



GUIDELINES ON THE USE OF MEDICATIONS

for Psychiatric Disorders with Substance Users

Adopted April 7, 1999, San Mateo Mental Health Services; Revised June 26, 2000

Robert Paul Cabaj, MD, Medical Director; Barbara Liang, PharmD, Director of Psychopharmacology

San Mateo Mental Health Services uses the following hierarchical or stepwise strategy when prescribing medications to patients with substance user disorders to minimize the potential abuse or dependency on prescribed medications. The basic principle is: low doses of safer and less abusable medications should be tried first, and higher doses or less safe agents should be used only if the initial approach is ineffective.

Insomnia/Sleep Disorders

When treating insomnia and sleep disorders in patients with substance use disorder, choose an approach that minimizes abuse potential.

First Tier: Simple "sleep hygiene" aids such as a glass of warm milk, a warm bath, meditation, or soothing music are the first recommended ways to deal with insomnia.

Second Tier: Trazodone (Desyrel) is an antidepressant and sleeping medication with no known abuse potential and low adverse effects. Dosage can start at 25 to 50 mg at bedtime and increase as needed to 100 to 200 mg.

Hydroxyzine (Vistaril, Atarax) or diphenhydramine (Benadryl). Doses can start at 25 to 50 mg at bedtime and increase to 100 to 150 mg. Some patients do get a "buzz" from the anticholinergic side effects and may overuse these medications.

Tricyclic antidepressants (TCAs) such as amitriptyline (Elavil) or doxepin (Sinequan). Doses for sleep can start at 25 to 50 mg at bedtime. Numerous adverse effects, and often lethal in overdose (amounts > 1 g [1,000 mg]).

Sedating antipsychotic medications such as chlorpromazine (Thorazine) should be used only in the presence of psychotic or manic symptoms, never for insomnia alone.

Third Tier: If the options above fail or are not appropriate, the non-benzodiazepine hypnotics should be considered, ideally on a short-term basis. Both zolpidem (Ambien) and zaleplon (Sonata) are effective, though tolerance and abuse of zolpidem has been reported. Both are relatively expensive.

Fourth Tier: If the medications listed above fail, a brief course of benzodiazepines should be considered, preferably on a short-term basis—ideally for less than two weeks. They should be moderately short acting, such as temazepam (Restoril) and lorazepam (Ativan), to minimize accumulation of medication and resultant sedation.

Ultra-short-acting agents such as triazolam (Halcion) should be avoided because they may cause withdrawal psychosis and confusion, including memory loss. Be cautious when prescribing long-acting medications such as diazepam (Valium) because of their cumulative effects. Flurazepam (Dalmane) also can have cumulative effects and may cause morning confusion ("hangover"). Caution is also urged with alprazolam (Xanax), which may be more abusable than other benzodiazepines

Anxiety Disorders

Chronic anxiety

First Tier: Alternatives to pharmacological intervention include relaxation techniques, meditation, supportive psychotherapy, or counseling, as well as stress management and reduction and possibly acupuncture.

Second Tier: Buspirone (Buspar) is a nonabusable medication for chronic anxiety, such as in generalized anxiety disorder. Buspirone is not effective in the treatment of acute anxiety, as it takes at least two weeks to act.

Serotonin reuptake inhibitors (SSRIs), such as sertraline (Zoloft), fluoxetine (Prozac) and paroxetine (Paxil), have been shown to be effective in the treatment of panic disorder. Due to their delayed onset of action, SSRIs are not effective for treating acute anxiety.

Tricyclic antidepressants (TCAs) such as imipramine (Tofranil) also are alternatives to potentially dependence-producing agents such as the benzodiazepines, and have been demonstrated to be effective for treating both generalized anxiety disorder and panic disorder. They are not effective for acute anxiety.

