the inclusion criteria and were randomized to receive PST or ST. Both PST and ST led to comparable improvement in disability in the first 6 weeks of treatment, but a more prominent reduction was noted in PST participants at weeks 9 and 12. The difference between PST and ST was greater in patients with greater cognitive impairment and more previous episodes. Reduction in disability paralleled reduction in depressive symptoms. The therapeutic advantage of PST over ST in reducing depression was, in part, due to greater reduction in disability by PST. Although disability increased during the 24 weeks after the end of treatment, the advantage of PST over ST was retained.

Conclusions: These results suggest that PST is more effective than ST in reducing disability in older patients with major depression and executive dysfunction, and its benefits were retained after the end of treatment. The clinical value of this finding is that PST may be a treatment alternative in an older patient population likely to be resistant to pharmacotherapy.

http://archpsyc.ama-assn.org/cgi/content/abstract/68/1/33?

THE SANDS OF FORGIVENESS

Learn to write your hurts in the sand and to carve your benefits in stone

SUBJECTIVE MEMORY PROBLEMS

Steve Ilife & Colleagues - BMJ

SUMMARY POINTS

- Subjective memory problems are much more common in later life than the objective problems that suggest minor cognitive impairment or dementia
- Subjective memory problems are not simply a characteristic of the "worried well" and should be taken seriously
- Depression is associated with subjective memory problems, as are older age, female sex, and low educational attainment
- Depression is itself a risk factor for dementia, making the diagnostic task even more difficult
- Subjective memory problems are a poor predictor of dementia syndrome (loss of memory and one other aspect of cognition sufficient to cause impairment)
- When deciding whether to refer to specialist services, practitioners need to rely on rules of thumb to evaluate the extent arid possible significance of symptoms or subjective memory loss

ARE SUBJECTIVE MEMORY PROBLEMS ASSOCIATED WITH CONCURRENT OBJECTIVE MEMORY IMPAIRMENT?

In the most recent review, eight studies with a pooled population of 9148 reported the rate of subjective memory problems in patients with dementia, seven reported the rate in those with mild cognitive impairment, and of these four compared the rates in dementia and mild cognitive impairment head to head. Subjective memory problems were reported by 43% of those with known dementia and 38% of those with known mild cognitive impairment. Across the spectrum of cognitive impairment (mild cognitive impairment or dementia) 40% of patients had subjective memory problems compared with 17% in healthy adult, controls. In this review the pooled sensitivity of subjective memory problems for prediction of dementia was -13% and the specificity was 86%. For mild cognitive impairment, the pooled sensitivity was 37% and specificity was 87%. In cross sectional community studies people with subjective memory problems only had 20-30% probability of concurrently having either dementia or mild cognitive impairment. Even with direct questioning, 60% of those with dementia and 62% of those with mild cognitive impairement do not report simple memory problems, suggesting that loss of awareness of change occurs early in cognitive impairement. If general practitioners asked directly about problems with memory the majority of the patient group they were trying to identify would deny any difficulty, whereas 17% of healthy adults would answer positively,

ARE SUBJECTIVE MEMORY PROBLEMS A RISK FACTOR FOR DEVELOPING DEMENTIA?

Most longitudinal studies have shown that patients with subjective memory problems have an increased risk of future cognitive decline or dementia. The risk of developing dementia if subjective memory problems are present varies, and studies use different methods to ascertain subjective and objective impairment. For example, in the Adult Changes of Thought study of 1883 people aged 65 and older, a subset with normal cognition at baseline but high levels of subjective memory problems were nearly three times more likely to develop dementia than their asymptomatic peers (odds ratio 2.7, 95% CI 1.45to4.*9S).Baseline cognitive impairment may be an important factor for progression to dementia in patients with subjective memory problems. In a study of 364 community dwelling older people without dementia, those who reported subjective memory problems at follow-up and not at baseline were nearly five times more likely to have signi ficant cognitive impairment than those without subjective memory problems at folJ ow-up (odds ratio 4.5, 95% CI 1.3 to 15.4). However, not all longitudinal studios support the view that subjective memory problems are associated with an increased risk of developingdementia. The Maastricht Aging Study, which involved 557 participants aged 55 to 8!: years, showed that although being forgetful might indicate slower general information processing and delayed recall at baseline, it did not predict cognitive change over six years.

TIMING OF HORMONE THERAPY AND DEMENTIA: THE CRITICAL WINDOW THEORY REVISITED

Whitmer RA et al _ Ann Neurol 2010

The use of hormone therapy (HT) to prevent dementia in women has been controversial, and studies have yielded mixed results. According to the "critical window theory," HT in perimenopause or early postmenopause is beneficial. Results of a preclinical study and a patient observation study lend strong support to this theory.

The information on HT and dementia from an observational cohort study of 5504 women, who were postmenopausal and reported midlife HT status at routine checkups in 1964-1973 (age range, 40-55) and were alive in 1994. Four groups were identified: no HT (45% of the sample), midlife HT (25%), late-life HT (1994-1998; 12%), and both mid- and late-life HT (18%). In 1999-2008, dementia was diagnosed in 27% of participants (median age in 1999, 80.4). The prevalence of dementia was lowest in the midlife HT group (below median age, 21%; above median age, 32%) and highest in the late-life HT group (23% and 36%, respectively). Compared with no use, HT at both times conferred a similar dementia risk (70% of patients were dementia-free), midlife HT conferred a 26% decrease in risk, and late-life HT conferred a 48% increase in risk. Women taking only late-life HT who had strokes had an increased dementia risk (63%).

The estrogen's effect on hippocampal synaptic function in ovariectomized rats showed the Estrogen that was started 9 or 15 months (but not 19 months) after ovariectomy increased synaptic function on several measures.

Comment: These two studies complement each other. Basic animal model findings substantiate a finding from a longitudinal patient cohort. HT timing seems to be critical to either preventing or accelerating dementia. Late-life HT negates any benefits of early administration. Several mechanisms of action might exist (hippocampal effects, ?-amyloid deposition, increased acetylcholine activity). With prospective controlled trials impracticable, clinicians must rely on retrospective and mechanistic findings in considering whether the potential benefits of HT justify its use.

