Vignettes Illustrating Special Psychiatric Populations

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Pregnancy

Martha is a 28 y.o. woman who is 28 weeks pregnant. For the past month, she has struggled with anhedonia, low energy, persistent guilty feelings, frequent sadness and crying spells, and passive suicidal thoughts. She denies any history of manic symptoms and is not currently manic. She is only taking a prenatal vitamin. Her husband joins the appointment briefly to express his concern that she seems apathetic and is not caring for their other two small children. There is no evidence of substance use.

Pregnancy

1. Should you prescribe and antidepressant?
   a. Yes, but just not Paxil.
   b. No.
   c. Maybe… depends...
2. What do you and Martha need to consider before starting an antidepressant?
   a. Her due date.
   b. Risk of low birth weight, likelihood of a NICU stay, poor mother-infant bonding
   c. Risk of autism, heart defects, PPHN, and discontinuation symptoms
   d. Her ability to exercise and the availability of psychotherapy.
   e. All of the above.

Pregnancy

What if Martha is presenting with pressured speech, extreme distractibility, euphoric mood, and the belief that she and her unborn child are going to relocate to Mars where they will found a colony of superhumans?

- Should you start an antiepileptic or mood stabilizer (lithium?, Depakote?, lamotrigine?)?
- What about an atypical antipsychotic?

Pregnancy

- Takeaways:
  - The risk/benefit discussion is paramount.
  - Antidepressants are definitely linked to bad outcomes, but causality and clinical relevance of the risk muddy the waters.
  - Anticonvulsants and lithium have slightly more well-defined risks. Antipsychotics' risks are less well-defined (no noted connection to congenital defects).
  - Always keep in mind alternative treatments. Mainly, psychotherapy and exercise. But… factor in how likely the patient is to participate.

Pregnancy

- Links:
  - MGH Center for Womens Health section on psychiatry and pregnancy: https://womensmentalhealth.org/specialty-clinics/psychiatric-disorders-during-pregnancy/?doing_wp_cron=1484799282.2347838878631591796875
  - Abstract of meta analysis examining potential SSRI link to Autism: https://www.ncbi.nlm.nih.gov/pubmed/25498856
  - Less scholarly article r.e. SSRIs/Autism: https://www.scientificamerican.com/article/antidepressants-in-pregnancy-tied-to-autism/
  - Mood Stabilizers in Pregnancy and Lactation: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539876/

Lactation

Depressed Martha had a partial response to psychotherapy during her pregnancy, but now that she has given birth, she wants to consider medication for her residual depression. She is breastfeeding her 1 month-old child and wants to continue.

Lactation

1. Which antidepressant is your best choice?
    a. Fluoxetine.
    b. Paroxetine.
    c. Selegiline.
    d. Cannabis.

Lactation

- And the answer is… b.
- Takeaways:
  - Risk to baby is considered relatively low with all antidepressants and breastfeeding, so, again, R/B discussion is paramount. Factors like past efficacy may dictate your choice more than concentration in breastmilk, baby drug level, etc.
  - My general ranking of antidepressants for breastfeeding mothers:

    Sertraline/paroxetine > citalopram (escitalopram) > venlafaxine > fluoxetine > bupropion

    ??? – duloxetine, mirtazapine
  - -- Always watch for effects in the infant.

Lactation

Manic Martha also wants to breastfeed. What now?

- Depakote is much safer in breastfeeding than pregnancy (minimally found in breast milk).

- General recommendation is to continue other anticonvulsants during breastfeeding. They also are minimally present in breastmilk.

- There is minimal data on Atypical Antipsychotics. Adverse effects in the infant have been reported; somnolence is most common.

Lactation

- Links:
  - http://www.bcmj.org/article/use-antidepressants-pregnancy-and-lactation
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539876/
  - http://www.infantrisk.com/content/antidepressant-usage-during-pregnancy-and-breastfeeding

Cannabis Users

Tommy is a 22 y.o. man requesting psychiatric help for his panic attacks. He has had brief, debilitating attacks 1-2 times a week for the past two years. He started smoking cannabis daily, usually just in the evenings and at bedtime, about 5 months ago. Smoking seems to help with his anxiety in the evenings, but not consistently, and he is still having daytime attacks that affect his job. He does not drink alcohol or use other drugs. But, he does occasionally smoke cannabis all day in an attempt to control his panic. He has a significant history of childhood trauma (physical abuse).

Cannabis Users

1. Should you even consider prescribing him medication?
    a. No.
    b. Yes.
    c. Maybe… depends…
2. If you do prescribe, why? If not, why not?
3. Do you recommend he quit?

Cannabis Users

Motivation and Education Points for Tommy:

- Heavy Cannabis use can interfere with psychotherapy (which is indicated for Tommy).
- Regular cannabis use affects cognition ( 6-8 IQ points).
  - Brain is generally still developing until age 26.
  - For developed brains, IQ loss reverses with abstinence. Research suggests IQ loss can be permanent in underdeveloped brains.
- Quitting regular cannabis use can result in up to 60 days of “post acute” withdrawal (anxiety, irritability, insomnia, etc.).

Cannabis Users

- Other Issues:
  - How much use is too much?
    - Generally have to find out by trial and error.
    - Daily, daytime, use is generally problematic for therapy.
    - Nightly use is debatable.
    - Intermittent use requires examination of behaviors/emotions/patterns surrounding use.
  - Sleep?
    - Tends not to improve sleep quality.
    - Effect on sleep initiation depends on the strain and individual.
  - Inconsistent dose, varying potency and effects.
  - Increases in psychosis, may induce panic, may trigger schizophrenia at earlier ages.

Elderly

An 82 y.o. man is brought in by his children because he has been talking (sometimes yelling) to people or “spirits” who are not actually there. He also has been hearing voices. In one instance he chased these spirits with a knife, in another instance, he attempted to load a gun to deal with them. He has appeared confused more often and his memory has gradually worsened over the past 18 months. He has complained of hallucinations for the past 3-4 months. Family reports he is more sad and irritable in the last 6 months.

Elderly

1. What's your first step?
   a. Start an antidepressant.
   b. Start an antipsychotic.
   c. Rule out "physical causes".
   d. Start a PRN benzodiazepine.
2. Physical causes came back negative, what is your next step?
   a. Start an antidepressant.
   b. Start an antipsychotic.
   c. Start a PRN benzodiazepine.

Elderly

1. What do you warn the elderly patient/guardian about when starting an antipsychotic medication that you wouldn't warn a patient younger than 65 about?
   a. Death.
   b. Tardive dyskinesia.
   c. Metabolic problems.
   d. Akathisia and EPS.

Elderly

- Takeaways:
  - Use smaller doses, but don't be afraid to increase if not responding.
  - Black Box Warning about increased mortality is for *all* antipsychotics (not just atypical or conventional).
    - Mortality rate: 4.5% for antipsychotic-treated, 2.6% placebo
    - Death is from varying causes.
  - Alternative management of psychosis (and aggression) such as modifying the environment should always be tried.
    - Depending on the severity of the psychosis and whether depression can also be a factor, it may be worth trying an antidepressant first.
    - Unfortunately, medications are generally your only option for *directly* targeting psychosis.

Elderly

- Takeaways:
  - Antipsychotics may:
    - Improve psychosis or agitation
    - Make agitation worse
    - Do nothing
    - Lead to: falls, worsened cognition, prolonged QTc, pneumonia, cardiovascular events (stroke), EPS, tardive dyskinesias, and metabolic problems.

  So… Risk vs. Benefit calculation is again Vital.

Elderly

- Links:
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2989835/
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3516138/