Third Tier: See third-tier section of Insomnia/Sleep Disorders above with the same cautions for the use of benzodiazepines: Choose relatively short-acting medications for limited-time use and at limited dosages

Acute anxiety

Other possible alternatives to the benzodiazepines for the treatment of acute anxiety disorders are beta-blockers such as propranolol (Inderal) and the antihypertensive agent clonidine. However, clonidine may pose a danger of overdose and should be dispensed in limited amounts (e.g., one week's supply). Hydroxyzine (Vistaril, Atarax) can also be used in doses of 25 to 50 mg in the daytime as needed as an antianxiety agent, although it is highly sedating. If these fail, then short-term (less than two or three weeks) use of benzodiazepines may be indicated.

Antipsychotics should not be used to treat anxiety if there is no evidence of psychosis, mania, or severe dementia.

Panic Attacks

First Tier: A non-benzodiazepine medication such as an SSRI should be tried first; if SSRIs fail, then try a TCA. Dosage should be in the

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ST. JOHNS WORT INTERACTIONS

Talia Puzantian, Pharm.D.

St. John's wort (*Hypericum perforatum*) (SJW) is widely used as an over-the-counter herbal remedy for depression. Although studies conducted in Germany have shown SJW to have comparable efficacy to tricyclic antidepressants, many of these studies had design limitations which have merited additional research. A recent study of SJW found the herb to be equivalent to placebo for the treatment of depression; currently another large-scale multi-center placebo- and sertraline- controlled trial funded by the NIMH is being conducted and these results should become available within the next year.

While we await further data to evaluate SJW's efficacy and its potential role in the management of depression, we must be aware and educate patients of the recent potentially significant interactions that have been reported with SJW used in combinations with various medications.

Serotonin syndrome - Patients taking sertraline or nefazodone with SJW had symptoms suggestive of serotonin syndrome (altered mental status, tremor, GI upset, headache, myalgia, restlessness).

Protease inhibitors - Eight healthy HIV-neg-

ative volunteers were given indinavir 800 mg q8hrs. SJW was added for 14 days and serum indinavir levels were compared pre- and post-SJW. Indinavir serum concentrations were reduced by a mean of 81% by SJW. This interaction in HIV-positive patients may be clinically critical as subtherapeutic serum levels of protease inhibitors often lead to antiretroviral resistance. The proposed mechanism of action of this interaction has been suggested to be cytochrome P450 3A4 induction by SJW. SJW may have a similar effect on other protease inhibitors as well as nonnucleoside reverse transcriptase inhibitors (NNRTIs) which are metabolized via the same pathway.

Cyclosporine - There has been a report of two previously stable heart transplant recipients and two renal transplant patients who had subtherapeutic cyclosporine serum levels and who experienced acute organ rejection after initiating SJW. After discontinuing the SJW, cyclosporine levels returned to normal therapeutic levels and rejection resolved. SJW may decrease cyclosporine levels by inducing CYP450 3A4 or by inducing the intestinal P-glycoprotein drug transporter.

Oral contraceptives - There have been reports of break-through bleeding when SJW was

combined with oral contraceptives containing ethinyl estradiol. Ethinyl estradiol is metabolized through the same pathway that SJW may induce, thereby reducing serum levels, and possibly efficacy, of oral contraceptives.

Warfarin - Several cases of subtherapeutic INRs have been reported when SJW was combined with previous stable warfarin therapy. SJW may induce the metabolism of warfarin, thereby resulting in subtherapeutic anticoagulation.

Digoxin - Subtherapeutic digoxin levels have been reported with the combination of SJW and digoxin. The proposed mechanism of this interaction is induction of the P-glycoprotein drug transporter. Caution should be exercised with this combination.

The examples described above are cases documented in the medical literature. There are many medications which are metabolized through similar pathways which may also be affected significantly. Health care providers should be aware of this potential risk and should alert patients about them. Serious reactions should be reported to the FDA Medwatch by phone (800) FDA-1088, fax (800) FDA-0178, or Internet <http://www.fda.gov/medwatch>.

