Letters

ANTIPSYCHOTICS AND THE ELDERLY

"Managing dementia: Risks of using vs. not using atypical antipsychotics" (CURRENT PSYCHIATRY, August 2005, p. 14-28) presents an informative debate on atypicals' risk-benefit ratio. It is good practice to monitor all elderly patients with risk factors for cerebrovascular and cardiovascular events, regardless of which psychotropic is prescribed.

The FDA, however, has reported increased mortality with atypical antipsychotics in elderly patients with dementia-related psychosis, but not among older persons with psychosis secondary to other causes, such as schizophrenia or mood disorders. Upon reading the "Bottom Line" of this well-written article, one might erroneously generalize the FDA warning to all elderly patients.

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It was amazing that in "Managing dementia: Risks of using vs. not using atypical antipsychotics," gabapentin was never mentioned among the anticonvulsants being used to stabilize mood.

Gabapentin is by far the most benign anticonvulsant with respect to drug-drug interactions, metabolism, and protein binding (so benign that it is not effective for mania because it lacks affinity for glutamate and other receptors). Montoring gabapentin blood levels is not necessary—a plus considering that added venipuncture is not desirable in easily agitated, often combative patients with dementia. Gabapentin may also provide pain relief.

Gamma-aminobutyric acid (GABA) is, after all, the universal inhibitor. Gabapentin is structurally related to the neuroregulator, but to my knowledge its mechanism of action has not been explained.

I have had good results when giving gabapentin, 100 mg/d to approximately 1,000 mg/d in divided doses, to agitated, nonpsychotic patients with dementia. Oversedation is the main —and certainly not unexpected— adverse effect. I recommend an atypical antipsychotic only if staff or I have heard frank delusions; quetiapine appears to be the most sedating and is associated with intermediate cardiovascular and metabolic risk.

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TALK BEFORE TESTOSTERONE

In "Nothing More than Feelings?" (CURRENT PSYCHIATRY, July 2005, p. 77-91), a psychiatrist is asked to decide whether a convicted child molester should receive testosterone treatment so that he can have sex with his girlfriend.

The article demonstrates a physician's failure to do one of his or her most important functions: obtain as much information as possible before deciding on any course of treatment.

First, talk in person with the girlfriend with whom the patient says he wishes to have sexual intercourse. Does she really exist, or did the patient make up this story to obtain testosterone? What does she have to say about the patient and his sexual potency? Is she a reliable informant?

Second, talk to the patient's parole agent. He or she is legally responsible for making sure that the patient stays out of trouble. The parole agent should have much information about the patient and be able to tell the psychiatrist whom else to contact. Also, talk to anyone else—such as a family member or roommate—who might have information about the patient.

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Finally, the physicians should have tried one of the newer erectile dysfunction medications, such as sildenafil, before considering testosterone therapy.

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The authors respond

We agree with Dr. Sherman's comments and thank him for his feedback. We are happy that this important article is grabbing readers' interest.

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ADOLESCENT VIOLENCE: IT TAKES TWO

As I read your article on adolescent violence (CURRENT PSYCHIATRY, June 2005, p. 12-22), I wondered whether two adolescent profiles contribute to school-related violence.

The first group may be as described in the article: adolescents who are alienated, victims of bullying, overwhelmingly male, and prone to outbursts of homicidal violence in response to vengeful feelings.

The second group may seem more connected to others and viewed as popular by peers. The basis for their violence—which takes the form of degrading and humiliating behavior—is less evident. These individuals populate the bully group and often victimize the first group, sometimes contributing to violent responses from the victims.

I appreciate this practical paper being published in a psychiatric journal. I look forward to possible further exploration of this important topic for psychiatrists.

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