Volume 41
Number 4
February 17, 2006

PSYCHIATRIC NEWS

Newspaper of the
American
Psychiatric
Association

APA's 159th Annual Meeting

FROM SCIENCE TO PUBLIC POLICY
ADVOCACY FOR PATIENTS & THE PROFESSION

TORONTO, CANADA • MAY 20-25, 2006

After an eight-year absence, APA is returning to vibrant, cosmopolitan, friendly Toronto. Long a cultural mecca, Canada's largest city has in the last decade gained fame for its prestigious international film festival and wealth of theater offerings.

A large part of Toronto's excitement comes from its incredibly diverse population. More than 80 ethnic groups have made their traditions, crafts, and cuisine an integral part of the fabric of this international city.

The program for the annual meeting is diverse as well. Sessions large and intimate will explore cutting-edge research and the latest knowledge in clinical advances, as well as explore the consequences of health care disparities. In keeping with the meeting's theme, many outstanding sessions will illuminate issues concerning the need for psychiatrists to be advocates for their profession and patients.

This issue of *Psychiatric News* contains the annual meeting preliminary program, help in navigating the meeting, and lots of suggestions for leisure activities.

For registration information, see page 4.

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Newspaper of the American Psychiatric Association **PSYCHIATRIC NEWS**

An Equal Opportunity Employer
Print version: ISSN 0033-2704; printed in U.S.
Online version: ISSN 1559-1255

Published on the first and third Fridays of each month. Periodicals postage paid at Arlington, VA., and additional offices. Postmaster: send address changes to *Psychiatric News*, American Psychiatric Association, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901.

Subscriptions
U.S.: individual, $82; student, $29.
International: APA members, $82; nonmembers, $148; student, $52. *Single issues:* U.S., $17; Canada and international, $27. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777, or e-mail appi@psych.org.

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Fascinating Sessions in Exciting City Promise Not-to-Be-Missed Meeting

Toronto claims to be the most diverse city in the world—a different kind of place that appeals to different kinds of people. What better backdrop could there for an annual meeting that offers a diverse program encompassing science, clinical issues, and public advocacy?

BY MARIAN BUTTERFIELD, M.D.

Even Goldilocks would be pleased by a trip to Toronto in May: it's not too hot, it's not too cold; it's just right!

Yes, this year's annual meeting is being hosted by our sophisticated northern neighbor, a city rich in culture and Canada's most important urban center. Located on the north shore of Lake Ontario, Toronto is the hub of the nation's commercial, financial, and industrial activities and is home to numerous museums, historic sites, and performing and visual arts centers.

The theme of this year's meeting, selected by APA President Steven Sharfstein, M.D., is "From Science to Public Policy: Advocacy for Patients and the Profession" (see facing page). As those of you who attended the 2005 annual meeting know, Dr. Sharfstein called on all APA members to become involved in advocacy work, whether on the local, state, or national level. All the scientific knowledge that psychiatry has gained in the last 20 years means little if Americans do not have access to high-quality mental health care. A number of sessions—including a series of presidential symposia that Dr. Sharfstein describes in his column—will expound on this important point.

With Dr. Sharfstein's input, the APA Scientific Program Committee and annual meetings staff have planned another outstanding program that offers you information on the latest clinical and research advances in psychiatry. That program will include a special track of sessions offered in collaboration with the National Institute on Alcohol Abuse and Alcoholism (see page 10). The track will focus on promising new treatments and research developments for people with alcohol use disorders. Using a "translational" approach, the sessions will provide information that is both accessible to practicing clinicians and compelling for researchers.

And that's just one of the highlights of this year's annual meeting. The program will begin in the Toronto Convention Centre on Sunday, May 21, when Dr. Sharfstein gives a "state of the APA union" address to members at the Opening Session. Incoming APA President Pedro Ruiz, M.D., will also make remarks.

On Monday, May 22, David K. Shipler will present the William C. Menninger Memorial Lecture at the Convocation of Fellows. Shipler won the Pulitzer Prize in 1987 for his nonfiction book *Wounded Spirits, Arab and Jew in the Promised Land.* This book was born out of his experiences as a *New York Times* correspondent in Jerusalem. He also wrote *A Country of Strangers: Blacks and Whites in America* and was invited to participate in President Clinton's first town meeting on race relations. Shipler's most recent book, *The Working Poor: Invisible in America*, highlights his keen understanding of the challenges and barriers faced daily by people who live in poverty. The Convocation will be held at 5:30 p.m. at the Toronto Convention Centre.

Afterward, don't rush to leave the convention center. At 7 p.m. the Toronto Welsh Male Voice Choir will perform in a concert to benefit the Disaster Relief Fund (see page 5). This fund was established by APA and the American Psychiatric Foundation to provide assistance to psychiatrists affected by disasters.

I urge you to attend the entire Distinguished Psychiatrist Lecture Series. Two lectures relate directly to the meeting theme: The first lecture, titled "Psychiatric Implications of Displacement: The Emotional Costs of Losing Human Habitat," will be given on Tuesday, May 23, at 11 a.m. by Mindy Thompson Fullilove, M.D., a research psychiatrist at the New York State Psychiatric Institute and a professor of clinical psychiatry and public health at Columbia University. She has extensively studied AIDS and other problems of inner-city neighborhoods and received a Robert Wood Johnson Health Policy Investigator Award to study the consequences of urban renewal on African-American communities. Her recent book, *Root Shock: How Tearing Up City Neighborhoods Hurts America and What We Can Do About It*, examines this issue.

please see ***Sessions*** *on page 65*

APA RESOURCES

- **APA and the APA Answer Center:** (888) 35-PSYCH in the U.S. and Canada; in other countries: (703) 907-3700. The Answer Center is open Monday through Friday, 8:30 a.m. to 6 p.m. Eastern time. All APA departments and staff may be reached through the Answer Center.
  Fax: (703) 907-1085
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  Phone: (703) 907-8512
  Web Site: www.PsychFoundation.org

Effective Advocacy Key to Future Of Research, Patient Care

BY STEVEN SHARFSTEIN, M.D.

The APA annual meeting is, in my view, the finest medical meeting in America. Whenever I have the opportunity to teach medical students, I show them the meeting's scientific program. With its hundreds of workshops, symposia, lectures, and other types of sessions that cover a wide variety of clinical and practice issues, the program demonstrates the breadth of our field and the excitement of our work at the interface between brain and mind.

For those of us who are already psychiatrists or in training to become one, the annual meeting is the best opportunity to remain current with the latest advances in treatments, new research findings, and critical issues that impact our field. It is no surprise that it is the largest psychiatric meeting worldwide with more than 20,000 attending, including 6,000 to 9,000 psychiatrists who come from every corner of the planet.

This year the annual meeting will be held in Toronto, Canada. The theme I have selected is "From Science to Public Policy: Advocacy for the Profession and Patients."

One of the perks of being president of APA is working with the Scientific Program Committee and staff to ensure that the program reflects the theme chosen for the meeting. One avenue is through "presidential symposia," and we will have three this year: The first, a joint symposium with the World Psychiatric Association, will discuss international perspectives on advocacy with an emphasis on the biopsychosocial approach in different countries throughout the world. The second, a symposium on public psychiatry, will have a major focus on advocacy for patients most in need with serious and persistent mental illness. The third is a symposium on ethical issues related to the interrogation of detainees at Guantanamo and elsewhere—an important topic as we struggle with terrorist threats and major challenges to the identity of our profession. The symposium will feature military leaders as well as prominent forensic psychiatrists.

Also related to the theme on advocacy are papers, special sessions, workshops, and other symposia on such critical issues as parity for mental health care under health insurance, the new Medicare Part D prescription drug benefit, cutbacks in Medicaid, and—a particularly appropriate topic since we're meeting in Canada—perspectives on the single-payer universal access system in contrast to the complex, multipayer, nonsystem we have in the United States.

For those who want to keep up on the latest from office practice to community psychiatry practice, care for specific age and ethnic populations, psychopharmacology and psychotherapy, APA's annual meeting is for you. It is also a tremendous opportunity for reunions and collegiality. The annual meeting is an opportunity to renew old friendships and catch up with colleagues from across the country. I find it a bit of a time warp when I encounter a colleague whom I haven't seen since the meeting last year or the year before and then begin our conversation in almost mid-sentence from the last encounter. Freud said that there is no sense of time in the unconscious.

I always look forward to the annual meeting, and this year especially. It's the best evidence for me that the most interesting medical specialty in America is psychiatry and confirmation for attendees that we made the right choice of professional practice.

So, come to beautiful Toronto. Enjoy the sights. See the new reinvigorated Toronto Blue Jays (who are in town during the meeting), and learn, learn, learn. This issue of *Psychiatric News* will tell you all about the city and give you ideas on how to plan your time during your stay. ■

Test Your Knowledge!

FOCUS AN INTERACTIVE SELF-ASSESSMENT SESSION LIVE!

Three "Focus Live" sessions will be held at APA's 2006 annual meeting in which an audience-response system (ARS) is used to allow participants to test their knowledge. The 90-minute sessions will cover topics from APA's newest journal, *Focus: The Journal of Lifelong Learning in Psychiatry.* During the sessions, experts will lead lively discussions based on multiple-choice questions that the audience answers using the ARS. The ARS instantly projects a histogram on a screen allowing private comparison with the responses of others in the audience and offers a new and entertaining way to learn. Sessions will be moderated by the editors of *Focus,* Deborah J. Hales, M.D., and Mark Hyman Rapaport, M.D., and will be held in Room 714A Level 700 Toronto Convention Centre South.

Monday, May 22

9 a.m.-10:30 a.m. **"Personality Disorders"**
Glen O. Gabbard, M.D.

11 a.m.-12:30 p.m. **"Eating Disorders and Sexual Disorders"**
Joel Yager, M.D., and Stephen B. Levine, M.D.

2 p.m.-3:30 p.m. **"Psychotherapy"**
Jerald Kay, M.D.

General Information About APA's 2006 Annual Meeting

Reminders

• **The Opening Session and Presidential Address** will be held on Sunday evening, May 21, 5 p.m. to 6:30 p.m. in Exhibit Hall A, North, Level 300, at the Toronto Convention Centre.

• **The Business Meeting and Forum (for voting members only)** will be held on Sunday, May 21, 12:30 p.m. to 1:30 p.m. in Room 106, North, Level 100, at the Toronto Convention Centre.

• **The Convocation** will take place Monday, May 22, 5:30 p.m. to 6:30 p.m., in Exhibit Hall A, North, Level 300, at the Toronto Convention Centre. APA's new fellows, distinguished fellows, life fellows, and distinguished life fellows will be inducted and awards presented. The William C. Menninger Memorial Convocation Lecture will be given by David K. Shipler.

• **Smoking Policy:** There will be no smoking in any public area. This includes hotels and the Toronto Convention Centre.

CME Courses

As part of the overall scientific program, 101 continuing medical education (CME) courses will be offered, either in a half-day or full-day format. Those attending courses will receive a CME certificate at the conclusion of each course attended. A full complement of courses will be presented starting Saturday, May 20. Admission to all courses is by annual meeting badge and course ticket only.

Presidential Symposia

There will be four Presidential Symposia this year: "The Public Mental Health System: Critical Issues" on Monday, May 22, 2 p.m. to 5 p.m., Room 701 A, South, Level 700, Toronto Convention Centre; "International Advocacy Toward a Psychiatry for the Person" on Tuesday, May 23, 2 p.m. to 5 p.m., Room 701 A, South, Level 700, Toronto Convention Centre; "Collaboration in Crisis: Academic Medical Centers' Response to Hurricanes Katrina and Rita" on Wednesday, May 24, 2 p.m. to 5 p.m., Room 701 A, South, Level 700, Toronto Convention Centre; "Psychiatric Participation in Interrogation of Detainees: Ethical Considerations" on Wednesday, May 24, 2 p.m. to 5 p.m., Ballroom A, Lower Level, Intercontinental Hotel.

New Research

The New Research program will build upon the experience of past successful activities, continuing the trend toward broader opportunities for exposure by clinicians to new research findings. Topics likely to be covered include AIDS and HIV; anxiety; alcohol and substance abuse; eating, mood, and personality disorders; schizophrenia; psychosocial research; geriatrics; health services; and psychopharmacology.

The New Research program will begin on Monday, May 22, at 9 a.m. with "New Research Young Investigators' Poster Session 1." This session was established to encourage medical students, residents, and research fellows to submit abstracts for presentation to highlight the scientific work of young investigators in psychiatry and emphasize the value of their efforts. It provides a forum in which young investigators may interact with their peers from around the country, along with attending senior investigators.

This session will be followed by "Young Investigators' Oral/Slide Sessions 2-4" from 1 p.m. to 2:30 p.m. These sessions feature the top-graded young investigator submissions and provide young investigators the opportunity to give more interactive presentations. Poster Session 5 will follow from 3 p.m. to 5 p.m. There will be five other poster sessions, two each Tuesday and Wednesday, May 23 and 24, from noon to 2 p.m., and 3 p.m. to 5 p.m.; and one on Thursday, May 25, from noon to 2 p.m. The oral/slide presentations and the poster sessions will be held in the Toronto Convention Centre.

There will be three research consultation sessions, one each on Monday, Tuesday, and Wednesday, May 22 to 24, 11 a.m. to 12:30 p.m., at the Intercontinental Hotel. This series allows junior researchers an opportunity to discuss difficult issues with prominent colleagues. These are limited to 25 participants on a first-come, first-served basis.

Master Educator Clinical Consultations

There will be 17 master educator clinical consultation sessions. These are clinically based seminars with outstanding educators. Formats and subject matter vary, but all utilize clinical material offered by participants. These sessions are limited to 25 participants on a first-come, first-served basis and are for APA members only. They will be held at the Toronto Convention Centre from 9 a.m. to 10:30 a.m. and 11 a.m. to 12:30 p.m., Monday through Thursday, May 22 to 25.

Photo: Tourism Toronto

Medical Updates

There will be four medical update sessions, one each on Monday through Thursday, May 22 to 25, 11 a.m. to 12:30 p.m., in Room 716 A, South, Level 700, at the Toronto Convention Centre. Titles include "Congestive Heart Failure," "ADD Kids Get Smart Naturally," "Testosterone Replacement Therapy in the Aging Male: Implications for Psychiatry and Other Disciplines," and "Liver Transplant Update: Current Outcomes and Challenges in 2006."

"Advances In" Series

There will be five "advances in" sessions. They will be held on Monday, May 22, from 2 p.m. to 5:30 p.m., and Tuesday and Wednesday, May 23 and 24, from 9 a.m. to 12:30 p.m. and 2 p.m. to 5:30 p.m. at the Toronto Convention Centre. These three-and-a-half-hour sessions are intended to highlight important new advances occurring in the field of psychiatry involving selected disorders or treatments. The sessions are chaired by editors of recent textbooks published by the American Psychiatric Publishing Inc. (APPI) and feature selected chapter authors from these texts. Discussed books may be purchased at the APPI bookstore or online at <www.appi.org>.

APPI Bookstore

American Psychiatric Publishing Inc. (APPI) will feature more than 40 new book titles at the APPI Bookstore in the Toronto Convention Center and will distribute free copies of the most recent issues of its six journals and *Psychiatric News*. APPI staff will also demonstrate how members can enjoy the benefits of PsychiatryOnline.com, its Web-based portal to books and journals. The new online service features *DSM-IV-TR* Online and the *American Journal of Psychiatry* along with many other key resource materials.

Here are some of the book titles that will be on sale at the bookstore:

• *Essentials of Clinical Psychopharmacology, Second Edition*, edited by Alan F. Schatzberg, M.D., and Charles B. Nemeroff, M.D., Ph.D.