CLOZAPINE-RELATED SIDE EFFECTS: TREATMENT OPTIONS

Keyur Parkih, Jennifer Herrmann. UCSF Pharmacy Students and Renee Williard, PhD.

HYPERSALIVATION (Incidence 30%)

- ◆ Encourage patients to sleep on their sides or with head slightly propped up. Advise patients to cover pillows and linens with towels.
- ◆ During daytime, some patients find chewing sugar-free gum helpful, possibly by promoting swallowing.
- ◆ Case study of 3 patients - atropine 1% Eye Drops - 1 drop sublingually at night (or 1 drop mixed in 8 oz of water and then swished around oral cavity.)
- ◆ If severe, consider the addition of an anticholinergic medication (benztropine 1-2 mg PO QD or trihexyphenidyl) or clonidine patch (0.1 mg patch applied QWeek (0.2mg if tolerance develops to 0.1 mg)). Amitriptyline 75-100 mg PO QD has also been used, but has sedating and anticholinergic properties.

SEDATION (Incidence 44%)

- ◆ Give lowest possible dose of clozapine and give most of it at bedtime.
- ◆ Avoid other CNS depressants.
- ◆ Monitor the use of Caffeine products. Both caffeine and clozapine are CYP 1A2 Substrates and studies show increases in clozapine levels with caffeine intake of 400-1000 mg/day.

- ◆ Some clinicians have used methylphenidate to ameliorate sedative side effects, but use with caution due to the possibility of worsening movement disorders and exacerbating psychoses.

SEIZURES (Incidence 3%)

- ◆ Occurrence appears to be dose related: 3% overall incidence, 1-2% for doses <300 mg. The majority of seizures are of the generalized tonic-clonic type and can usually be managed without discontinuation of clozapine.
- ◆ Factors that appear to increase seizure risk are rapid dose titration (both up and down), previous history of seizure disorders, and drugs that decrease the seizure threshold. Increasing clozapine dose too rapidly (>100 mg/day) and high dosage (>600 mg/day) seem to be more likely to precipitate a seizure. Slow titration, both up and down, usually can help to prevent seizures.
- ◆ If seizures are suspected or confirmed, obtain an EEG and neurology consult, reduce clozapine dosage by 50%, and consider adding a concomitant anticonvulsant such as divalproex sodium (avoid phenytoin, benzodiazepines, and carbamazepine).

AGRANULOCYTOSIS (Incidence 1-2 %)

- ◆ Weekly WBC monitoring. If WBC <3.5, recheck levels; if WBC <3.0 or ANC <1500, hold clozapine; if WBC <2.0 or Granulocyte/ANC ratio is <1000, discontinue clozapine and do not rechallenge.
- ◆ Avoid combining clozapine with other drugs that have the potential for suppressing bone marrow (i.e. other antipsychotics, carbamazepine, phenytoin)
- ◆ Patient education about monitoring for signs of infection (fever, chills, sore throat, urinary frequency or burning).
- ◆ Isolated case studies report the safe and effective use of Granulocyte-macrophage colony stimulating factor (GM-CSF) 75-150 mg SQ BID and 300 mcg of G-CSF in decreasing the duration of clozapine-induced agranulocytosis. A return to near normal levels of precursor bone marrow cells occurred within 5 to 8 days.

CONSTIPATION (Incidence 14%)

- ◆ Avoid concomitant anticholinergic and opiate-type medications.
- ◆ Ensure adequate hydration, encourage prune juice and high fiber diet.
- ◆ Add psyllium and/or docusate sodium.
- ◆ If unrelieved, consider bisacodyl or other laxatives.

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ALAMEDA COUNTY BEHAVIORAL HEALTH CARE

BHCS PHARMACY SYSTEM

Doug DelPaggio, PharmD

It has been another banner year for our BHCS Pharmacy System. With the co-operation of PCN (Pharmaceutical Care Network), we have negotiated an additional 5 year contract to continue the high level of services provided. In its fifth year of operation, the pharmacy network currently covers 21 programs throughout Alameda County, and consists of over 45 local pharmacies. For patients without a payer source receiving services through BHCS, overall medication costs for the past year were \$760,000. This figure has remained virtually constant over the past 4 years, (Graph #1) due to several cost-saving programs. Without these programs, our medication spending would have topped \$3 million dollars in 2000.

