Subspecialties Included

- Academic Psychiatry
- Geriatric Psychiatry
- Addiction Psychiatry
- Neuropsychiatry
- Child & Adolescent Psychiatry
- Psychosomatic Medicine
- Forensic Psychiatry
- Hospice and Palliative Medicine

Journals Included

- American Journal of Psychiatry
- American Journal of Geriatric Psychiatry
- Academic Psychiatry
- Current Psychiatry
- Psychosomatics
- Journal of the American Academy of Child & Adolescent Psychiatry
- JAMA Psychiatry
- New England Journal of Medicine

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CLASSICS IN PSYCHIATRY

Mahitha Kolli, MD


Objective: The authors presented results of the phase 1B of the CATIE study which compared treatment with olanzapine, quetiapine, and risperidone among patients who had discontinued perphenazine in phases 1 and 1A.

Methods: The CATIE study was conducted between January 2001 and December 2004 at 57 US clinical sites. Patients who were assigned to treatment in phase 1 with perphenazine and who discontinued it then entered phase 1B and received randomized, double-blinded treatment with olanzapine, quetiapine, or risperidone. Primary outcome measure was time until treatment discontinuation due to all causes. The secondary outcome was reason for treatment discontinuation and secondary efficacy outcomes included PANSS and CGI scores at study baseline and after 1, 3, 6, 9, 12, 15 and 18 months. Secondary outcome variables of safety and tolerability included incidences of serious adverse events, treatment-emergent adverse events, and changes in weight, neurologic side effects and laboratory analytes. Statistical analysis included Kaplan-Meier survival curves (time until treatment discontinuation), Cox proportional hazards regression model (treatment group comparisons), ANCOVA (treatment group comparison of PANSS, CGI severity scores at months 3, 6, 9), ANOVA (baseline characteristics).

Results: 60% of eligible patients accepted random assignment to phase 1B, of whom 68% discontinued treatment before completion of the study. The time to discontinuation for all causes was significantly lower for quetiapine and olanzapine than for risperidone. For those who discontinued perphenazine due to inefficacy, the lowest rate of discontinuation for all causes was with olanzapine. For those who discontinued perphenazine due to intolerability and EPS side effects, the highest rate of discontinuation for any reason was with risperidone. No notable difference in PANSS scores was observed among treatment groups. Slightly greater reductions in the CGI global severity measurement was noted with olanzapine and quetiapine than with risperidone at 3 and 9 months but this difference was not present at 6 or 12 months. Lowest rate of hospitalization was seen in patients with quetiapine and highest with olanzapine. The drugs did not differ in incidence of serious adverse events, EPS, akathisia, QTc interval effects, or abnormal movements and no completed suicides or suicide attempts were reported in phase 1B. Highest weight gain was seen with olanzapine (> 7% baseline body weight). Discontinuation due to metabolic side effects were not seen with quetiapine and were 5% with risperidone and 13% with olanzapine. Olanzapine was associated with the highest increases in total cholesterol and triglyceride levels.

Conclusions: The authors showed that quetiapine and olanzapine were more effective than risperidone in patients who had discontinued perphenazine, and olanzapine was associated with substantial weight gain and adverse effects on lipid metabolism. Quetiapine and olanzapine were similar in their overall effectiveness.

Punchline: This study shows that heterogeneity in response to antipsychotic treatment occurs due to differences in tolerability and adverse effects profile.
**CHILD & ADOLESCENT PSYCHIATRY**

Carlos Molina, MD


**Objectives:** The authors examined the association between peer victimization and suicidal ideation and suicide attempts among adolescents.

**Methods:** The investigators analyzed data collected from a sample of participants from the Quebec Longitudinal Study of Child Development (QLSCD). The sample included 55% of the original cohort and measures were collected at both 13 and 15 years of age. Suicidal ideation was assessed with one question administered to participants at 13 and 15 years of age. Peer victimization was assessed at ages 13 and 15 years, using 7 items, 4 of which were based on *Self-report Victimization Scale*. Investigators used logistic regressions for cross sectional and longitudinal analyses, and they adjusted the association of victimization and suicidal ideations for suicidality at baseline, mental health problems by age 12 years and for confounders including, socioeconomic status, intelligence, family functioning, hostile-reactive parenting and maternal suicidality history.