• *The American Psychiatric Publishing Textbook of Mood Disorders*, edited by Dan J. Stein, M.D., Ph.D., David J. Kupfer, M.D., and Alan F. Schatzberg, M.D.

• *The American Psychiatric Publishing Textbook of Schizophrenia*, edited by Jeffrey A. Lieberman, M.D., T. Scott Stroup, M.D., M.Ph., and Diana O. Perkins, M.D., M.Ph.

• *The American Psychiatric Publishing Textbook of Suicide Assessment and Management*, edited by Robert I. Simon, M.D., and Robert E. Hales, M.D., M.B.A.

• *Essentials of Child and Adolescent Psychiatry*, edited by Mina K. Dulcan, M.D., and Jerry M. Wiener, M.D.

• *Concise Guide to Psychopharmacology, Second Edition*, by Lauren B. Marangell, M.D., and James M. Martinez, M.D.

• *Study Guide to Geriatric Psychiatry: A Companion to the American Psychiatric Publishing Textbook of Geriatric Psychiatry, Third Edition*, by Lloyd Benjamin, M.D., James A. Bourgeois, O.D., M.D., Narriman C. Shahrokh, and Dan G. Blazer, M.D., Ph.D.

• *Handbook of Medicine in Psychiatry*, edited by Peter Manu, M.D., Raymond E. Suarez, M.D., and Barbara J. Barnett, M.D.

Please stop by the APPI Bookstore and browse through the hundreds of books, journals, and electronic products that APPI publishes. Authors who wish to schedule an appointment to present a new book idea or discuss a book in progress should contact Tina Coltri-Marshall at (916) 921-5448 or email: tmarchallucdavis@comcast.net. ■

Key Locations

Toronto Convention Centre ***(North Building unless otherwise indicated)***

American Journal of Psychiatry	Exhibit Halls D-G, South, Level 800
Annual Meetings Office	Room 204, Level 200
APA Communications Center	Room 101, Level 100
A/V Preview Room	Room 203 B, Level 200
CME Course Enrollment	Exhibit Hall C, Level 300
Computerized Evaluation	South Registration Area, Level 600
Daily Bulletin	Room 103 A, Level 100
Education Office	Room 201E, Level 200
Exhibits	Exhibit Halls D-G, South, Level 800
Information Center	North Foyer, Level 200
Internet Village	South Registration Area, Level 600
Lost and Found	Room 204, Level 200
Message Center	North Foyer, Level 200
Press Briefing Room	Room 101, Level 100
Registration	Exhibit Hall C, Level 300

Royal York

Annual Meetings Satellite Office	Prince Edward Island Room, Mezzanine Floor

How to Register

There are two easy ways for APA members to register for APA's 2006 annual meeting:

• Go to APA's Web site at www.psych.org, click on "2006 APA Annual Meeting," and select "Online Registration for Members." You will be asked to log into Members Corner. Also, reserve your hotel room by clicking on "Reservations for Members."

• Fill out the forms in the 2006 Annual Meeting Advance Registration Information packet and submit them by mail or fax. If you have not yet received your packet, call the APA Answer Center at (888) 35-PSYCH; from outside the U.S. and Canada, call (703) 907-3800.

The deadline for course enrollment and advance registration is **April 21**.

8 a.m.-Noon
CME Courses 1-3

9 a.m.-4 p.m.
CME Courses 4-9

10 a.m.-5 p.m.
APA Member Center Opens
Publishers' Bookfair Opens
Registration/Course Enrollment Opens

12:30 p.m.-3:30 p.m.
Industry-Supported Symposia
IS1. New Augmentation Strategies in Depression for Better Outcomes
Supported by GlaxoSmithKline

A. Polypharmacy in Depression: How Often is it Used and Why? *Joshua A. Israel, M.D.*

B. "How To" Augmentation Strategies in Resistant Depression *Charles DeBattista, M.D.*

C. When Does Polypharmacy Lead to Higher Remission Rates? *Jonathan E. Alpert, M.D.*

D. Adding Psychotherapy: Pearls for Improved Outcomes *Amy Farabaugh, Ph.D.*

E. Pharmacological Antidotes for Antidepressant-Induced Side Effects *Anita H. Clayton, M.D.*

IS2. Strategies for Maintaining Wellness in Patients With Bipolar Disorder: Moving Beyond Efficacy to Effectiveness *Supported by Bristol-Myers Squibb Company and Otsuka America Pharmaceutical, Inc.*

A. Impact of Misdiagnosis of Bipolar Disorder on Patient Outcomes *Claudia F. Baldassano, M.D.*

B. Brains and Genes: Implications for the Treatment of Bipolar Disorder *Kiki D. Chang, M.D.*

C. Evaluation of Clinical Trials in Bipolar Disease *Gary S. Sachs, M.D.*

D. Impact of Patient Satisfaction With Treatment on Treatment Outcomes *Holly A. Swartz, M.D.*

IS3. Navigating the Maze: Understanding Methods, Results, and Risks in Psychiatric Research *Supported by Forest Laboratories, Inc.*

A. Assessing Statistical and Clinical Significance in Medical Research *David J. Kupfer, M.D.*

B. All Risk Factors Are Not Created Equal: The Importance of Defining and Interpreting Risk on Medical Decision Making and Patient Care *Helena C. Kraemer, Ph.D.*

C. Determining Efficacy: Sound Clinical Trial Design and Interpretation *Cornelius Katona, M.D.*

D. Treating Depression in Children and Adolescents: What's a Clinician to Do? *Jeff Q. Bostic, M.D.*

E. How to Treat in the Absence of Scientific Evidence: A Focus on Anxiety Disorders in the Elderly *Eric J. Lenze, M.D.*

IS4. Bridging Sleep Science and Public Policy *Supported by Takeda Pharmaceuticals North America, Inc.*

A. The Science of Sleep *David N. Neubauer, M.D.*

B. Adolescents and School Start Times: The Intersection of Research and Public Policy *R. Robert Auger, M.D.*

C. Shiftwork, Sleep, and Performance *Gregory Belenky, M.D.*

D. Medical Education and Resident Duty Hours *Phyllis C. Zee, M.D.*

E. Insomnia and Public Policy *Daniel J. Buysse, M.D.*

1 p.m.-5 p.m.
CME Courses 10-14

6 p.m.-9 p.m.
Industry-Supported Symposia
IS5. Mania in Special Populations
Supported by Shire US, Inc.

A. Recent Developments in the Treatment of Mania *Robert M.A. Hirschfeld, M.D.*

B. Recognition and Management of Child and Adolescent Bipolar Disorder *Karen D. Wagner, M.D.*

C. Bipolar Disorders in Women: Clinical and Metabolic Correlates *Natalie L. Rasgon, M.D.*

D. Bipolar Disorder in the Older Patient *Brent P. Forester, M.D.*

E. Recognizing Bipolar Disorder in African Americans *William B. Lawson, M.D.*

IS6. Verging on Reality: Emergent Therapeutic Approaches for Schizophrenia *Supported by Bristol-Myers Squibb Company and Otsuka America Pharmaceutical, Inc.*

A. Functional Genomics and the Therapeutic Effects of Antipsychotics *Anil K. Malhotra, M.D.*

B. Insights From Neuroimaging to Guide Drug Choice and Development *Carol A. Tamminga, M.D.*

C. The Science of Subjective Tolerability: "Wellness" as a Treament Outcome *Meera Narasimhan, M.D.*

D. Recovery and Remission: Definitions, Dilemmas, and the Emergent Role of Peer Support *Peter F. Buckley, M.D.*

IS7. Bipolar Disorder: Creating a Consensus From Science to Public Policy *Supported by Solvay Wyeth Pharmaceuticals*

A. Treatment Considerations for Mania in Young Children *Barbara Geller, M.D.*

B. Treatment of Bipolar Disorder in U.S. Jails and Prisons *Joseph R. Calabrese, M.D.*

C. The Impact of Psychosocial Treatment on the Course and Prognosis of Bipolar Disorder *Ellen Frank, Ph.D.*

D. A Rational Approach for the Longitudinal Pharmacologic Management of Patients With Bipolar Disorder: An Argument for Changing Public Policy *Mark H. Rapaport, M.D.*

E. Alternative Pharmacologic Approaches to the Care of Bipolar Patients *Alexander H. Fan, M.D.*

IS8. Treatment-Resistant Depression: New Data, New Approaches *Supported by Cyberonics, Inc.*

A. Definitions and Clinical Characteristics of Treatment-Resistant Depression *David L. Dunner, M.D.*

B. Treatment Resistance and Genes: The Biology Versus Pharmacology Enigma *Francisco A. Moreno, M.D.*

C. PET of Chronic Vagal Nerve Stimulation in Severe, Treatment-Resistant Depression *Jose V. Pardo, M.D.*

D. Augmentation Strategies for Patients With Difficult-to-Treat MDD *Alicia R. Ruelaz, M.D.*

E. Brain Stimulation Therapies for Treatment-Resistant Depression *Linda L. Carpenter, M.D.* ■

Choir Hopes Old Music Will Help Heal Modern Crisis

Drawn from a century-old tradition begun in the coal-mining valleys of Wales, a New World choir sings to help psychiatrists and psychiatry residents harmed by natural disasters, such as Hurricane Katrina.

BY AARON LEVIN

APA annual meeting attendees can listen to a century-old musical tradition and help psychiatrists who were victims of Hurricane Katrina at the same time.

The Toronto Welsh Male Voice Choir will perform selections from its wide repertoire in a benefit concert at the Toronto Convention Centre on Monday evening, May 22, at 7 p.m. The proceeds will go the Disaster Relief Fund of APA and the American Psychiatric Foundation.

Toronto psychiatrist and APA member D. Ray Freebury, M.D., suggested the program. The 60-member choir includes a number of physicians. Freebury graduated from the Welsh National School of Medicine in Cardiff, Wales, as did two of his fellow choristers. Child psychiatrist Gordon Yanchyshyn, M.D., is also a member. Together, the group could probably staff a small clinic.

"We also have a pediatrician, a radiologist, and a couple of family physicians, one of whom has been known to leave practice early to deliver a baby," said Freebury in an interview.

Founded in 1995, the majority of the choir are Welsh expatriates living in the Toronto area, but anyone who can sing is welcome to join. The choir performs about 25 percent of its music in Welsh, mostly hymns and folk songs, but includes operatic selections, Broadway show tunes, and spirituals. "I suspect you will hear 'When the Saints Go Marching in' and 'The Battle Hymn of the Republic,' too," said Freebury.

The Welsh male choral tradition began in the coal-mining valleys of Wales. Men sang to lighten the burdens of a miner's life or, in more recent years, the hard times that came when the mines closed.

"For the non-native speaker, Welsh is a difficult language to sing because there aren't a whole lot of vowels," said music writer Joan Oliver Goldsmith, author of *How Can We Keep From Singing: Music and the Passionate Life* (W.W. Norton, 2001), a book of essays on choral singing, in an interview. "But singing in the language of their ancestors is one way the Welsh have kept their heritage alive and added to the richness of the new world."

The Toronto choir is a registered charity, and previous concerts have raised funds to support refugee resettlement services, hospice and seniors programs, and scholarships for music students.

More information about the Toronto Welsh Male Voice Choir is posted on its Web site at <www.twmvc.com>. ■

Photo courtesy of the Toronto Welsh Male Voice Choir

The Toronto Welsh Male Voice Choir performs about a quarter of its music in Welsh.

7:30 a.m.-5 p.m.
Registration/Course Enrollment Open

8 a.m.-11 a.m.
Industry-Supported Symposia
IS9. Differentiating Atypical Antipsychotics in the Treatment of Schizophrenia: From Theory to Practice *Supported by Pfizer Inc.*

A. Pharmacodynamic Differences Among Antipsychotic Treatments *Anissa Abi-Dargham, M.D.*

B. Translating Scientific Research Into Clinical Practice *W. Gordon Frankle, M.D.*

C. Metabolic Outcome During Antipsychotic Treatment: Lessons From CATIE and Other Recent Studies *John W. Newcomer, M.D.*

D. Cognitive Responses to Atypical Antipsychotic Medications: Factors Affecting the Potential to Differentiate Treatments *Philip D. Harvey, Ph.D.*

E. Clinical Integration in the Care of Patients With Schizophrenia: What Are the Current Best Practices? *Robert A. Rosenheck, M.D.*

IS10. Fibromyalgia: Scientific Advances to Reduce the Burden of Illness *Supported by Eli Lilly and Co.*

A. The Socioeconomic Burden of Fibromyalgia *Sharon B. Stanford, M.D.*

B. New Evidence for the Pathophysiological Basis of Fibromyalgia *Lesley M. Arnold, M.D.*

C. Current and Emerging Strategies for the Pharmacologic Management of Fibromyalgia *Leslie J. Crofford, M.D.*

D. Living With Fibromyalgia: A Patient's Perspective *Lesley M. Arnold, M.D.*

IS11. Expanding the Neurobiological and Neuropsychological Foundation of ADHD: Impact on Clinical Practice *Supported by Shire US Inc.*

A. ADHD Neuropsychology and Executive Function Deficits *Larry J. Seidman, Ph.D.*

B. Stimulants: Therapeutic and Reinforcing Effects *Nora D. Volkow, M.D.*

C. The Relevance of the Trace Amine PEA (Pheneylethylamine) to ADHD *Bertha K. Madras, Ph.D.*

D. New Insights Into the Noradrenergic System in ADHD *Amy Arnsten, Ph.D.*

E. Advances in the Therapeutics of ADHD *Paul Hammerness, M.D.*

IS12. The Impact of Anxiety Disorders: A Case-Based Approach to Improving Outcomes and Removing Stigma *Supported by Cephalon Inc.*

A. Public Health Consequences of Anxiety: A Surgeon General's Perspective *David Satcher, M.D.*

B. Individual Consequences of Anxiety *Risa B. Weisberg, Ph.D.*

C. Anxiety Disorders: A Glimpse Inside the Brain *Ned H. Kalin, M.D.*

D. Linking Symptoms to Treatment Selection in Anxiety Disorders *Murray B. Stein, M.D.*

E. Nonpharmacologic Approach to the Treatment of Anxiety Disorders *Edna B. Foa, Ph.D.*

IS13. New Vistas in Treatment-Resistant Depression *Supported by Pfizer Inc.*

A. Evolving Concepts in Treatment-Resistant Depression *Charles B. Nemeroff, M.D.*

B. Neuropharmacological Basis for Treatment Strategies in the Management of Refractory Depression *Stephen M. Stahl, M.D.*

C. Re-evaluating Concepts of Depression: Bipolar Spectrum *S. Nassir Ghaemi, M.D.*

D. New Strategies for Treatment-Resistant Depression *Linda L. Carpenter, M.D.*

8 a.m.-Noon
CME Courses 15-22

9 a.m.-4 p.m.
CME Courses 23-30

10 a.m.-4:30 p.m.
Exhibits Open
APA Member Center Open
Publishers' Bookfair Open

12:30 p.m.-1:30 p.m.
Business Meeting and Forum (voting members only)

1 p.m.-5 p.m.
CME Courses 31-37

1:30 p.m.-4:30 p.m.
Industry-Supported Symposia
IS14. New Developments in Schizophrenia: From Neurobiology to Public

continued on page 13

Lifers Plan Events

May 23 is Lifers Day at APA's 2006 annual meeting. The day begins at 7:30 a.m., when the Lifers of APA will hold its annual business meeting and forum in the York Room of the Royal York Hotel. At 11 a.m., the group will present the workshop "Integrating Evidence-Based Psychiatry with Clinical Intelligence" in Room 707, Level 700, Toronto Convention Centre, South. The Lifers reception will take place from 7 p.m. to 9 p.m. in the British Columbia Room at the Royal York Hotel.

