Overlooked mania

The article "Depression, medication and 'bad blood'" (Cases That Test Your Skills, Current Psychiatry, May 2007, p. 97-107) discussed a case of reduced white blood cell (WBC) count in a patient the authors ultimately diagnosed as having a mood disorder with depressive features secondary to a general medical condition. However, I believe the authors missed the extent of the patient's manic features.

The first clue was that the patient had "become increasingly irritable and volatile, often arguing with a staff nurse and other patients." This behavior possibly was iatrogenic and caused by venlafaxine treatment. The authors added lithium at a low dose of 300 mg bid (no lithium blood levels given). This measure was done to increase WBC count, but it fortuitously may have helped reduce manic symptoms. At follow-up, "after 3 months of continuous hospitalization," the patient was still described as "at times oversensitive and combative."

Missing manic symptoms because of nonclassical ways they can present is a major clinical concern. For example, a patient may feel irritable, hostile, or labile instead of expansive or euphoric. I wonder if this patient's manic symptoms could have been better controlled with titrating the lithium dose and following up by monitoring blood levels.

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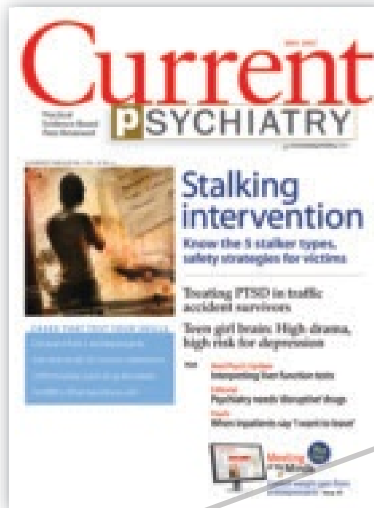
'Disruptive' corporations



May 2007

I read Dr. Henry Nasrallah's plea for "disruptive" new drugs ("Innovation deficit disorder: Psychiatry needs 'disruptive' new drugs," From the editor, Current Psychiatry, May 2007, p. 13-14) with incredulity. I do not know if Dr. Nasrallah has ties to the pharmaceutical industry, but I do know that only a fierce critic of pharmaceutical companies could credibly suggest that we take steps to make this enterprise more lucrative than it already is. With all due respect, his 3 ideas bore an uneasy resemblance to a corporate lobbyist's speaking points.

His recommendation that drug companies receive a pass in terms of product liability particularly is outrageous. I shudder to contemplate the consequences of allowing pharmaceutical companies to introduce drugs to the market with no meaningful consequences should they turn out to be unsafe or inadequately investigated.

If our government was not dominated by special interests, we might be able to spend fewer public dollars on medication purchases and more money on research. A properly funded National Institute of Mental Health (NIMH) is quite capable of independently developing innovative drugs without the encumbrance of profit seekers. If we allow the private sector to guide research and development, then we should expect continued recycling of existing treatments—or slightly tweaked versions—to treat exciting newly created niches such as jumpy leg disorder, excessive daytime apathy, and involuntary emotional unavailability syndrome. There are plenty of well-heeled, neurotic people who are eager to spend their money on such maladies, especially if advertised on television.

As Dr. Nasrallah mentioned, we applaud the profitability of high-tech or apparel companies. But there is one key difference: the consumer can choose not to purchase new clothing. Any physician who cannot appreciate this dilemma should be spending more time with patients and less with pharmaceutical representatives.

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Dr. Nasrallah responds

My editorial critiqued the pharmaceutical industry and its recent lack of innovation, but I understand its need to make a profit—like any other corporation. If a pharmaceutical company is not profitable, it will not invest in research to develop new medications.

Let's consider the following:

- *The pharmaceutical industry is the only U.S. entity developing psychiatric drugs. If we suffocate this industry, our patients might not have treatment options and we could return to locking up the mentally ill as we did before the psychopharmacology era.*

continued

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• *I would love for the National Institutes of Health (NIH) to fund psychotropic drug development, but it will never happen. The budget of the National Institute of Mental Health (NIMH) is approximately $1.6 billion, and the entire NIH budget is approximately $30 billion. To replicate pharmaceutical companies' CNS franchise, the NIMH budget would have to increase more than 50 fold to approximately $80 to $100 billion per year.*

• *I did my psychopharmacology post-residency research fellowship in neuropsychopharmacology at NIMH. If pharmaceutical companies did not exist, psychopharmacology researchers, teachers, and clinicians like myself would not be able to conduct research or teach and would not have medications to treat patients. Everybody suffers if we do not have an industry incentivized to "invent" new agents to treat serious mental illness.*

• *Gaps in knowledge about the biological causes of psychiatric brain disorders make designing and developing new treatments particularly difficult. This is why I suggested a private-public partnership between NIMH and the pharmaceutical industry to expedite progress in discovering drugs to help treat patients with any of the 88% of DSM-IV-TR diagnoses that do not have an FDA-approved drug.*

As clinicians and researchers, we must encourage innovations in drug development by any entity for the sake of our patients. At present, that entity is the for-profit pharmaceutical industry.

Henry A. Nasrallah, MD
Editor-In-Chief

DAMA dispute

As one who has been practicing acute inpatient psychiatry for approximately 20 years, I have to take issue with "'I want to leave now': Handling discharge against medical advice" (Pearls, CURRENT PSYCHIATRY, May 2007, p. 116).

Psychiatrists' power to involuntarily confine citizens needs to be exercised with the greatest care and sensitivity. Every case where a voluntary inpatient requests discharge needs to be evaluated in a careful and individualized manner that often has little to do with the items listed in the article as disqualifiers for discharge against medical advice (DAMA).

Specifically, I have seen numerous cases where patients with delusions, dementia, and even acute psychosis have been discharged despite the treatment team's wish that they stay longer because the patients did not meet criteria for involuntary hospitalization in New York. I suspect laws in other states also would have mandated these patients' discharge. The same situation has occurred with patients expressing homicidal or suicidal ideation. Many patients have chronic suicidal "ideation" but do not intend to act upon these thoughts.

I don't think the table of patient characteristics that are risk factors for DAMA has much clinical value. In fact I would venture to say that a large percentage of DAMA patients have every one of the factors listed.

This is not to say that the decision to discharge these patients is made without great deliberation. The point is that looking at a few isolated symptoms often is a misleading oversimplification. The decision is a complex process focusing on acute suicidal, violent, or criminal potential that cannot be operationalized.

I agree with the authors that "DAMA does not absolve the physician of responsibility for poor outcomes." The psychiatrist needs to carefully document the factors that lead to the decision to discharge a patient. The documentation needs to reflect that the DAMA decision was necessary given the state's statutes.

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