Minimizing metabolic risks

We enthusiastically read Dr. Nasrallah's December editorial ("Why are metabolic guidelines being ignored?" Current Psychiatry, From the Editor, December 2012, p. 4-5; http://bit.ly/FTE1212) on the importance of metabolic monitoring. Psychiatrists are prescribing second-generation antipsychotics (SGAs) to a growing number of patients to treat a range of psychiatric disorders and symptoms. SGAs have several advantages over first-generation antipsychotics. Improvements in negative symptoms, fewer extrapyramidal symptoms, and more recently, evidence suggesting better relapse prevention have been noted,[1] yet there is growing concern regarding their propensity to cause weight gain and induce insulin resistance and dyslipidemia. The importance of such cardiometabolic effects cannot be underestimated.

Among individuals attending public mental health clinics, up to 27% are overweight, 51% have elevated triglycerides, and 52% meet diagnostic criteria for metabolic syndrome.[2] Because many psychiatrists prescribe SGAs to patients who are in late adolescence or early adulthood, rapid increased weight gain during these years may lead to increased stigma, psychological anguish, and worse clinical outcomes.[3] Weight gain has been shown to be a significant factor in medication compliance.[4]

Resident education and quality improvement projects have demonstrated some improvements in enhancing metabolic screening for our patients.[5] Unfortunately, significant barriers persist—eg, challenges in communicating between specialties, time constraints in clinics, and limitations in residency didactics. These medications are associated with significant cardiometabolic risks, and current monitoring practices generally are suboptimal.

Residency training is the best time to begin incorporating metabolic monitoring into patient care to establish it as a career-long practice. We would like to see a greater emphasis on developing a curriculum to promote resident understanding and practice in regard to metabolic monitoring when prescribing SGAs.

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References

1. Nasrallah HA. Atypical antipsychotic-induced metabolic side effects: insights from receptor-binding profiles. Mol Psychiatry. 2008;13(1):27-35.
2. Correll CU, Druss BG, Lombardo I, et al. Findings of a U.S. national cardiometabolic screening program among 10,084 psychiatric outpatients. Psychiatr Serv. 2010;61(9):892-898.
3. De Hert M, Peuskens B, van Winkel R, et al. Body weight and self-esteem in patients with schizophrenia evaluated with B-WISE. Schizophr Res. 2006;88(1-3):222-226.
4. Weiden PJ, Mackell JA, McDonnell DD. Obesity as a risk factor for antipsychotic noncompliance. Schizophr Res. 2004;66(1):51-57.
5. Wiechers IR, Viron M, Stoklosa J, et al. Impact of a metabolic screening bundle on rates of screening for metabolic syndrome in a psychiatry resident outpatient clinic. Acad Psychiatry. 2012;36(2):118-121.

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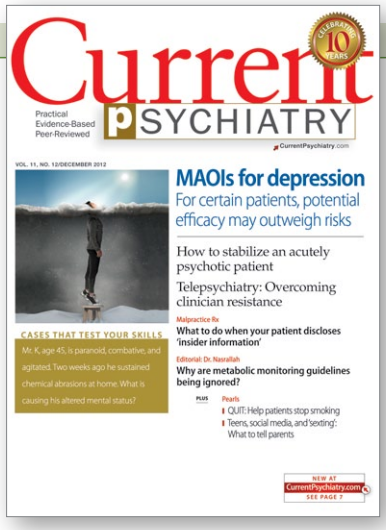
Paying for metabolic tests

Regarding Dr. Nasrallah's excellent editorial ("Why are metabolic guidelines being ignored?" From the Editor, Current Psychiatry, December 2012, p. 4-5; http://bit.ly/FTE1212): The next step is to get insurance companies, the Veterans Administration (VA), and the government to recognize that persons with "behavioral" illnesses may need a psychiatrist to identify and treat physical illnesses to comprehensively address—and in some cases, cure—the patient's behavioral problem.



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It is maddening that some insurance companies categorize mental illnesses apart from physical illnesses and will not process nonmental health service codes submitted by psychiatrists. Psychiatrists get chastised by insurance companies, the VA, and the government for ordering too many laboratory tests, as if there were no need for patients with mental illnesses to undergo metabolic monitoring. If the test is not reimbursed, then the test is not ordered. If psychiatrists are demeaned by mainstream medicine for holistically caring for their patients, then it's no wonder psychiatry is a specialty on its way out.

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See this article at
CurrentPsychiatry.com
for Dr. Nasrallah's response and a letter on working with NPs

Dr. Nasrallah responds

I thank Drs. Goldsmith and Vahabzadeh and Mr. Mertz for their letters.

Psychiatrists and nurse practitioners routinely order lab tests for patients as part of a physical assessment before starting any medication, whether at baseline or follow-up. Third-party payers cover complete blood counts, liver function tests, kidney function tests, and other tests. Thus, metabolic monitoring tests—including fasting glucose, fasting triglycerides, and fasting high-density lipoprotein—are no exception.

Any insurer who refuses to reimburse those tests for a patient receiving atypical antipsychotics can be liable in a court of law, especially in light of FDA recommendations.

Henry A. Nasrallah, MD
Editor-in-Chief

Working with NPs

I want to acknowledge the foresight of Current Psychiatry's editorial staff in publishing "How to collaborate effectively with psychiatric nurse practitioners" (Current Psychiatry, November 2012, p. 49-53; http://bit.ly/NPs23). Your article was the first of its kind that I have read published in a national psychiatry journal.

Having trained at Children's Psychiatric Hospital at the University of Michigan, I also am proud of the article's authors, who are associated with my alma mater's psychiatry department. Nursing schools should increase their efforts to bring affordable, quality mental health services to all via the innovative role of collaborator.

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