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

Silpa Balachandran M.D.


Objective: Authors describe a study which assessed the sensitivity and specificity of a screening instrument for bipolar spectrum disorder called the Mood Disorder Questionnaire (MDQ).

Method: Patients at five outpatient psychiatric mood disorders clinics completed the MDQ and were subsequently interviewed via a telephone within 2 weeks, while a psychiatric research social worker blind to MDQ results, used the Structured clinical Interview for DSM-IV (SCID) to diagnose participants with bipolar spectrum disorders (including bipolar I, bipolar II and bipolar not otherwise specified). A positive screen required a threshold number of symptom items, response of “yes” on the item asking if symptoms clusters occurred in the same time period causing “moderate” or “severe” level of distress. Sensitivity and Specificity for various symptoms threshold cutoff scores were calculated.

Results: 109 of the 198 patients who underwent the telephone SCID interview received a diagnosis of bipolar spectrum disorder (bipolar I: N=70, bipolar II: N=26, and bipolar disorder not otherwise specified: N=13). 34.2 % to 77.2% of the MDQ items were endorsed with “easily distracted,” “racing thoughts,” and “irritability” being the endorsed the most. A MDQ screening score of 7 or more was chosen as the optimal cutoff, as it provided a good sensitivity (0.73, 95% confidence interval [CI] =0.84-0.96) and very good specificity (0.90, 95% CI=0.84-0.96).

Conclusion: This study concluded that at the threshold cutoff score of 7 or more the MDQ had a good sensitivity and very good specificity for the screening of bipolar spectrum disorders in outpatient psychiatric clinics.

Punchline: The Mood Disorder Questionnaire is a validated screening tool for bipolar spectrum disorders.

ADDITION PSYCHIATRY

Karel Routhier, M.D.


Objectives: To review the epidemiology, neurobiology and pharmacotherapy of Post-Traumatic Stress Disorder (PTSD) with comorbid alcohol, opiate and cannabis use disorders. An important aim would be to create innovative combined treatment, in the form of a single medication, of these two disorders to decrease the risk of side-effects from medication interactions, polypharmacy and poor medication adherence.

Methods: Using a PUBMED search of the literature on the combination of PTSD and Substance Use Disorder (SUD) in humans (both military and civilian trauma studies included), this review article covered the epidemiology, neurobiology and pharmacotherapy of PTSD with comorbid alcohol, opiate and cannabis use disorders. The first two listed SUD have FDA-approved pharmacotherapies while the third one does not.
Results: Epidemiology of PTSD and SUD: 
SUD are two to three times more likely to occur among individuals with lifetime PTSD. The lifetime prevalence of any SUD in community samples of persons with PTSD is between 21.6-43% versus 8.1-24.7% in those persons without PTSD. Gender differences have been found across several non-veteran samples where drug abuse appears to put women at greater risk than men for developing PTSD.

Neurobiology of PTSD and SUD: The conceptual model of PTSD is the one of a disorder of fear conditioning and extinction. The neuroanatomical correlates include amygdalar hyperactivity (hyper-responsiveness to stimuli), hippocampal dysfunction (over-generalization of stimuli) and medial prefrontal and anterior cingulate cortex malfunctioning (poor anger control and failure to extinguish maladaptive behaviors). Amygdalar hyperactivity is also seen in addiction especially in the setting of chronic activation of brain stress systems and increased CRF during acute withdrawal of all major drugs of abuse. Also, the development of associations between previously neutral cues and substance of abuse contributes to cravings and perpetuation of addiction.

| Psychopharmacotherapy of PTSD and comorbid Alcohol SUD, Opiate SUD or Cannabis SUD |
|-----------------------------------------------|-----------------|-----------------|
| Alcohol SUD\(^1\) | Opiate SUD\(^2\) | Cannabis SUD\(^3\) |
| Agent | Outcome | Agent | Outcome | Findings |
| Sertraline | Reduced alcohol consumption when PTSD symptoms improved. | Opioid agonist (Methadone or buprenorphine) | Equivalent effectiveness in decreasing substance abuse in patients with or without PTSD. | PTSD was found to be associated with increased odds of lifetime cannabis use as well as daily cannabis use. |
| Valproate (500-1500 mg daily) | No better than SSRI alone. | | | |
| Olanzapine (5-20 mg daily) | Reduction in PTSD symptoms in two open trials. | | | PTSD contributes to the development of cannabis use disorders especially in persons with higher levels of peer deviance or family history of SUD. |
| Risperidone (1-6 mg daily) | Reduction in PTSD symptoms > SSRI alone. | | | Some studies have found cannabis to decrease PTSD symptoms. Preclinical trials found cannabis to be anxiolytic. |
Disulfiram | Lowers hyperarousal scores on CAPS > Naltrexone as SSRI adjunct. Also lowers PTSD symptoms. | at low-dose versus anxiogenic at high-dose.

