Welcome to the sixth issue of Psychademic! Although we are transitioning release frequency we continue to strive for enhancement as physicians and medical professionals to improve quality of patient care. We hope the transition will allow more time for community engagement and submissions. We open with a piece submitted by Dr. Wadhwania. She completed her adult psychiatry residency at ECU/Vidant. She was a previous chief resident and has since transitioned to an outpatient practice in Georgia. Thank you and we hope you enjoy.

Into The Real World!
Dr. Munisha Wadhwania, MD
Adult Outpatient Psychiatrist in GA

In the ‘real world’ practicing in an urban public mental health center, under my own license was a little scary to begin with. Maintaining communication with “co-residents– turned–friends” has been a huge external support throughout the transition. I have also been lucky to build some great relationships with ECU faculty and my colleagues here, whom I can turn to for advice and recommendations. More seasoned psychiatrists here, have not only turned to me for questions related to the EHR and navigating the technology, but have also asked for second opinions on their cases, which feels empowering.

The first 3-4 months was a period of adjustment– new place, new people, getting to know the system I am working in, building my case load, learning the state specific rules/regulations, and of course preparing for and writing boards, which is definitely a nightmare.

No matter how much you study for it, or don’t study enough for it in residency (something which I am guilty of), the 3 months preceding the boards are critical. Make sure your work load at your new job is not exhausting you, so you have enough time to prepare and study– something you would have to be mindful of when you sign your contract.

Investing in Beat the Boards and for the last month, getting Board Vitals, was a savior. Prepare for the worst during the exam– I went in to the exam with a sinus infection, fever and a migraine, but I pulled through and all the hard work paid off.

This past year I have come across some different things such as sitting in a death review of your own patient, learning the billing of notes as it relates to productivity, and of course the massive and extensive paperwork that we are blessed with from patients that go beyond just disability forms– there is citizenship paperwork, emotional support animal letter request, student loan extension request forms, fmla, etc. And I’ve learned to say ‘no’ to most of those requests eloquently.

All in all besides better compensation compared to residency, you get the added benefit of not needing to actually “request permission from multiple authorities” for time off, which was a little awkward for me the first time I put in my PTO. Comparatively, I now have more time for myself, for activities, for reading (other than journal articles and medicine), for traveling etc. But remember to save, save, save no matter how much you are earning!
Resident Spotlight

Congratulations to Dr. William Bridge IV, one of the upcoming Chief Residents. Dr. “Bill” Bridge is from Cleveland, Ohio. His favorite aspect of psychiatry is the acute inpatient setting and the process of diagnosing patient decompensation. He is interested in practicing in a setting in which he can combine his training in internal medicine as well as psychiatry. Ideally he would practice in: Charleston, Savannah, or Wilmington. He currently has a girlfriend Elizabeth and a Newfoundland puppy named Lincoln. In his spare time, he enjoys running, tutoring, web design, and real estate ventures.

The following is one of Dr. Bridge’s favorite experiences in psychiatry: While in medical school, a patient with history of schizophrenia, was admitted by IVC after seen running down the freeway with a T-shirt tied around his neck like a cape in the middle of the winter. He presented paranoid and refused to be interviewed in a private room and requested that his admission evaluation be completed at the common area/dayroom table.

A few minutes into the interview, a bearded patient, pulls up the only available chair at the table (myself, the attending, and the caped crusader, taking up the other 3 chairs). The bearded patient proceeds to put his head down on the table, while remaining silent.

The new patient and attending were not concerned and the interview proceeds. The attending continues, “It says here on your admission paperwork that you told the police, that you were Superman.” The new patient replies, “Yes, it’s true, that is me.” The attending asks, “How may I ask do you, know this to be true?” New patient says, “Because Jesus Christ, the Lord, Our Savior came to me and told me that I’m Superman.” Immediately, the bearded patient, picks up his head from off the table and says, “Excuse Me, that’s BULL... I never told him that!”

Resident of the Month

We would also like to spotlight one of our recent resident of the month, Dr. Megan Mertesdorf! Dr. Mertesdorf grew up in Wilmington, graduated from medical school at ECU, and plans on staying in North Carolina in the future, to hopefully practice inpatient psychiatry. Her favorite aspect of psychiatry is getting to know individuals at a very personal and intimate level; and feels honored when patients trust her with their personal troubles. She has a boyfriend named Taylor who is completing his PhD in clinical health psychology at ECU. She enjoys spending her spare time with friends and family while hanging out “uptown” or going the movies.

The following is one of Dr. Mertesdorf’s favorite experiences in psychiatry: An individual from several states away presented to our ED with some minor injuries. While in the ED, he appeared to be delusional and psychiatry was consulted. He claimed that several other people were tracking him down to kill him. He had destroyed his phone so that people could not track him, and was actively trying to avoid cameras. He was extremely paranoid and agitated on interview, and appeared to be decompensated from a mental illness such as schizophrenia. However, when he finally agreed to give us phone numbers to his family members it turned out he had participated in an illegal activity and people really were tracking him over state lines to get him. This case really drove home how important collateral information can be!
**Resident Council Updates**
Interested in a resident sub-committee? Diversity Committee, Education and Evaluation Committee, Quality and Safety Committee, Technology and Communications Committee are a few. Contact your resident council representatives Dr. Brooks or Dr. Alami.