(http://dx.doi.org/10.1002/ana.22239)

HOW DOES EDUCATION PROTECT AGAINST DEMENTIA?

Howard S. Kirshner,MD

Journal Watch Neurology Sep 28, 2010

Numerous studies have shown that higher educational levels are associated with lower dementia risk. The mechanism might be either reducing pathological changes in the brain (protection) or increasing "brain reserve" (which compensates for pathological changes). To examine these hypotheses, researchers conducted a coordinated analysis of findings from three European studies in which participants' demographic features were recorded on recruitment and neuropathological findings were studied at death. Dementia was ascertained by patient and informant interviews, medical records, and death certificates. Of 872 participants whose brains were analyzed, 56% had dementia.

Education level correlated with higher brain weight and with lower incidence of dementia but did not protect against either neurodegenerative or vascular brain pathology. Higher educational level was associated with lower incidence of dementia, regardless of the severity of pathological changes, except for the most severe. The reduction in risk for dementia with higher education level was maximal at lower brain weights. The authors concluded that education does not protect against the development of pathology but increases the reserve against dementia, up to but not including the most severe pathological changes.

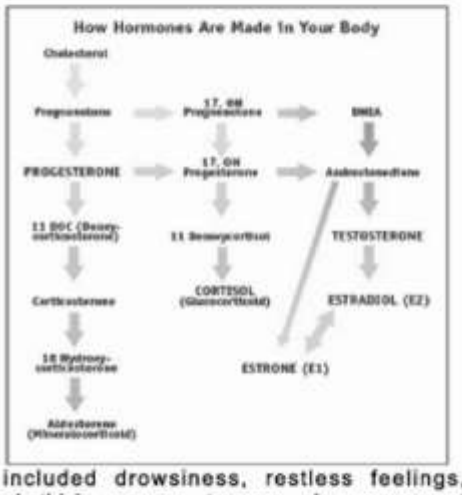
http://neurology.jwatch.org/cgi/content/full/2010/928/4

FDA OKAYS NOVEL SCHIZOPHRENIA DRUG

By Cole Petrochko - MedPage Today

The FDA has approved the novel, atypical antipsychotic lurasidone (Latuda) for the treatment of adult schizophrenia.

Approval was based on the results of four six-week trials evaluating drug safety and efficacy. Patients taking lurasidone showed fewer schizophrenia symptoms than those treated with placebo.Adverse events in the trial included drowsiness, restless feelings, akathisia, nausea, tremors, slow movement, Parkinsonism, and agitation.



"Some patients do not respond well to certain types of drug therapy, so it is important to have multiple treatment options available.Atypical antipsychotics have a boxed warning noting that off-label use may put a patient at increased risk of death, the statement said. The drug should not be used in patients with dementia-related psychosis.Lurasidone is manufactured by Sunovion Pharmaceuticals of Fort Lee, N.J.

http://www.medpagetoday.com/psychiatry/schizophrenia/23049

POLYTHERAPY INCREASES THE RISK OF INFERTILITY IN WOMEN WITH EPILEPSY

Sukumaran S, et al _ Neurology 2010

Women with epilepsy who want to have children may find it hard to become pregnant – a prospective study from India has found a high rate of infertility among epileptic women.

The study, which followed 375 women with epilepsy for up to 10 years, found that 38.4% failed to conceive.

Factors associated with a greater likelihood of being infertile included being older than 25, less than 10 years of education, and the use of three or more antiepileptic medications (P<0.05 for all).

Based on the findings of this study, women with epilepsy should be counseled about the potential risk of infertility and referred for an infertility evaluation if there is a failure to conceive.

Women with epilepsy who enrolled in India's Kerala Registry of Epilepsy and Pregnancy in the preconception phase (within 15 days of their last menstrual period) from 1998 to 2007 were followed. All of the women planned to get pregnant.

Over a follow-up of one to 10 years, among the 375 women included in the analysis, 231 became pregnant and 144 did not. Pregnancy occurred within two years for most of the women who did conceive.

Although the study did not include a control group, the researchers compared the infertility rate with that of a similarly-aged group of married women living in Kerala, finding it to be more than twice as high in the women with epilepsy (38.4% versus 15.13%).

Among the study cohort, only 3.7% were not taking any antiepileptics; most (56.2%) were on monotherapy, 22.9% were taking two drugs, and 15.5% were taking at least three epilepsy medications.

The rate of infertility increased linearly as exposure to antiepileptics increased from none (7.1%) to three or more (60.3%) (P=0.001 for trend).

Polytherapy was associated with a greater likelihood of infertility compared with monotherapy (OR 1.33, 95% CI 1.11 to 1.60).

When looking at specific drugs, the researchers found that only phenobarbital had a definite relationship with the likelihood of infertility -- both as monotherapy (OR 1.52, 95% CI 0.94 to 2.46) and as either monotherapy or polytherapy (OR 1.43, 95% CI 1.09 to 1.87).

Other antiepileptics, including valproate, did not appear to be related to infertility.

"The enzyme-inducing antiepileptic drugs like phenobarbital and carbamazepine may influence the concentration of steroid hormones and the sex hormone binding globulin, resulting in decreased bioavailability of estradiol, which in turn may lead to menstrual irregularity.

Low educational levels and being age 25 or older were both determined to be significant predictors of infertility (P<0.05 for both).

In addition, using at least three antiepileptics was associated with a greater likelihood of infertility, which "may be due to the direct adverse effect of polytherapy or the indirect effect of underlying refractory epilepsy that required polytherapy.In a statement, he said that "patients with more severe epilepsy can be expected to have a higher incidence of cognitive problems, mood disorders, and hyposexuality, which may also lead to higher rates of infertility."The study was limited by the lack of a control group, and urged that larger studies addressing demographic factors such as age and educational status need to be carried out.

http://www.medpagetoday.com/tbprint.cfm?tbid=22690

ESTIMATING RISK FOR DEVELOPING EPILEPSY: A POPULATION-BASED STUDY IN ROCHESTER, MINNESOTA

Hesdorffer DC, et al _ Neurology 2011

One in 26 Americans will develop epilepsy at some point in their lifetime, according to a population-based study. Lifetime risk up to age 50 was 1.6% and rose to 3.0% at age 80. Given the current U.S. population, nearly 12 million individuals (3.9%) can be expected to develop epilepsy in their remaining lifetime. However, the data came from individuals diagnosed 31 to 50 years ago.

