

Study: Gambling Common Among Disabled

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WASHINGTON — People with intellectual disabilities do exhibit pathological gambling behavior, and gambling in general is common in this population, a study of 79 people in the Las Vegas area shows.

Two of the study participants (2.5%) met DSM-IV-TR criteria for pathological gambling. This rate is comparable with

rates identified for the state of Nevada, which range from 2.7% to 4.3%. In addition, five study participants met the criteria for problem gambling (6.3%), which also was comparable with the rates identified for Nevada (2.2%-3.6%), Dr. Coni Kalinowski of the University of Nevada, Las Vegas, reported at the annual meeting of the American Psychiatric Association.

For this survey, the researchers modified the Gambling Symptom Assessment Scale (G-SAS) and the Structured Clinical Inter-

view for Pathological Gambling (SGI-PG) to make them more suitable for individuals with intellectual disability. The researchers also performed a health screening to identify psychiatric diagnoses, common medical/neurological conditions, and any psychotropic medications used.

Participants in this study included those aged 21 years and older who had a documented intellectual disability with full-scale IQ of 75 or less. Intellectual disabilities include mental retardation from any

cause, autism spectrum disorders, refractory epilepsy, cerebral palsy, and permanent cognitive impairment occurring before the age of 18. These individuals had to be their own guardians (because of state requirements). All participants were clients of a dual diagnosis clinic in Las Vegas.

In all, data were collected for 79 individuals (53% female). Most were white (66%), followed by African American (23%), Hispanic/Latino (9%), and Asian and Pacific Islander (1% each). The ma-

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Important Safety Information (continued)

- A potentially fatal symptom complex, sometimes referred to as Neuroleptic Malignant Syndrome (NMS), has been reported in association with administration of antipsychotic drugs, including SEROQUEL. Rare cases of NMS have been reported with SEROQUEL. Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. The management of NMS should include immediate discontinuation of antipsychotic drugs
- Tardive dyskinesia (TD), a potentially irreversible syndrome of involuntary dyskinetic movements, may develop in patients treated with antipsychotic drugs. The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and total cumulative dose of antipsychotic drugs administered to the patient increase. TD may remit, partially or completely, if antipsychotic treatment is withdrawn. SEROQUEL should be prescribed in a manner that is most likely to minimize the occurrence of TD
- Hyperglycemia, in some cases extreme and associated with ketoacidosis, hyperosmolar coma, or death, has been reported in patients treated with atypical antipsychotics, including SEROQUEL. The relationship of atypical use and glucose abnormalities is complicated by the possibility of increased risk of diabetes in the schizophrenic population and the increasing incidence of diabetes in the general population. However, epidemiological studies suggest an increased risk of treatment-emergent, hyperglycemia-related adverse events in patients treated with atypical antipsychotics. Patients starting treatment with atypical antipsychotics who have or are at risk for diabetes should undergo fasting blood glucose testing at the beginning of and periodically during treatment. Patients who develop symptoms of hyperglycemia should also undergo fasting blood glucose testing
- Leukopenia, neutropenia, and agranulocytosis (including fatal cases), have been reported temporally related to atypical antipsychotics, including SEROQUEL. Patients with a pre-existing low white blood cell (WBC) count or a history of drug induced leukopenia/neutropenia should have their complete blood count monitored frequently during the first few months of therapy. In these patients, SEROQUEL should be discontinued at the first sign of a decline in WBC absent other causative factors. Patients with neutropenia should be carefully monitored, and SEROQUEL should be discontinued in any patient if the absolute neutrophil count is < 1000/mm³
- Precautions include the risk of seizures, orthostatic hypotension, and cataracts. Examination of the lens by methods adequate to detect cataract formation, such as slit lamp exam or other appropriately sensitive methods, is recommended at initiation of treatment, or shortly thereafter, and at 6-month intervals during chronic treatment

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majority of participants were younger than 40 years (70%). Overall, 89% reported ever gambling and 71% reported gambling in the past year. These numbers were comparable with the Nevada population.