**Results:** Overall prevalence of suicidal ideation increased from 4.5% at age 13 years to 5.9% at age 15 years and was higher and elevated among females (5.3-8.6%) compared to males (3.7-3.0%). Adolescents who were victimized had higher rates of suicidal ideation at age 13 years (11.6-14.7%) and suicide attempt at age 15 years old (5.4-6.8%) compared to those who had not been victimized (2.7-4.1% for suicide ideation and 1.6-1.9% for suicide attempt). Additionally, frequent victimization at 13 years predicted suicidal ideation (increased the risk by 2.27 times) and suicide attempt (increased the risk by 3.05 times) two years later. Furthermore their data analyses found that chronic victims had an increased risk of suicidal ideation at age 15 (OR=5.41; 95% CI= 2.53-11.53) and suicide attempt (OR=5.85; 95% CI=2.12-16.18).

**Conclusions:** The investigators concluded that peer victimization increases the risk of suicidal ideation and suicide attempts over and above prior mental health problems and concurrent suicidality.

**Punchline:** *Peer victimization increases the risk of suicidal ideation and suicide attempt among adolescents.*

**GERIATRIC PSYCHIATRY**

Rajesh Tampi, MD


**Objectives:** The investigators wanted to assess the risk of progression to dementia among individuals with incident MCI who have NPS.

**Methods:** The investigators included individuals with incident MCI who were ≥60 years in age in the study. An individual was considered have incident MCI if they had MCI at a current visit but were cognitively normal at their previous (yearly) visit. The investigators considered the visit at which the individual was diagnosed with MCI as their “baseline” visit and the time to dementia diagnosis was measured from that point. The Neuropsychiatric Inventory Questionnaire (NPI-Q), the Mini-Mental State Examination (MMSE) and the Geriatric Depression Scale (GDS) were administered at each study visit.
MCI was diagnosed using the modified Petersen criteria. Possible and probable Alzheimer’s Disease (AD) diagnoses were made using the NINCDS-ADRDA criteria. Vascular dementia was diagnosed using National Institute of Neurological Disorders and Stroke Association criteria and frontotemporal dementia was diagnosed using the consensus criteria.

**Results:** The median length of follow-up was approximately 2 years. Of the 540 individuals with incident MCI who were included in the study 419 (78%) were not diagnosed with dementia during the follow-up period. A total of 121 individuals (22%) were diagnosed with dementia during the follow-up period.

Depression (22%) was the most common behavioral symptom followed by irritability (21%), anxiety (18%), nighttime behaviors (17%), apathy (12%), agitation (12%) and eating behaviors (11%).

The investigators developed three behavioral clusters: ‘Severe cluster’ included individuals who had high rates of almost all symptoms; ‘affective’ cluster who had high rates of depression and anxiety; and ‘asymptomatic’ cluster who had low rates of behavioral symptoms.

Compared with individuals who did not progress to dementia, individuals who progressed to dementia had greater NPI-Q and GDS scores.

Individual in the severe and affective clusters had a higher risk for developing dementia with the severe cluster having more than 2 times the risk of the asymptomatic cluster and the affective cluster having more than 1.5 times the risk of the asymptomatic cluster.

Among the individuals who progressed to dementia, 68% were diagnosed with possible or probable AD and 5% were diagnosed with vascular dementia. Additionally individuals who progressed to dementia were older at baseline, were more likely to be women and had lower MMSE scores.

**Conclusions:** The investigators concluded that among individuals with incident MCI the presence of NPS increases the risk of progression to dementia.

**Punchline:** This cohort study indicates that the presence of NPS increases the risk of progression of MCI to dementia.

**Rajesh Tampi, MD**


**Objectives:** The investigators wanted to assess the association between diabetes mellitus (DM), cerebrovascular disease and dementia and its subtypes (Alzheimer's disease [AD] and vascular dementia [VD]) among older adults.

