Current PSYCHIATRY

AMERICAN ACADEMY OF CLINICAL PSYCHIATRISTS

PSYCHIATRY UPDATE 2013

SOLVING CLINICAL CHALLENGES, IMPROVING PATIENT CARE

CURRENT PSYCHIATRY and the American Academy of Clinical Psychiatrists were pleased to host more than 550 psychiatric practitioners for this conference, led by Meeting Chair Richard Balon, MD, and Meeting Co-Chairs Donald W. Black, MD, and Nagy Youssef, MD, April 4-6, 2013 at the Swissôtel in Chicago, IL. Attendees could earn up to *18 AMA PRA Category 1 Credits*™.

▲ Roger S. McIntyre, MD, FRCPC

▲ Kathleen Brady, MD, MPH

THURSDAY, APRIL 4, 2013

MORNING SESSIONS

Evidence-based medicine and treatment guidelines may not address complex patients with treatment-resistant depression (TRD). **Andrew A. Nierenberg, MD, Massachusetts General Hospital**, reviewed newer medications for TRD, including olanzapine-fluoxetine combination, ketamine, riluzole, and L-methylfolate; however, use of these medications requires careful consideration of risks and benefits.

Many FDA-approved drugs have a "black-box" warning, but still are widely used. **Henry A. Nasrallah, MD, University of Cincinnati**, reviewed black-box warnings for antipsychotics, antidepressants, mood stabilizers, benzodiazepines, stimulants, opiates, and hypnotics and offered strategies on how to incorporate these warnings into clinical practice.

Dr. Nierenberg discussed the outcomes of 3 published medication effectiveness studies for bipolar disorder (BD)—STEP-BD, BALANCE, and LiTMUS—and one currently underway, CHOICE. These studies examined monotherapy and combination therapy with antidepressants, anticonvulsants, antipsychotics, and psychosocial interventions.

Although there is an association between psychosis and violence, most psychotic patients are not violent. **Rajiv Tandon, MD, University of Florida**, reviewed modifiable and nonmodifiable risk factors for violence, key clinical questions to consider, and scales to use when assessing a patient's risk of violence.

AFTERNOON SESSIONS

Measuring biomarkers can augment other clinical methods to help identify metabolic, structural, and functional brain changes associated with preclinical stages of cognitive disorders. **James Ellison, MD, MPH, McLean Hospital, Harvard Medical School**, explained how biomarkers can improve the differential diagnosis of memory impairments and aid in identifying different types of dementia.

Case-control studies have found a strong association between schizophrenia and type II diabetes, which contributes to higher mortality among schizophrenia patients. Along with vigilant metabolic monitoring, **Dr. Tandon** recommended a therapeutic approach that includes changing antipsychotics, prescribing metformin, suggesting lifestyle interventions, and treating comorbid conditions.

▲ George T. Grossberg, MD, (left) speaks with attendees

Depressed older adults may report anxiety, hopelessness, anhedonia, or somatic symptoms, rather than sadness. Depressive symptoms may be associated with vascular disease or cognitive impairment. **Dr. Ellison** reviewed psychotherapeutic and pharmacologic treatments for older depressed patients.

FRIDAY, APRIL 5, 2013

MORNING SESSIONS

Many strategies exist for treating patients with TRD; adding an atypical antipsychotic has the best evidence, but there are tolerability considerations. **Dr. Nierenberg** suggested using a combination of treatments.

Pregnancy is inherently risky for women who take antipsychotics. In all patients of childbearing potential, take a thorough reproductive history and ask about contraception use. **Marlene P. Freeman, MD, Massachusetts General Hospital**, explained that psychotropics with unfavorable FDA pregnancy ratings may be among first-line choices.

Clinical symptoms, cognitive deficits, psychiatric comorbidities, genetic factors, neuroimaging features, and pharmacotherapy may overlap considerably between schizophrenia and BD. **Dr. Nasrallah** described clinical features that differentiate the 2 disorders.

Cognitive enhancers can improve activities of daily living, behavior, and cognition in patients with Alzheimer's disease. **George T. Grossberg, MD, St. Louis University**, reviewed the evidence for acetylcholinesterase inhibitors, the NMDA

Donald W. Black, MD, (right) receives the 2013 George Winokur Research Award from Carol S. North, MD, for his article on pathological gambling

receptor antagonist memantine, combination therapy, and atypical antipsychotics.

