Southern California

PSYCHIATRIST

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President's Column

May President's Column

Larry Lawrence, M.D.

Hello and welcome to the May Newsletter. SCPS has had a busy springtime with special events. The Women's Comittee has been quite active, enthusiastic and engaging members to address a wide variety of psychiatric , professional and personal issues. Maria Lymberis and the PER foundation sponsored a marvelous evening on April 14 at the Colburn School of music in downtown L.A. My wife and I were fortunate to be in attendance with many friends and colleagues. The evening was quite special, with presentation of the PER Advocate Award to Sharon Dunas, MFT. Sharon represents NAMI west LA and has been a tireless advocate for clients ,families, collaboration and education.

Her reception speech was gracious and selfless, focussing on her personal journey, and her gratitude to those who helped her by instruction, support, and and focus on common goals. Congratulations and thanks to Sharon.

Maria Lymberis had promised a special treat after the award ceremony. She brought the program Beethoven, Creative Genius and Psychiatric Illness, presented by Dr Richard Kogan. Dr Kogan put on a striking performance, blending live piano playing, detailing the life of Beethoven, placing the music in the context of life events of a troubled genius. The life details so expertly intertwined with the music was a joy to behold. It left us, a group usually at ease with words, searching for terms to describe this event. Many thanks to all involved and especially to Maria Lymberis, M.D. for her vision and energy.

Our Installation and Awards ceremony on April 21st was well attended and quite enjoyable. Thanks to all involved, Dr. Ira Lesser, our awards committee (Chaired by M. Christina Benson, M.D.), to Dr. Larry Gross, for his presentation of the PER Foundation Excellence in Psychiatric Education awards to Resident Physicians in our seven local psychiatric residency programs. The residents so honored displayed notable leadership, development of innovative programs, response to patient and staff needs in their respective programs. We congratulate them all and I plan to spotlight each of their contributions in my newsletter notes this year. I believe the decision to award a resident in each program was a wise decision, which opened our eyes to all the energy, enthusiasm, altruism that exists in all our programs. A special thanks to John Luo, M.D., who gave this year's presentation on Professional Exposure: Protecting Your Online Privacy.

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In This Issue...

Special appreciation to Dr Mary Ann Schaepper. We enjoyed her unique President's Award to Dr. George Harding, her father, a psychiatrist, teacher, professor emeritus,and chairman of several academic programs in the past.

Thanks to our award recipient, Kitty Dukakis, in honoring her service and advocacy for mental health and addictions treatment and program development and her courageous autibiography sharing her recovery, struggles, and insight.

Mary Ann has made the trip to LA with me from the IE for a couple years now, and we have had ample time to talk about family, friends, weddings, conferences, residency programs, medical services, and administrative, political and financial challenges to providing quality patient care. We will continue to collabarate as she represents the SCPS in the Assembly. Thanks for your friendship collegiality, and for making our SCPS meetings a very welcoming place.

I look forward to seeing many of you at the APA Annual Meeting in Philadelphia, May 5th to 9th. Also get ready to serve as hosts when the 2013 APA meeting arrives in San Francisco next year. I will make a point of discussing some of our committees and the fine work they are engaged in as the year progresses. We will also look for members interested in both SCPS and CPA committee participation. Finally thanks to all our Council members who have completed their service to the SCPS. See you at the APA. Larry Lawrence, MD

SCPS would like to thank the South Bay Psychiatric Society for their generous donation in memory of Theodore Markellos, M.D., their "Treasurer for Life."

Dr. Markellos was involved with the South Bay Psychiatric Society since its inception. The organization has now disbanded.

Letter from the Editor

How I Love You NAMI

Colleen Copelan, M.D.

The Ventura County NAMIWalk was bigger and better than ever this year at the Ventura Beach Promenade: 1,200 people and more than $100,000!

We started with musical warm-ups, pep talks and support speeches from county leaders, including the county CEO, a city councilman running for supervisor and two county supervisors, one running for Congress.

NAMI Vice President Mark Gale was there as well

And, we were treated to an a cappella, re-worded version of “Mammy,” from whence the title of this piece.

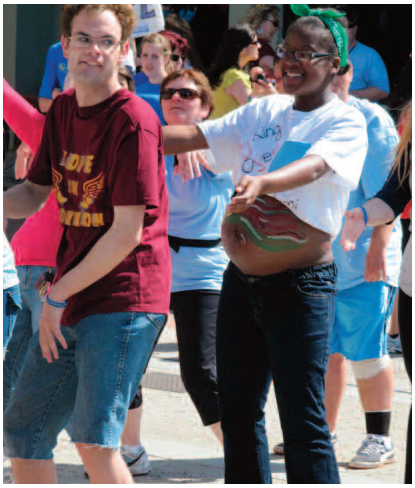
We held down the SCPS table and took lots of pictures. Cocopelan@aol.com

Crowd gathers at registration.