**Resident Opportunities**
*APA 100% Club for Residency Training Programs* The APA 100% Club was established to encourage residents throughout the United States and Canada to join the APA with fellow trainees in their programs.

**Conference Watch:** Local Eighth Annual NC Community Psychiatrists' Leadership Network Symposium May 19, 2018 Chapel Hill, NC.

**Depression and Suicide in Children and Adolescents by Charlotte Area Health Education Center (AHEC) May 21, 2018 Charlotte, NC.**

Psychopharmacology of Addiction and Co-Morbid Mental Disorders May 31, 2018 Charlotte, NC. Understanding the underlying mechanism of this co-morbidity is essential in adopting effective treatments for these mental disorders. Participants attending this workshop will develop a broad scientific perspective on psychopharmacology of addiction and co-morbid disorders.

**Buprenorphine Office-Based Treatment for Opioid Use Disorders June 22, 2018 Asheville, NC.** Treating patients with opioid use disorders in office-based settings and clinical vignettes to help trainees think through “real life” experiences in opioid use disorders treatment.

**Geriatrics Psychiatry and Palliative Medicine Jun 22 - 24, 2018 Asheville, NC**

**NCPA 2018 Annual Meeting & Scientific Session**
September 27-30, 2018 Asheville, NC **Submission Deadline: June 30 Applicants notified by: July 31**

**Requiring Travel**
International Stress and Behavior Society (ISBS) 14th International Regional Neuroscience and Biological Psychiatry Conference June 22-23, 2018 Miami Beach, FL

2018 APA Annual Meeting 5/5-5/9 NYC, NY. The 73rd SOBP Annual Meeting will take place in New York City May 10th-12th, immediately AFTER the APA meeting. The theme of the 2018 Annual Meeting is “Biomarkers, Biomodels, and Psychiatric Disorders.”


The 2018 ASCP Annual Meeting Miami Beach, FL from May 29 - June 1, 2018. Key aspects of neuropsychiatric drug development, including the impact of diagnostic changes and personalized interventions based on biomarkers or genetic information.

**Focus on Neuropsychiatry 2018: Solving Clinical Challenges, Improving Patient Care**

centric advances and emerging trends in the assessment, treatment and monitoring of patients with neuropsychiatric disorders.

June 15-16, 2018 Arlington, VA. The clinical emphasis on neuropsychiatry will be the focus throughout. Following an Update on the Neuropsychiatry of Ketamine, topics include Sport Concussion, Traumatic Brain Injury, Autism, Aggression, Impulsivity, ADHD, Epilepsy, Schizophrenia, Bipolar Disorder, Parkinson’s Disease, Neuroplasticity in Depression.
Yoga has been around likely since 6th and 5th centuries BCE. It did not get introduced to western civilization until 19th and 20th centuries. In western civilization, it has been mainly used as physical exercise, however it has been meditative and spiritual in Indian tradition. Yoga has been used to promote relaxation, reduce stress, and improve some medical conditions. Recently more workplaces have been incorporating yoga, as it has been shown to reduce stress, enhance emotional well being, and improve resilience. A quick article search shows numerous studies testing how yoga can be incorporated into the workplace to improve these factors. As mental health professionals, we need to care for our own emotional well being as we encourage our patients to do the same. Wouldn't it be great to practice what we preach?

One study, *Improving physical and mental health in front line mental health care providers: Yoga-based stress management versus cognitive behavioral stress management*, attempted to see how yoga could impact mental and physical well being specifically in mental health care providers. This study focused on health related quality of life, coping skills, emotion regulation, mindfulness, and self compassion. Many of these factors, including overall mental health, improved in the yoga treatment group. Many other similar studies faltered on continuing employee engagement with yoga practices and trying to find a time that worked well for employees to have a class. Despite these barriers, it is my impression that yoga could be a beneficial addition to our workplace.

*Be on the lookout for further information about upcoming yoga sessions that will take place for all psychiatry residents, faculty, and staff to partake in!*
Violence Risk Assessments and Managements

Although many people with mental illness are not violent, mental health professionals are often called upon to perform violence risk assessments in a variety of settings and situations. Currently about 3-5% of all violence is attributable to mental illness. The level of violence is not statistically higher among those being treated for mental illness than the general population.

**Goal of risk assessment:** identify factors and situations derived from research or personal history that place a person at a greater risk for violence and then to use the assessment to develop a plan of action to reduce risk.

**Risk factors**:

**Static and Dynamic**
- Static: factors that cannot be altered.
- Dynamic: factors that can be altered. These are often the targets for treatment.