More information is available by contacting Barbara Matos at bmatos@psych.org. ■

ADHD treatment: Bringing new options into FOCUS

As valuable as current ADHD treatments are, researchers continue to investigate new options. After all, no two patients are exactly alike. Each one presents with a unique constellation of symptoms and circumstances, resulting in a unique response to any given therapy.

As research brings more treatment options to clinical practice, physicians will be better able to tailor therapy to the needs of each patient. They will be able to manage an array of symptoms associated with ADHD in a more individualized manner. This will help more patients achieve better outcomes.

ADHD is a serious problem, and other treatment options that can help physicians best treat symptoms would be welcome. Cephalon is focused on achieving that goal.

Cephalon®
deliver more®

Museums Explore History, Rich Cultural Life

A wide range of cultural, historic, modern, and downright bizarre experiences are on display in Toronto's many museums and are guaranteed to pique the interest of almost any visitor.

BY RICH DALY

Toronto features an impressive array of museums that reflect its rich immigrant history and its emergence as one of Canada's leading cultural and business hubs.

• One of the must-see sites of the city is the **Art Gallery of Ontario**. The eighth-largest art museum in North America presents an awe-inspiring permanent collection of more than 36,000 works representing 1,000 years of extraordinary art.

Those in town early might stop by for an exhibition of paintings by David Milne, long recognized as one of Canada's most original and influential artists. After showing at the British Museum and New York's Metropolitan Museum of Art, "David Milne Watercolours: Painting Toward the Light" will return home to Canada and the gallery until May 21.

• Dedicated to promoting an understanding of human identity through textiles, the **Textile Museum of Canada** will feature an exhibition titled "The Lion King of Mali," which includes African textiles inspired by ancient kingdoms of West Africa. The exhibition tells the story of the great West African kingdoms of the third through 16th centuries and also presents a selection of cloths, ritual garments, and beadwork created in more recent years.

The museum's curators describe the exhibit as an indicator of how these powerful and beautiful ancient cultures continue to inform contemporary African textiles.

The institution's permanent collection spans nearly 2,000 years of human history and conserves more than 11,000 works from 200 countries and regions.

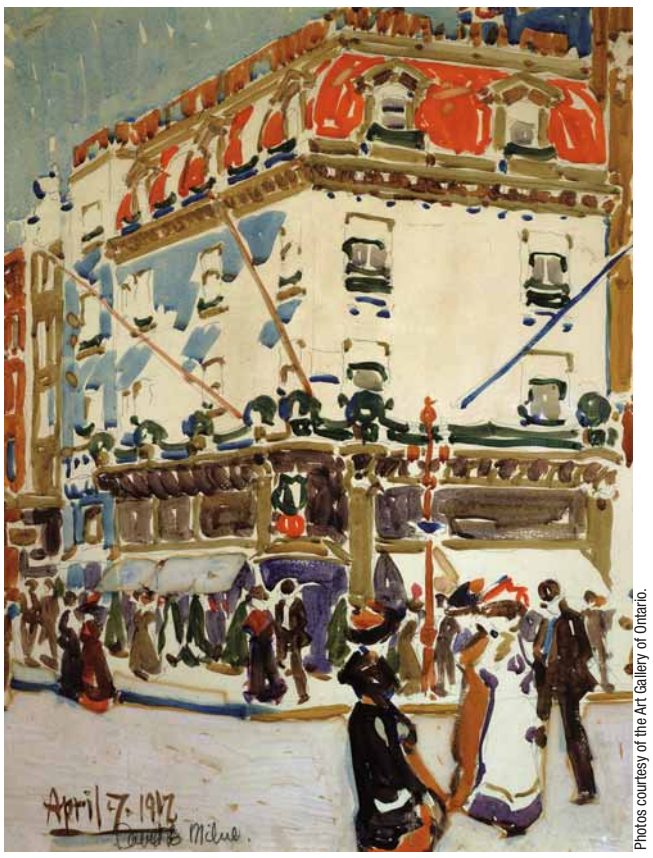
• Located in the original home of the Toronto Stock Exchange, the **Design Exchange (DX)** is committed to increasing the public's understanding of design's role in everyday life.

Have you ever wanted to see a large collection of household chairs from the 1950s gathered in one place? The DX museum has made it its mandate to preserve examples of such modern Canadian industrial design dating from 1945. Its permanent collection includes historical and contemporary examples of decorative arts, furniture, graphic design, housewares, lighting, medical equipment, sporting goods, and tableware.

• Man's inhumanity to nature will be illustrated in the **Museum of Contemporary Canadian Art (MOCCA)** exhibit "Imaging a Shattering Earth." The collection of photographs chronicles "man-induced disasters from a big-picture viewpoint," focusing on mining, nuclear weapons, and toxic waste. One of Toronto's newest museums, MOCCA focuses on art created since 1985.

• A place where televisions are revered and collected, the **MZTV Museum of Television** boasts more than 250 examples of these "milestones in technology or design." The museum spans the evolution of television from the scanning discs of the 1920s to the solid-state electronics of the 1970s. If rarity is any indication of value, the museum's chair tells visitors, there are fewer prewar television sets than Stradivarius violins. Exhibits include the histories of television pioneers and technology.

• Of the many historic houses, inns, and military memorials in Toronto, one of the best known is the **Spadina Museum**. The soaring mansion depicts the bygone elegance and homey preoccupations of early Toronto and is flanked by a six-acre garden that more than 300 flower and vegetable varieties call home. Completed in 1866 by Toronto entrepreneur James Austin and his wife, Susan Bright, the house carries on the tradition of balls and parties its founders started. Tours showcase the museum's historic collection of art, furniture, and decorative objects.



Photos courtesy of the Art Gallery of Ontario.

"Fifth Avenue, Easter Sunday" is one of the images that will be in the David Milne exhibit at the Art Gallery of Ontario during APA's annual meeting.

• A great place to have a picnic is the **Todmorden Mills Heritage Museum and Art Centre**. Set along the scenic Don River, Todmorden Mills explores the early days of industry in Toronto. Settled in the 1790s, the site includes historic millers' homes, the Brewery Gallery, Paper Mill Gallery and Theatre, and the relocated Don train station. Springtime visitors might also enjoy a stroll through the adjacent wildflower preserve.

• Those with a historical interest should take time to see the site of the 1813 Battle of York and the birthplace of modern Toronto. **Fort York** is home to Canada's largest collection of original War of 1812 buildings and now houses exhibits and restored period room settings. The site offers guided tours, musket drills, and music demonstrations.

• A final picturesque historic destination lies moored in Hamilton Harbour. The **HMCS Haida Naval Museum**, a destroyer built for the Royal Canadian Navy, is one of only three remaining World War II Canadian warships. The ship contributed to the D-Day invasion and took part in the Korean War. ■

Toronto Museums

Art Gallery of Ontario
317 Dundas Street West
www.ago.net
(416) 979-6648

Design Exchange
234 Bay Street
www.dx.org
(416) 363-6121

Fort York
100 Garrison Road
www.toronto.ca/culture/fort_york.htm
(416) 392-6907

Museum of Contemporary Canadian Art
952 Queen Street West
www.mocca.toronto.on.ca
(416) 395-7430

MZTV Museum of Television
277 Queen Street West
www.mztv.com
(416) 599-7339

Textile Museum of Canada
55 Centre Avenue
www.textilemuseum.ca/
(416) 599-5321

Todmorden Mills Heritage Museum and Art Centre
850 Coxwell Avenue
www.toronto.ca/todmorden
(416) 396-2819

Ever Wonder What It's Like To Walk in Their Shoes?

At one unique Toronto museum, understanding the legacy of famous entertainers, religious leaders, and ancient nomads is best accomplished with a little sole searching.

BY EVE BENDER

Imelda Marcos doesn't have anything on Toronto's Bata Shoe Museum. That's because while she owned about 1,500 pairs of shoes, more than 12,000 shoes are on display in the museum, some of which were worn as long as 4,500 years ago.

While many who stroll through the museum are shoe fanatics, history buffs are also enthralled by the museum.

Visitors learn that shoes are not just a fashion statement, but a reflection of local culture, society, religious views, and social status.

The museum features shoes worn by popes, sports stars, rock musicians, and royalty throughout the ages: for instance, a pair of Princess Diana's dress shoes and Queen Victoria's ballroom slippers are on display, as are the ceremonial shoes of Pope Leo XIII and the sprinting shoes of Olympic gold-medal winner Harry Jerome.

Some of the more popular exhibits include Elton John's silver and red platform boots from 1973, Marilyn Monroe's red-leather pumps, and John Lennon's "Beatle boots" from the early 1960s.

Some of the museum's oldest footwear includes wooden sandals from about 2,500 B.C., which were designed to take those who had died on a journey into the afterlife.

There is also a collection of shoes worn by members of indigenous tribes in North America, the Arctic, and Russia. Alaska natives, for example, wore boots made of seal skin. Socks worn inside the boots were usually made of woven grass.

Photos courtesy of the Bata Shoe Museum

Elton John's silver and red platform boots are among the most popular exhibits at the Bata Shoe Museum.

According to the Bata Museum Web site, it was only in the 14th century that shoes began to be constructed from "quality textiles and fine leathers" and became a form of aesthetic expression and a new way to display social status.

Pointed-toe shoes were one of the first trends in shoe design and appeared in 14th century Poland. As the trend swept across Europe, "Edicts were proclaimed limiting the length of the toe," according to the Web site.

Museum founder Sonja Bata began collecting shoes as a hobby in the late 1940s while traveling around the world on business trips with her husband, an international shoe manufacturer, and had "personal contact with most of the great stars of shoe design," she has said. In 1979, she founded the Bata Shoe Museum Foundation to manage her growing collection of shoes and sponsor research on the role that shoes have played through history.

The museum is not only known for its shoes, but its architecture.

Architect Raymond Moriyama designed the museum, which opened in 1995.

The museum looks a little like a shoebox

please see ***Shoes*** *on page 62*

In the treatment of transient
or chronic insomnia

Take a closer look...

Important Safety Information

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be ingested immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients should not take LUNESTA unless they are prepared to get a full night's sleep. As with other hypnotics, patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (eg, operating machinery or driving a motor vehicle) after ingesting the drug, including potential impairment of the performance of such activities that may occur the day following ingestion of LUNESTA. In clinical trials, the most common adverse events associated with LUNESTA were unpleasant taste, headache, somnolence, dizziness, dry mouth, infection, and pain.

LUNESTA has been classified as a Schedule IV controlled substance. Sedative hypnotics have produced withdrawal signs and symptoms following abrupt discontinuation. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic. Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

References: 1. LUNESTA prescribing information. **2.** Zammit GK, McNabb LJ, Caron J, et al. Efficacy and safety of eszopiclone across 6-weeks of treatment for primary insomnia. *Curr Med Res Opin.* 2004;20:1979-1991. **3.** Krystal AD, Walsh JK, Laska E, et al. Sustained efficacy of eszopiclone over 6 months of nightly treatment: results of a randomized, double-blind, placebo-controlled study in adults with chronic insomnia. *SLEEP.* 2003;26:793-799.

Please see brief summary of complete prescribing information.

improves sleep maintenance...

for a fresh start

A full night's sleep can make all the difference

- LUNESTA provides a full night of sleep (7 to 8 hours)[1,2]
- FDA-approved for long-term use—supported by a 6-month, placebo-controlled trial[1,3]
- No evidence of tolerance throughout 6 months of nightly use[1,3]
- No significant rebound insomnia upon discontinuation[1,2]
- No next-day residual effects in most patients[1,2]

The failure of insomnia to remit after 7 to 10 days of treatment should be medically evaluated.

In the treatment of transient or chronic insomnia

Leave the rest to...

Lunesta™

(eszopiclone)

1, 2 AND 3 MG TABLETS

Lunesta™ (eszopiclone) ℞
1, 2 AND 3 MG TABLETS

BRIEF SUMMARY

INDICATIONS AND USAGE

LUNESTA is indicated for the treatment of insomnia. In controlled outpatient and sleep laboratory studies, LUNESTA administered at bedtime decreased sleep latency and improved sleep maintenance.

CONTRAINDICATIONS

None known.

WARNINGS

Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia or the emergence of new thinking or behavior abnormalities may be the consequence of an unrecognized psychiatric or physical disorder. Such findings have emerged during the course of treatment with sedative/hypnotic drugs, including LUNESTA. Because some of the important adverse effects of LUNESTA appear to be dose-related, it is important to use the lowest possible effective dose, especially in the elderly (see **DOSAGE AND ADMINISTRATION in the Full Prescribing Information**).

A variety of abnormal thinking and behavior changes have been reported to occur in association with the use of sedative/hypnotics. Some of these changes may be characterized by decreased inhibition (e.g., aggressiveness and extroversion that seem out of character), similar to effects produced by alcohol and other CNS depressants. Other reported behavioral changes have included bizarre behavior, agitation, hallucinations, and depersonalization. Amnesia and other neuropsychiatric symptoms may occur unpredictably. In primarily depressed patients, worsening of depression, including suicidal thinking, has been reported in association with the use of sedative/hypnotics.

It can rarely be determined with certainty whether a particular instance of the abnormal behaviors listed above are drug-induced, spontaneous in origin, or a result of an underlying psychiatric or physical disorder. Nonetheless, the emergence of any new behavioral sign or symptom of concern requires careful and immediate evaluation.

Following rapid dose decrease or abrupt discontinuation of the use of sedative/hypnotics, there have been reports of signs and symptoms similar to those associated with withdrawal from other CNS-depressant drugs (see **DRUG ABUSE AND DEPENDENCE**).

LUNESTA, like other hypnotics, has CNS-depressant effects. Because of the rapid onset of action, LUNESTA should only be ingested immediately prior to going to bed or after the patient has gone to bed and has experienced difficulty falling asleep. Patients receiving LUNESTA should be cautioned against engaging in hazardous occupations requiring complete mental alertness or motor coordination (e.g., operating machinery or driving a motor vehicle) after ingesting the drug, and be cautioned about potential impairment of the performance of such activities on the day following ingestion of LUNESTA. LUNESTA, like other hypnotics, may produce additive CNS-depressant effects when coadministered with other psychotropic medications, anticonvulsants, antihistamines, ethanol, and other drugs that themselves produce CNS depression. LUNESTA should not be taken with alcohol. Dose adjustment may be necessary when LUNESTA is administered with other CNS-depressant agents, because of the potentially additive effects.

PRECAUTIONS

General

Timing Of Drug Administration: LUNESTA should be taken immediately before bedtime. Taking a sedative/hypnotic while still up and about may result in short-term memory impairment, hallucinations, impaired coordination, dizziness, and lightheadedness.

Use In The Elderly And/Or Debilitated Patients: Impaired motor and/or cognitive performance after repeated exposure or unusual sensitivity to sedative/hypnotic drugs is a concern in the treatment of elderly and/or debilitated patients. The recommended starting dose of LUNESTA for these patients is 1 mg (see **DOSAGE AND ADMINISTRATION in the Full Prescribing Information**).

Use In Patients With Concomitant Illness: Clinical experience with eszopiclone in patients with concomitant illness is limited. Eszopiclone should be used with caution in patients with diseases or conditions that could affect metabolism or hemodynamic responses.

A study in healthy volunteers did not reveal respiratory-depressant effects at doses 2.5-fold higher (7 mg) than the recommended dose of eszopiclone. Caution is advised, however, if LUNESTA is prescribed to patients with compromised respiratory function.