The authors did the best analysis possible with the data available, but these data from a long-past era of epilepsy classification, diagnosis, and care may not reflect the current reality of neurology practice.

The study may underestimate lifetime risk of epilepsy -- particularly for males -- since life expectancy has risen in the U.S.

The lack of surveillance data gives epilepsy a disadvantage in research funding compared with other chronic conditions of similar public health impact, and hampers the public health response to it.

Epilepsy is a common, serious neurologic disorder with a major impact on public health and therefore deserves the best public health response directed by timely high-quality surveillance data.

Hesdorffer's study marks the first to measure lifetime risk (current age through remaining lifetime, adjusted for competing risk of dying) for epilepsy, which the group called useful both for physicians and public health planning as a forecast of the burden in the community.

The impact of this calculation is greatest in the elderly who have the highest incidence, an important concern given the aging population.

The group used linked medical records from all facilities in Southeastern Minnesota to identify the 412 Rochester residents with epilepsy onset (two or more unprovoked seizures) from 1960 through 1979.

More cases were diagnosed toward the later portion of the study period, "representing a trajectory of growth and aging of the population," the researchers noted. Lifetime risk -- defined as risk through age 87 -- also increased over time, from 3.5% in 1960-1969 to 4.2% in 1970-1979.

The median age at epilepsy incidence was 25.9 years, but 26.9% were 60 or older at diagnosis.

Cumulative incidence was 0.9% to age 20, 1.7% to age 50, and 3.4% to age 80. This measure diverged from lifetime risk noticeably after age 70 as competing risk of mortality grew.

Men were more likely to develop epilepsy than women (1 of 21 versus 1 of 28).

The researchers noted that these data could be used for individual risk prediction with the usual caveats that lifetime risk was based on population estimates without taking into account individual risk factors and family history.

The projections would likely generalize to other developed countries with comparable sociodemographics but not those with substantially lower life expectancy.

http://www.medpagetoday.com/24085

SELF-INJURY IN ADOLESCENTS WITH EATING DISORDERS: CORRELATES AND PROVIDER BIAS

Peebles R, et al _ J Adolesc Health 2010

If a young patient has an eating disorder, chances are he or she is also engaging in other forms of self-harm, like cutting.

Just over 40% of patients enrolled in an eating disorder program between January 1997 and April 2008 admitted to other self-injurious behaviors including cutting and burning themselves.

This implies a need for increased screening of these behaviors in adolescent patients who have eating disorders

Estimates put the percentage of adolescents who exhibit self-injurious behavior, which has been shown to be associated with eating disorders, at between 13% and 40%.

These behaviors can predict increased mortality from suicide and other causes.

Charts of 1,432 patients ages 10 to 21 who were diagnosed with an eating disorder and enrolled in a treatment program between January 1997 and April 2008.

Just over 90% of these patients were female, three-quarters of them were white, and their mean age was 15.

The researchers found that 40.8% of them reported self-injurious behavior.

That prevalence is more than the prevalence reported in the literature for the general population and consistent with studies of adult eating disorder patients.

Cutting was the most common form of self-mutilation, occurring in 85.2% of those patients.

Certain characteristics were associated with an increased risk of self-injurious behavior, including:

- being female
- having bulimia nervosa
- having a history of binging or purging
- having a history of substance abuse

More than half of those reporting self-injurious behavior engaged in purging (52.8%) and 26.8% participated in binge eating. Just over 58% said they binged and then purged.

Yet, the researcher found, healthcare providers had documented screening for harmful behaviors in fewer than half of patients.

Providers were more likely to have screened if the patient fit a profile of a self-injurer, with characteristics such as older teenage years, binging, purging, or having a history of substance use.

http://www.medpagetoday.com/Pediatrics/EatingDisorders/22621

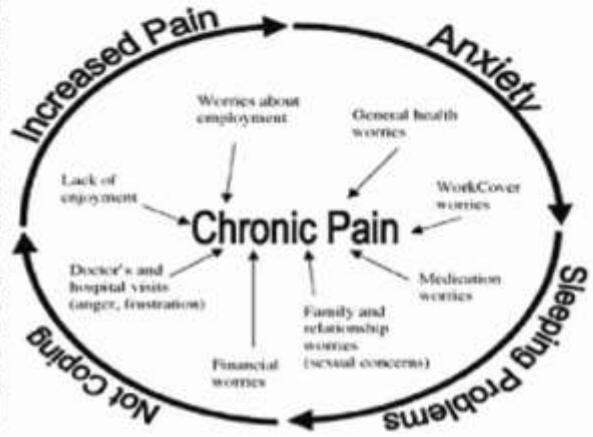
THE MISSING P IN PSYCHIATRIC TRAINING

Why It Is Important to Teach Pain to Psychiatrists

Igor Elman, MD & Colleagues - Arch Gen Psychiatry. 2011

Context Pain problems are exceedingly prevalent among psychiatric patients. Moreover, clinical impressions and neurobiological research suggest that physical ar psychological aspects of pa are closely related entitie Nonetheless, remarkably fe pain-related themes ar currently included i psychiatric residency training

Objectives To provid clinical and scientific rationa for psychiatric-trainin enrichment with basic tene of pain medicine and to rai the awareness and sensitiv of physicians, scientists, ar educators to this important unmet clinical and publ health need.



