

PRESENT

# PSYCHIATRY UPDATE 2017

**SOLVING CLINICAL  
CHALLENGES, IMPROVING  
PATIENT CARE**

**THURSDAY, MARCH 30, 2017**

**MORNING SESSION**

**Douglas Mossman, MD, University of Cincinnati**, described malingering as intentional lying with an external incentive, such as avoiding work or obtaining drugs. He described malingered symptoms of posttraumatic stress disorder and psychosis. A detailed evaluation can reveal exaggerated and improbable symptoms with inconsistent history.

**Henry A. Nasrallah, MD, Saint Louis University School of Medicine**, discussed the difference between **typical vs atypical antipsychotics**—the former is neurotoxic, the latter is neuroprotective. Because patients with schizophrenia experience a loss of brain volume and cerebral gray



◀ George T. Grossberg, MD



◀ William B. Lawson, MD, PhD, DLFAPA, middle, receives the 2017 George Winokur Research Award for his article, "Racial differences in antipsychotic use: Claims database analysis of Medicaid-insured patients with schizophrenia," from Carol S. North, MD, MPE, DFAPA. At left: Meeting Co-chair Donald W. Black, MD

**CURRENT PSYCHIATRY** and the **American Academy of Clinical Psychiatrists** welcomed more than 500 psychiatric practitioners from across the United States and abroad to this annual conference, which was headed by Meeting Co-chairs Richard Balon, MD, and Donald W. Black, MD, March 30 to April 1, 2017, at the Marriott Chicago Magnificent Mile in Chicago, Illinois. Attendees earned as many as 18 AMA PRA Category 1 Credits™. **We welcome you to join us at Psychiatry Update Encore in Las Vegas, December 10 to 12, 2017 or next year in Chicago, March 22 to 24, 2018.**

matter and increased lateral ventricle volume, consider atypical antipsychotics for their neuroprotective properties.

**Dr. Mossman** discussed the **legal risks of using technology** in psychiatric

practice, such as Facebook, texting, e-mail, and Skype to connect with patients. Use of social media can blur boundaries and using e-mail, texting, or Skype to communicate with patients brings up issues of privacy, confidentiality, and liability.

In patients with treatment-resistant schizophrenia, **Dr. Nasrallah** asked, "What do you do when everything else fails?" Clozapine, the only drug approved for **refractory schizophrenia and suicidality**, is an underutilized medication for such patients.

**AFTERNOON SESSION**

Each day more than 1,000 people are treated in emergency departments for improper use of prescription opioids. **Mark S. Gold, MD, Washington University**, reviewed established and newer **treatments for opioid abuse**, including naloxone and naltrexone.

**Donald W. Black, MD, University of Iowa**, discussed the impact of a **personality disorder** when managing a comorbid psychiatric disorder

and compared the evidence of medications when treating comorbid personality disorders.

For **cocaine and methamphetamine abuse**, there are no effective medical treatments for overdose or relapse prevention other than traditional group and residential treatment approaches. **Dr. Gold** reviewed the neuroscience underlying stimulant abuse and evidence for **pharmacologic approaches**.

**FRIDAY, MARCH 31, 2017**

**MORNING SESSION**

Although only 9% of *Cannabis* users become dependent, **Kevin Hill, MD, MHS, McLean Hospital**, recommended talking to all patients who use *Cannabis* about the risks, such as problems with work, school, and relationships. When treating patients with ***Cannabis* use disorder**, explore reasons that the individual would want to stop using *Cannabis*, take a careful history, and most importantly, build a good therapeutic alliance.

**Marlene P. Freeman, MD, Massachusetts General Hospital**, discussed the important role mental health providers play in helping **women during pregnancy** decrease medical and obstetrical risks, such as nutrition and maintaining a healthy weight. Because one-half of pregnancies in the United States



▲ Henry A. Nasrallah, MD



are unplanned, consider medications that are compatible with pregnancy, and recommend omega-3 fatty acids and lifestyle changes such as diet.

To diagnose **premenstrual dysphoric disorder**, **Dr. Freeman** recommends asking your patient to document and rate daily moods using a mobile app or calendar. In **perimenopause**, the risk of depression increases because estrogen has antidepressant effects. Although, there are no guidelines for treating depression in women in perimenopause, consider serotonergic antidepressants, supplements such as omega-3 fatty acids, isoflavones, and black cohosh, and sleep aids for patients with insomnia—a common feature of menopause.