One of these cost savings programs is the BHCS MIA Program, implemented in 1998. Last year

we saved a record \$540,000 (Graph #2) through these collective programs. With the co-ordinated efforts of physician, case manager, clinic staff, pharmacy and our office, these complex programs have help reduced our total medication spending by supplying our indigent clients with free medications. We currently are working with 10 different programs, of which both Lilly's Zyprexa and Abbott's Depakote have been most successful, with 605 and 295 prescriptions filled respectively this past year.

The antipsychotic manufacturer indigent medication programs help reduce the per prescription cost of the medication. Both the average dose and prescription cost for 2000 are listed below:

DRUG NAME	AVG DOSE	AVG \$/Rx
Quetiapine	321 mg	\$ 171
Risperidone	4 mg	\$ 155
Olanzapine	15 mg	\$ 145
Clozapine	530 mg	\$ 70

Keeping total medication spending similar to that of 4 years ago is particularly challenging due to the newer antipsychotics (Zyprexa, Risperdal, Seroquel, Clozaril) which will account for 67% of the total antipsychotic prescriptions written during 2001 (Graph #3). These medications are much more expensive on a per prescription basis than the older antipsychotics, but bring unique improvements to the therapy of schizophrenia. Financially, these agents will account for 92% of the total antipsychotic costs in 2001. Furthermore, BHCS will spent over half of the entire medication budget on just these four drugs this year.

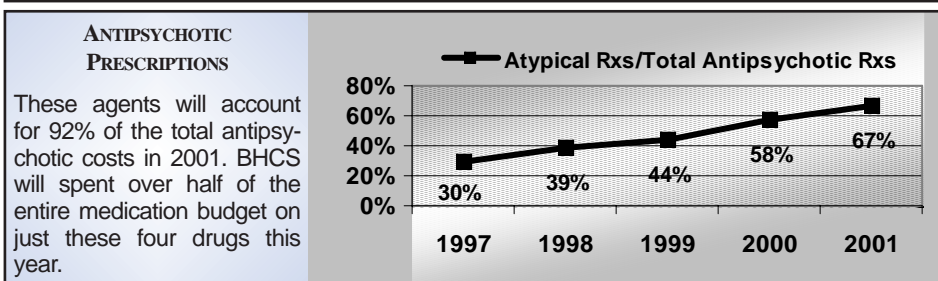
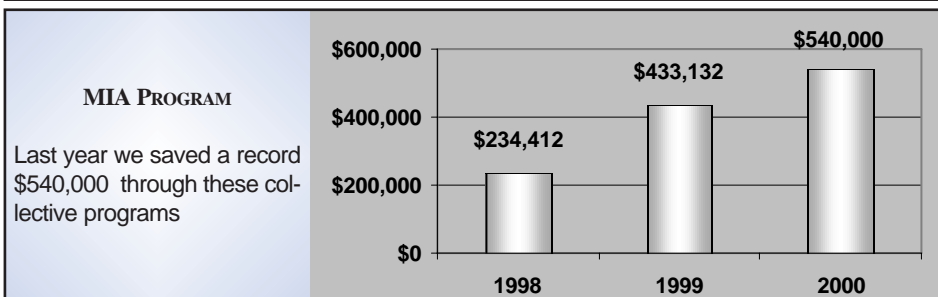
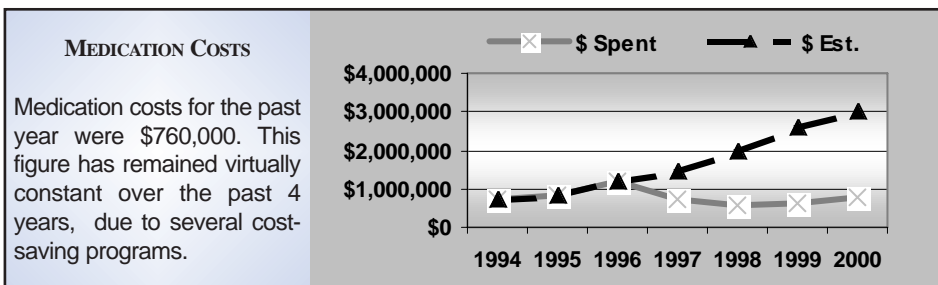
This year the Risperidone Outcome Study will be completed to add to our experience with olanzapine. Previously, our Olanzapine Study showed a reduction in acute inpatient utilization and costs, and conversely an increase in outpatient service utilization and clinical improvement. The overall impact of medication costs was insignificant in this intent to treat analysis.