Results We present 3 lines of translational research evidence, extracted from a comprehensive literature review, in support of our objectives. First, the neuroanatomical and functional overlap between pain and emotion/ reward/ motivation brain circuitry suggests integration and mutual modulation of these systems. Second, psychiatric disorders are commonly associated with alterations in pain processing, whereas chronic pain may impair emotional and neurocognitive functioning. Third, given its stressful nature, pain may serve as a functional probe for unraveling pathophysiological mechanisms inherent in psychiatric morbidity.

Conclusions Pain training in psychiatry will contribute to deeper and more sophisticated insight into both pain syndromes and general psychiatric morbidity regardless of patients' pain status. Furthermore, it will ease the artificial boundaries separating psychiatric and medical formulations of brain disorders, thus fostering cross-fertilizing interactions among specialists in various disciplines entrusted with the care of patients experiencing pain.

http://archpsyc.ama-assn.org/cgi/search?

FULL SPECTRUM OF PSYCHIATRIC OUTCOMES AMONG OFFSPRING WITH PARENTAL HISTORY OF MENTAL DISORDER

Kimberlie Dean & Colleagues - Arch Gen Psychiatry

Context While concordant parent/offspring risks for specific mental disorders are well established, knowledge of the broader range of psychiatric outcomes among offspring with parental history of mental disorder is lacking.

Objective To examine the full range of mental health outcomes among offspring of parents with serious and other mental disorders compared with those whose parents had no such history.

Design Population-based cohort study. Offspring were followed up from their 14th birthday for the development of mental disorders based on both outpatient and inpatient hospital data.

Setting Danish population.

Participants All offspring born in Denmark between 1980 and 1994 (N = 865 078) with follow-up to December 2008.

Main Outcome Measures Incidence rates, incidence rate ratios, and cumulative incidences for offspring psychiatric outcomes.

Results Parental serious mental disorder (SMD) (nonaffective or affective psychosis) was found to be positively associated with virtually all offspring psychiatric outcomes, including those not hitherto regarded as clinically related. Offspring of parents without SMD but with a history of "other mental disorder" were also found to be at increased risk of developing a range of mental disorders. The strongest associations were found where both parents had a history of mental disorder (eg, offspring of 2 parents with SMD were 13 times more likely to develop schizophrenia). Elevated risks were not confined to concordant parent/offspring disorders (eg, offspring of 2 parents with SMD were 8 times more likely to develop substance misuse disorders).

Conclusions The impact of parental history of mental disorder was not confined to elevated offspring risk of concordant disorders but rather offspring are at increased risk of a wide range of mental disorders, particularly those with 2 affected parents. Our results imply an important role for etiological factors giving rise to broad, as well as specific, familial vulnerabilities. These findings also have potential implications for diagnostic classification.

http://archpsyc.ama-assn.org/cgi/content/abstract/67/8/822?

DOES MARRIAGE INHIBIT ANTISOCIAL BEHAVIOR?

An Examination of Selection vs Causation via a Longitudinal Twin Design

S. Alexandra Burt & Colleagues- Arch Gen Psychiatry. 2010

Context Previous studies have indicated that marriage is negatively associated with male antisocial behavior. Although often interpreted as a causal association, marriage is not a random event. As such, the association may stem from selection processes, whereby men less inclined toward antisocial behavior are more likely to marry.

Objective To evaluate selection vs causation explanations of the association between marriage and desistence from antisocial behavior.

Design Co-twin control analyses in a prospective twin study provided an analogue of the idealized counterfactual model of causation. The co-twin control design uses the unmarried co-twin of a married twin to estimate what the married twin would have looked like had he remained unmarried. Discordant monozygotic (MZ) twins are particularly informative because they share a common genotype and rearing environment.

Setting General community study.

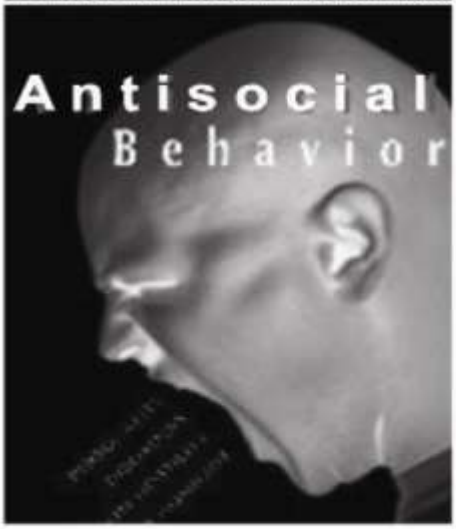
Participants Two hundred eighty-nine male-male twin pairs (65.1% MZ) from the Minnesota Twin Family Study underwent assessment at 17, 20, 24, and 29 years of age. None of the participants were married at 17 years of age, and 2.6% were married at 20 years of age. By 29 years of age, 58.8% of the participants were or had been married.

Main Outcome Measure A tally of criterion C symptoms of DSM-III-R antisocial personality disorder, as assessed via structured clinical interview.

Results Mean differences in antisocial behavior across marital status at age 29 years were present even at 17 and 20 years of age, suggesting a selection process. However, the within-pair effect of marriage was significant for MZ twins, such that the married twin engaged in less antisocial behavior following marriage than his unmarried co-twin. Results were equivalent to those in dizygotic twins and persisted when controlling for prior antisocial behavior.

Conclusions Results indicate an initial selection effect, whereby men with lower levels of antisocial behavior are more likely to marry. However, this tendency to refrain from antisocial behavior appears to be accentuated by the state of marriage.

http://archpsyc.ama-assn.org/cgi/content/abstract/67/12/1309?ct



RANDOMIZED CLINICAL TRIAL COMPARING FAMILY-BASED TREATMENT WITH ADOLESCENT-FOCUSED INDIVIDUAL THERAPY FOR ADOLESCENTS WITH ANOREXIA NERVOSA

James Lock, MD, PhD & Colleagues - Arch Gen Psychiatry. 2010

Context Evidence-based treatment trials for adolescents with anorexia nervosa are few.

Objective To evaluate the relative efficacy of family-based treatment (FBT) and adolescent-focused individual therapy (AFT) for adolescents with anorexia nervosa in full remission.

Design Randomized controlled trial.