Supervisor and Mental Health Board Member, Linda Parks.

The walk begins.

Our dogs are ready to go.



Warm-up dance.

Vital balance.

Council Highlights
April 12, 2012
Anita Red, M.D., *Secretary*

The meeting was called to order by Dr. Schaepper. Dr. Shaner made a motion to accept March's minutes. All voted in favor, and none opposed. Dr. Schaepper gave personal comments then an update on the maintenance of certification requirements. Dr. Schaepper announced next year's elected positions. The NAMI walk in Ventura is May 6th. The NAMI walk in Los Angeles is the first weekend in October, and we have been invited to represent our organization in a booth. There is a NAMI event on April 22nd called "Pathways to Wellness: The Annual Community Conference on Mental Health." The SCPS has been invited to support this event and represent our organization in a booth as well. Dr. Shaner made a motion to support this event with $100 and further inquiry will be made regarding the booth. All voted in favor. None opposed. The annual NAMI dinner will be held Thursday, June 7th.

Dr. Red gave an update on the Website Committee. The committee proposes to allow website advertising in a text-only form after first advertising in the newsletter. The classified ad for the website will be put up on the day it is received, at least for 30 days or more, before the next newsletter. SCPS members may utilize this benefit free of charge. Non members will be charged an additional $25. Any display ad (with graphics) will be converted to text and will be charged 10% of the newsletter price. There will also be a disclaimer added to the classifieds page. Tim is working diligently on the site, and we should have something to bring to Council soon!

Dr. Shaner made the motion to go forward with advertising on the website as proposed plus specify pricing relating to the 10% fee. All voted in favor. None opposed. Dr. Burchuk gave an update for the Installation Event 4/21/11. Dr. Gross gave an update for the PER fundraising event. Dr. Schaepper recommended that Executive Director, Mindi Thelen, attend the annual CPA meetings. The Treasurer will further investigate budget requirements with the director then report back to the Council. Dr. Cheung gave a report on the conflict of interest committee. He summarized the COI policy and the revisions made since the last meeting. Dr. Shaner brought to the Council's attention that the bylaws should reflect all SCPS policies. Dr. Silverman led a discussion about what is an appropriate internal regulation mechanism. Dr. Burchuk commented to Council that the SCPS's COI policy is consistent with the APA's COI policy.

Dr. Shaner made the motion "It is the policy of the SCPS that officers, directors, and key contracts adhere to an appropriate COI policy. The bylaws committee is requested and authorized to explore and make recommendations to the council in consultation with the COI committee on whether the bylaws should be amended to appropriately implement this policy. If the bylaws committee's recommendation is for such bylaws revisions, then the committee should propose to the council such revisions." A second was made to the motion. All voted in favor, and none opposed.

Dr. Lawrence gave the president elect's report which included ideas to streamline the Installation Event. He also gave a reminder of the APA Annual Meeting and some of the committee membership opportunities.

Dr. Thurston gave the legislative report which included an update on the Affordable Care Act. The Legislature has named a Kaiser HMO small group/individual plan--with good mental health and substance abuse benefits--as a benchmark for the exchanges. There is a proposal to extend the sunset clause on Laura's Law, which regards involuntary psychiatric outpatient treatment. Other possible legislation is The Physician's Health

Plan, which is similar to the previous physician diversion program.

Dr. Ettekal gave the treasurer's report. There was a discussion about member retention. Dr. Ettekal will draft a letter explaining benefits of membership in organized psychiatry. Dr. Ettekal made a motion to approve the SCPS's 2011 tax return. All voted in favor. None opposed.

Dr. Lawrence gave the membership committee report and made the motion to approve the new member nominations. All voted in favor. None opposed

Dr. Gales gave the program committee's report which includes the idea for a "Basic Sciences Symposium" program for next year. Dr. Soldinger suggested a program with updates in fields of medicine in relation to psychiatry, such as internal medicine, cardiology, and neurology. Dr. Burchuck would like the council to entertain the motion for the program committee to move forward with their basic sciences symposium. Ms. Thaeen has new business. An SCPS member would like to donate archived issues of the American Journal of Psychiatry.