1: The two FDA-approved SSRI for PTSD treatment are sertraline and paroxetine. Adjunctive drugs to SSRI’s include anticonvulsants, antipsychotics and adrenergic blockers.

2: PTSD among opiate-addicted persons in methadone clinics has been associated with poorer compliance to treatment and higher rates of co-occurring substance abuse.

3: There are currently no FDA approved medications for the treatment of CUD. Something to think about – Currently six states list PTSD as a condition for which medical marijuana can be prescribed.

Innovative PTSD Treatments: Prazosin (alpha-1 adrenergic antagonist) found effective in reducing hyperarousal and sleep disorders, however these agents can also block extinction of aberrant learned associations. GABA agonists can enhance PTSD symptom relief but also block extinction learning. Stimulation of NMDA receptors with partial agonist agents (D-Cycloserine) is associated with reduction in anxiety, avoidance and numbing. It has also demonstrated an ability to augment the learning process for extinction of conditioned fear responses in both animal and human models.

Conclusion(s): Comorbid PTSD and SUD increase lethality and treatment complexity. Despite sharing some important neurobiology, these two disorders rarely respond to a single pharmacologic agent and usually require medication combinations and more tailoring to the type of SUD.

Punchline: Pharmacologic approaches focusing on the modulation of extinction learning processes may have efficacy in treating both PTSD and SUD.

GERIATRIC PSYCHIATRY

Rajesh Tampi, MD


Objectives: The investigators wanted to study the association between anxiety at the time of hospitalization and falls within one month of post-discharge among the elderly.

Methods: The participants for this study were individuals who were ≥ 70 years in age who had been hospitalized between 2009 and 2011 for an acute non-disabling diagnosis. Falls were defined as any event that resulted in an individual coming to rest inadvertently on a lower level. Data regarding the number of falls during the month following discharge from the hospital was collected. Symptoms of anxiety were assessed 48 hours after admission using the Short Anxiety Screening Test (SAST). Functional status was assessed using the modified Barthel Index (MBI). Cognitive status was assessed at the time of admission using Pfeiffer’s Short Portable
Mental Status Questionnaire (SPMSQ). Depression was measured using Tucker’s short interviewer-assisted Depression Rating Scale.

**Results:** The investigators found that of the total of 556 participants, 12.9% reported falling within a month after discharge from the hospital. Of these, 18.1% reported falling more than once. Approximately 10% of participants had a history of anxiety. A total of 18.7% of the participants showed anxiety symptoms at the time of hospitalization. The group with anxiety symptoms were predominately female (73.3% vs. 43.5%), had poorer pre-morbid function and had higher rates of co-morbid depression (43.8% vs. 8.0%).

The investigators found that prior-to-discharge functional decline among fallers was higher than among non-fallers (51.4% vs. 31.0%). Anxiety was more common among the fallers when compared to the non-fallers (30.6% vs. 17.1%). Without accounting for functional decline, the odds of falling was higher among individuals with anxiety when compared to individuals without anxiety [odds ratio (OR), 2.13].

After adjustment for age, gender, baseline functional status and both functional decline from baseline to discharge, the investigators found that in-hospital anxiety was still an important predictor for falls (OR, 1.89). The odds of falling were higher among individuals who experienced functional decline (OR, 2.11) when compared to individuals who did not experience functional decline. Depression was not found to be associated with greater risk for falls one month post-hospitalization.

**Conclusions:** The investigators concluded that anxiety at time of hospitalization is associated with greater risk of falls within one month post-discharge among the elderly.

**Punchline:** Even after controlling for demographics and pre-morbid and in-hospital functional decline, anxiety during hospitalization is associated with greater risk of post-discharge falls.

Rajesh Tampi, M.D.