The dose of LUNESTA should be reduced to 1 mg in patients with severe hepatic impairment, because systemic exposure is doubled in such subjects. No dose adjustment appears necessary for subjects with mild or moderate hepatic impairment. No dose adjustment appears necessary in subjects with any degree of renal impairment, since less than 10% of eszopiclone is excreted unchanged in the urine.

The dose of LUNESTA should be reduced in patients who are administered potent inhibitors of CYP3A4, such as ketoconazole, while taking LUNESTA. Downward dose adjustment is also recommended when LUNESTA is administered with agents having known CNS-depressant effects.

Use In Patients With Depression: Sedative/hypnotic drugs should be administered with caution to patients exhibiting signs and symptoms of depression. Suicidal tendencies may be present in such patients, and protective measures may be required. Intentional overdose is more common in this group of patients; therefore, the least amount of drug that is feasible should be prescribed for the patient at any one time.

Information For Patients: Patient information is printed in the complete prescribing information.

Laboratory Tests: There are no specific laboratory tests recommended.

Drug Interactions

CNS-Active Drugs

Ethanol: An additive effect on psychomotor performance was seen with coadministration of eszopiclone and ethanol 0.70 g/kg for up to 4 hours after ethanol administration.

Paroxetine: Coadministration of single doses of eszopiclone 3 mg and paroxetine 20 mg daily for 7 days produced no pharmacokinetic or pharmacodynamic interaction.

Lorazepam: Coadministration of single doses of eszopiclone 3 mg and lorazepam 2 mg did not have clinically relevant effects on the pharmacodynamics or pharmacokinetics of either drug.

Olanzapine: Coadministration of eszopiclone 3 mg and olanzapine 10 mg produced a decrease in DSST scores. The interaction was pharmacodynamic; there was no alteration in the pharmacokinetics of either drug.

Drugs That Inhibit CYP3A4 (Ketoconazole): CYP3A4 is a major metabolic pathway for elimination of eszopiclone. The AUC of eszopiclone was increased 2.2-fold by coadministration of ketoconazole, a potent inhibitor of CYP3A4, 400 mg daily for 5 days. C_{max} and $t_{1/2}$ were increased 1.4-fold and 1.3-fold, respectively. Other strong inhibitors of CYP3A4 (e.g., itraconazole, clarithromycin, nefazodone, troleandomycin, ritonavir, nelfinavir) would be expected to behave similarly.

Drugs That Induce CYP3A4 (Rifampicin): Racemic zopiclone exposure was decreased 80% by concomitant use of rifampicin, a potent inducer of CYP3A4. A similar effect would be expected with eszopiclone.

Drugs Highly Bound To Plasma Protein: Eszopiclone is not highly bound to plasma proteins (52-59% bound); therefore, the disposition of eszopiclone is not expected to be sensitive to alterations in protein binding. Administration of eszopiclone 3 mg to a patient taking another drug that is highly protein-bound would not be expected to cause an alteration in the free concentration of either drug.

Drugs With A Narrow Therapeutic Index

Digoxin: A single dose of eszopiclone 3 mg did not affect the pharmacokinetics of digoxin measured at steady state following dosing of 0.5 mg twice daily for one day and 0.25 mg daily for the next 6 days.

Warfarin: Eszopiclone 3 mg administered daily for 5 days did not affect the pharmacokinetics of (R)- or (S)-warfarin, nor were there any changes in the pharmacodynamic profile (prothrombin time) following a single 25-mg oral dose of warfarin.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis: In a carcinogenicity study in Sprague-Dawley rats in which eszopiclone was given by oral gavage, no increases in tumors were seen; plasma levels (AUC) of eszopiclone at the highest dose used in this study (16 mg/kg/day) are estimated to be 80 (females) and 20 (males) times those in humans receiving the maximum recommended human dose (MRHD). However, in a carcinogenicity study in Sprague-Dawley rats in which racemic zopiclone was given in the diet, and in which plasma levels of eszopiclone were reached that were greater than those reached in the above study of eszopiclone, an increase in mammary gland adenocarcinomas in females and an increase in thyroid gland follicular cell adenomas and carcinomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 150 (females) and 70 (males) times those in humans receiving the MRHD. The mechanism for the increase in mammary adenocarcinomas is unknown. The increase in thyroid tumors is thought to be due to increased levels of TSH secondary to increased metabolism of circulating thyroid hormones, a mechanism that is not considered to be relevant to humans.

In a carcinogenicity study in B6C3F1 mice in which racemic zopiclone was given in the diet, an increase in pulmonary carcinomas and carcinomas plus adenomas in females and an increase in skin fibromas and sarcomas in males were seen at the highest dose of 100 mg/kg/day. Plasma levels of eszopiclone at this dose are estimated to be 8 (females) and 20 (males) times those in humans receiving the MRHD. The skin tumors were due to skin lesions induced by aggressive behavior, a mechanism that is not relevant to humans. A carcinogenicity study was also performed in which CD-1 mice were given eszopiclone at doses up to 100 mg/kg/day by oral gavage; although this study did not reach a maximum tolerated dose, and was thus inadequate for overall assessment of carcinogenic potential, no increases in either pulmonary or skin tumors were seen at doses producing plasma levels of eszopiclone estimated to be 90 times those in humans receiving the MRHD—i.e., 12 times the exposure in the racemate study.

Eszopiclone did not increase tumors in a p53 transgenic mouse bioassay at oral doses up to 300 mg/kg/day.

Mutagenesis: Eszopiclone was positive in the mouse lymphoma chromosomal aberration assay and produced an equivocal response in the Chinese hamster ovary cell chromosomal aberration assay. It was not mutagenic or clastogenic in the bacterial Ames gene mutation assay, in an unscheduled DNA synthesis assay, or in an *in vivo* mouse bone marrow micronucleus assay.

(S)-N-desmethyl zopiclone, a metabolite of eszopiclone, was positive in the Chinese hamster ovary cell and human lymphocyte chromosomal aberration assays. It was negative in the bacterial Ames mutation assay, in an *in vitro* ^{32}P-postlabeling DNA adduct assay, and in an *in vivo* mouse bone marrow chromosomal aberration and micronucleus assay.

Impairment Of Fertility: Eszopiclone was given by oral gavage to male rats at doses up to 45 mg/kg/day from 4 weeks premating through mating and to female rats at doses up to 180 mg/kg/day from 2 weeks premating through day 7 of pregnancy. An additional study was performed in which only females were treated, up to 180 mg/kg/day. Eszopiclone decreased fertility, probably because of effects in both males and females, with no females becoming pregnant when both males and females were treated with the highest dose; the no-effect dose in both sexes was 5 mg/kg (16 times the MRHD on a mg/m² basis). Other effects included increased preimplantation loss (no-effect dose 25 mg/kg), abnormal estrus cycles (no-effect dose 25 mg/kg), and decreases in sperm number and motility and increases in morphologically abnormal sperm (no-effect dose 5 mg/kg).

Pregnancy

Pregnancy Category C: Eszopiclone administered by oral gavage to pregnant rats and rabbits during the period of organogenesis showed no evidence of teratogenicity up to the highest doses tested (250 and 16 mg/kg/day in rats and rabbits, respectively; these doses are 800 and 100 times, respectively, the maximum recommended human dose [MRHD] on a mg/m² basis). In the rat, slight reductions in fetal weight and evidence of developmental delay were seen at maternally toxic doses of 125 and 150 mg/kg/day, but not at 62.5 mg/kg/day (200 times the MRHD on a mg/m² basis). Eszopiclone was also administered by oral gavage to pregnant rats throughout the pregnancy and lactation periods at doses of up to 180 mg/kg/day. Increased post-implantation loss, decreased postnatal pup weights and survival, and increased pup startle response were seen at all doses; the lowest dose tested, 60 mg/kg/day, is 200 times the MRHD on a mg/m² basis. These doses did not produce significant maternal toxicity. Eszopiclone had no effects on other behavioral measures or reproductive function in the offspring.

There are no adequate and well-controlled studies of eszopiclone in pregnant women. Eszopiclone should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor And Delivery: LUNESTA has no established use in labor and delivery.

Nursing Mothers: It is not known whether LUNESTA is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when LUNESTA is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of eszopiclone in children below the age of 18 have not been established.

Geriatric Use: A total of 287 subjects in double-blind, parallel-group, placebo-controlled clinical trials who received eszopiclone were 65 to 86 years of age. The overall pattern of adverse events for elderly subjects (median age = 71 years) in 2-week studies with nighttime dosing of 2 mg eszopiclone was not different from that seen in younger adults. LUNESTA 2 mg exhibited significant reduction in sleep latency and improvement in sleep maintenance in the elderly population.

ADVERSE REACTIONS

The premarketing development program for LUNESTA included eszopiclone exposures in patients and/or normal subjects from two different groups of studies: approximately 400 normal subjects in clinical pharmacology/pharmacokinetic studies, and approximately 1550 patients in placebo-controlled clinical effectiveness studies, corresponding to approximately 263 patient-exposure years. The conditions and duration of treatment with LUNESTA varied greatly and included (in overlapping categories) open-label and double-blind phases of studies, inpatients and outpatients, and short-term and longer-term exposure. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tabulations that follow, COSTART terminology has been used to classify reported adverse events.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while the patient was receiving therapy following baseline evaluation.

Adverse Findings Observed in Placebo-Controlled Trials

Adverse Events Resulting in Discontinuation of Treatment: In placebo-controlled, parallel-group clinical trials in the elderly, 3.8% of 208 patients who received placebo, 2.3% of 215 patients who received 2 mg LUNESTA, and 1.4% of 72 patients who received 1 mg LUNESTA discontinued treatment due to an adverse event. In the 6-week parallel-group study in adults, no patients in the 3 mg arm discontinued because of an adverse event. In the long-term 6-month study in adult insomnia patients, 7.2% of 195 patients who received placebo and 12.8% of 593 patients who received 3 mg LUNESTA discontinued due to an adverse event. No event that resulted in discontinuation occurred at a rate of greater than 2%.

Adverse Events Observed at an Incidence of ≥2% in Controlled Trials. The following lists the incidence (% placebo, 2 mg, 3 mg, respectively) of treatment-emergent adverse events from a Phase 3 placebo-controlled study of LUNESTA at doses of 2 or 3 mg in non-elderly adults. Treatment duration in this trial was 44 days. Data are limited to adverse events that occurred in 2% or more of patients treated with LUNESTA 2 mg (n=104) or 3 mg (n=105) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients (n=99).[1]

Body as a whole: headache (13%, 21%, 17%), viral infection (1%, 3%, 3%). Digestive system: dry mouth (3%, 5%, 7%), dyspepsia (4%, 4%, 5%), nausea (4%, 5%, 4%), vomiting (1%, 3%, 0%). Nervous system: anxiety (0%, 3%, 1%), confusion (0%, 0%, 3%), depression (0%, 4%, 1%), dizziness (4%, 5%, 7%), hallucinations (0%, 1%, 3%), libido decreased (0%, 0%, 3%), nervousness (3%, 5%, 0%), somnolence (3%, 10%, 8%). Respiratory system: infection (3%, 5%, 10%). Skin and appendages: rash (1%, 3%, 4%). Special senses: unpleasant taste (3%, 17%, 34%). Urogenital system: dysmenorrhea* (0%, 3%, 0%), gynecomastia** (0%, 3%, 0%).

*Gender-specific adverse event in females

**Gender-specific adverse event in males

[1]Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abnormal dreams, accidental injury, back pain, diarrhea, flu syndrome, myalgia, pain, pharyngitis, and rhinitis.

Adverse events that suggest a dose-response relationship in adults include viral infection, dry mouth, dizziness, hallucinations, infection, rash, and unpleasant taste, with this relationship clearest for unpleasant taste.

The following lists the incidence (% placebo, 2 mg, 3 mg, respectively) of treatment-emergent adverse events from combined Phase 3 placebo-controlled studies of LUNESTA at doses of 1 or 2 mg in elderly adults (ages 65-86). Treatment duration in these trials was 14 days. Data are limited to events that occurred in 2% or more of patients treated with LUNESTA 1 mg (n=72) or 2 mg (n=215) in which the incidence in patients treated with LUNESTA was greater than the incidence in placebo-treated patients.[1]

Body as a whole: accidental injury (1%, 0%, 3%), headache (14%, 15%, 13%), pain (2%, 4%, 5%). Digestive system: diarrhea (2%, 4%, 2%), dry mouth (2%, 3%, 7%), dyspepsia (2%, 6%, 2%). Nervous system: abnormal dreams (0%, 3%, 1%), dizziness (2%, 1%, 6%), nervousness (1%, 0%, 2%), neuralgia (0%, 3%, 0%). Skin and appendages: pruritus (1%, 4%, 1%). Special senses: unpleasant taste (0%, 8%, 12%). Urogenital system: urinary tract infection (0%, 3%, 0%).

[1]Events for which the LUNESTA incidence was equal to or less than placebo are not listed, but included the following: abdominal pain, asthenia, nausea, rash, and somnolence.

Adverse events that suggest a dose-response relationship in elderly adults include pain, dry mouth, and unpleasant taste, with this relationship again clearest for unpleasant taste. These figures cannot be used to predict the incidence of adverse events in the course of usual medical practice because patient characteristics and other factors may differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators.

The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contributions of drug and non-drug factors to the adverse event incidence rate in the population studied.

Other Events Observed During The Premarketing Evaluation Of LUNESTA. Following is a list of modified COSTART terms that reflect treatment-emergent adverse events as defined in the introduction to the **ADVERSE REACTIONS** section and reported by approximately 1550 subjects treated with LUNESTA at doses in the range of 1 to 3.5 mg/day during Phase 2 and 3 clinical trials throughout the United States and Canada. All reported events are included except those already listed here or listed elsewhere in labeling, minor events common in the general population, and events unlikely to be drug-related. Although the events reported occurred during treatment with LUNESTA, they were not necessarily caused by it.

Events are listed in order of decreasing frequency according to the following definitions: **frequent** adverse events are those that occurred on one or more occasions in at least 1/100 patients; **infrequent** adverse events are those that occurred in fewer than 1/100 patients but in at least 1/1,000 patients; **rare** adverse events are those that occurred in fewer than 1/1,000 patients. Gender-specific events are categorized based on their incidence for the appropriate gender.

Frequent: chest pain, migraine, peripheral edema.

Infrequent: acne, agitation, allergic reaction, alopecia, amenorrhea, anemia, anorexia, apathy, arthritis, asthma, ataxia, breast engorgement, breast enlargement, breast neoplasm, breast pain, bronchitis, bursitis, cellulitis, cholelithiasis, conjunctivitis, contact dermatitis, cystitis, dry eyes, dry skin, dyspnea, dysuria, eczema, ear pain, emotional lability, epistaxis, face edema, female lactation, fever, halitosis, heat stroke, hematuria, hernia, hiccup, hostility, hypercholesteremia, hypertension, hypertonia, hypesthesia, incoordination, increased appetite, insomnia, joint disorder (mainly swelling, stiffness, and pain), kidney calculus, kidney pain, laryngitis, leg cramps, lymphadenopathy, malaise, mastitis, melena, memory impairment, menorrhagia, metrorrhagia, mouth ulceration, myasthenia, neck rigidity, neurosis, nystagmus, otitis externa, otitis media, paresthesia, photosensitivity, reflexes decreased, skin discoloration, sweating, thinking abnormal (mainly difficulty concentrating), thirst, tinnitus, twitching, ulcerative stomatitis, urinary frequency, urinary incontinence, urticaria, uterine hemorrhage, vaginal hemorrhage, vaginitis, vertigo, vestibular disorder, weight gain, weight loss.