Setting Stanford University and The University of Chicago (April 2005 until March 2009).

Participants One hundred twenty-one participants, aged 12 through 18 years, with DSM-IV diagnosis of anorexia nervosa excluding the amenorrhea requirement.

Intervention Twenty-four outpatient hours of treatment over 12 months of FBT or AFT. Participants were assessed at baseline, end of treatment (EOT), and 6 months' and 12 months' follow-up post-treatment.

Main Outcome Measures Full remission from anorexia nervosa defined as normal weight (95% of expected for sex, age, and height) and mean global Eating Disorder Examination score within 1 SD of published means. Secondary outcome measures included partial remission rates (>85% of expected weight for height plus those who were in full remission) and changes in body mass index percentile and eating-related psychopathology.

Results There were no differences in full remission between treatments at EOT. However, at both the 6- and 12-month follow-up, FBT was significantly superior to AFT on this measure. Family-based treatment was significantly superior for partial remission at EOT but not at follow-up. In addition, body mass index percentile at EOT was significantly superior for FBT, but this effect was not found at follow-up. Participants in FBT also had greater changes in Eating Disorder Examination score at EOT than those in AFT, but there were no differences at follow-up.

Conclusion Although both treatments led to considerable improvement and were similarly effective in producing full remission at EOT, FBT was more effective in facilitating full remission at both follow-up points.

http://archpsyc.ama-assn.org/cgi/content/abstract/67/10/1025

HIGH PREVALENCE OF RESTLESS LEGS SYNDROME AMONG PATIENTS WITH FIBROMYALGIA: A CONTROLLED CROSS-SECTIONAL STUDY

Viola-Saltzman M, et al _ J Clin Sleep Med 2010

Patients with fibromyalgia have a high prevalence of restless legs syndrome, which may contribute to the sleep disruption and fatigue they commonly experience, a cross-sectional study suggested.

The age- and sex-adjusted prevalence of restless legs syndrome among a cohort of fibromyalgia patients was 33% (95% CI 25.9 to 40.1) compared with 3.1% (95% CI 0 to 7.4, P<0.01) in a group of healthy controls.

Moreover, patients with fibromyalgia had significantly higher scores on the Pittsburgh Sleep Quality Index, a validated tool for rating insomnia, at 10.6 versus 4.5 (P<0.01).

Fibromyalgia and restless legs syndrome share certain features, including familial clustering, female predominance, and leg movements during sleep.

To explore a possible link between the two conditions, Viola-Saltzman and colleagues recruited 172 patients with fibromyalgia and 63 pain-free controls.

Patients' mean age was 50 years, and more than 90% were women.

Mean age among the controls was 41 years, and 56% were women.

A total of 57% of the fibromyalgia patients were married, compared with only one-third of controls, but only 29% of patients were employed compared with 73% of controls.

Restless legs syndrome was diagnosed through a self-administered diagnostic interview that required patients to meet four criteria: presence of recurrent, uncomfortable sensations in the legs while sitting or lying down; discomfort that was worse when resting; discomfort that improved with walking; and discomfort that was worse in the evening or at night. Only patients who met all four criteria were included.

The age- and sex-adjusted odds ratio for restless legs syndrome in the fibromyalgia cohort was 11.7 (95% CI 2.6 to 53, P<0.01), and in a fully adjusted model that also included marital status, employment, and education, the odds ratio remained above 11 (OR 11.2, 95% CI 2.3 to 54.6, P<0.01).

On other measures of sleep quality and pain, patients with fibromyalgia fared worse than controls:

* Insomnia Severity Index, 18.9 versus 12.1, P<0.01
* Epworth Sleepiness Scale, 9.4 versus 5.7, P<0.01
* Total body pain, 47 versus 4, P<0.01

Moreover, among fibromyalgia patients with and without restless legs syndrome, scores were worse on the Pittsburgh Sleep Quality Index for those with the syndrome (11.8 versus 9.9, P=0.01).

This indicated greater sleep impairment as a function of restless legs syndrome status. Factors that could contribute to the overlap between fibromyalgia and restless legs syndrome include sensory alterations, the use of antidepressants that can influence the dopamine system, and beneficial effects for exercise.

An important implication of the study, according to the researchers, is that restless legs syndrome is treatable with drugs such as dopamine agonists, so physicians should ask fibromyalgia patients about symptoms such as nocturnal leg movements and unpleasant sensations in the lower extremities.

Alleviating these symptoms may improve sleep and quality of life in this challenging disorder.

http://www.medpagetoday.com/22757

SEROTONIN SELECTIVELY INFLUENCES MORAL JUDGMENT AND BEHAVIOR THROUGH EFFECTS ON HARM AVERSION

Crockett MJ et al._ Proc Natl Acad Sci U S A 2010 Oct 5

When we act morally, are we controlling unwanted impulses or attempting to avoid harming others? Serotonin, by decreasing violent impulses and reactions to provocation and increasing harm aversion, may be involved in both mechanisms. Researchers have found that tryptophan depletion increases perceptions of unfairness. In placebo-controlled, double-blind, cross-over experiments, the same researchers have now compared harm aversion and fairness perception in 24 healthy volunteers with elevated levels of serotonin (from the SSRI citalopram) or norepinephrine (from atomoxetine, a reuptake inhibitor of this neurotransmitter). Subjects were rated for trait empathy.

Harm aversion was tested by the presentation of dilemmas with different degrees of personal involvement (e.g., saving 5 lives; killing an innocent individual to save 5 lives; or diverting a train, which would kill someone, to save 5 lives). With citalopram, compared with atomoxetine and placebo, subjects were more likely to rate choices involving personal harm as forbidden. In the ultimatum game, a participant must accept or reject another player's fair or unfair monetary offers. Citalopram was associated with lower rejection rates of unfair offers. In further analyses of the influence of trait empathy, the prosocial effects of citalopram in both experiments were driven by results in the high-empathy subgroup.