Most of the problem gamblers (71%) were between the ages of 21 and 39 years. Most of the problem gamblers were female (86%). Problem gamblers (those who met criteria for pathological or problem gambling) differed from their nonproblem gambling counterparts in several ways. Problem gamblers were more likely to live in the family home (57%), compared with other study subjects (18%). Most of the participants without problem gambling

(60%) lived in group residences. None of the problem gamblers lived independently, compared with almost a quarter of those without problem gambling (24%).

Problem gamblers were somewhat more likely to use highly accessible venues, like grocery stores. Problem gamblers also were more likely to gamble alone—43% versus 24% for nonproblem gamblers. Those without problem gambling were more likely to gamble with family. “While both groups frequently gambled with friends or staff, we also learned that very often group-home staff would use gambling as a positive reinforcer,” Dr. Kalinowski said.

Nearly all gamblers had played slots or electronic game machines. In addition, scratch cards and bingo were common among all gamblers. Both groups predominantly gambled \$5-\$20 per episode.

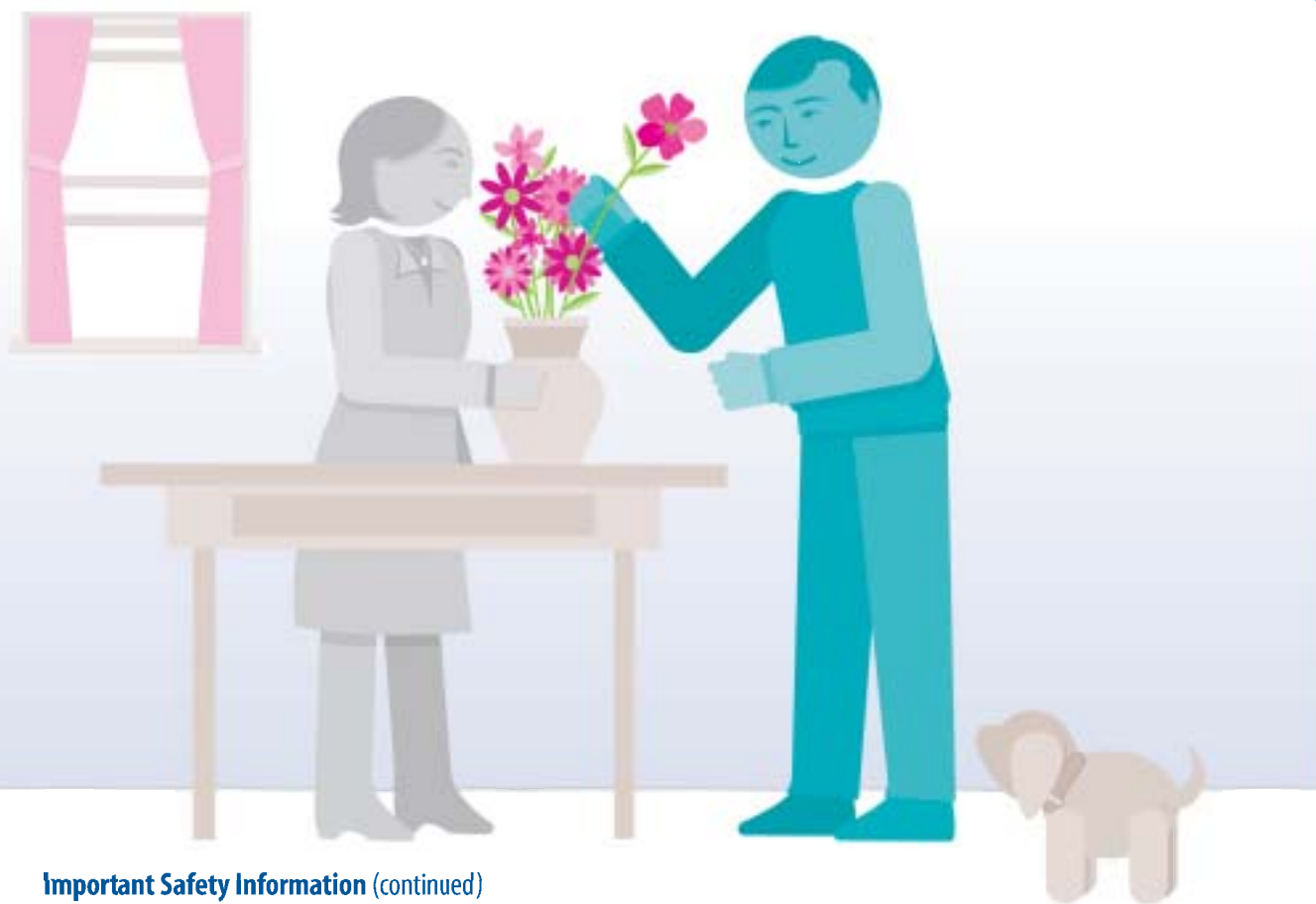
However, problem gamblers (29%) were more likely to have wagered larger amounts than those without problem gambling (8%).