HERB - DRUG INTERACTIONS IN PSYCHIATRY



Mark D. Watanabe, PharmD, PhD, BCPP

Interest in herbal medicine has continued to increase since the Food and Drug Administration categorized such remedies as "dietary supplements" in 1990. A 1997 survey estimated that nearly 60 million use medicinal herbs, resulting in annual sales exceeding \$2 billion (1). Given that many of these individuals are also taking prescription medications, patients may be placing themselves at risk for potential herb-drug interactions. Because the FDA does not hold manufacturers and distributors of dietary supplements to the same strict quality assurance standards applied to legend pharma-



TOBACCO SETTLEMENT FUNDS HEALTH CARE SERVICES EXPANSION

Richard Singer, M.D., Medical Director

In January 2000, the Alameda County Board of Supervisors adopted general policies regarding the allocation of funds received through the County's Tobacco Master Settlement Fund. These included broad recommendations to allocate no less than \$8 million for new program initiatives organized around four service clusters - school-linked services, expanded health coverage, behavioral health care for indigents, and public health. Between August and November, thirteen public hearings were held across the county to elicit input from all concerned citizens in order to develop more specific recommendations that were recently made to the Board of Supervisors. Both the program needs identified through this process and the monies requested for them far exceed the available funds, necessitating prioritization of the requests. David Kears, Health Care Services Agency Director, recently did so based in large part on assessing where augmentations could bring the greatest returns.

Specific program recommendations are as follows:

Expanded Behavioral Health Care Coverage to Indigents:

- ♦ \$2 million to develop and support a BHCS "insurance" plan for county indigents

Public Health:

- ♦ \$1 million to support Tobacco Cessation and Control Activities
- ♦ \$400,000 to support Public Health Infrastructure Needs and Enhanced Data Analysis
- ♦ \$300,000 to augment AIDS related activities

- ♦ \$300,000 to support expanded dental, senior and youth prevention activities within the Public Health department

School-Linked Services:

- ♦ \$1 million to Adolescent School-Based Clinics (stabilization of 7 existing ones and expansion to three or four new schools or areas)
- ♦ \$1 million to "Our Kids" (still in development; conceived as a multi-departmental, early intervention program aimed at high-risk children and youth not yet identified by our County system)

Expanded Health Coverage for the Indigent:

- ♦ \$1 million to support health coverage for IHSS (In Home Support services) providers (collaborative effort between Social Services Agency, HCSA and SEIU 616)
- ♦ \$1 million to support expansion of health insurance through the Kellogg/Robert Wood Johnson Initiative (to low income residents not covered by existing State, Federal or private programs)

The potential for improved outcomes and ability to leverage other revenue streams along with existing Board commitments and priorities, also led to the development of these recommendations.

In addition, Mr. Kears has recommended that approximately \$4 million of uncommitted Tobacco Settlement Funds be set aside to support capital projects and needs among the HCSA community-based provider network and within HCSA. These funds include savings incurred through the delayed implementation of the "new initiative" component of the Board's Tobacco

Master Settlement Fund (TMSF) policy.