**Objectives:** The investigators wanted to evaluate the risk of dementia with anticholinergic medication use among elderly nursing home residents who have depression.

**Methods:** The investigators used the Minimum Data Set (MDS)-the Medicare linked data set from all 50 states for the years 2007–2010 for this study. They also used data from the Medicare Part A, B, and D from the Chronic Condition Data Warehouse (CCW). The investigators used a nested case-control design to evaluate the risk of dementia within a cohort of elderly individuals with depression.

The cases for the study were identified as individuals with depression who had an incident diagnosis of dementia according to the CCW files. The event date for the cases was identified as the date of the first ever diagnosis of dementia. Exposure to anticholinergics was based on the Anticholinergic Drug Scale (ADS). The primary exposure was defined as a prescription of higher-level anticholinergic medication 30 days prior to the event date.
Individuals who were not exposed to these medications 30 days before the case event were defined as non-users and they constituted the control group. For this study, four control subjects were selected per case at random.

Results: Among the study population of individuals with depression there were 28,388 individuals who developed dementia between January 1, 2008, and December 31, 2010. There were a total of 113,552 control subjects (incidence density ratio: 1:4) during the same time period.

Medications with clinically significant anticholinergic properties were more commonly prescribed to the cases than to controls (19.19% versus 16.45%). After controlling for other factors, the investigators found that exposure to higher-level anticholinergic medications was associated with a 26% greater risk for dementia (OR: 1.26) when compared to no exposure.

They also found that the risk estimates for dementia remained consistent across different study periods and levels of anticholinergic drug potency across the two groups. The study results were significant when either the MDS or CCW definition was used to define base cohort and dementia cases. The strength of the findings increased when both MDS and CCW files were used together.

Conclusions: The investigators concluded that the use of anticholinergic medications was associated with a 26% increase in the risk of dementia among elderly nursing home residents who have depression.

Punchline: This nested case-control study adds further proof that the use of anticholinergic medications in the elderly with depression increases the risk for dementia.

Rajesh Tampi, M.D.


Objectives: The investigators wanted to study the association between loneliness and cardiovascular or non-cardiovascular mortality among older men.

Methods: In this prospective population-based study which was started in 1985, men who were born between 1900 and 1920 were invited to participate in the study. The demographic and health characteristics of these individuals were collected.

Participants were seen for face-to-face interviews between March 1 and June 30 of 1985, 1990, 1995 and 2000. These individuals were then followed for causes of mortality for up to 25 years until 2010. The causes of death were obtained from a central registry and verified with information obtained from the hospital and the general practitioners. The final coding for cause of death was done by an experienced clinical epidemiologist. The primary and secondary causes of death were also included in the analyses. The presence of cardiovascular disease or other chronic diseases at baseline was determined by a survey questionnaire and confirmed by hospital discharge data and written information from the general practitioners. The investigators evaluated the feelings of loneliness in 1985, 1990, 1995 and 2000 using the De Jong Gierveld loneliness scale which is a 11-item questionnaire consisting of emotional
loneliness scale and the social loneliness scale. Simultaneously, dispositional optimism was evaluated using a questionnaire consisting of four items on a three-point scale from a survey.

Additionally, the presence of disability was assessed using a 13-item Activities of Daily Living questionnaire.

**Results:** There were a total of 719 men in the final sample. Loneliness was present in 302 participants. Of these 92.4% of the participants were rated as being moderately lonely and 7.6% as being severely lonely. Loneliness was associated with living alone, not being married, having lower education, and lower baseline dispositional optimism.

There was a statistically significant increase in loneliness over time. The investigators found that there was a significant increase in emotional loneliness scores and a significant decrease in social loneliness scores during the follow-up period.

After controlling for all demographic and cardiovascular risk factors, the age at death was similar between not lonely, moderately lonely and severely lonely men.

Additionally, when compared to not lonely men, moderately lonely and severely lonely men had similar cardiovascular or non-cardiovascular mortality rates. There was no association noted between emotional loneliness scores, social loneliness scores and mortality rates between any of the groups.

**Conclusions:** The investigators concluded that loneliness is not associated with greater cardiovascular or non-cardiovascular mortality among older men.

_Punchline: This population based cohort study indicates that although loneliness is common among older men, it is not associated with greater cardiac or non-cardiac mortality._