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Installation and Awards Ceremony
April 21, 2012

Attendees listen to John Luo, M.D.'s presentation.

John Luo, M.D., Professional Exposure: Protecting Your On-line Privacy.

Ira Lesser, M.D., presents award to Kathleen Moreno, M.D.

Robert Burchuk, M.D., presents award to Yara Salman, M.D.

Larry Gross, M.D. announces the winners of the PER residents awards.

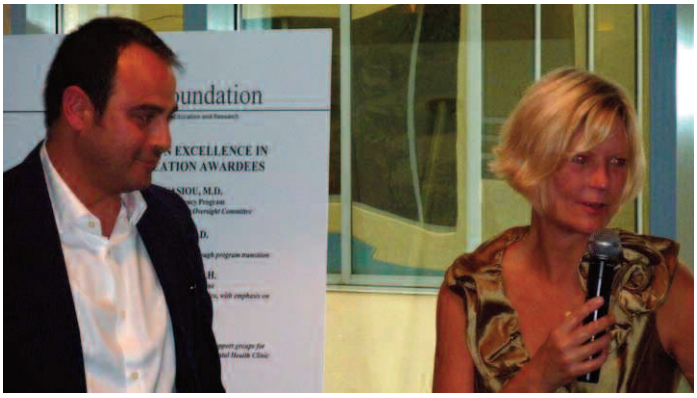
PER Board Members and awardees.

Thomas Trott, M.D., presents award to William Arroyo, M.D.

Mary Ann Schaepper, M.D., presents the year's special award to Operation SafeHouse.

Mary Ann Schaepper, M.D. presents award to Maria Lymberis, M.D.

Mary Ann Schaepper, M.D. presents award to Jacquelyn Green, M.D.



Mary Ann Schaepper, M.D. presents award to Amir Ettekal, M.D.

Mary Ann Schaepper, M.D. presents award to George T. Harding, III, M.D., her dad.

Incoming President, Larry Lawrence, M.D., presents the President's Plaque to Mary Ann Schapper, M.D., in thanks for her leading with warmth, thoughtfullness, and spunk.

A History of Treatment Resistant Generalized Anxiety Disorder (GAD), Or Is It Bipolar Spectrum Disorder?

by: David Fogelson, M.D.

A version of this case will appear in E Focus, a publication of the American Psychiatric Association.

A colleague asks you to consult on a patient who is a 19 year old single white female sophomore college student. She is enrolled in a competitive undergraduate program designed to guarantee entry into a professional school. She describes increasing anxiety and tension. She says, "I over think everything. I find it difficult to shut off my mind." She complains that anxiety has been causing her to lose sleep and that she feels like a wreck the next day. She complains of fatigue and believes stress is causing stomach problems, shakiness, and sweating. She feels overwhelmed by routine tasks and assignments. She has previously received treatment with trazodone which she could not tolerate because it caused daytime sedation. She has been receiving weekly psychoanalytically oriented supportive psychotherapy for two years.

Her anxiety does not prevent her from taking risks. She loves technical sports and has repeated injuries resulting in two knee surgeries and three shoulder surgeries. You determine that she does not suffer from a mood disorder or from psychosis. You rule out Obsessive Compulsive Disorder, Panic Disorder, Social Anxiety Disorder, and Post Traumatic Stress Disorder. There is no history of childhood physical or sexual abuse. There is no history for abuse of caffeine, alcohol, or drugs. She does not smoke cigarettes. You make a presumptive diagnosis of Generalized Anxiety Disorder (GAD).

She has had a recent physical examination and laboratory testing. A metabolic panel, complete blood count, and thyroid function tests are within normal limits. You order a 24 hour urine collection to measure catecholamines and 5-HIAA which are found to be within normal limits.

You obtain a family history and determine that none of her first degree relatives meet criteria for a psychiatric diagnosis. Her maternal grandmother has been diagnosed with Bipolar Disorder. She grew up in a financially secure home. She has always been an outstanding student and is earning all A's in college.

You recommend that she begin treatment with citalopram. You initiate treatment at 10 mg per day to avoid provoking a panic attack with too high an initial dose. After seven days you instruct her to increase the dose to 20

mg per day. She complains that the medication has increased daytime fatigue and has increased her daily sleep by one hour. She decreases the dose back down to 10 mg. After four weeks at this dose she has no improvement in her presenting symptoms.

What is the next treatment option you would recommend?