Comment: In these normal subjects, a serotonin-increasing drug influenced moral judgment and behavior, especially in those who are empathic, by increasing their aversion to harming others. What are the costs and benefits of this change? Being more "moral" may decrease antisocial behaviors (although antisocial individuals are unlikely to have high trait empathy). However, if people become more inclined to accept an unfair offer, they may be at risk of being exploited (and, perhaps, have increased masochistic tendencies). We should be sensitive to these subtle changes in our patients treated with SSRIs.

http://psychiatry.jwatch.org/cgi/content/full/2010/1108/2#

DEXTROMETHORPHAN PLUS ULTRA LOW-DOSE QUINIDINE REDUCES PSEUDOBULBAR AFFECT

Pioro EP et al. _ Ann Neurol 2010 Nov

Some patients with neurological disorders such as multiple sclerosis (MS) and amyotropic lateral sclerosis (ALS) experience involuntary episodes of laughing, crying, or both. These episodes have been variously termed as pathologic laughing and crying, emotional incontinence, and pseudobulbar affect. Controlled studies have demonstrated the efficacy of 30 mg of the cough medicine dextromethorphan (Dm), combined with 30 mg of the antiarrhythmic quinidine (Q; an inhibitor of cytochrome P450 2D6) to increase Dm levels. These researchers ascertained the safety and effectiveness of a much lower Q dose (10 mg). In a randomized, controlled, manufacturer-funded study, 326 patients with MS or ALS received 30 or 20 mg Dm combined with 10 mg Q (DmQ 30/10 or DmQ 20/10) or placebo for 12 weeks.

Episode frequency diminished in all groups, but significantly more so with either DmQ dose than with placebo (47%-49% reductions compared with placebo). The 12-week mean change in daily episode rate was -3.9 to -4.1 for DmQ and -3.0 for placebo. Remission (no episodes in the final 14 study days) was seen in significantly more patients receiving DmQ than placebo (about 50% vs. about 30%). Social functioning and mental health improved with the higher Dm dose. No significant electrocardiographic changes were seen.

Comment: This underrecognized clinical syndrome might affect patients with many neurological disorders. Although some publications have reported efficacy of selective serotonin reuptake inhibitors for this condition, more data exist on this new combination, approved in October 2010 by the FDA at the 20/10 dose. DmQ was well tolerated, with dizziness, nausea, diarrhea, and urinary tract infections reported as more frequent with the higher (unapproved) DmQ dose than with placebo. The medication appears both safe and effective, but clinicians might still use SSRIs initially because of their familiarity. Could DmQ be used for other indications, such as irritability or depression? These potential therapeutic uses could be explored.

http://psychiatry.jwatch.org/cgi/content/full/2010/1115/1

RECHARGING OUR SPIRITUAL BATTERY

Each day we all need to recharge our spiritual battery, otherwise the light of our consciousness becomes dim, thoughts become scattered, and decisions are filled with doubt. Power is available inside and outside. Inside us we have a spiritual centre, at the center of our consciousness, pure radiant spiritual light. This is what we are. However it is now blocked by our attachments, the record of all our life experiences and many negative beliefs and perceptions (way of looking at situations). Outside us we have the Supreme Soul, the source, the Supreme Being, invisible to our physical eyes but only one second away when we are able to quieten and focus our mind on him. Meditation connects us to both sources of power - that's why meditation is the way to access the real vitamins and the minerals that the soul longs for. Sit quietly and connect your mind to each source and allow yourself to recharge.

IMPROVED LANGUAGE PERFORMANCE IN ALZHEIMER DISEASE FOLLOWING BRAIN STIMULATION

Cotelli M, et al _ J Neurol Neurosurg Psychiatry 2010

Patients with Alzheimer's disease had significant improvement in language comprehension after four weeks of repetitive transcranial magnetic stimulation (rTMS).

A group of 10 Alzheimer patients was randomly assigned to four weeks of rTMS brain stimulation, while the other half underwent a two-week placebo treatment followed by two weeks of real rTMS stimulation.

Among patients who had four weeks of rTMS, the proportion of correct responses in a sentence comprehension test increased from 66% at baseline to 77% at two weeks (P=0.008) and remained significantly different at four weeks (P=0.04).

Sentence comprehension did not change in patients who received placebo stimulation for two weeks followed by real stimulation for an additional two weeks. The benefits of rTMS simulation persisted to 12 weeks.

The present preliminary results highlight the therapeutic potential of the induction of long-term neuromodulatory effects using brain stimulation. They hold considerable promise, not only for advancing our understanding of brain plasticity mechanisms, but also for designing new rehabilitation strategies in patients with neurodegenerative disease.

The limited effectiveness of available drug therapies for Alzheimer's disease has stimulated interest in nonpharmacologic interventions, but the neural mechanisms that may underlie the potential benefits of nondrug treatments remain largely unknown.

Neuroimaging studies have suggested that rehabilitation in patients with developmental and acquired cerebral damage may lead to functional cortical reorganization, a process mediated by plasticity mechanisms. The same mechanisms may play a role in brain aging and Alzheimer's disease.

The rTMS brain stimulation process involves delivery of magnetic pulses in rapid sequences at frequencies as high as 100 Hz. The stimulation can modulate neuronal activity in a frequency-dependent manner.

However, the long-term effects of rTMS in Alzheimer's patients have not been evaluated

A previous study suggesting improvement in naming among Alzheimer's patients treated with transcranial magnetic stimulation. On the basis of these earlier results, it was hypothesized that the stimulation might improve language performance.

A small randomized clinical study to explore the neurocognitive effects of two or four weeks of high-frequency rTMS in the left dorsolateral prefrontal cortex of Alzheimer's patients.

The study involved 10 patients who met diagnostic criteria for moderate Alzheimer's. The authors randomized the patients to four consecutive weeks of rTMS or to two weeks of placebo stimulation followed by two weeks of real stimulation.

Treatment consisted of five weekly sessions of rTMS stimulation, each lasting 20 minutes. Stimulation intensity was set to 100% of each patient's motor threshold, and 2,000 20-Hz

pulses were administered during each session.