**Methods:** The investigators obtained data from the 2010 Medicare Current Beneficiary Survey (MCBS) Cost and Use files which is a nationally representative, longitudinal survey of Medicare beneficiaries conducted by the Centers for Medicare and Medicaid Services (CMS). They included all MCBS respondents who completed the Cost and Use survey in 2010. The International Classification of Diseases, ninth version, Clinical Modification (ICD-9-CM) codes were used to identify dementia, DM, VD, AD and cerebrovascular disease from the Medicare claims files for each respondent.

**Results:** There were a total of 1482 diabetic and 3678 non-diabetic enrollees aged ≥65 years in the MCBS sample for 2010. The weighted percentages of individuals with overall dementia among diabetic and non-diabetic enrollees were 12.92% and 8.02% respectively. The weighted percentages of
individuals with cerebrovascular disease among diabetic and non-diabetic enrollees were 23.21% and 12.95% respectively.

The investigators found that DM was associated with overall dementia. When cerebrovascular disease was controlled the association was reduced but still significant. The investigators also found an association between DM and VD but this association became non-significant once the cerebrovascular disease was controlled. Additionally the investigators noted an association between DM and AD but this association became non-significant once the cerebrovascular disease was controlled.

Conclusions: The investigators concluded that DM is independently associated with overall dementia among older adults but not with VD or AD.

Punchline: This retrospective cross sectional study indicates that the DM is independently associated with overall dementia. The cerebrovascular disease associated with DM only partially explains the mechanism by which diabetes can cause dementia.

Rajesh Tampi, MD


Objectives: The investigators wanted to assess the prevalence of potentially inappropriate prescribing including potentially inappropriate medications (PIMs) and potential prescription omissions (PPOs) in older adults with psychiatric illness who are hospitalized.

Methods: The participants were individuals who were ≥ 65 years in age and who had been hospitalized for any psychiatric condition. The data for this study was collected between November 2013 and February 2014.

The investigators used the Beers criteria 2012 and STOPP/START criteria to assess potentially inappropriate prescribing prevalence. All medications were coded in accordance with the Anatomical Therapeutic Chemical (ATC) classification system.

The Beers criteria is a consensus-based list of drugs that are considered to be potentially inappropriate for use in older adults living in nursing homes. The updated version of Beers criteria (2012) was used for this study. The STOPP consists of 65 criteria that help clinicians systematically identify PIMs. The START consists of 22 criteria that identifies PPOs. The modified Dutch version published in 2012 was used for this study.

Results: A total of 164 individuals met the inclusion criteria.

According to the Beers 2012 criteria, a total of 199 PIMs were prescribed to 77 (47%) participants: 18% of the individuals were prescribed with one PIM, 8% were prescribed with two PIMs and 21% were prescribed with three or more PIMs. The most common PIMs were the use of benzodiazepines in individuals with dementia or cognitive impairment, the use of anticholinergic medication and antispasmodics in individuals with chronic constipation and the use of benzodiazepines in individuals with a history of falls or fractures. A total of 153 PIMs (77%) involved psychotropic medications.

According to the STOPP criteria, a total of 331 PIMs were prescribed in 130 (79%) participants: 27% of individuals were prescribed with one PIM, 15% were prescribed with two PIMs and 37% were prescribed with three or more PIMs. The most common PIMs were the long-term use of antipsychotics as neuroleptics as long-term hypnotics, the use of duplicate class drugs and the use of proton pump inhibitors for peptic ulcer disease at full therapeutic dosage for more than 8 weeks. Benzodiazepines were the most common duplicate prescription, followed by antipsychotics.
and antidepressants. In total, 218 (66%) of the identified PIMs concerned psychotropic drugs.

A total of 158 PPOs were noted in 97 (59%) individuals. Of these, 61% of individuals were not prescribed with one PPO, 24% were not prescribed with two PPOs and 15% were not prescribed with three or more potentially beneficial medicines.

Conclusions: The investigators concluded that potentially inappropriate prescribing is common among hospitalized older adults with psychiatric illness.

Punchline: Clinicians caring for these individuals should always be vigilant for inappropriate prescribing as it can lead to adverse outcomes in this vulnerable population.
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