#### AFTERNOON SESSION

The most robust data for **medical Cannabis** is for chronic pain, neuropathic pain, and spasticity associated with multiple sclerosis; however, there are more than 70 indications among the 28 states that allow its use. **Dr. Hill** suggests having a written policy, engage in conversation about why the patient wants medical *Cannabis*, be open to evaluating such a patient, and consider treating the patient's symptoms with traditional modalities.

**Attention-deficit/hyperactivity disorder** (ADHD) and **bipolar disorder** (BD) may share an underlying biological etiology, **Jeffrey R. Strawn, MD, FAACP, University of Cincinnati**, explained. Shared risk factors include in utero events, dietary factors, and genetics. Differentiating ADHD from BD depends on the developmental stage of the patient. Symptoms overlap, which could lead to overdiagnosis of ADHD in youths with BD.

**Dr. Strawn** discussed how children with depression might display mood lability and irritability, rather than verbalizing

feelings because they do not use language effectively until age 7. Children may have somatic symptoms early and irritability might decrease into adolescence. **Anxiety disorder in children** emerges early—usually as a phobia—around age 12 to 14, with an increase in onset of depressive disorders. **Dr. Strawn** reviewed screening tools to diagnose and track anxiety symptoms, as well as the pros and cons of pharmacological treatments.

### SATURDAY, APRIL 1, 2017

#### MORNING SESSION

Psychotic symptoms could be common in older adults; therefore it is important to evaluate whether these symptoms cause emotional suffering or impairment in daily function. **George T. Grossberg, MD, Saint Louis University**, recommended that when treating **psychotic disorders in geriatric patients** to first evaluate and treat underlying medical problems and identify offending medications or environmental or psychosocial triggers, then consider psychosocial or environmental interventions. Consider antipsychotics for patients who are experiencing severe emotional distress or those who pose a high safety risk. If antipsychotics are necessary, pick an agent based on side effects, “start low, go slow,” and discuss the risks and benefits with the family.

**Somatizing patients** experience symptoms all of the time, whether a headache or nausea, but most symptoms do not have an organic cause, and they might seek treatment for any or all symptoms. The goal of treating somatizing patients is to not harm them with unneeded workup and treatment.

**Alexander W. Thompson, MD, MBA, MPH, University of Iowa Carver College of Medicine**, recommends providing a letter to the patient's primary care physician with your recommendations, which can reduce medical

costs and improve physical function. Although there are no clear pharmacotherapies, cognitive-behavioral therapy focused on health and anxiety can help.

In his presentation on **the role of psychiatrists in long-term care facilities**, **Dr. Grossberg** described common disorders including the behavioral and psychiatric symptoms of dementia, as well as risk for depression. Overprescribing is common in long-term care facilities; therefore when considering a patient's medication regimen, often less is more. **Dr. Grossberg** also discussed common undertreated or undercorrected physical health problems, including hearing or vision deficits, obstructive sleep apnea, and malnutrition.

Fatigue experienced by patients with **chronic fatigue syndrome** is unrelenting, is not the result of ongoing exertion, and is unrelieved by rest. When approaching a patient with extreme fatigue, start with a thorough evaluation in collaboration with a primary care physician, **Dr. Thompson** said. Establish a rapport with the patient, limit iatrogenic harm, and treat chronic fatigue as you would any chronic condition. Rintatolimod and valganciclovir have showed some evidence of benefit, and graded exercise therapy has shown success.

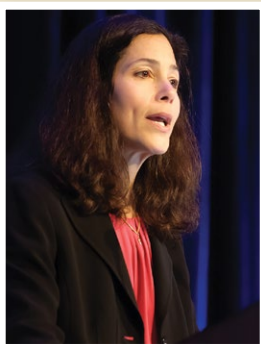
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▲ Donald W. Black, MD



◀ Marlene P. Freeman, MD

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**Come to the AACP Encore, December 10 to 12, 2017, at the Cosmopolitan Las Vegas. Visit [CPAACP-CME.com/site/encore](http://CPAACP-CME.com/site/encore) for more details.**