The two groups were similar with respect to baseline demographic and clinical variables. Auditory sentence comprehension averaged 66% to 67% at baseline. Among those patients allocated to four weeks of stimulation therapy, sentence comprehension improved to 77% after two weeks (P=0.008) and remained significantly different at one month (P=0.04). Analysis of the effects of rTMS over time showed a significant difference from baseline at two, four, and 12 weeks (P=0.02).

Patients who initially received placebo stimulation showed no significant improvement in sentence comprehension at any time point.

Neither group showed improvement in other language abilities (such as naming) or in other cognitive outcomes.

"The administration of repetitive transcranial magnetic stimulation for four weeks did not result in additional improvement in performance compared with the application of repetitive transcranial magnetic stimulation for two weeks," the authors wrote.

As regards the long-term effects, we identified an improvement in sentence comprehension eight weeks after the end of the repetitive transcranial magnetic stimulation. To date, this is the first study that shows a long-lasting cognitive effect of repetitive transcranial magnetic stimulation treatments in Alzheimer's disease patients.

http://www.medpagetoday.com/tbprint.cfm?tbid=20860

FDA OKAYS BOTOX TO PREVENT MIGRAINES

By Joyce Frieden- MedPage Today

The FDA has approved onabotulinumtoxina (Botox) for prevention of migraine headaches in adults.

Chronic migraine is one of the most disabling forms of headache.Patients with chronic migraine experience a headache more than 14 days of the month. This condition can greatly affect family, work, and social life, so it is important to have a variety of effective treatment options available.When used for the new indication, the drug is given approximately every 12 weeks as multiple injections around the head and neck to try to dull future headache symptoms, the agency noted, adding that it has not been shown to work for the treatment of migraine headaches that occur 14 days or less per month, or for other forms of headache.

Interest in botulinum toxin as a potential therapy for migraine has evolved over a decade, following the observation that patients treated for hyperfunctional facial lines had a reduction in migraine symptoms.

In one small study of 18 patients published in February, patients with imploding and ocular headaches who were undergoing botulinum treatment for cosmetic procedures of the upper face saw a decrease in mean migraine frequency from more than seven a month to fewer than one. The most common adverse reactions reported by patients being treated for chronic migraine were neck pain and headache, according to the FDA.Adverse events also have been known to occur if botulinum toxin spreads to other areas of the body, including swallowing and breathing difficulties that can be life-threatening, the agency noted; however, "there has not been a confirmed serious case of spread of toxin effect whenthe drug has been used at the recommended dose to treat chronic migraine" or other conditions.The FDA approved botulinum toxin, which is made by Allergan, as treatment for flexor muscle spasm of the elbow, wrist, and fingers in adult patients.

http://www.medpagetoday.com/22781

DSM-V DRAFT PROMISES BIG CHANGES IN SOME PSYCHIATRIC DIAGNOSES

By John Gever - MedPage Today

Substantial changes are in the offing for the the Diagnostic and Statistical Manual of Mental Disorders, according to a draft of the forthcoming fifth edition.

The American Psychiatric Association (APA) has posted the draft of DSM-V on a special Web site, www.dsm5.org, to obtain comments from its members, other members of the mental health community, and the public.

Several substantial innovations proposed are:

" Recategorizing learning disorders, including creation of a single diagnostic category for autism and other socialization disorders, and replacing the controversial term "mental retardation" with "intellectual disability"

" Eliminating "substance abuse" and "substance dependence" as disorders, to be replaced with a single "addiction and related disorders" category

" Creating a "behavioral addictions" category that will include addictions to gambling but not to the Internet or sex

" Offering a new assessment tool for suicide risk

" Including a category of "risk syndromes" for psychosis and cognitive impairment, intended to capture mild versions of these conditions that do not always progress to full-blown psychotic disorders or dementia, but often do

" Adding a new disorder in children, "temper dysregulation with dysphoria," for persistent negative mood with bursts of rage

" Revising criteria for some eating disorders, including creation of a separate "binge eating disorder" distinct from bulimia

" Using "dimensional assessments" to account for severity of symptoms, especially those that appear in multiple diagnostic categories

The APA will accept comments through April 20. The work groups managing the revision will consider them and make further changes as needed to the draft.

The draft diagnostic criteria will then undergo two years of field testing. The final DSM-V is scheduled for release in May 2013.

New Categories for Dyslexia, Autism

In the area of neurodevelopmental disorders, DSM-V will put dyslexia and dyscalculia -- reflecting disabilities of reading and mathematics, respectively -- into a new category of learning disabilities.

Autism, Asperger's syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified will make up the new "autism and related disorders" category.

Substance dependence and abuse had no basis in the research on addictions.

There really isn't evidence for an intermediate stage short of addiction that is now known as abuse. Instead, there will be substance use disorders for each of the major types of drugs that cause problems, such as alcohol.

He added that the term "dependence" was problematic as a psychiatric diagnosis because some types of physical dependence are "completely normal" for some medications, such as opioid painkillers.

In fact, under the draft, DSM-V will include "discontinuation syndromes" to allow

physicians to properly assess symptoms of withdrawal from psychoactive substances, including caffeine.

He also said his work group had considered including sex and Internet addictions as disorders, but decided there was insufficient evidence to allow development of reliable diagnostic criteria for them.

Consequently, gambling addiction is slated to be the only disorder formally listed in the behavioral addictions category.

Dimensional and Risk Assessments

APA leaders also emphasized the two new suicide risk assessment scales planned for DSM-V, one for adolescents and one for adults.That suicide nearly always occurs in the context of some psychiatric disorder, but not always depression.The new risk assessment tools focus on risk factors such as impulsive behavior, heavy drinking, and chronic severe pain and illness.

The genesis of the proposed new childhood disorder, temper dysregulation with dysphoria (TDD) was also explained.About 40% to 60% of the cases [seen by child psychiatrists] will be children who are doing things that other people don't want them to do. Many of these are children who are "stubborn and resistant and disobedient and moody.

There is currently a recognized syndrome known as oppositional defiant disorder, but some children also display severe aggression and negative moods that go beyond mere stubbornness.