A. Switch to a different serotonin reuptake inhibitor antidepressant (SSRI)

B. Switch to a serotonin norepinephrine reuptake inhibitor antidepressant (SNRI)

C. Switch to a benzodiazepine

D. Add cognitive behavioral therapy (CBT)

There is no one best answer. Current treatment guidelines suggest a switch to an SNRI would be a good choice. Based upon the literature of the treatment of depression with SSRIs one might consider a switch to another SSRI to be as likely to work as a switch to an SNRI. I preferred this route because it has been my clinical experience that SNRIs are associated with a much worse discontinuation syndrome than most SSRIs. For this same reason I elected to not prescribe a benzodiazepine. I encouraged the addition of CBT which the patient declined.

One month's treatment with fluoxetine 10 mg per day was well tolerated with no complaints of side effects and with substantial resolution of symptoms. Since residual symptoms of excessive worry persisted the dose was increased to 20 mg per day. After four weeks of additional treatment the patient reported, "I don't feel the tension. I don't feel the anxiety. She reported feeling "much improved." She was continuing to experience residual symptoms of "tension, over thinking, over analyzing, shakiness, and excessive sweating. There were no reports of side effects. The dose was increased to 30 mg per day for two weeks and then increased to 40 mg per day. Two weeks after increasing the fluoxetine to 40 mg per day the patient reported feeling 75% better but complained of increasing bouts of moodiness, over-reactions to minor situations, and feeling over emotional. She said, "I still feel nervous all the time and have begun to have insomnia."

I elected to adopt a wait and see strategy. Antidepressant medications usually do not have a maximum therapeutic benefit until four to six weeks into treatment with a given dose. This strategy failed. When the patient returned four weeks later she presented in a moderate depressed state. She felt down, experienced recurrent feelings of worthlessness, had become withdrawn, anhedonic, experienced diminished sleep for a couple weeks followed by sleeping ten hours per night. I revised her diagnosis to Major Depressive Disorder (MDD).

How would you treat her depression?

A. Augment with another antidepressant

B. Switch to another antidepressant

C. Augment with an atypical antipsychotic agent

D. Augment with omega three fatty acid/methyl folate

I did not think her clinical severity justified the use of an antipsychotic. Most treatment algorithms recommend a combination strategy as more likely to be effective than a switch. I believed her clinical condition was deteriorating and that augmentation with nutraceuticals would prove to be insufficient. I elected to augment with bupropion. I

was not convinced that she had “cycled” into depression, which would have suggested she might have a bipolar spectrum disorder, but rather that her generalized anxiety disorder was a forme fruste of major depression; major depression and GAD are thought to share a common genetic diathesis.

Nine days after the addition of bupropion I received a phone call from the patient. She reported that she was, “more on edge, talking too much, having too many thoughts, that her mind just kept going and going,” At the same time as feeling edgy, she reported that she was sleeping excessively and was experiencing depression and fatigue. On further query, she reported that during the week prior to this she was only sleeping five to six hours per night and had impulsively dyed her hair blonde. I made a diagnosis of rapid cycling induced by antidepressants, current state, mixed hypomania.

How would you modify her medication regimen?

A. Add an atypical antipsychotic agent to her antidepressants

B. Taper her off her antidepressants and add a mood stabilizer

C. Add lithium to her antidepressant(s)

D. Immediately discontinue her antidepressants and start lamotrigine

E. Immediately discontinue bupropion, taper sertraline, add a mood stabilizer.

I elected E. I chose to immediately discontinue bupropion as its addition was correlated with her rapid cycling. I preferred to taper sertraline as I was concerned immediate discontinuation would provoke a discontinuation syndrome. My experience is that bupropion has a negligible discontinuation syndrome.

Which mood stabilizer would you select?

A. Lamotrigine

B. Lithium

C. Valproate

D. Carbamazepine

E. Atypical Antipsychotic

I selected lithium. Given her current mixed state, I believed lamotrigine might prove ineffective in the treatment of her manic symptoms. After two months of persistent depression on therapeutic levels of lithium, I elected to add lamotrigine. She remained depressed after two months at 200 mg of lamotrigine. As the depression persisted she developed increasing social anxiety. I opted to cross titrate lithium with quetiapine. She has been in remission for five years on a combination of lamotrigine 200 mg per day and quetiapine 300 mg per day. Over the past six months I have been tapering the quetiapine. She is currently taking 150 mg per day of quetiapine and remains in stable remission.

Editor’s Note: Information included in this article has been changed to protect confidentiality. Hence, the situations presented are constructs provided for educational purposes.

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