Folks,

The number of opioid deaths in Maryland is exceeded only by deaths from cardiovascular diseases and cancer. The number of deaths would be much higher if we were not, fortunately, seeing a vast increase in the use of Naloxone. The state has created an Opioid Operational Command Center to help address this epidemic. For more information:

https://search.aol.com/aol/search?s_it=webmail-searchbox&q=Maryland%20Opioid%20Operational%20Command%20Center

“Fear of deportment” is a growing concern of patients for themselves, for family members, and for other people important to them. When you believe it has reached the DSM-5 level of a mental illness — that is, “clinically significant distress or impairment in social, occupational, or other important areas of functioning" — and want to give it an ICD-10-CM code, we suggest: “F41.8 Fear of Deportation.”

Another approach that may be more accurate for some patients is to select that Disorder closest to the person’s symptoms (e.g., major depressive disorder) and also select the relevant Z-code (e.g., Z60.5, Target of Adverse Discrimination and Persecution). Actually, you can use the code Z60.5 with a more specific title, such as “Fear of Deportation.”

As to treatment, I find little empirical studies, but we can hypothesize that belonging to a support group would help regardless of symptoms, including being active in one’s mosque, church, synagogue, temple or other religious community.

Related to encouraging attendance at religious services to reduce dysphoria are studies that find such activities at least once a week produces a “five-fold reduction in suicide” [this month’s JAMA Psychiatry]. This is not the easiest topic for the County to weigh in on. An atheist might object?

A sign of the nation’s inadequate number of psychiatric beds: a South Dakota hospital tells psychotic patients, “Go directly to jail. Not welcome here.”

Eight years ago, the Washington Psychiatric Society [Sorel et al] called on the American Psychiatric Association to champion the integration of psychiatry with primary care, especially focused on the Collaborative Care Model [CoCMI]. But the model had been limited by not being paid for separately for this work. CMS has attempted to address this issue for Medicare by creating three codes that facilitate payments of practitioners within collaborate care. Using these three new codes, the primary care clinician can bill Medicare for each month in which a threshold amount of time is spent delivering CoCM services (for the first month, approximately $140 for 70 minutes per beneficiary; for subsequent months, approximately $125 for 60 minutes per beneficiary; and for all months, approximately $65 for each additional 30 minutes per beneficiary).

Medicare wants the psychiatric consultant to be a medical professional with psychiatric training and — given the prevalence and potential complexity of pharmacotherapy — be qualified to prescribe the full range of medications, and so this might be a psychiatrist, a psychiatric nurse practitioner or a physician assistant. This consultant must have a continuous relationship with the primary care practice (although he or she will typically be located elsewhere) and be able to help facilitate behavioral health specialty referral when indicated.

Consistent with the wishes of DSM-5 leadership to have fewer disorders than in DSM-IV-TR, vaginismus was not included, but, in answer to a recent question, it is still in ICD-10-CM, for those needing to so diagnose: F52.5. Given its somewhat unique treatment, we should have carried it over from DSM-IV-TR.

If wanting to emphasize to the patient that sugar consumption is a medical etiological agent via diagnosis, the code, I think, would be "R 63.8 [sugar over-consumption]."

In today's NY Times, "Drug used by Trump caries warnings," says that three of the medications used to treat baldness [Propecia, Proscar, Avodart], have permanent effects that continue after the medications discontinued. It goes on to say that this might include depression and suicidality.

In this month's Worst Pills, Best Pills:

1] In Dangerous Dosing Errors Rampant Among Parents Measuring Liquid Medications, the claim that four of five parents make at least one dosing error. The article suggests we write prescriptions in milliliters and suggest to parents that they use oral syringes with clear milliliter markings – and never use household spoons.

2] In prescribing for ADHD, many recommend screening for heart conditions. For the American Heart Association, "screening" consists of asking about heart-related signs, such as fainting, seizures, chest pain and whether there is a family history of such, and obtaining an EKG. The American Academy of Pediatrics, however, does not recommend EKGs be routinely done.

From the Lakphy Desk: Article on the many mental benefits of physical exercise in youth suggested the benefit is greater in adolescents who get to choose the intensity of the exercise. Speaking of " intensity," today's NY Times article on "Lessons From a 105-Year-Old," sugest that workouts that are 80% at an easy intensity and 20% be strenuous could improve fitness, even improve one's VO2 max. The aqrticle aslso suggests this 105 year-old's cognition is fine.

Roger