All,

In this month's American J of Psychiatry, none of the 15 articles are focused on medications.

Last weekend's American Psychiatric Association Board of Trustees meeting addressed some 40 motions, including approving the APA Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder, to become available in a few months.

Twenty-eight years ago, the Washington Psychiatric Society launched a motion that the APA develop Guidelines. The requirements, however, to develop a guideline have become very taxing, so the number of Guidelines that are current (less than five years old) is far less than was the case a decade ago. Despite the challenge, we expect to champion a motion that the APA develop a Guideline on the non-pharmacological approaches to alcoholism.

Prescribers should be happy with the Swedish study of a large national registry that could not identify a significant association between maternal use of antidepressants and neurodevelopmental abnormalities in their children. After the researchers adjusted for potential confounders, use of antidepressants during pregnancy was found as only a non-significant trend toward increased risk of intellectual disability in the offspring, reported Alexander Viktorin, PhD, of Icahn School of Medicine at Mount Sinai in New York City, and colleagues.

"Exercise's Scary Side Effect" [NY Times, 18 July] advises that when prescribing physical exercise, one suggest a gradual increase in intensity because rhabdomyolysis can be caused by being too intensive in early sessions.

JAMA, 18 July, Relative to treating anxiety:

1] No new FDA approvals for this condition in the last decade.

2] For most patients with new onset anxiety, a thyroid-stimulating hormone test should be obtained.

3] Clinicians can investigate less-common diagnostic entities among patients who do not respond to anxiety treatment.

4] Asking "how is your anxiety" is not an adequate measure of progress. Better to use self-reporting measure at each visit, e.g., GAD-7 [free on line].

5] It is reasonable to start with:

A] physical exercise

B] mindfulness

and

C] have patients go to online resources of high-quality information about their illness and its treatment.

6] Most will need more than the three supra:

A] CBT by qualified therapist, which involves one or more:

1] Education

2] Self-monitoring

3] Cognitive restructuring

4] Exposure therapy

5] Breathing training and relaxation

Or

B] SSRI or SSRIs. Should begin at lowest available dose, and dose should be up-titrated every 2 – 4 weeks. The highest tolerable dose approved by FDA should be used for at least 2 weeks before med is deemed ineffective, at which point a different SSRI or SNRI should be tried.

i] If a med is effective, it should be continued for 9 to 12 months before considering tapering and discontinuing.

ii] If meds are ineffective, consider CBTs.

7] Benzodiazepines are to anxiety what opioids are to pain. When CBT has failed and meds are ineffective, benzodiazepines can be considered. They are highly effective in the short run, liable to be abused by some patients, and generally discouraged but sometimes indispensable for chronic use. Benzodiazepines should be avoided in patients with a history of substance abuse. [Gabapentin or pregabalin are potential substitutes.] Clonazepam, taken as scheduled not “as needed,” could be considered for treatment-refractory patients.

8] Yoga, meditation, and massage confer benefits to some patients.

9] Article recommends against ketamine awaiting further controlled studies.

10] Cannabis products are not recommended.

Roger

P.S. Today's news reminds me that several years ago, three of us tried, without success, to develop an understanding of why about 22% of us die of cancer, but only one person elected president [3%] has so died, the heavy smoking Ulysses S. Grant. We asked the living ex-Presidents if they had any explanation. Jimmy Carter wrote back, "Interesting, but I have no explanation."