None of the problem gamblers reported using alcohol while gambling. Roughly a quarter of participants admitted to gambling more money than they wanted, thinking about gambling when they didn't want to, or borrowing money to gamble, Dr. Kalinowski said.

These individuals are often more dependent on others, so that gambling behavior may be significantly determined by opportunity or the gambling habits of others.

In addition, externally imposed supports and controls may limit the life consequences of problem gambling in this population but may not limit subjective distress. Gambling might even have benefits for individuals with intellectual disabilities by offering low-demand socialization, nonstigmatized recreation, and a fully “adult activity,” she said.

Dr. Kalinowski reported that she had no relevant conflicts of interest. ■



Important Safety Information (continued)

- The most commonly observed adverse events associated with the use of SEROQUEL monotherapy versus placebo in clinical trials for schizophrenia and bipolar disorder were dry mouth (9%-44% vs 3%-13%), sedation (30% vs 8%), somnolence (18%-28% vs 7%-8%), dizziness (11%-18% vs 5%-7%), constipation (8%-10% vs 3%-4%), SGPT increase (5% vs 1%), dyspepsia (5%-7% vs 1%-4%), lethargy (5% vs 2%), and weight gain (5% vs 1%). The most commonly observed adverse events associated with the use of SEROQUEL versus placebo in clinical trials as adjunct therapy with lithium or divalproex in bipolar mania were somnolence (34% vs 9%), dry mouth (19% vs 3%), asthenia (10% vs 4%), constipation (10% vs 5%), abdominal pain (7% vs 3%), postural hypotension (7% vs 2%), pharyngitis (6% vs 3%), and weight gain (6% vs 3%)
- In long-term clinical trials of quetiapine, hyperglycemia (fasting glucose ≥ 126 mg/dL) was observed in 10.7% of patients receiving quetiapine (mean exposure 213 days) vs 4.6% in patients receiving placebo (mean exposure 152 days)

* Data combined from two 8-week, multicenter, randomized, double-blind, placebo-controlled, monotherapy bipolar depression trials. SEROQUEL (300 mg/day; n=327) showed significant improvement from baseline in Montgomery-Asberg Depression Rating Scale total score at Week 1 continuing through Week 8 vs placebo (n=330; P values ≤ 0.0001).

† Data combined from two 12-week, multicenter, randomized, double-blind, placebo-controlled, monotherapy mania trials. SEROQUEL (n=208) showed significant improvement from baseline in Young Mania Rating Scale (YMRS) total score at Day 4 continuing through Day 84 vs placebo (n=195; P values ≤ 0.05).

‡ In pivotal mania trials, the average dose in responders (patients with $\geq 50\%$ improvement in YMRS total score) was 600 mg/day.

§ Twice daily.

References: 1. Data on file, AstraZeneca Pharmaceuticals LP, DA-SER-51. 2. Prescribing Information for SEROQUEL. 3. Calabrese JR, Keck PE, Macfadden W, et al. *Am J Psychiatry*. 2005;162:1351-1360. 4. Thase ME, Macfadden W, Weisler RH, et al, for the BOLDER II Study Group. *J Clin Psychopharmacol*. 2006;26:600-609. 5. Endicott J, Rajagopalan K, Minkwitz M, et al, for the BOLDER Study Group. *Int Clin Psychopharmacol*. 2007;22:29-37. 6. Vieta E, Mullen J, Brecher M, et al. *Curr Med Res Opin*. 2005;21:923-934. 7. Sachs G, Chengappa KNR, Suppes T, et al. *Bipolar Disord*. 2004;6:213-223. 8. Data on file, AstraZeneca Pharmaceuticals LP, DA-SER-45.

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