Current PSYCHIATRY

Improving collaboration

I read with interest Dr. Henry A. Nasrallah's perspective on the difficulties psychiatry has had in "Integrating psychiatry with other medical specialties" (From the Editor, CURRENT PSYCHIATRY, September 2010, p. 14-15). Dr. Nasrallah highlighted the "geographic separation" of psychiatric practice locations as a main barrier to integration. I strongly agree, but the geographic separation applies not only to practicing psychiatrists but also to trainees. I recently attended a lecture for psychiatrists on how to better collaborate and communicate with other physicians. I left the lecture contemplating why psychiatrists needed this lecture when communication with other physicians is an inherent part of medical practice for most physicians.

Changing the culture of poor communication must start with psychiatry training from the first day of residency. Trainees in other medical specialties work side by side, forming relationships that lend themselves to increased communication, referrals, and curbside consultation. Because psychiatry residents often train in separate locations, they might not work with physicians from other specialties. They might meet very few physicians of other specialties during training, and as a result fewer collaborative relationships are formed. This may contribute to psychiatrists' decreased willingness to call other physicians to discuss patients or ask clinical questions. In contrast, most primary care physicians know clinicians in subspecialties who they refer to or call with a question. It seems that many of these physicians do not have that same familiarity with psychiatrists, which may further contribute to the perception that our specialty is "different." Collaborative care models have been effective in mental health treatment in primary care settings,[1,2] but implementation outside of research settings has been limited.[3] Any attempt at integration is more likely to be sustainable if it also involves implementing changes during training that encourage career-long patterns of communication with our colleagues across specialties.

September 2010

Rachel Weir, MD
Clinical Assistant Professor of Psychiatry
University of Utah
Salt Lake City, UT

References

1. Unützer J, Katon W, Callahan CM, et al, for the IMPACT Investigators (Improving Mood-Promoting Access to Collaborative Treatment). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA. 2002;288(22):2836-2845.
2. Roy-Byrne P, Craske M, Sullivan G, et al. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. JAMA. 2010;303(19):1921-1928.
3. Meredith LS, Mendel P, Pearson M, et al. Implementation and maintenance of quality improvement for treating depression in primary care. Psychiatr Serv. 2006;57:48-55.

Affording self-respect

I couldn't agree more with Dr. Henry A. Nasrallah's editorial, "Integrating psychiatry with other medical specialties" (From the Editor, CURRENT PSYCHIATRY, September 2010, p. 14-15). We cannot expect our colleagues to take us seriously if we don't afford ourselves self-respect. I came from family practice to psychiatry and have found it a convoluted place with identity issues. We want to be taken seriously but separate ourselves. I am also taken aback by blurry boundaries, starting with the term "client." When did "patient" become a dirty word? We are doctors, not "friends" or "coaches." In no other field of medicine is being a doctor or patient treated as a contagion to be avoided. Patient is a sacred term that implies trust and accountability. If I strive to maintain this boundary and sacred trust by wearing my lab coat and referring to my patients as "Mr." or "Mrs." rather than by their first name, am I somehow being elitist? Our patients have enough hurdles and gray areas in their lives; the patient-doctor relationship shouldn't be 1 of them. We have a duty to walk a fine line with utmost care because our treatment is founded on that patient-doctor relationship. As a mentor once said, "In surgery they use scalpels. In psychiatry, we are the scalpels."

Elizabeth Faust, MD
Psychiatrist
Iowa City, IA

Delirium diagnosis

I appreciated "The psychotic pot smoker" (Cases that Test Your Skills, CURRENT PSYCHIATRY, September 2010, p. 42-47). There were few pointers

continued on page 50

To comment on articles in this issue or other topics, send letters in care of Christina Thomas, CURRENT PSYCHIATRY, 7 Century Drive, Suite 302, Parsippany, NJ 07054, christina.thomas@qhc.com or visit CurrentPsychiatry.com and click on the "Send Letters" link.

continued from page 5

that suggested looking for benzodiazepine or alcohol withdrawal, especially because the authors lacked a reliable history from the patient. They mentioned that the patient had mild tachycardia (101 bpm), elevated blood pressure (149/57 mm Hg), orientation to name (and I assume disoriented to place and time), and hyperreflexia (due to GABA effect).

One differential diagnosis was missing: delirium. I did not read about cognitive testing in this patient with a differential diagnosis of delirium; maybe a clock test would have done some good.

I would have approached this case as delirium and then proceeded with lab and imaging tests. Elevated white blood cell count and creatine phosphokinase test were distractors (lumbar puncture and electroencephalography can be justified). How would you justify giving diphenhydramine to a patient with delirium, considering that it might worsen confusion or agitation?

I agree, however, that this case was complex and can't help but emphasize that benzodiazepine or alcohol withdrawal is a simple condition that can be life-threatening if missed.

Ghazanfar Khan, MD
PGY-IV, Psychiatry
University of Mississippi Medical Center
Jackson, MS

Substance abuse clarifications

"How to manage medical complications of the 5 most abused substances" (Current Psychiatry, November 2009, p. 35-47) contains several errors of fact, emphasis, and inappropriate citation of references that may mislead readers.