More specifically regarding Behavioral Health Care's initiative, we are all aware of the limitations of

our present system of care in serving non-Medi-Cal and uninsured residents seeking mental health and drug and alcohol services. Due to current funding and mandates, generally only the most seriously and persistently mentally ill can be served by our Level I service delivery system of county-operated and CBO programs. Others with less severe illnesses are served by our Mental Health Plan network of private sector and other community providers, but only if they have Medi-Cal or other insurance coverage. In anticipation of the Tobacco Settlement funds, BHCS Administration has been in the process of developing an indigent care "insurance" product that is modeled after the existing Mental Health/AOD Medi-Cal benefit plan with the number of enrollees limited by the funds available. Pharmacy benefits are of course critical to any insurance plan, and whatever finally emerges will include some level of medication coverage as well.

It is anticipated that some level of Mental Health/AOD coverage for indigent residents of Alameda County will be implemented in 2001. While we know that the funds currently available fall far short of what is necessary to provide a comprehensive plan to all those in need, we nevertheless look forward to being able to at least begin making some inroad into this gap in our service delivery system.



HERB - DRUG INTERACTIONS

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ceuticals, available products of any given herb may differ in quantity or quality of active ingredient. This may confound definitive characterizations of any reported interaction. However, clinicians should be aware that more case reports are coming to light that implicate herbs in adversely influencing the effects of prescription medications. For example, a patient taking both alprazolam and kava together experienced increased sedation, leading to coma (2). St. John's wort, commonly used to self-treat mild to moderate depression, has been shown to decrease blood levels of both digoxin (3) and the protease

inhibitor, indinavir (4). This latter report may be of particular concern to those working in psychiatric medicine because it implies that St. John's wort stimulates the metabolic activity of cytochrome P450 3A4, a major catalyst in breaking down many psychotropic drugs. The clinical significance of these types of interactions beyond the anecdotal arena continues to be defined. The National Institutes of Health established in 1998 the National Center for Complementary and Alternative Medicine to conduct basic and applied research in order to help clarify some of the public health issues; their Web site address is: <http://nccam.nih.gov>. Other sources of information include the benchmark "Commission E Monographs" on phytomedicine, developed by

the German Federal Institute for Drugs and Medicinal Devices (Germany's equivalent to the FDA), summaries of which may be found in Herbal Companion to AHFS DI, published by the American Society of Health-System Pharmacists. While taking medication histories, it is important that clinicians ask each client about any supplemental use of herbal remedies. In this way, some potential herb-drug interactions may be identified beforehand, prompting a reasonable plan of action.

- (1) Drug Topics 1999 (Apr); 19: 101-110
- (2) Ann Int Med 1996; 125: 940-941
- (3) Clin Pharmacol Ther 1999; 66(4): 338-345
- (4) Lancet 2000; 355: 547-548

GUIDELINES

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same range that would be used to treat depression. Response takes two to four weeks.

Second Tier: If SSRIs or TCAs are ineffective, too risky, or not tolerated because of adverse effects, benzodiazepines could be used. Any benzodiazepine is likely to be effective when used in divided doses totaling approximately 10 to 60 mg per day of diazepam (Valium) or its equivalents.

Mood Disorders

Major depressive disorders

First Tier: The initial approach should include supportive psychotherapy (individual or group) and possibly peer-based supportive counseling. A careful evaluation must always be done before medications are prescribed. Mood disorder patients are at risk of suicide.

Second Tier: The serotonin reuptake inhibitor (SSRI) antidepressants-fluoxetine (Prozac), 20 mg per day; sertraline (Zoloft), 100 to 200 mg per day, paroxetine (Paxil), 20 to 50 mg per day, and citalopram (Celexa), 20 to 40 mg, are all safe and effective. They tend to be non-sedating and generally are safe even in overdoses. They are usually the most tolerable antidepressants.

Trazodone (Desyrel) also is safe but its sedating properties limit its usefulness. However, it can be useful as a sleeping medication.