**Examples**:
- Static: history of violence, age, sex (male)
- Dynamic: Substance use, current mental state, compliance with medications, access to weapons, intent to harm, sees self as victim, role of social support (either not protective or provocative)
- unstable housing, unemployment

"Central Eight" Criminogenic Risk Factors (increase risk of violence in both general population and people with mental illness)
- History of antisocial/criminal behavior
- Antisocial personality pattern
- Antisocial cognitions/attitudes
- Antisocial associates
- Substance abuse
- Employment instability
- Family problems
- Low engagement in social leisure activities

There are risk factors associated with violence that are outside the scope of psychiatry including: poverty, homelessness, exposure to violence.

1. **Gather history:** When gathering a history, the patient provides you with clues to make an acute assessment. They provide an account of past behaviors (best predictor of future behavior), employment, social relationships, substance use, affective control. For people in early stages of mental illness without a history of usual risk factors, pay attention to the change in their function which can help you gauge the burden of their disorder and a change in risk. Decline in rational thought, emotional control, and problem solving may be just as much of a measure of risk as it is an indicator of severity of their illness. For example, a patient in the early stages of psychosis may be experiencing issues with social perception, rational thought, paranoia which may contribute to aggressive and unpredictable behavior.

2. **Get Collateral:** Patients are not always forthcoming with history of violence, substance use, or delusions. Call those who know them better to get a sense of how they have been doing.

3. **Assess Risk:** Having a high acute risk is different than having a high chronic risk of violence. The acute risk is most important when working in the emergency room as this is the difference between going home or being admitted.

4. **Decide Disposition:** Admit to inpatient or discharge are your ultimate decisions in the emergency room.

**Managing risk:**

As mental health professionals, we have the ability to treat certain dynamic factors which in turn mitigates their overall risk. If patient is experiencing psychosis, paranoia, or delusions, we treat with medications. If the patient is experiencing symptoms of aggression or psychosis secondary to substance use, we remove patient from this and assist with abstinence in the acute setting.

Violence and aggression are multifactorial and therefore cannot always be treated with medications alone. MHPs can assist patient with coping skills in order to help them reduce their anger in certain situations.
What is Hemophagocytic Lymphohistiocytosis?

On April 27th 2018 many of you may have seen that the FDA issued a safety announcement regarding a rare side, but serious immune reaction caused by Lamotrigine. As we all know Lamotrigine (Lamictal) has been approved for the treatment of patients for Bipolar Disorder and seizures. According to the FDA there have been reports of hemophagocytic lymphohistiocytosis (HLH) in some patient taking Lamictal. HLH is an uncontrolled response by the immune system and typically presents with a persistent fever (usually greater than 101F). HLH can ultimately lead to severe problems with blood cells and organs throughout the body such as the liver, kidneys, and lungs. If the reaction is not diagnosed or treated quickly and can ultimately lead to hospitalization and death.

According to the report there have been eight worldwide cases of confirmed or suspected HLS. Of the eight cases, three were suspected only fulfilling four of the eight HLH-2004 diagnostic criteria. All the cases reported hospitalization, three reported other serious medical events, two reported outcomes being life-threatening, and there was one reported death. The symptoms of HLH were reported to have occurred within eight to 24 days of initiating Lamictal. The treatment reported in the eight cases included discontinuing Lamictal, steroids, intravenous immunoglobulin, blood products, and chemotherapy.

Diagnosis of HLH is often complicated because early signs and symptoms, such as fever and rash are not specific. It can be confused with other serious immune-related adverse reactions such as Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS). A diagnosis of HLH can be established if a patient has at least five of the following eight signs or symptoms:

- Fever and rash
- Enlarged spleen
- Cytopenias
- Elevated levels of triglycerides or low blood levels of fibrinogen
- High levels of blood ferritin
- Hemophagocytosis identified through bone marrow, spleen, or lymph node biopsy
- Decreased or absent natural killer cell activity
- Elevated blood levels of CD25 showing prolonged immune cell activation.

As a result, the FDA is requiring the risk of HLH be added to the prescribing information in the lamotrigine drug labels. The FDA also encourages prescribers and patients to report side effects involving Lamictal and other medicines to the FDA MedWatch program.
The Joy of Psychotropics

Across
4. This medication blocks voltage gated Na channels and inhibits glutamate release.
7. Atypical antidepressant that can be used for anxiety at low doses.
8. The SSRI that is the most sedating, greatest weight gain, and greatest sexual side effects.
9. This medication has the highest risk of hyperprolactinemia.
11. The injectable can cause post-injection delirium and must be given at a healthcare facility and monitored for 3 hours.
12. This can be used to treat Akathisia.
13. This medication can cause dose related QT prolongation.
14. The SSRI that has the lowest weight gain and greatest risk for serotonin syndrome.

Down
1. The most sedating antidepressant.
2. This is one of the Benzos approved for panic disorder.
3. This medication can be used for depression and neuropathic pain.
4. The signs of toxicity are tremor, polyuria, thirst, cognitive impairment, and nausea and diarrhea.
5. This medication requires that you monitor WBC and ANC frequently.
6. This is one of the medications that can cause Steven-Johnson Syndrome.
10. Medication that lowers the seizure threshold and has stimulant effects.

References

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