The article states "marijuana use can double or triple the risk of cancer

November 2009

of the respiratory tract and lungs" and cites a reference by Tashkin et al.[1] In fact, that review article states " … evidence that marijuana smoking may lead to … respiratory cancer is limited and inconsistent." A subsequent case-control study by Tashkin and colleagues found no increased risk of lung or upper respiratory tract cancer among heavy marijuana smokers.[2] A smaller case-control study from New Zealand did find an 8% increased risk of lung cancer associated with each joint-year of marijuana smoking.[3] However, the Current Psychiatry article grossly exaggerated the cancer risk from marijuana smoking and cited an inappropriate supporting reference.

The article states that "growing evidence shows that marijuana use could lead to cardiac arrhythmias, such as atrial fibrillation" and cites 1 supporting reference.[4] That article reviewed the 6 published cases of atrial fibrillation (AF) associated with marijuana smoking and acknowledged "the exact incidence of AF related to marijuana smoking is difficult to be estimated." Other reviews of the cardiovascular effects of marijuana smoking take a broader view, eg, "marijuana's cardiovascular effects are not associated with serious health problems for most young, healthy users."[5] Given the ratio between 6 published case reports and the millions of people smoking marijuana daily, this may be a more appropriate perspective for a review article.

The article states "some studies show persistent cognitive impairments in longer term cannabis users, even after 2 years of abstinence" and cites 1 supporting reference by Pope et al[6] (incorrectly cited as Harrison et al). In fact, that study did not test subjects beyond 28 days of abstinence; at the time, "the differences between users and controls had narrowed and were mostly nonsignificant." Other studies have found no significant differences between marijuana smokers and non-users after 3 months of abstinence,[7] nor are significant long-term cognitive deficits mentioned in recent reviews of the topic.[8] Thus, we are not aware of any scientific basis for the statement in the article, which is not supported by the 1 study cited.

The paragraph on "cardiac complications" of cocaine use presents an incomplete picture of the risk of myocardial infarction (MI) and cites only 1 (2001) review article. What would have been useful to the reader was:

- cocaine-associated MI occurs in up to 6% of patients with cocaine-associated chest pain[9]
- cocaine-associated MI may have atypical symptomatic presentation, eg, without chest pain[9]
- in a large, population-based study, adults age 18 to 45 who used cocaine >10 times had a 3.5-fold increased risk of MI[10]
- two-thirds of MIs occur within 3 hours of cocaine ingestion, but MI may occur >18 hours after ingestion

To comment on articles in this issue or other topics, send letters in care of Christina Thomas, Current Psychiatry, 7 Century Drive, Suite 302, Parsippany, NJ 07054, christina.thomas@qhc.com or visit CurrentPsychiatry.com and click on the "Send Letters" link.

(possibly due to pharmacologically active cocaine metabolites).[9] The recent review by McCord et al,[9] which includes treatment recommendations from the American Heart Association, would have been useful to cite.

Most readers of Current Psychiatry are not specialists in the topics covered by its review articles. This places increased responsibility for ensuring accurate and balanced topic coverage with citation of appropriate, up-to-date review articles.

David A. Gorelick, MD, PhD
National Institute on Drug Abuse
Baltimore, MD

References

1. Tashkin DP. Smoked marijuana as a cause of lung injury. Monaldi Arch Chest Dis. 2005;63(2):93-100.
2. Hashibe M, Morgenstern H, Cui Y, et al. Marijuana use and the risk of lung and upper aerodigestive tract cancers: results of a population-based case-control study. Cancer Epidemiol Biomarkers Prev. 2006;15(10):1829-1834.
3. Aldington S, Harwood M, Cox B, et al. Cannabis use and risk of lung cancer: a case-control study. Eur Respir J. 2008;31(2):280-286.
4. Korantzopoulos P, Liu T, Papaioannides D, et al. Atrial fibrillation and marijuana smoking. Int J Clin Pract. 2008;62(2):308-313.
5. Jones RT. Cardiovascular system effects of marijuana. J Clin Pharmacol. 2002;42(11 suppl): 58S-63S.
6. Pope HG Jr, Gruber AJ, Hudson JI, et al. Cognitive measures in long-term cannabis users. J Clin Pharmacol. 2002;42(11 suppl):41S-47S.
7. Fried PA, Watkinson B, Gray R. Neurocognitive consequences of marihuana—a comparison with pre-drug performance. Neurotoxicol Teratol. 2005;27(2):231-239.
8. Schweinsburg AD, Brown SA, Tapert SF. The influence of marijuana use on neurocognitive functioning in adolescents. Curr Drug Abuse Rev. 2008;1(1):99-111.
9. McCord J, Jneid H, Hollander JE, et al. Management of cocaine-associated chest pain and myocardial infarction: a scientific statement from the American Heart Association Acute Cardiac Care Committee of the Council on Clinical Cardiology. Circulation. 2008;117(14):1897-1907.
10. Aslibekyan S, Levitan EB, Mittleman MA. Prevalent cocaine use and myocardial infarction. Am J Cardiol. 2008;102(8):966-969.

The authors respond

Dr. Gorelick's detailed comments brought up many points, which we address below.