Rare: abnormal gait, arthrosis, colitis, dehydration, dysphagia, erythema multiforme, euphoria, furunculosis, gastritis, gout, hepatitis, hepatomegaly, herpes zoster, hirsutism, hyperacusis, hyperesthesia, hyperlipemia, hypokalemia, hypokinesia, iritis, liver damage, maculopapular rash, mydriasis, myopathy, neuritis, neuropathy, oliguria, photophobia, ptosis, pyelonephritis, rectal hemorrhage, stomach ulcer, stomatitis, stupor, thrombophlebitis, tongue edema, tremor, urethritis, vesiculobullous rash.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: LUNESTA is a Schedule IV controlled substance under the Controlled Substances Act. Other substances under the same classification are benzodiazepines and the nonbenzodiazepine hypnotics zaleplon and zolpidem. While eszopiclone is a hypnotic agent with a chemical structure unrelated to benzodiazepines, it shares some of the pharmacologic properties of the benzodiazepines.

Abuse, Dependence, and Tolerance

Abuse and Dependence: In a study of abuse liability conducted in individuals with known histories of benzodiazepine abuse, eszopiclone at doses of 6 and 12 mg produced euphoric effects similar to those of diazepam 20 mg. In this study, at doses 2-fold or greater than the maximum recommended doses, a dose-related increase in reports of amnesia and hallucinations was observed for both LUNESTA and diazepam.

The clinical trial experience with LUNESTA revealed no evidence of a serious withdrawal syndrome. Nevertheless, the following adverse events included in DSM-IV criteria for uncomplicated sedative/hypnotic withdrawal were reported during clinical trials following placebo substitution occurring within 48 hours following the last LUNESTA treatment: anxiety, abnormal dreams, nausea, and upset stomach. These reported adverse events occurred at an incidence of 2% or less. Use of benzodiazepines and similar agents may lead to physical and psychological dependence. The risk of abuse and dependence increases with the dose and duration of treatment and concomitant use of other psychoactive drugs. The risk is also greater for patients who have a history of alcohol or drug abuse or history of psychiatric disorders. These patients should be under careful surveillance when receiving LUNESTA or any other hypnotic.

Tolerance: Some loss of efficacy to the hypnotic effect of benzodiazepines and benzodiazepine-like agents may develop after repeated use of these drugs for a few weeks.

No development of tolerance to any parameter of sleep measurement was observed over six months. Tolerance to the efficacy of LUNESTA 3 mg was assessed by 4-week objective and 6-week subjective measurements of time to sleep onset and sleep maintenance for LUNESTA in a placebo-controlled 44-day study, and by subjective assessments of time to sleep onset and WASO in a placebo-controlled study for 6 months.

OVERDOSAGE

There is limited premarketing clinical experience with the effects of an overdosage of LUNESTA. In clinical trials with eszopiclone, one case of overdose with up to 36 mg of eszopiclone was reported in which the subject fully recovered. Individuals have fully recovered from racemic zopiclone overdoses up to 340 mg (56 times the maximum recommended dose of eszopiclone).

Signs And Symptoms: Signs and symptoms of overdose effects of CNS depressants can be expected to present as exaggerations of the pharmacological effects noted in preclinical testing. Impairment of consciousness ranging from somnolence to coma has been described. Rare individual instances of fatal outcomes following overdose with racemic zopiclone have been reported in European postmarketing reports, most often associated with overdose with other CNS-depressant agents.

Recommended Treatment: General symptomatic and supportive measures should be used along with immediate gastric lavage where appropriate. Intravenous fluids should be administered as needed. Flumazenil may be useful. As in all cases of drug overdose, respiration, pulse, blood pressure, and other appropriate signs should be monitored and general supportive measures employed. Hypotension and CNS depression should be monitored and treated by appropriate medical intervention. The value of dialysis in the treatment of overdosage has not been determined.

Poison Control Center: As with the management of all overdosage, the possibility of multiple drug ingestion should be considered. The physician may wish to consider contacting a poison control center for up-to-date information on the management of hypnotic drug product overdosage.

Rx only.

3/05

Walkable Neighborhoods Spotlight Diverse Cultures

Toronto's diversity is probably best exemplified by its neighborhoods, which, though close in proximity, are wonderfully dissimilar from one another.

BY EVE BENDER

The heart and soul of Toronto can be found in its neighborhoods, which are brimming with unique shops, outstanding restaurants, and friendly residents.

Each neighborhood has a distinct character that has been shaped by the families who settled there more than 100 years ago and those who have arrived since.

Entrepreneur Joseph Bloor founded **Yorkville** in 1830 as a middle-class suburb of Toronto characterized by Victorian houses, tidy gardens, and quiet streets. By the 1880s, it was no longer a suburb but a vital part of an ever-expanding metropolis.

Small specialty shops moved from the bustling downtown area to Yorkville in the 1950s, and in the 1960s the area became a mecca for the counterculture. Canadian musicians such as Joni Mitchell, Neil Young, and Gordon Lightfoot spent the early part of their careers playing in venues around Yorkville.

The area became gentrified in the 1980s and 1990s, and coffee houses and head shops gave way to high-end boutiques, art galleries, and trendy restaurants.

Today Yorkville is bounded by Bloor Street, Yonge Street, Avenue Road, and Davenport Road and is known as an upscale dining and shopping area. Bloor Street West is dotted with shops such as Tiffany's, Cartier, Holt Renfrew, and Hermès.

Other popular Yorkville stores include Birks, which is known for its jewelry, and William Ashley's, which sells fine china.

The neighborhood retains much of its old-world charm from the 1850s; cobblestone lanes extend from busy streets lined with antique shops, cafés, art galleries, and wrought-iron benches. Specialty gifts and fashions can be found in Hazleton Lanes, a striking shopping center built around a series of courtyards.

September in Yorkville is prime time for celebrity spotting—each year the Toronto International Film Festival draws celebrities to Yorkville and its theaters.

Yorkville is accessible by subway via the Bay or Yonge/Bloor stops.

Though it is just a mile or two south of Yorkville, Toronto's **Chinatown** is worlds away, populated by about 400,000 Chinese-Canadian residents. It is centered at the intersection of Dundas Street West and Spadina Road.

Chinatown formed around the turn of the century as immigrants began arriving from China, and by 1935 there were 300 Chinese laundries within a four-block radius. The population of Chinese immigrants grew rapidly between the mid-1940s and 1960 and included students, laborers, and business leaders from Hong Kong and Chinese communities in other countries. In the past 15 to 20 years, new throngs of Chinese immigrants have fanned out to form five additional Chinatowns, most of which are located in the city's suburbs.

Streets signs in the main area of Chinatown, centered at the intersection of Dundas Street West and Spadina Avenue, appear in Chinese and English. The open-air food stalls, souvenir stores, and restaurants entice visitors to tarry a while.

At Dragon City, a shopping mall at the corner of Spadina and Dundas, visitors can buy Chinese herbs and preserves, as well as Asian books, music, and clothes.

Some of the city's best Asian food can be found in Chinatown. At the Bright Pearl Seafood Restaurant on Spadina Road, carts of dim sum tantalize diners throughout the day.

Just as lively is Toronto's Greektown, or **The Danforth,** because it runs along Danforth Street on the east side of the city. Many of the street signs are in Greek and English, and Greek restaurants, pastry shops, and produce stands abound.

Around the turn of the century, the area around Danforth was primarily Anglo-Saxon, and later Italian. It was not until the 1950s that Greek immigrants who arrived in Ontario to work on the railroads and mines began to flock to the Danforth area.

Today, Toronto's Greek population is the second largest outside of Greece, making it the perfect location for the 2002 movie "My Big Fat Greek Wedding." The largest Greek population resides in the Queens borough of New York City.

The area along Church and Wellesley streets, known as **Gay Village,** is located downtown, just a short walk east from the Wellesley Station. It is home to one of the largest gay communities in North America. In addition to its many restaurants and street cafés, Gay Village is packed with trendy nightspots and bars.

Zelda's and Woody's along Church Street are popular local bars, as is El Convento Rico on College Street, a lively club where Latino music provides the beat for the crowd on the dance floor.

The Showtime series "Queer as Folk" is not actually shot in Pittsburgh, where the storyline is set, but in Gay Village.

No visit to Toronto is complete without a stop at **St. Lawrence Market,** known both as a neighborhood and a market.

The market is located in the oldest part of town. In 1793, when the town of York (now Toronto) was established, the town's center stood at the corner of Front and Jarvis streets. A market stood a block away in a building that also housed the city council chambers.

Though a fire destroyed most of the neighborhood in 1849, St. Lawrence Market was rebuilt around the turn of the 20th century and now comprises two buildings that stand on Front Street.

The north building, open only on Saturdays, offers some of the area's best produce. The south building is home to dozens of permanent stalls where vendors sell meats, cheeses, breads, and crafts and is open each day of the week. ■

Get Walking!

Overview of Toronto's neighborhoods: www.123toronto.com/toronto-neighborhoods.htm; www.torcon3.on.ca/outside/neighborhoods.html

Chinatown: www.showmetoronto.com/toronto_tour_chinatown.htm

The Danforth: http://danforthtoronto.com/tour/

Gay Village: www.angelfire.com/home/qaf/toronto.html

St. Lawrence Market: www.stlawrencemarket.com/

Yorkville: www.bloor-yorkville.com

NIAAA Series Showcases Latest In Research, Clinical Advances

Wide-ranging presentations in the series will stress the translation of research advances into clinical practice.

At APA's 2006 annual meeting in Toronto, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) is collaborating with APA on a series of sessions on recent advances in understanding and treating alcohol use disorders (AUDs) and highlighting issues related to the co-occurrence of AUDs with other drug use and mental disorders.

The collaborative sessions include more than 50 lectures, workshops, and symposia by nationally recognized experts. They explore the latest findings on at-risk drinking, alcoholism, and comorbidity and feature new resources and techniques in pharmacotherapy, screening, and other important clinical advances.

"This promises to be a terrific track at the annual meeting," said Eric Strain, M.D., chair of APA's Council on Addiction Psychiatry. "Along with NIAAA's release of its new publication, *Helping Patients Who Drink Too Much—A Clinician's Guide*, the track will give general psychiatrists substantial opportunities to update their clinical skills and learn about recent research findings related to alcohol use disorders."

In keeping with the theme of this year's meeting, "From Science to Public Policy: Advocacy for the Profession and Patients," several sessions address the mental health profession's broader influence on public policy in areas such as college drinking and the prevention of underage drinking. Other presentations explore the potential impact of data from recent studies—including NIAAA's National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)—on developing the next edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*.

Comorbidity a Key Issue

NESARC data indicated that almost 40 percent of people who reported a major depressive episode in their lifetime also had experienced AUDs. Significant rates of comorbidity were also found with co-existing anxiety disorders, antisocial syndromes, and other conditions, according to NIAAA Director Ting-Kai Li, M.D.

These data not only clarify the extent and severity of comorbidity, but also have immediate clinical implications. How can practitioners best screen for and diagnose alcohol problems among psychiatric patients? To what extent does alcohol misuse impact on psychiatric treatment? What types of interventions are effective among patients with comorbid alcohol and mental disorders? Does heavy alcohol consumption alter the effectiveness of psychiatric medications? Are there shared factors that contribute to the risk of AUDs and other psychiatric disorders? How might practitioners comprehensively address the need for specialized follow-up and referrals for people with addiction and co-occurring disorders? Several NIAAA-supported sessions are designed to offer information on advances in dual diagnosis, screening and brief intervention, and therapy.

Alcohol and Adolescent Development

According to Li, alcohol is the drug of choice among adolescents, and addressing alcohol disorders in young people remains a priority. Even as increasing scientific interest is shedding light on the effects of alcohol consumption on adolescent development, important opportunities exist for practitioners to address alcohol-related problems in young patients.

Li said, "This is the intersection where science and medicine can make significant progress, both by integrating screening and diagnosis for alcohol disorders in adolescents, as well as by influencing policy decisions about prevention, intervention, and treatment to safeguard the health of young people."

A special symposium titled "Alcohol Use Disorders and Psychiatric Comorbidity" addresses important challenges in the psychiatric assessment and management of adolescents with AUDs and co-occurring mental illness. The objective of the session, which will be chaired by NIAAA Associate Director Howard B. Moss, M.D., is to inform clinical practitioners of research findings on the assessment and treatment of adolescent AUDs and specific comorbidities.

Bridging Research, Practice, and Policy

NIAAA and APA organizers have put together a wide range of sessions that feature leading specialists in pharmacotherapy, genetics, the neurobiology of alcoholism, and other fields.

Two sessions chaired by Mark L. Willenbring, M.D., director of NIAAA's Division of Treatment and Recovery Research, emphasize practical techniques for screening and brief intervention, motivational enhancement strategies, and the use of medications for AUDs and comorbid disorders in general psychiatric practice. The presentations highlight an important resource for psychiatrists and mental health professionals, NIAAA's 2005 edition of *Helping Patients Who Drink Too Much—A Clinician's Guide*.

A number of presentations focus on NESARC, the largest study ever conducted of the co-occurrence of psychiatric disorders among U.S. adults. The study's director, Bridget F. Grant, Ph.D., chief of NIAAA's Laboratory of Epidemiology and Biometry, will co-chair several sessions, including the symposium "Substance Use Disorders: Planning a Research Agenda for *DSM-V*," a look ahead at critical questions related to revisions in the criteria and definitions fundamental to psychiatry.

Finally, the symposium "Taking Science to Policy: Efforts to Reduce Harm Related to Alcohol Misuse" considers how mental health experts can leverage their unique expertise to promote policy changes. Case studies on underage drinking, drunken driving, and trauma-center policies are reviewed in this session, which will be co-chaired by Willenbring and Ralph W. Hingson, Sc.D., director of NIAAA's Division of Epidemiology and Prevention Research.

Each of the NIAAA sessions is noted in the annual meeting program as a "Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism." ■

When treating depressed patients with associated anxiety symptoms

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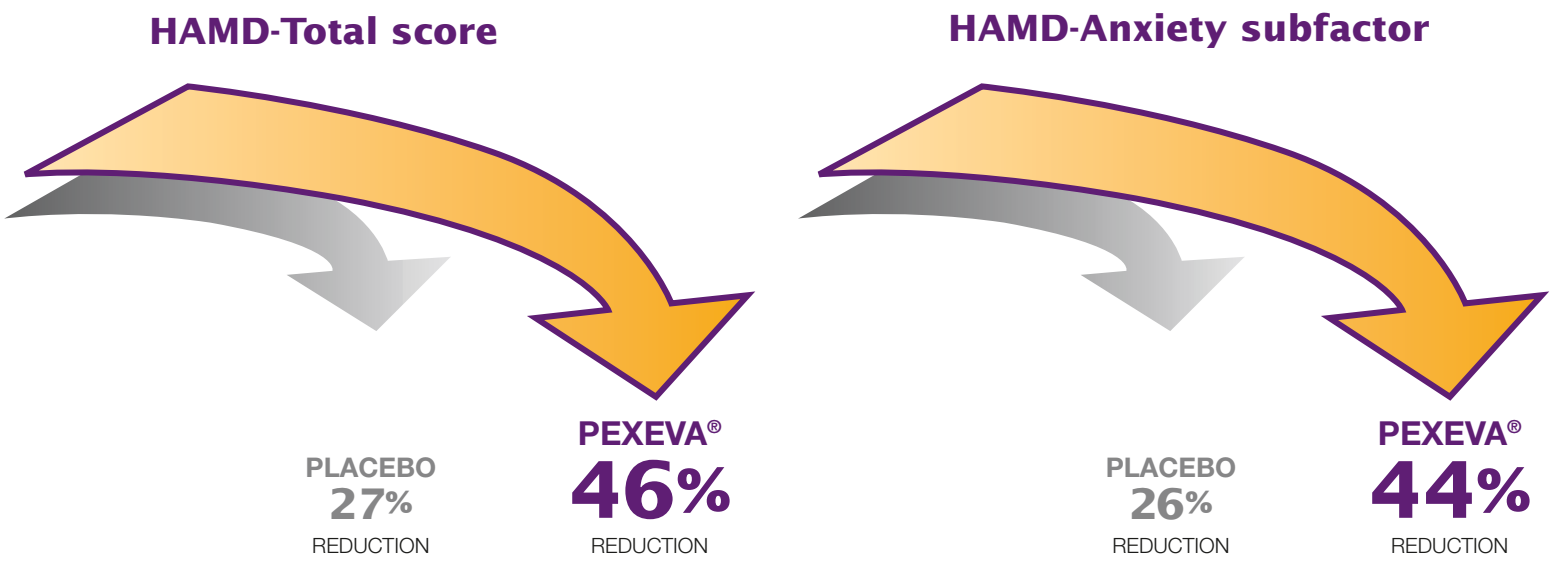
Significant reduction in Hamilton Depression Rating Scale (HAMD)[1]*



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PAROXETINE
(AS MESYLATE) TABLETS

*Combined analysis of 4 double-blind, placebo-controlled, 6-week clinical studies with matching protocols.[1]

Please see Brief Summary of Prescribing Information, including **Black Boxed WARNING and Pregnancy Warning**, on bottom of page.

