Folks,

In Sentinel 137, we listed codes that began with “R.” “R” means: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified.

From the lakphy desk:

1] US Preventive Services Task Force (USPSTF) recommends that children six and older be screened for obesity during routine checkups, and has released a report finding that “behavioral programs, which include individual and family therapy sessions focused on diet, exercise, and portion control have the greatest effect on weight loss.”

2] If your patients with obesity suggest that they can only be helped if they receive bariatric surgery, they are probably a NY Times reader. Tuesday’s NY Times had an article, ”Many Wrong on Causes of Obesity, Study Finds,” that championed the use of bariatric surgery and condemned efforts to blame diet and a lack of physical exercise. “Researchers say obesity, which affects one-third of Americans, is caused by interactions between the environment and genetics and has little to do with sloth or gluttony. There are hundreds of genes that can predispose to obesity in an environment where food is cheap and portions are abundant.” The article was published in Bariatric Surgery Journal and only bariatric surgery was championed as a treatment. Not clear why the NY Times’s article was not more balanced.

A review article on hepatic encephalopathy [NEJM, 27 Oct 2016] points out that the initial symptoms may be reduced awareness of surroundings, yawning, and dozing off.

For those wanting their patients to avoid sugary drinks, believing such leads to obesity, diabetes, and tooth decay, and suggesting its seriousness with a medical code, would suggest: “E67.8.” As for nomenclature, I don’t think we have a term, so maybe “eating too much sucrose” will do?

Suggested ways to foster resilience in your traumatized patients [Monitor on Psychology, Nov 2016]:
1] Encourage patients to have supportive relationships.
2] Help them create a narrative of their lives.
3] Teach them mindfulness.
4] Replace “why me?” with “what steps can I take to deal with the situation?”
5] Tell patients that setbacks are experiences to learn from, not be defeated by.

If you think deciding on whether a mentally ill person is competent to agree to surgery is easy, you have not read, “Closing the Morality Gap – Mental illness and Medical Care,” NEJM, 20 Oct 2016. Great review that suggests that the mentally ill’s dying 13-30 years before the rest of us may be partly due to barriers of physicians relating successfully to the mentally ill. The article addresses physician bias, assessing capacity, understanding the patient, and “it takes a village,” and suggests that an integrated health care system might make a different, but that idea is only rational, not empirical.

State hospitals, to which we do not want to return, did provide an integrated health care system. My recollection is that the mortality rate was not that different from the rest of the population. St Es occasionally held 100-year birthdays for a few of its long-term patients.

“Exposure to SSRIs during pregnancy was associated with an increased risk of speech/language disorder. This finding may have implications for understanding associations between SSRIs and child development” JAMA Psychiatry, Nov 2016.

In this week’s JAMA:

As to medications reducing violent crimes on released Swedish prisoners:

1] Those on antipsychotics, 42% decrease
2] Those on stimulants: 38% decrease
3] Those on addiction-focused meds: 52% decrease
4] Those receiving psychotherapy: lowered rate of violent crimes, but not as much as meds
5] Those on antidepressants: no decrease in violent crimes after release.
Article suggests that combining psychotherapy with one of the first three meds is probably the ideal approach to reducing violence from released prisoners.

Roger