***Marijuana and cancer**—Dr. Gorelick commented that the article "grossly exaggerated the cancer risk from marijuana smoking" due to the cited reference stating that the evidence is "limited and inconsistent." We agree the article mentions the evidence is not clear. However, in further reading of their discussion of the risk of lung cancer the authors point to several epidemiologic studies, some of which showed increased risk of cancer. Specifically, a study from the United States showed "a history of daily or near-daily marijuana smoking was associated with a 2.6-fold greater risk for developing head and neck cancer."*

In our article we focused more on the positive results than on the entire picture and would have served our readers better by not making such an equivocal statement about the increased risk of cancer.

***Marijuana and AF**—Dr. Gorelick questioned the tenacity of the association between marijuana and AF, stating "given the ratio between 6 published cases reports and the millions of people smoking marijuana daily, this may be a more appropriate perspective for a review article."*

Our comments were based on the following statements from the cited study: "During the past few years an increasing number of case reports indicate an association between marijuana smoking and the development of AF." Also, "despite the small number of these reports, the observed close temporal relationship between marijuana smoking and AF occurrence, especially in young people without structural heart disease or other precipitating factors for AF, strongly supports an association between the two conditions."

We mentioned AF because this is not something most people consider as a side

effect of marijuana and we felt it was useful to call attention to it as a potential complication. However, we do agree that the sentence could have been worded differently because the number of cases remains low and the risk of developing AF in young healthy adults is low.

Marijuana and cognitive effects— *Dr. Gorelick commented that there is "no scientific basis for the statement in the article" and that the article cited looked only at 28 days post-cannabis use. The following comments were made in the article we cited: "However, one electroencephalographic study suggested greater abnormalities in longer term cannabis users, and another found a strong correlation between performance on a selective attention task and duration of cannabis use, even in users abstinent for a mean of 2 years."*

Also, that article concluded "… an opposite impression emerges from a recent large, carefully controlled study by Solowij et al, who found that longer term cannabis users showed significantly greater deficits on several neuropsychological measures than shorter term users, and that these measures were often negatively correlated with lifetime duration of use."

Again, we agree that our comment was likely too broad because the evidence is limited and not clear, which is why we wrote, "However, most studies suggest that marijuana-associated cognitive deficits are reversible and related to recent exposure."

Cocaine and cardiac complications—*We thank Dr. Gorelick for providing additional information and resources about the very important association between cocaine use and the MI risk. We certainly agree that the inclusion of his suggested references would have been appropriate.*

Raheel Khan, DO
Assistant Clinical Professor
Psychosomatic Medicine
Department of Psychiatry
and Behavioral Sciences

Robert M. McCarron, DO
Training Director, Internal Medicine/
Psychiatry Residency
Department of Psychiatry
and Behavioral Sciences
Department of Internal Medicine
University of California, Davis
Sacramento, CA

Psychiatry's best hope

In Dr. Henry A. Nasrallah's "Psychiatric futurology" (From the Editor, Current Psychiatry, July 2010, p. 9-10) he seems to suggest that the best hope for the future of psychiatry is continued advances in neuroscience. I contend that clinical outcomes for patients with schizophrenia and bipolar disorder have remained static despite high-profile advances. Perhaps psychiatry's orientation has moved too far in favor of biologic approaches and our patients would be better served by improving psychosocial approaches, such as assertive community treatment and supportive employment. These approaches, enacted in partnership with allied mental health providers, can act synergistically with biologic approaches, leading to wellness and recovery through community integration. Such an approach may provide the best hope for the future success of psychiatry.

Walter Rush, MD
South-Metro Human Services ACT
St. Paul, MN

Off-label bupropion

"Bupropion: Off-label treatment for cocaine and methamphetamine addiction" (Pearls, Current Psychiatry, July 2010, p. 52) was a well-written, succinct article addressing a pharmacologic treatment in a difficult population. Bupropion has been utilized to target cravings associated with cocaine and methamphetamine addiction with mixed success.[1] Hopefully the cocaine vaccine mentioned in the article will be approved, which will provide clinicians with another agent for treating dual diagnosis patients.

Timothy R. Berigan, DDS, MD
Contract Psychiatrist
Behavioral Health Services
Fort Huachuca, AZ

Reference

1. Berigan TR. The many uses of bupropion and bupropion sustained release (SR) in adults. Prim Care Companion J Clin Psychiatry. 2002;4(1):30-32.

Appreciating med checks

I read with great appreciation Dr. Douglas Mossman's column, "Successfully navigating the 15-minute 'med check'" (Malpractice Rx, Current Psychiatry, June 2010, p. 40-43). At first I thought Dr. Mossman believed this practice is inferior care, but I was grateful to see that this is not necessarily so. I have been working to make my med checks "strength-based" and therapeutic despite the brevity, and greatly admire my patients' tenacity despite their suffering. Thank you for legitimizing the work done by community psychiatrists.

Linda J. Griffith, MD
Chief Medical Officer
Consolidated Care, Inc
Assistant Clinical Professor
Department of Psychiatry
Wright State University
Boonshoft School of Medicine
Dayton, OH