Indications PEXEVA® is indicated for the treatment of major depressive disorder, obsessive compulsive disorder, and panic disorder.

Important Safety Information Suicidality in Children and Adolescents: Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of paroxetine mesylate or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. PEXEVA® (paroxetine mesylate) is not approved for use in pediatric patients. (See Warnings and Precautions: Pediatric Use in full Prescribing Information.)

Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

Adult patients with MDD or comorbid depression in the setting of other psychiatric illness being treated with antidepressants should be observed similarly for clinical worsening and suicidality, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. Concomitant use of PEXEVA® in patients taking monoamine oxidase inhibitors (MAOIs) or thioridazine is contraindicated. PEXEVA® (paroxetine mesylate) tablets are contraindicated in patients with a hypersensitivity to paroxetine or any of the inactive ingredients in PEXEVA® (paroxetine mesylate) tablets.The most common adverse events (incidence of 5% or greater and incidence for PEXEVA® at least twice that for placebo) include asthenia, sweating, nausea, dry mouth, constipation, decreased appetite, somnolence, dizziness, insomnia, libido decreased, tremor, nervousness, abnormal ejaculation, impotence, other male genital disorders, and female genital disorders.

Reference: 1. Claghorn J. A double-blind comparison of paroxetine and placebo in the treatment of depressed outpatients. *Int Clin Psychopharmacol*. 1992;6(suppl 4):25-30.

JDS PHARMACEUTICALS LLC

PX06-25 February 2006

PEXEVA® (paroxetine mesylate) tablets

BRIEF SUMMARY: See full prescribing information for complete details about PEXEVA.

Suicidality in Children and Adolescents: Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of paroxetine mesylate or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. PEXEVA® (paroxetine mesylate) is not approved for use in pediatric patients. (See Warnings and Precautions: Pediatric Use). Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

CONTRAINDICATIONS: Concomitant use in patients taking either monoamine oxidase inhibitors (MAOIs) or thioridazine is contraindicated. PEXEVA (paroxetine mesylate) tablets are contraindicated in patients with a hypersensitivity to paroxetine or any of the inactive ingredients in PEXEVA (paroxetine mesylate) tablets. **WARNINGS: Clinical Worsening and Suicide Risk:** Patients with major depressive disorder (MDD), both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. There has been a long-standing concern that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients. Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Pooled analyses of short-term placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with MDD, OCD, other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal behavior or thinking (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. There was considerable variation in risk among drugs, but a tendency toward an increase for almost all drugs studied. The risk of suicidality was most consistently observed in the MDD trials, but there were signals of risk arising from some trials in other psychiatric indications (obsessive compulsive disorder and social anxiety disorder) as well. **No suicides occurred in any of these trials.** It is unknown whether the suicidality risk in pediatric patients extends to longer-term use, i.e., beyond several months. It is also unknown whether the suicidality risk extends to adults. **All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. Such observation would generally include at least weekly face-to-face contact with patients or their family members or caregivers during the first 4 weeks of treatment, then every other week visits for the next 4 weeks, then at 12 weeks, and as clinically indicated beyond 12 weeks. Additional contact by telephone may be appropriate between face-to-face visits. Adults with MDD or co-morbid depression in the setting of other psychiatric illness being treated with antidepressants should be observed similarly for clinical worsening and suicidality, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.** The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms. If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (see PRECAUTIONS and DOSAGE AND ADMINISTRATION - Discontinuation of Treatment with Paroxetine, for a description of the risks of discontinuation of paroxetine). **Families and caregivers of pediatric patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers.** Prescriptions for PEXEVA (paroxetine mesylate) should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose. Families and caregivers of adults being treated for depression should be similarly advised. **Screening Patients for Bipolar Disorder:** A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that PEXEVA (paroxetine mesylate) is not approved for use in treating bipolar depression. **Potential for Interaction with Monoamine Oxidase Inhibitors: In patients receiving another serotonin reuptake inhibitor drug in combination with a monoamine oxidase inhibitor (MAOI), there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued that drug and have been started on a MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. While there are no human data showing such an interaction with paroxetine, limited animal data on the effects of combined use of paroxetine and MAOIs suggest that these drugs may act synergistically to elevate blood pressure and evoke behavioral excitation. Therefore, it is recommended that paroxetine not be used in combination with a MAOI, or within 14 days of discontinuing treatment with a MAOI. At least 2 weeks should be allowed after stopping PEXEVA before starting a MAOI. Potential Interaction with Thioridazine:**