Such children are often tagged as having juvenile bipolar disorder, but research has shown that the label is often inappropriate, since they usually do not qualify for a bipolar disorder diagnosis when they reach adulthood, although they remain dysfunctional. More often, these children are diagnosed as depressed when they become adults.The addition of TDD would better describe the severity and frequency of irritable behavior while also recognizing the mood disorder that goes with it.Another innovation in DSM-V will be the extensive use of so-called dimensional assessments. Whereas DSM-IV relied heavily on present-absent symptom checklists, the new edition will include severity scales for symptoms, such as anxiety or insomnia that may appear to larger or smaller degrees in many different mental illnesses.

Gender Identity Disorder Stays

A closely watched issue in the DSM-V revision has been whether to change or do away with gender identity disorder, now listed in DSM-IV. In the draft, APA leaders are proposing to rename the condition "gender incongruence" for adults and children.

People who consider themselves "transgendered" have long criticized DSM-IV and previous editions for labeling them with a mental disease when their problems, they believe, are purely somatic -- that is, they have the wrong genitalia and hormonal balance. At the APA's annual meeting last May, members of the transgender community made a case for dropping gender identity disorder from DSM-V, but keeping some kind of "gender variance" diagnosis as a medical condition. Such an approach would eliminate the stigma of a psychiatric diagnosis while leaving a pathway for third-party payment for gender transition treatments.

APA officials said the organization planned more discussions with members of the transgender community.

It was stressed that further changes in many diagnostic categories are likely following the comment period and field trials.

Final revisions will be submitted in 2012 for approval by the APA's two governing bodies, the Assembly and the board of trustees.

http://www.medpagetoday.com/18399

DEEP BRAIN STIMULATION OF THE NUCLEUS ACCUMBENS FOR TREATMENT-REFRACTORY OBSESSIVE-COMPULSIVE DISORDER

Denys D et al. _ Arch Gen Psychiatry 2010 Oct

Deep brain stimulation (DBS) for refractory obsessive-compulsive disorder (OCD) usually targets behavior-generating systems like the ventral striatum or its fibers as they pass through the anterior limb of the internal capsule. These researchers addressed dysfunctional reward systems by targeting the nucleus accumbens in 16 patients with refractory OCD (illness duration, 8-46 years; 3-13 medication trials; 1-8 cognitive-behavioral therapy [CBT] trials).

Electrodes were implanted bilaterally in the nucleus accumbens. The study had three phases. The 8-month, open-label phase 1 involved active stimulation; weekly CBT started at week 8. In the double-blind, cross-over phase 2, patients were randomized to active or sham stimulation for 2 weeks and then the opposite condition for another 2 weeks. Phase 3 provided open-label active stimulation for 1 year.

At 21 months, mean OCD symptoms decreased by 52%; nine patients were responders (defined as symptom decrease, 35%), with a mean symptom decrease of 71%. In patients first receiving sham stimulation during phase 2, symptoms worsened rapidly and then improved significantly during active treatment. In contrast, in patients first receiving active stimulation, the difference between active and sham treatment was not significant, possibly because the group showed slightly worsened scores at the start of phase 2 and had a higher proportion of nonresponders. Anxiety- and depression-rating scale scores significantly decreased with active treatment. Patients with perfectionism, hoarding, or symmetry needs responded less than other patients.

Comment: OCD symptoms may result from an interaction between behavior generation and excessive depression and anxiety in response to OCD cues. Interrupting particular systems may be effective for specific OCD subtypes, although the exact syndromes that respond best to DBS in the striatum versus in the limbic system remain to be defined. As more is learned about the interventions best suited to specific refractory disorders, DBS will become more useful.

http://psychiatry.jwatch.org/cgi/content/full/2010/1108/3

ASTRAZENECA SETTLES ON QUETIAPINE CHARGES FOR $520M

By John Gever, Senior Editor, MedPage Today

AstraZeneca is paying $520 million to settle charges that it improperly marketed the antipsychotic drug quetiapine (Seroquel) for unapproved indications.

The firm will also send letters to physicians informing them of the settlement and will make public all its future payments to individual physicians, as part of an agreement with the U.S. Department of Justice and a consortium of state Medicaid agencies.

The government charged that AstraZeneca promoted the drug to physicians for a host of unapproved indications from 2001 to 2006, when it had FDA approval only for schizophrenia and, starting in 2004, manic episodes in bipolar disorder.

The unapproved uses cited by the Justice Department included aggression, Alzheimer's disease, anger management, anxiety, attention deficit hyperactivity disorder, bipolar maintenance, dementia, depression, mood disorder, post-traumatic stress disorder, and sleeplessness.

These included ghostwritten journal articles that the named authors did not write and reported studies they did not conduct.

In addition, the company allegedly paid physicians directly "to give promotional lectures to other healthcare professionals about unapproved and unaccepted uses" for quetiapine, the Justice Department said.

The $520-million payment "is the largest amount ever paid by a company in a civil-only settlement of off-label marketing claims," U.S. Attorney General Eric Holder said in a statement.

http://www.medpagetoday.com/tbprint.cfm?tbid=19794

Question on addiction, sex, psychiatric or the possession syndromes

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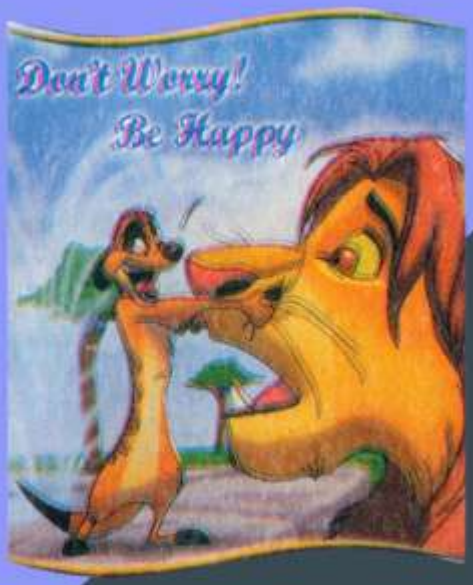

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