Dietary consultation for older patients might help delay or decrease their risk of dementia. Patients should consume omega-3 fatty acids, whole grains, fresh fruits and vegetables, beans, legumes, and certain spices. **Dr. Grossberg** also suggested patients engage in physical and mental exercises, social and spiritual activities, and stress reduction, and control cardiovascular risk factors.

AFTERNOON SESSIONS

Many women experience anxiety during pregnancy, and the risk is highest during the first trimester. **Dr. Freeman** reviewed prevalence, diagnosis, and treatment of panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and posttraumatic stress disorder during pregnancy and postpartum.

Kathleen Brady, MD, PhD, Medical University of South Carolina, explained how methylenedioxypyrovalerone, also known as bath salts, and other designer drugs are not detectable on standard urine drug screens. Agitation, tachycardia, combative behavior, hyperthermia, and hallucinations have been reported.

Alcohol abuse and depression are highly comorbid and are associated with higher suicidality, more severe symptoms, and poorer treatment response than either disorder alone. Depressive symptoms often are seen during alcohol withdrawal, and may resolve with abstinence. **Dr. Brady** reviewed the evidence for treating depressed alcoholics with antidepressants, medications targeting alcohol dependence such as disulfiram and naltrexone, and psychotherapy.

Ralph Aquila, MD, Columbia College of Physicians and Surgeons, discussed risk factors for and consequences of treatment nonadherence in patients with schizophrenia. **Leslie L. Citrome, MD, MPH, New York Medical College**, covered strategies to improve adherence, including identifying and addressing barriers to adherence for individual patients, improving the therapeutic alliance, and considering long-acting injectable antipsychotics.

SATURDAY, APRIL 6, 2013

MORNING SESSIONS

Forty-six percent of depressed patients will stop pharmacotherapy before they have a chance to respond. To minimize short-term side effects, **Andrew J. Cutler, MD, Florida Clinical Research Center**, suggested educating patients and slowly titrating medications; options for reducing long-term side effects or residual symptoms include switching or augmenting pharmacotherapy.

When treating patients addicted to opioids, outcome measures go beyond general health to obtaining employment and reducing criminal activity. Pharmacotherapy options include methadone maintenance therapy, oral and injectable naltrexone, and oral, sublingual, and implantable buprenorphine. **Walter Ling, MD, David Geffen School of Medicine at UCLA**, described factors that may improve patient outcomes.

Geriatric BD is relatively common in clinical settings, but there is a lack of evidence-based clinical practice guidelines. **James W. Jefferson, MD, University of Wisconsin School of Medicine and Public Health**, recommended choosing a treatment based on the illness phase and balancing the benefit of certain pharmacotherapies against short- and long-term risks.

Most medications for treating alcohol dependence work by modulating functions of opioids, glutamate, GABA, and serotonin. **Dr. Ling** reviewed the evidence base, dosing guidelines, and clinical recommendations for disulfiram, oral and injectable naltrexone, and acamprosate, which are FDA-approved for treating alcohol dependence. He also recommended combining medications with nonpharmacologic treatments, such as 12-step programs.

Most people who die by suicide deny suicide ideation at their last mental health visit. Risk factors for suicide include family history of suicide, childhood or adult trauma, substance abuse, stressful life events, chronic illness, and psychiatric disorders. **Dr. Jefferson** described suicide rating and tracking scales and encouraged clinicians to document suicide risk evaluations.

AFTERNOON SESSION

Robert M.A. Hirschfeld, MD, University of Texas Medical Branch, discussed how the concept of allostatic load—bodily "wear and tear" that emerges with sustained allostatic states—may help explain cognitive and physical decline associated with BD. **Roger S. McIntyre, MD, FRCPC, University of Toronto**, emphasized that BD is a progressive disorder and comorbidities such as metabolic problems may promote this progression. **Terence A. Ketter, MD, Stanford School of Medicine**, covered new developments in BD treatment, including certain second-generation antipsychotics, dopaminergic neurotransmission enhancers, mood stabilizers, adjunctive antidepressants, and adjunctive psychotherapy.

COULDN'T ATTEND?
Visit CurrentPsychiatry.com/AACP for more details