Thioridazine administration alone produces prolongation of the QTc interval, which is associated with serious ventricular arrhythmias, such as torsade de pointes-type arrhythmias, and sudden death. This effect appears to be dose-related. An *in vivo* study suggests that drugs which inhibit P450IID6, such as paroxetine, will elevate plasma levels of thioridazine. Therefore, it is recommended that paroxetine not be used in combination with thioridazine. Usage in Pregnancy: Teratogenic Effects: Epidemiological studies have shown that infants born to women who had first trimester paroxetine exposure had an increased risk of cardiovascular malformations, primarily ventricular and atrial septal defects (VSDs and ASDs). In general, septal defects range from those that are symptomatic and may require surgery to those that are asymptomatic and may resolve spontaneously. If a patient becomes pregnant while taking paroxetine, she should be advised of the potential harm to the fetus. Unless the benefits of paroxetine to the mother justify continuing treatment, consideration should be given to either discontinuing paroxetine therapy or switching to another antidepressant. For women who intend to become pregnant or are in their first trimester of pregnancy, paroxetine should only be initiated after consideration of the other available treatment options. A study based on Swedish national registry data evaluated infants of 6,896 women exposed to antidepressants in early pregnancy (5,123 women exposed to SSRIs; including 815 for paroxetine). Infants exposed to paroxetine in early pregnancy had an increased risk of cardiovascular malformations (primarily VSDs and ASDs) compared to the entire registry population (OR 1.8; 95% confidence interval 1.1-2.8). The rate of cardiovascular malformations following early pregnancy paroxetine exposure was 2% vs. 1% in the entire registry population. Among the same paroxetine exposed infants, an examination of the data showed no increase in the overall risk for congenital malformations. A separate retrospective cohort study using US United Healthcare data evaluated 5,956 infants of mothers dispensed paroxetine or other antidepressants during the first trimester (n = 815 for paroxetine). This study showed a trend towards an increased risk for cardiovascular malformations for paroxetine compared to other antidepressants (OR 1.5; 95% confidence interval 0.8-2.9). The prevalence of cardiovascular malformations following first trimester dispensing was 1.5% for paroxetine vs. 1% for other antidepressants. Nine out of 12 infants with cardiovascular malformations whose mothers were dispensed paroxetine in the first trimester had VSDs. This study also suggested an increased risk of overall major congenital malformations (inclusive of the cardiovascular defects) for paroxetine compared to other antidepressants (OR 1.8; 95% confidence interval 1.2-2.8). The prevalence of all congenital malformations following first trimester exposure was 4% for paroxetine vs. 2% for other antidepressants. **Animal Findings:** Reproduction studies were performed at doses up to 50 mg/kg/day in rats and 6 mg/kg/day in rabbits administered during organogenesis. These doses are approximately 8 (rat) and 2 (rabbit) times the MRHD on an mg/m^2 basis. These studies have revealed no evidence of teratogenic effects. However, in rats, there was an increase in pup deaths during the first 4 days of lactation when dosing occurred during the last trimester of gestation and continued throughout lactation. This effect occurred at a dose of 1 mg/kg/day or approximately one-sixth of the MRHD on an mg/m^2 basis. The no-effect dose for rat pup mortality was not determined. The cause of these deaths is not known. **Nonteratogenic Effects:** Neonates exposed to PEXEVA and other SSRIs or serotonin and norepinephrine reuptake inhibitors (SNRIs) late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome. There have also been postmarketing reports of premature births in pregnant women exposed to paroxetine or other SSRIs. When treating a pregnant woman with paroxetine during the third trimester, the physician should carefully consider the potential risks and benefits of treatment. **PRECAUTIONS: General:** ***Activation of Mania/Hypomania:*** During premarketing testing, hypomania or mania occurred in approximately 1.0% of paroxetine-treated unipolar patients compared to 1.1% of active-control and 0.3% of placebo-treated unipolar patients. In a subset of patients classified as bipolar, the rate of manic episodes was 2.2% for paroxetine and 11.6% for the combined active-control groups. Paroxetine should be used cautiously in patients with a history of mania. ***Seizures:*** During premarketing testing, seizures occurred in 0.1% of paroxetine-treated patients, a rate similar to that associated with other drugs effective in the treatment of major depressive disorder. Paroxetine should be used cautiously in patients with a history of seizures. It should be discontinued in any patient who develops seizures. Because of well-established comorbidity between major depressive disorder and other psychiatric disorders, the same precautions observed when treating patients with major depressive disorder should be observed when treating patients with other psychiatric disorders. ***Discontinuation of Treatment with Paroxetine:*** Recent clinical trials supporting the various approved indications for paroxetine employed a taper-phase regimen, rather than an abrupt discontinuation of treatment. The taper-phase regimen used in GAD and PTSD clinical trials involved an incremental decrease in the daily dose by 10 mg/day at weekly intervals. When a daily dose of 20 mg/day was reached, patients were continued on this dose for 1 week before treatment was stopped. With this regimen in those studies, the following adverse events were reported for paroxetine at an incidence at least twice that reported for placebo: abnormal dreams, paresthesia, and dizziness. In the majority of patients, these events were mild to moderate and were self-limiting and did not require medical intervention. During paroxetine marketing and other SSRIs and SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), there have been spontaneous reports of adverse events occurring upon the discontinuation of these drugs (particularly when abrupt), including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g. paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, and hypomania. While these events are generally self-limiting, there have been reports of serious discontinuation symptoms. Patients should be monitored for these symptoms when discontinuing treatment with paroxetine. A gradual reduction in the dose, rather than abrupt cessation, is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate. ***Hyponatremia:*** Several cases of hyponatremia have been reported. The hyponatremia appeared to be reversible when paroxetine was discontinued. The majority of these occurrences have been in elderly individuals, some in patients taking diuretics or who were otherwise volume depleted. ***Abnormal Bleeding:*** Published case reports have documented the occurrence of bleeding episodes in patients treated with psychotropic drugs that interfere with serotonin reuptake. Subsequent epidemiological studies, both of the case-control and cohort design, have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding. In two studies, concurrent use of a nonsteroidal anti-inflammatory drug (NSAID) or aspirin potentiated the risk of bleeding. Although these studies focused on upper gastrointestinal bleeding, there is reason to believe that bleeding at other sites may be similarly potentiated. Patients should be cautioned regarding the risk of bleeding associated with the concomitant use of paroxetine with NSAIDS, aspirin, or other drugs that affect coagulation. ***Use in Patients with Concomitant Illness:*** Clinical experience with paroxetine in patients with certain concomitant systemic illness is limited. Caution is advisable in using paroxetine in patients with diseases or conditions that could affect metabolism or hemodynamic responses. Mydriasis has been infrequently reported in the premarketing studies with paroxetine. A few cases of acute angle closure glaucoma associated with paroxetine therapy have been reported in the literature. As mydriasis can cause acute angle closure in patients with narrow angle glaucoma, caution should be used when paroxetine is prescribed for patients with narrow angle glaucoma. Paroxetine has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were excluded from clinical studies during the product's premarket testing. Increased plasma concentrations of paroxetine occur in patients with severe renal impairment (creatinine clearance <30 ml/min) or severe hepatic impairment. A lower starting dose should be used in such patients. **Information for Patients:** Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with paroxetine mesylate and should counsel them in its appropriate use. A patient Medication Guide About Using Antidepressants in Children and Teenagers is available for paroxetine mesylate. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. The complete text of the Medication Guide is available in the full prescribing information. Patients should be advised of the following issues and asked to alert their prescriber if these occur while taking paroxetine mesylate. **Clinical Worsening and Suicide Risk:** Patients, their families, and their caregivers should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during antidepressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to observe for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's prescriber or health professional, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication. ***Interference with Cognitive and Motor Performance:*** Any psychoactive drug may impair judgment, thinking, or motor skills. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that paroxetine therapy does not affect their ability to engage in such activities. ***Completing Course of Therapy:*** While patients may notice improvement with paroxetine therapy in 1 to 4 weeks, they should be advised to continue therapy as directed. ***Concomitant Medication:*** Patients should be advised to inform their physician if they are taking, or plan to take, any prescription or over-the-counter drugs, since there is a potential for interactions. Patients should be made aware that paroxetine, the active ingredient in PEXEVA, is also the active ingredient of Paxil® (paroxetine hydrochloride) and that these two medications should not be taken concomitantly. ***Alcohol:*** Patients should be advised to avoid alcohol while taking PEXEVA. ***Pregnancy:*** Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. ***Nursing:*** Patients should be advised to notify their physician if they are breast-feeding an infant. **Paxil® (paroxetine hydrochloride):** Paroxetine, the active ingredient in PEXEVA, is also the active ingredient of Paxil®. Thus, these two agents should not be coadministered. **Drug interactions:** ***Tryptophan:*** As with other serotonin reuptake inhibitors, an interaction between paroxetine and tryptophan may occur when they are co-administered. Adverse experiences, consisting primarily of headache, nausea, sweating, and dizziness, have been reported when tryptophan was administered to patients taking paroxetine. Consequently, concomitant use of paroxetine with tryptophan is not recommended. ***Monoamine Oxidase Inhibitors:*** See CONTRAINDICATIONS and WARNINGS. ***Thioridazine:*** See CONTRAINDICATIONS and WARNINGS. ***Warfarin:*** Preliminary data suggest that there may be a pharmacodynamic interaction (that causes an increased bleeding diathesis in the face of unaltered prothrombin time) between paroxetine and warfarin. Since there is little clinical experience, the concomitant administration of paroxetine and warfarin should be undertaken with caution. ***Sumatriptan:*** There have been rare postmarketing reports describing patients with weakness, hyperreflexia, and incoordination following the use of a selective serotonin reuptake inhibitor (SSRI) and sumatriptan. If concomitant treatment with sumatriptan and an SSRI (e.g., fluoxetine, fluvoxamine, paroxetine, sertraline) is clinically warranted, appropriate observation of the patient is advised. ***Drugs Affecting Hepatic Metabolism:*** The metabolism and pharmacokinetics of paroxetine may be affected by the induction or inhibition of drug-metabolizing enzymes. **Cimetidine**–Cimetidine inhibits many cytochrome P450 (oxidative) enzymes. In a study where paroxetine (30 mg q.d.) was dosed orally for 4 weeks, steady-state plasma concentrations of paroxetine were increased by approximately 50% during co-administration with oral cimetidine (300 mg t.i.d.) for the final week. Therefore, when these drugs are administered concurrently, dosage adjustment of paroxetine after the 20 mg starting dose should be guided by clinical effect. The effect of paroxetine on cimetidine's pharmacokinetics was not studied. **Phenobarbital**–Phenobarbital induces many cytochrome P450 (oxidative) enzymes. When a single oral 30 mg dose of paroxetine was administered at phenobarbital steady state (100 mg q.d. for 14 days), paroxetine AUC and $T_{1/2}$ were reduced (by an average of 25% and 38%, respectively) compared to paroxetine administered alone. The effect of paroxetine on phenobarbital pharmacokinetics was not studied. Since paroxetine exhibits nonlinear pharmacokinetics, the results of this study may not address the case where the 2 drugs are both being chronically dosed. No initial paroxetine dosage adjustment is considered necessary when co-administered with phenobarbital; any subsequent adjustment should be guided by clinical effect. **Phenytoin**–When a single oral 30 mg dose of paroxetine was administered at phenytoin steady state (300 mg q.d. for 14 days), paroxetine AUC and $T_{1/2}$ were reduced (by an average of 50% and 35%, respectively) compared to paroxetine administered alone. In a separate study, when a single oral 300 mg dose of phenytoin was administered at paroxetine steady state (30 mg q.d. for 14 days), phenytoin AUC was slightly reduced (12% on average) compared to phenytoin administered alone. Since both drugs exhibit nonlinear pharmacokinetics, the above studies may not address the case where the two drugs are both being chronically dosed. No initial dosage adjustments are considered necessary when these drugs are co-administered; any subsequent adjustments should be guided by clinical effect. ***Drugs Metabolized by Cytochrome P450IID6:*** Many drugs, including most drugs effective in the treatment of major depressive disorder (paroxetine, other SSRIs and many tricyclics), are metabolized by the cytochrome P450 isozyme P450IID6. Like other agents that are metabolized by P450IID6, paroxetine may significantly inhibit the activity of this isozyme. In most patients (>90%), this P450IID6 isozyme is saturated early during paroxetine dosing. In one study, daily dosing of paroxetine (20 mg q.d.) under steady-state conditions increased single dose desipramine (100 mg) C_{max}, AUC, and $T_{1/2}$ by an average of approximately two-, five-, and three-fold, respectively. Concomitant use of paroxetine with other drugs metabolized by cytochrome P450IID6 has not been formally studied but may require lower doses than usually prescribed for either paroxetine or the other drug. Therefore, co-administration of PEXEVA with other drugs that are metabolized by this isozyme, including certain drugs effective in the treatment of major depressive disorder (e.g., nortriptyline, amitriptyline, imipramine, desipramine, and fluoxetine), phenothiazines, risperidone, and Type 1C antiarrhythmics (e.g., propafenone, flecainide, and encainide), or that inhibit this enzyme (e.g., quinidine), should be approached with caution. However, due to the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, paroxetine, and thioridazine should not be co-administered. At steady state, when the P450IID6 pathway is essentially saturated, paroxetine clearance is governed by alternative P450 isozymes, which, unlike P450IID6, show no evidence of saturation. ***Drugs Metabolized by Cytochrome P450IIIA4:*** An *in vivo* interaction study involving the co-administration under steady-state conditions of paroxetine and terfenadine, a substrate for cytochrome P450IIIA4, revealed no effect of paroxetine on terfenadine pharmacokinetics. In addition, *in vitro* studies have shown ketoconazole, a potent inhibitor of P450IIIA4 activity, to be at least 100 times more potent than paroxetine as an inhibitor of the metabolism of several substrates for this enzyme, including terfenadine, astemizole, cisapride, triazolam, and cyclosporine. Based on the assumption that the relationship between paroxetine's *in vitro* Ki and its lack of effect on terfenadine's *in vivo* clearance predicts its effect on other IIIA4 substrates, paroxetine's extent of inhibition of IIIA4 activity is not likely to be of clinical significance. ***Tricyclic Antidepressants (TCA):*** Caution is indicated in the co-administration of tricyclic antidepressants (TCAs) with PEXEVA, because paroxetine may inhibit TCA metabolism. Plasma TCA concentrations may need to be monitored and the dose of TCA may need to be reduced, if a TCA is co-administered with PEXEVA. ***Drugs Highly Bound to Plasma Protein:*** Because paroxetine is highly bound to plasma protein, administration of PEXEVA to a patient taking another drug that is highly protein bound may cause increased free concentrations of the other drug, potentially resulting in adverse events. Conversely, adverse effects could result from displacement of paroxetine by other highly bound drugs. ***Drugs That Interfere With Hemostasis (NSAIDs, Aspirin, Warfarin, etc.):*** Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of the case-control and cohort design that have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding have also shown that concurrent use of an NSAID or aspirin potentiated the risk of bleeding. Thus, patients should be cautioned about the use of such drugs concurrently with paroxetine. ***Alcohol:*** Patients should be advised to avoid alcohol while taking PEXEVA. ***Lithium:*** A multiple-dose study has shown that there is no pharmacokinetic interaction between paroxetine and lithium carbonate. However, since there is little clinical experience, the concurrent administration of paroxetine and lithium should be undertaken with caution. ***Digoxin:*** The steady-state pharmacokinetics of paroxetine was not altered when administered with digoxin at steady state. Mean digoxin AUC at steady state decreased by 15% in the presence of paroxetine. Since there is little clinical experience, the concurrent administration of paroxetine and digoxin should be undertaken with caution. ***Diazepam:*** Under steady-state conditions, diazepam does not appear to affect paroxetine kinetics. The effects of paroxetine on diazepam were not evaluated. ***Procyclidine:*** Daily oral dosing of paroxetine (30 mg q.d.) increased steady-state AUC0-24, C_{max} and C_{min} values of procyclidine (5 mg oral q.d.) by 35%, 37%, and 67%, respectively, compared to procyclidine alone at steady state. If anticholinergic effects are seen, the dose of procyclidine should be reduced. ***Beta-Blockers:*** In a study where propranolol (80 mg b.i.d.) was dosed orally for 18 days, the established steady-state plasma concentrations of propranolol were unaltered during co-administration with paroxetine (30 mg q.d.) for the final 10 days. The effects of propranolol on paroxetine have not been evaluated. ***Theophylline:*** Reports of elevated theophylline levels associated with paroxetine treatment have been reported. It is recommended that theophylline levels be monitored when these drugs are concurrently administered. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** ***Carcinogenesis:*** Two-year carcinogenicity studies were conducted in rodents given paroxetine in the diet at 1, 5, and 25 mg/kg/day (mice) and 1, 5, and 20 mg/kg/day (rats). These doses are up to 2.4 (mouse) and 3.9 (rat) times the maximum recommended human dose (MRHD) for major depressive disorder on a mg/m^2 basis. Because the MRHD for major depressive disorder is slightly less than that for OCD (50 mg vs. 60 mg), the doses used in these carcinogenicity studies were only 2.0 (mouse) and 3.2 (rat) times the MRHD for OCD. There was a significantly greater number of male rats in the high-dose group with reticulum cell sarcomas (1/100, 0/50, 0/50, and 4/50 for control, low-, middle-, and high-dose groups, respectively) and a significantly increased linear trend across groups for the occurrence of lymphoreticular tumors in male rats. Although there was a dose-related increase in the number of tumors in mice, there was no drug-related increase in the number of mice with tumors. The relevance of these findings to humans is unknown. ***Mutagenesis:*** Paroxetine produced no genotoxic effects in a battery of 5 *in vitro* and 2 *in vivo* assays that included the following: bacterial mutation assay, mouse lymphoma mutation assay, unscheduled DNA synthesis assay, and tests for cytogenetic aberrations *in vivo* in mouse bone marrow and *in vitro* in human lymphocytes and in a dominant lethal test in rats. ***Impairment of Fertility:*** A reduced pregnancy rate was found in reproduction studies in rats at a dose of paroxetine of 15 mg/kg/day, which is 2.9 times the MRHD for major depressive disorder or 2.4 times the MRHD for OCD on a mg/m^2 basis. Irreversible lesions occurred in the reproductive tract of male rats after dosing in toxicity studies for 2 to 52 weeks. These lesions consisted of vacuolation of epididymal tubular epithelium at 50 mg/kg/day and atrophic changes in the seminiferous tubules of the testes with arrested spermatogenesis at 25 mg/kg/day (9.8 and 4.9 times the MRHD for major depressive disorder; 8.2 and 4.1 times the MRHD for OCD and PD on a mg/m^2 basis). **Pregnancy: Pregnancy Category D.