Bupropion (Wellbutrin) is another non-TCA that is generally safer in overdose than the TCAs. It must be given in two or three divided doses up to a max of 400mg to 450mg per day. Bupropion tends to increase the risk of seizures more than other antidepressants, but has a lower incidence of sexual dysfunction.

Nefazodone (Serzone) is also a non-TCA, and is generally better tolerated than TCAs. It may be helpful for patients with sleep difficulties or sexual adverse effects associated with SSRIs. Nefazodone generally is given in at least two doses per day, totaling a daily dose ranging from 300 to 500 mg/day.

Mirtazapine (Remeron) is yet another non-TCA. It is sedating and is associated with weight gain, but has little adverse sexual effects and can be given in a single nighttime dose ranging from 15 to 45 mg per day.

Third Tier: TCAs are not addictive, but they have a number of troublesome side effects, which may be offset by low dosages. Substance-abusing patients may be more likely to request TCAs that have sedating effects, such as doxepin (Sinequan) and amitriptyline (Elavil).

All of the TCAs are lethal in overdose and should not be given to unmonitored suicidal patients.

Fourth Tier: Psychostimulants may be useful for treatment refractory patients with severe psychomotor retardation. Some dramatic, rapid improvement has been observed. Extreme caution however is necessary with amphetamine abusers and cocaine or crack abusers and psychostimulant use is best avoided.

Monoamine oxidase (MAO) inhibitors should be avoided unless all other treatments fail. Use of these medications requires dietary restrictions and carries the potential for lethal hypertensive interactions with other drugs.

Bipolar disorder

Evaluation of the substance user with mania must include a high level of suspicion that the disorder is caused by use of substances such as stimulants.

Lithium is nonabusable but must be monitored carefully because of side effects, which include dehydration, diarrhea, and altered mental state. Other adverse effects of lithium include tremor, excessive thirst, frequent urination, and weight gain.

The anticonvulsant medication carbamazepine (Tegretol) is also useful but it can cause severe neutropenia (bone marrow suppression). (Note: Patients maintained on methadone and carbamazepine may induce liver enzymes that can metabolize methadone more rapidly than normal and lead to opiate withdrawal symptoms, which may necessitate higher doses of methadone.)

Valproic acid or divalproex sodium (Depakote) is another alternative to lithium. It avoids the problems of carbamazepine and may be safer to use.

Gabapentin (Neurontin) has also been suggested as a mood stabilizer but no controlled studies have demonstrated its effectiveness.

Psychosis/Severe Manic States

Psychosis is frequently caused by substance use such as "crack" cocaine intoxication or alcohol withdrawal. Substance use should always be evaluated thoroughly before prescribing.

The atypical antipsychotics such as olanzapine (Zyprexa), risperidone (Risperdal), and quetiapine (Seroquel) are the first line medications for patients newly diagnosed with psychotic disorders and should be considered for all patients on traditional antipsychotic medications. The traditional antipsychotics, however, may be best for treatment of brief or transient psychotic states including substance-induced psychosis.

Traditional antipsychotic medications include haloperidol (Haldol), chlorpromazine (Thorazine), thioridazine (Mellaril), trifluoperazine (Stelazine), and many others. These medications are also occasionally used for the management of agitated confusional states, such as in late-stage dementia. Haloperidol is effective in the management of substance-induced psychosis, on a short-term basis.

Attention Deficit/Hyperactivity Disorder (Adults)

A thorough psychiatric evaluation of the patient should precede the use of psychiatric medications. ADHD in adults is rare and almost always in preceded by a documented history of child ADHD. Adults who use stimulants are often diagnosed with ADHD; they may be trying to seek stimulant medications.

First Tier: If medications are indicated, antidepressants are the first choice.

TCAs have been shown to be effective, but may take some time to work. Supportive therapy may be quite helpful in that period. (Desipramine should be avoided in children.)

All of the TCAs are lethal in overdose and should not be given to unmonitored suicidal patients.

