# Focus on Comorbidities, Not Tics, in Tourette's

BY PATRICE WENDLING
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NEW YORK — Tourette's syndrome treatment should be targeted to improve comorbidities rather than on the characteristic vocal and motor tics, Dr. John T. Walkup said at a psychopharmacology update sponsored by the American Academy of Child and Adolescent Psychiatry.

"To enhance outcome, go for the comorbidity; don't go for the tics," said Dr. Walkup of the department of psychiatry and behavioral sciences at Johns Hopkins University, Baltimore.

"As tics are easy to spot, doctors have a tendency to treat tics first and then stop," Dr. Walkup said at the meeting. "It's an impulse I would encourage everyone to restrain."

As tics wax and wane even during treatment, treating physicians can get caught "chasing" tics by upping the dose, and adding or changing meds. Because tics wax and wane, doctors may falsely believe that the medication just delivered was responsible for the improvement, Dr. Walkup said.

Additionally, the comorbidity may not respond to tic-suppressing medications, and a few children with Tourette's will actually develop anxiety or depressive disorders on antipsychotics, Dr. Walkup said.

Tics can present in upward of 25% of school-aged children. Tourette's syndrome is associated with several coexisting conditions, including obsessive-compulsive disorder, attention-deficit hyperactivity disorder (ADHD), anxiety and depressive disorders, and other behavioral problems.

A small percentage of patients have a poor outcome from tics alone, Dr. Walkup said.

Taking a good family and social history is essential to identifying genetic and

## Brief Counseling Achieves the Best Cessation Results

NEW ORLEANS — Behavioral interventions aimed at smoking cessation showed modest albeit statistically significant efficacy in a new meta-analysis of 51 randomized controlled trials totaling nearly 27,000 smokers, Salvatore Mottillo reported at the annual meeting of the American College of Cardiology.

There were four types of interventions: brief physician-given advice to quit, typically a one-on-one intervention lasting 30 seconds to a couple of minutes; individual counseling by a therapist or physician in a more in-depth session of at least 20 minutes; group counseling; or proactive telephone counseling in which a nurse or therapist makes multiple phone calls to follow up on the patient's smoking status.

All of the studies used biochemically validated patient self-reported smoking abstinence at 6 and/or 12 months as an end point.

Control subjects were individuals who felt motivated to quit smoking but got no assistance. Their success rate was about 10%. All four types of behavioral intervention boosted the success rate to about 15%-17%, with no significant difference among them, according to Mr. Mottillo.

"Clearly, there's not one intervention that stands out as being more effective than the others. It seems as though minimal clinical intervention—that's the brief advice provided by a physician—may be as effective as these more resource-intensive interventions requiring more time and a lot more money," said Mr. Mottillo, an undergraduate student at McGill University, Montreal, in an interview. He said he and his coinvestigators have applied to the Canadian Institutes for Health Research for funding of a head-to-head comparative trial testing that hypothesis.

Nicotine patches and other pharmacotherapies appear to be slightly more effective than are behavioral interventions.

In a separate meta-analysis, Mr. Mottillo's coinvestigators found that motivated patients given pharmacotherapeutic help were roughly twice as likely to quit smoking as controls. However, there has not been a randomized trial that compares behavioral and pharmacologic interventions, Mr. Mottillo noted.

**—Bruce Jancin**