All,

NEMJ, 29 June:

1] In the eighteen hundreds, direct electrical current to the skull was a treatment for the mentally ill. In 29 June NEJM, a study that used direct-current stimulation with depressed patients got results that were far better than placebo and were "noninferior" to escitalopram. Study used 2 mA of direct current for 30 minutes. Side effects included mania. No coma. Could a different intensive of the electric current get even better results? The NEJM article does not mention direct current's 170-or-so-year use.

2] From lakphy desk: For treatment of irritable bowel syndrome, increase physical exercise along with dietary recommendations and an effective physician-patient relationship. Usefulness of SSRIs is "unclear." Tricyclics found to be effective for this syndrome, but tricyclics's side effects could be problematic.

A recent headline in a psychiatric publication raises the question, what's new? "Clozapine, injectable antipsychotics linked to best schizophrenia outcomes." As you know, those two treatments for schizophrenia have been around for a long time.

An article in last Tuesday's NY Times, "The Physical Side of Anxiety or Depression," reviews one of our biggest worries: that we will miss an etiologically-based diagnosis. DSM-5 is limited help, focusing on what other psychiatric conditions to rule out, not what medical conditions [including psychiatric] to rule out.

Of help on ruling out conditions was a Psychiatric Times article early this year that had a listing of 47 conditions we may miss. It also listed 30 categories of medications whose side effects may include depression or anxiety.

Another approach, used by the Mayo Clinic, are the following three questions that suggest -- repeat, only suggest -- an etiologically-based condition when the patient is depressed or anxious:

1] No relatives had anxiety or depression

2] No anxiety or depression as a child

3] The anxiety or depression came out of the blue.

This month's JAMA Psychiatry:

1] Editorial says psychiatry "is slowly advancing from solely descriptive disease classification toward a biological-base taxonomy." Not noted in the article is that 40% of DSM-5 conditions are not descriptive-based, but etiologically-based.

2] In a prior Sentinel we noted a study saying there is a higher incidence of suicides in patients recently discharged from psychiatric hospitalization. In this month's JAMA Psychiatry, a study that is not just "recent" but shows an increase going back 10 years.

3] A study found that depression is a prodromal for dementia if it is a late-life depression, but no such association with early-life depression.

4] If there are 20 FDA-approved meds for schizophrenia, and someone wants to use two of them, I gather there are 190 possible combinations from which to choose. A study of 42 cotreatments concluded that none of the 42 cotreatments got positive results. Some studies have claimed positive results, but this review found methodological problems with those studies' conclusions.

Over the last four decades the Washington Psychiatric Society [WPS] has been setting the agenda of the American Psychiatric Association [APA] more so than the other 72 district Branches through about six motions annually to the APA Assembly over the past forty years. Over the summer, we can make suggestions to WPS -- suggestions ["Action Papers"] that WPS could advocate through APA's governance.
Some possible motions:

1] Explore adding Electronic Device Disorder to the next DSM.

2] Ask the Council on Research whether it would be useful to set some standards as to approved metaphors in psychiatry. For example, it is alleged that the metaphor that depressed patients suffer from a "chemical imbalance," even though the chemical was not established, was harmful to patients in suggesting, in the eyes of some, that psychosocial approaches would not be helpful.

3] The concept of "treatment resistant" is crucial clinically and in research. Its definition varies. Because of its importance, the field would be well served to have an agreed-upon definition that would vary from Disorder to Disorder.

4] Many psychiatric conditions are impacted by lifestyle. Under what circumstances is it ethically indicated to prescribe the lifestyle change before prescribing psychotherapy or a medication? For example, for mild or moderate depression, when it is more appropriate to prescribe physical exercise before resorting to prescribing a medication?

Tomorrow, be safe.

Roger

P.S. FDA's approval of valbenazine for tardive dyskinesia takes me back to the early 1980s for a long-winded reminiscence.

In the early 80s, I was at St Es as Director of this nation's largest mental health training Department – 13 programs, more than Harvard, Stanford or Hopkins. My feelings of self-satisfaction came to a halt when I got a call from Fuller Torrey saying it was time I did something useful and take over one of his wards in addition to my "very soft" education job.

I asked for a description of his wards, and one caught my attention. Fuller had the courage to say one of his wards consisted of 24 gentlemen who would be poorly served if they were placed in the community (not something you were ever supposed to say). Since I was championing the concept that asylum was the best choice for a small percentage of patients, that ward was attractive. It was a "1,000-year ward" in that the gentlemen, averaging about 40 years each at St. Es, had been there a total of 1,000 years.

I had the ward name changed from "12D" to the "Asylum Community," and we concentrated on giving those men as full a life as we could: walks on Saint Es' lovely grounds, movies, ball games, bus visits to what DC had to offer, and beer parties on Saturdays [Fuller, thinking his patients were more cultured, served white wine.].

By the early 1980s, the men had been on antipsychotics for decades, usually at high doses, in part because one way of abolishing tardive dyskinesia is to raise the antipsychotic dose.

Thinking each of the men deserved a trial without antipsychotics, I gradually reduced their dosage to see who needed it. Four of the 24 got worse, and we kept those four on their antipsychotics. A fifth developed joyous hallucinations, so we kept him off too.

But the downside was that I had St Es' largest crop of lip smackers, lip pursing, and so forth. NIMH researchers wanted me to agree to testing their newest med for tardive dyskinesia with these patients, but I said no because the men had no interest in being research subjects, and they were not much bothered by their tardive dyskinesia.

A very attractive finding about valbenazine is the claim that it abolishes tardive dyskinesia whether one continues or discontinues the antipsychotic. Let's hope that holds up.