Second Tier: Bupropion (Wellbutrin) has been shown to be effective for Adult ADHD and may be better tolerated and safer to use than the TCAs.

The role of other non-TCAs, including SSRIs, is not well studied but MAOIs have also been shown to be effective but have the dietary restrictions.

Third Tier: Psychostimulants are very effective in children and may be effective in adults but have the risk of dependency and addiction and should never be used with patients who have histories of stimulant abuse. The most common medication is methylphenidate (Ritalin). A mixture of salts of D- and L-amphetamine (Adderall) is also effective but has high risk of dependency and addiction and is best avoided.

TREATMENT OPTIONS

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TACHYCARDIA (Incidence 25%)

- ◆ Usually transient and related to rate of dose titration.
- ◆ Rule out cardiovascular disease through EKG and appropriate testing
- ◆ If persistent and symptomatic, treatment with a peripheral Beta-blocker may be required (preferably atenolol).

URINARY INCONTINENCE (Incidence 5%)

- ◆ Decrease fluid intake, especially in the evening to avoid nocturnal enuresis.
- ◆ Alpha-agonist at bedtime: Ephedrine 25 mg HS, increase by 25 mg to a max of 150 mg.
- ◆ Intranasal desmopressin (dDAVP) 20 mcg (10 mcg into each nostril).



CONTINUING MEDICAL EDUCATION

<p><i>Doug DelPaggio, PharmD MPA</i> Sleep Disorders <i>Charles DeBattista, MD</i> January, 31 2001 12-1pm Alameda Co. BHCS (510) 567-8106</p>	<p>Pharmacotherapy: impulsivity <i>Alan Swann, MD</i> March 2, 2001 12-1pm SFGH Room 7M30, 1001 Potrero Ave (415) 206-4938</p>
<p>Psychiatric Problems of Russian Speaking Immigrants <i>Masha Mednikov, PhD</i> February 6, 2001 12:15-1:45pm Mills Peninsula , 1783 El Camino (650) 696-5813</p>	<p>Substance Abuse <i>Pablo Stewart, MD</i> March 13, 2001 12:15-1:30pm San Mateo MHS, 225 West 37th St. (650) 573-2530</p>
<p>Schizophrenia & Diabetes <i>Richard Petty, MD</i> February 8, 2001 12-1pm Alameda Co. BHCS (510) 567-8106</p>	<p>Anger Mgmt <i>Pamela Rudd</i> March 27, 2001 12:15-1:30pm San Mateo MHS, 225 West 37th St. (650) 573-2530</p>
<p>Psychiatry and Spirituality <i>Elizabeth Targ, MD</i> February 13, 2001 12:15-1:30pm San Mateo MHS, 225 West 37th St. (650) 573-2530</p>	<p>Update: Cognition & Atypicals <i>TBA</i> March 28, 2001 12-1pm Alameda Co. BHCS (510) 567-8106</p>
<p>Dialectic Behavioral Therapy <i>Joris Wiggers, MD</i> February 27, 2001 12:15-1:30pm San Mateo MHS, 225 West 37th St. (650) 573-2530</p>	<p>TBA <i>Todd Denys, PhD</i> April 10, 2001 12:15-1:30pm San Mateo MHS, 225 West 37th St. (650) 573-2530</p>
<p>Tx Options: BAD <i>Ralph Aquila, MD</i> March 1, 2001 12-1pm Alameda Co. BHCS (510) 567-8106</p>	<p>Giving in Psychotherapy <i>Randy Wiengarten, MD</i> April 24, 2001 12:15-1:30pm San Mateo MHS, 225 West 37th St. (650) 573-2530</p>

The Bay Area Psychopharmacology Newsletter

is produced quarterly. Please submit questions or comments to the newsletter at 2532 Santa Clara Ave., PMB 219, Alameda, CA 94501.

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THIS NEWSLETTER IS SUPPORTED BY UNRESTRICTED EDUCATIONAL GRANTS FROM:

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