** If a patient becomes pregnant while taking paroxetine, she should be advised of the potential harm to the fetus. Unless the benefits of paroxetine to the mother justify continuing treatment, consideration should be given either to discontinuing paroxetine treatment or switching to another antidepressant. For women who intend to become pregnant or are in their first trimester of pregnancy, paroxetine should only be initiated after consideration of the other available treatment options. **See WARNINGS—Usage in Pregnancy: Teratogenic and Nonteratogenic Effects. Labor and Delivery:** The effect of paroxetine on labor and delivery in humans is unknown. **Nursing Mothers:** Like many other drugs, paroxetine is secreted in human milk, and caution should be exercised when PEXEVA is administered to a nursing woman. **Pediatric Use:** Safety and effectiveness in the pediatric population have not been established (see BOX WARNING and WARNINGS–Clinical Worsening and Suicide Risk). Three placebo-controlled trials in 752 pediatric patients with MDD have been conducted with paroxetine, and the data were not sufficient to support a claim for use in pediatric patients. Anyone considering the use of paroxetine mesylate in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use:** In worldwide pre-marketing paroxetine clinical trials, 17% of paroxetine-treated patients (approximately 700) were 65 years of age or older. Pharmacokinetic studies revealed a decreased clearance in the elderly, and a lower starting dose is recommended; there were, however, no overall differences in the adverse event profile between elderly and younger patients, and effectiveness was similar in younger and older patients. **ADVERSE REACTIONS: Associated with Discontinuation of Treatment:** Twenty percent (1,199/6,145) of paroxetine patients in worldwide clinical trials in major depressive disorder (MDD) and 11.8% (64/542) and 9.4% (44/469) of paroxetine patients in worldwide trials in OCD and panic disorder, respectively, discontinued treatment due to an adverse event. The most common events (≥1%) associated with discontinuation and considered to be drug related (i.e., those events associated with dropout at a rate approximately twice or greater for paroxetine compared to placebo) included the following: **CNS:** somnolence (MDD: 2.3% vs. 0.7%; panic disorder: 1.9% vs. 0.3%); insomnia (OCD: 1.7% vs. 0%; panic disorder: 1.3% vs. 0.3%); agitation (MDD: 1.1% vs. 0.5%); tremor (MDD: 1.1% vs. 0.3%); dizziness (OCD: 1.5% vs. 0%). **Gastrointestinal:** constipation (OCD: 1.1% vs. 0%); nausea (MDD: 3.2% vs. 1.1%; OCD: 1.9% vs. 0%; panic disorder: 3.2% vs. 1.2%); diarrhea (MDD: 1.0% vs. 0.3%); dry mouth (MDD: 1.0% vs. 0.3%); vomiting (MDD: 1.0% vs. 0.3%). **Other:** asthenia (MDD: 1.6% vs. 0.4%; OCD: 1.9% vs. 0.4%); abnormal ejaculation (MDD: 1.6% vs. 0%; OCD: 2.1% vs. 0%; incidence corrected for gender); sweating (MDD: 1.0% vs. 0.3%); and impotence (OCD: 1.5% vs. 0%; incidence corrected for gender). Where numbers are not provided the incidence of the adverse events in paroxetine patients was not >1% or was not greater than or equal to two times the incidence of placebo. **Commonly Observed Adverse Events:** ***Major Depressive Disorder:*** The most commonly observed adverse events associated with the use of paroxetine (incidence of 5% or greater and incidence for paroxetine at least twice that for placebo, derived from Table 1 below) were: asthenia, sweating, nausea, decreased appetite, somnolence, dizziness, insomnia, tremor, nervousness, ejaculatory disturbance, and other male genital disorders. ***Obsessive Compulsive Disorder:*** The most commonly observed adverse events associated with the use of paroxetine (incidence of 5% or greater and incidence for paroxetine at least twice that of placebo, derived from Table 2 below) were: nausea, dry mouth, decreased appetite, constipation, dizziness, somnolence, tremor, sweating, impotence, and abnormal ejaculation. ***Panic Disorder:*** The most commonly observed adverse events associated with the use of paroxetine (incidence of 5% or greater and incidence for paroxetine at least twice that for placebo, derived from Table 2 below) were: asthenia, sweating, decreased appetite, libido decreased, tremor, abnormal ejaculation, female genital disorders, and impotence. **Incidence in Controlled Clinical Trials:** The prescriber should be aware that the figures in the tables following cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence rate in the populations studied. ***Major Depressive Disorder:*** Table 1 enumerates adverse events that occurred at an incidence of 1% or more among paroxetine-treated patients who participated in short-term (6-week) placebo-controlled trials in which patients were dosed in a range of 20 to 50 mg/day. Reported adverse events were classified using a standard COSTART-based Dictionary terminology. **TABLE 1: Treatment-Emergent Adverse Experience Incidence in Placebo-Controlled Clinical Trials for Major Depressive Disorder (paroxetine: n=421; placebo: n=421).* Body as a Whole:** headache (18% vs. 17%); asthenia (15% vs. 6%). **Cardiovascular:** palpitation (3% vs. 1%); vasodilation (3% vs. 1%). **Dermatologic:** sweating (11% vs. 2%); rash (2% vs. 1%). **Gastrointestinal:** nausea (26% vs. 9%); dry mouth (18% vs. 12%); constipation (14% vs. 9%); diarrhea (12% vs. 8%); decreased appetite (6% vs. 2%); flatulence (4% vs. 2%); oropharynx disorder (includes mostly "lump in throat" and "tightness in throat") (2% vs. 0%); dyspepsia (2% vs. 1%). **Musculoskeletal:** myopathy (2% vs. 1%); myalgia (2% vs. 1%); myasthenia (1% vs. 0%). **Nervous System:** somnolence (23% vs. 9%); dizziness (13% vs. 6%); insomnia (13% vs. 6%); tremor (8% vs. 2%); nervousness (5% vs. 3%); anxiety (5% vs. 3%); paresthesia (4% vs. 2%); libido decreased (3% vs. 0%); drugged feeling (2% vs. 1%); confusion (1% vs. 0%). **Respiration:** yawn (4% vs. 0%). **Special Senses:** blurred vision (4% vs. 1%); taste perversion (2% vs. 0%). **Urogenital System:** ejaculatory disturbance (mostly "ejaculatory delay") (13% vs. 0%; percentage corrected for gender); other male genital disorder (includes "anorgasmia", "erectile difficulties", "delayed ejaculation/orgasm", "sexual dysfunction", and "impotence") (10% vs. 0%; percentage corrected for gender); urinary frequency (3% vs. 1%); urination disorder (includes mostly "difficulty with micturition" and "urinary hesitancy") (3% vs. 0%); female genital disorders (includes mostly "anorgasmia" and "difficulty reaching climax/orgasm") (2% vs. 0%; percentage corrected for gender). *Events reported by at least 1% of patients treated with paroxetine are included, except the following events which had an incidence on placebo ≥ paroxetine: abdominal pain, agitation, back pain, chest pain, CNS stimulation, fever, increased appetite, myoclonus, pharyngitis, postural hypotension, respiratory disorder (includes mostly "cold symptoms" or "URI"), trauma, and vomiting. ***Obsessive Compulsive Disorder and Panic Disorder:*** Table 2 enumerates adverse events that occurred at a frequency of 2% or more among OCD patients on paroxetine who participated in placebo-controlled trials of 12-weeks duration in which patients were dosed in a range of 20 to 60 mg/day or among patients with panic disorder on paroxetine who participated in placebo-controlled trials of 10- to 12-weeks duration in which patients were dosed in a range of 10 to 60 mg/day. **TABLE 2: Treatment-Emergent Adverse Experience Incidence of Placebo-Controlled Clinical Trials for Obsessive Compulsive Disorder (paroxetine: n=542; placebo: n=265) and Panic Disorder (paroxetine: n=469; placebo: n=324).** Body as a Whole:** asthenia (OCD: 22% vs. 14%; panic disorder: 14% vs. 5%); abdominal pain (panic disorder: 4% vs. 3%); chest pain (OCD: 3% vs. 2%); back pain (panic disorder: 3% vs. 2%); chills (OCD: 2% vs. 1%; panic disorder: 2% vs. 1%). **Cardiovascular:** vasodilation (OCD: 4% vs. 1%); palpitation (OCD: 2% vs. 0%). **Dermatologic:** sweating (OCD: 9% vs. 3%; panic disorder: 14% vs. 6%); rash (OCD: 3% vs. 2%). **Gastrointestinal:** nausea (OCD: 23% vs. 10%; panic disorder: 23% vs. 17%); dry mouth (OCD: 18% vs. 9%; panic disorder: 18% vs. 11%); constipation (OCD: 16% vs. 6%; panic disorder: 8% vs. 5%); diarrhea (OCD: 10% vs. 10%; panic disorder: 12% vs. 7%); decreased appetite (OCD: 9% vs. 3%; panic disorder: 7% vs. 3%); increased appetite (OCD: 4% vs. 3%; panic disorder: 2% vs. 1%). **Nervous System:** insomnia (OCD: 24% vs. 13%; panic disorder: 18% vs. 10%); somnolence (OCD: 24% vs. 7%; panic disorder: 19% vs. 11%); dizziness (OCD: 12% vs. 6%; panic disorder: 14% vs. 10%); tremor (OCD: 11% vs. 1%; panic disorder: 9% vs. 1%); nervousness (OCD: 9% vs. 8%); libido decreased (OCD: 7% vs. 4%; panic disorder: 9% vs. 1%); agitation (panic disorder: 5% vs. 4%); anxiety (panic disorder: 5% vs. 4%); abnormal dreams (OCD: 4% vs. 1%); concentration impaired (OCD: 3% vs. 2%); depersonalization (OCD: 3% vs. 0%); myoclonus (OCD: 3% vs. 0%; panic disorder: 3% vs. 2%); amnesia (OCD: 2% vs. 1). **Respiratory System:** rhinitis (panic disorder: 3% vs. 0%). **Special Senses:** abnormal vision (OCD: 4% vs. 2%); taste perversion (OCD: 2% vs. 0%). **Urogenital System:** abnormal ejaculation (OCD: 23% vs. 1%; panic disorder: 21% vs. 1%; percentage corrected for gender); female genital disorder (OCD: 3% vs. 0%; panic disorder: 9% vs. 1%; percentage corrected for gender); impotence (OCD: 8% vs. 1%; panic disorder: 5% vs. 0%; percentage corrected for gender); urinary frequency (OCD: 3% vs. 1%; panic disorder: 2% vs. 0%); urination impaired (OCD: 3% vs. 0%); urinary tract infection (OCD: 2% vs. 1%; panic disorder: 2% vs. 1%). **Events reported by at least 2% of OCD or panic disorder paroxetine-treated patients are included, except the following events which had an incidence on placebo ≥ paroxetine [OCD]: abdominal pain, agitation, anxiety, back pain, cough increased, depression, headache, hyperkinesia, infection, paresthesia, pharyngitis, respiratory disorder, rhinitis, and sinusitis. [Panic Disorder]: abnormal dreams, abnormal vision, chest pain, cough increased, depersonalization, depression, dysmenorrhea, dyspepsia, flu syndrome, headache, infection, myalgia, nervousness, palpitation, paresthesia, pharyngitis, rash, respiratory disorder, sinusitis, taste perversion, trauma, urination impaired, and vasodilation. ***Dose Dependency of Adverse Events:*** A comparison of adverse event rates in a fixed-dose study comparing paroxetine 10, 20, 30, and 40 mg/day with placebo in the treatment of **major depressive disorder** revealed a clear dose dependency for some of the more common adverse events associated with paroxetine use, as shown in the following table. **TABLE 3: Treatment-Emergent Adverse Experience Incidence in a Dose-Comparison Trial in the Treatment of Major Depressive Disorder (placebo: n=51; paroxetine 10 mg: n=102, 20 mg: n=104, 30 mg: n=101, 40 mg: n=102)** (Rule for including adverse events in table: incidence at least 5% for one of paroxetine groups and ≥ twice the placebo incidence for at least one paroxetine group.) **Body as a Whole:** asthenia (0.0% vs. 2.9%, 10.6%, 13.9%, 12.7%). **Dermatology:** sweating (2.0% vs. 1.0%, 6.7%, 8.9%, 11.8%). **Gastrointestinal:** constipation (5.9% vs. 4.9%, 7.7%, 9.9%, 12.7%); decreased appetite (2.0% vs. 2.0%, 5.8%, 4.0%, 4.9%); diarrhea (7.8% vs. 9.8%, 19.2%, 7.9%, 14.7%); dry mouth (2.0% vs. 10.8%, 18.3%, 15.8%, 20.6%); nausea (13.7% vs. 14.7%, 26.9%, 34.7%, 36.3%). **Nervous System:** anxiety (0.0% vs. 2.0%, 5.8%, 5.9%, 5.9%); dizziness (3.9% vs. 6.9%, 6.7%, 8.9%, 12.7%); nervousness (0.0% vs. 5.9%, 5.8%, 4.0%, 2.9%); paresthesia (0.0% vs. 2.9%, 1.0%, 5.0%, 5.9%); somnolence (7.8% vs. 12.7%, 18.3%, 20.8%, 21.6%); tremor (0.0% vs. 0.0%, 7.7%, 7.9%, 14.7%). **Special Senses:** blurred vision (2.0% vs. 2.9%, 2.9%, 2.0%, 7.8%). **Urogenital System:** abnormal ejaculation (0.0% vs. 5.8%, 6.5%, 10.6%, 13.0%); impotence (0.0% vs. 1.9%, 4.3%, 6.4%, 1.9%); male genital disorders (0.0% vs. 3.8%, 8.7%, 6.4%, 3.7%). In a fixed-dose study comparing placebo and paroxetine 20, 40, and 60 mg in the treatment of OCD, there was no clear relationship between adverse events and the dose of paroxetine to which patients were assigned. No new adverse events were observed in the paroxetine 60 mg dose group compared to any of the other treatment groups. In a fixed-dose study comparing placebo and paroxetine 10, 20, and 40 mg in the treatment of panic disorder, there was no clear relationship between adverse events and the dose of paroxetine to which patients were assigned, except for asthenia, dry mouth, anxiety, libido decreased, tremor and abnormal ejaculation. In flexible dose studies, no new adverse events were observed in patients receiving paroxetine 60 mg compared to any of the other treatment groups. ***Adaptation to Certain Adverse Events:*** Over a 4- to 6-week period, there was evidence of adaptation to some adverse events with continued therapy (e.g., nausea and dizziness), but less to other effects (e.g., dry mouth, somnolence, and asthenia). ***Male and Female Sexual Dysfunction with SSRIs:*** Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that selective serotonin reuptake inhibitors (SSRIs) can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labelling are likely to underestimate their actual incidence. In placebo-controlled clinical trials involving more than 1,800 patients, the ranges for the reported incidence of sexual side effects in males and females with major depressive disorder, OCD, and panic disorder are displayed in Table 4. **Table 4. Incidence of Sexual Adverse Events in Controlled Clinical Trials (in males only: paroxetine: n=925; placebo: n=655):** decreased libido (6% - 14% vs. 0% - 5%), ejaculatory disturbance (13% - 28% vs. 0% - 1%), impotence (2% - 8% vs. 0% - 1%); **(in females only: paroxetine: n=932; placebo: n=694):** decreased libido (1% - 9% vs. 0% - 2%), orgasmic disturbance (2% - 9% vs. 0% -1%). There are no adequate and well-controlled studies examining sexual dysfunction with paroxetine treatment. Paroxetine treatment has been associated with several cases of priapism. In those cases with a known outcome, patients recovered without sequelae. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. ***Weight and Vital Sign Changes:*** Significant weight loss may be an undesirable result of treatment with paroxetine for some patients but, on average, patients in controlled trials had minimal (about 1 pound) weight loss vs. smaller changes on placebo and active control. No significant changes in vital signs (systolic and diastolic blood pressure, pulse and temperature) were observed in patients treated with paroxetine in controlled clinical trials. **Other Events Observed During the Premarketing Evaluation of Paroxetine:** During its premarketing assessment in major depressive disorder, multiple doses of paroxetine were administered to 6,145 patients in phase 2 and 3 studies. The conditions and duration of exposure to paroxetine varied greatly and included (in overlapping categories) open and double blind studies, uncontrolled and controlled studies, inpatient and outpatient studies, and fixed-dose and titration studies. During premarketing clinical trials in OCD and panic disorder, 542 and 469 patients, respectively, received multiple doses of paroxetine. Untoward events associated with this exposure were recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of untoward events into a smaller number of standardized event categories. In the tabulations that follow, reported adverse events were classified using a standard COSTART-based Dictionary terminology. The frequencies presented, therefore, represent the proportion of the 9,089 patients exposed to multiple doses of paroxetine who experienced an event of the type cited on at least one occasion while receiving paroxetine. All reported events are included except those already listed in Tables 1 and 2, those reported in terms so general as to be uninformative and those events where a drug cause was remote. It is important to emphasize that although the events reported occurred during treatment with paroxetine, they were not necessarily caused by it. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients (only those not already listed in the tabulated results from placebo-controlled trials appear in this listing); infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. Events of major clinical importance are also described in the PRECAUTIONS section. ***Body as a Whole:*** *infrequent:* allergic reaction, chills, face edema, malaise, neck pain; *rare:* adrenergic syndrome, cellulitis, moniliasis, neck rigidity, pelvic pain, peritonitis, sepsis, ulcer. ***Cardiovascular System:*** *frequent:* hypertension, tachycardia; *infrequent:* bradycardia, hematoma, hypotension, migraine, syncope; *rare:* angina pectoris, arrhythmia nodal, atrial fibrillation, bundle branch block, cerebral ischemia, cerebrovascular accident, congestive heart failure, heart block, low cardiac output, myocardial infarct, myocardial ischemia, pallor, phlebitis, pulmonary embolus, supraventricular extrasystoles, thrombophlebitis, thrombosis, varicose vein, vascular headache, ventricular extrasystoles. ***Digestive System:*** *infrequent:* bruxism, colitis, dysphagia, eructation, gastritis, gastroenteritis, gingivitis, glossitis, increased salivation, liver function tests abnormal, rectal hemorrhage, ulcerative stomatitis; *rare:* aphthous stomatitis, bloody diarrhea, bulimia, cardiospasm, chlolelithiasis, duodenitis, enteritis, esophagitis, fecal impactions, fecal incontinence, gum hemorrhage, hematemesis, hepatitis, ileitis, ileus, intestinal obstruction, jaundice, melena, mouth ulceration, peptic ulcer, salivary gland enlargement, sialadenitis, stomach ulcer, stomatitis, tongue discoloration, tongue edema, tooth caries. ***Endocrine System:*** *rare:* diabetes mellitus, goiter, hyperthyroidism, hypothyroidism, thyroiditis. ***Hemic and Lymphatic Systems:*** *infrequent:* anemia, leukopenia, lymphadenopathy, purpura; *rare:* abnormal erythrocytes, basophilia, bleeding time increased, eosinophilia, hypochromic anemia, iron deficiency anemia, leukocytosis, lymphedema, abnormal lymphocytes, lymphocytosis, microcytic anemia, monocytosis, normocytic anemia, thrombocythemia, thrombocytopenia. ***Metabolic and Nutritional:*** *frequent:* weight gain; *infrequent:* edema, peripheral edema, SGOT increased, SGPT increased, thirst, weight loss; *rare:* alkaline phosphatase increased, bilirubinemia, BUN increased, creatinine phosphokinase increased, dehydration, gamma globulins increased, gout, hypercalcemia, hypercholesteremia, hyperglycemia, hyperkalemia, hyperphosphatemia, hypocalcemia, hypoglycemia, hypokalemia, hyponatremia, ketosis, lactic dehydrogenase increased, non-protein nitrogen (NPN) increased. ***Musculoskeletal System:*** *frequent:* arthralgia; *infrequent:* arthritis, arthrosis; *rare:* bursitis, myositis, osteoporosis, generalized spasm, tenosynovitis, tetany. ***Nervous System:*** *frequent:* emotional lability, vertigo; *infrequent:* abnormal thinking, alcohol abuse, ataxia, dystonia, dyskinesia, euphoria, hallucinations, hostility, hypertonia, hypesthesia, hypokinesia, incoordination, lack of emotion, libido increased, manic reaction, neurosis, paralysis, paranoid reaction; *rare:* abnormal gait, akinesia, antisocial reaction, aphasia, choreoathetosis, circumoral paresthesias, convulsion, delirium, delusions, diplopia, drug dependence, dysarthria, extrapyramidal syndrome, fasciculations, grand mal convulsion, hyperalgesia, hysteria, manic-depressive reaction, meningitis, myelitis, neuralgia, neuropathy, nystagmus, peripheral neuritis, psychotic depression, psychosis, reflexes decreased, reflexes increased, stupor, torticollis, trismus, withdrawal syndrome. ***Respiratory System:*** *infrequent:* asthma, bronchitis, dyspnea, epistaxis, hyperventilation, pneumonia, respiratory flu; *rare:* emphysema, hemoptysis, hiccups, lung fibrosis, pulmonary edema, sputum increased, stridor, voice alteration. ***Skin and Appendages:*** *frequent:* pruritus; *infrequent:* acne, alopecia, contact dermatitis, dry skin, ecchymosis, eczema, herpes simplex, photosensitivity, urticaria; *rare:* angioedema, erythema nodosum, erythema multiforme, exfoliative dermatitis, fungal dermatitis, furunculosis, herpes zoster, hirsutism, maculopapular rash, seborrhea, skin discoloration, skin hypertrophy, skin ulcer, sweating decreased, vesiculobullous rash. ***Special Senses:*** *frequent:* tinnitus; *infrequent:* abnormality of accommodation, conjunctivitis, ear pain, eye pain, keratoconjunctivitis, mydriasis, otitis media; *rare:* amblyopia, anisocoria, blepharitis, cataract, conjunctival edema, corneal ulcer, deafness, exophthalmos, eye hemorrhage, glaucoma, hyperacusis, night blindness, otitis externa, parosmia, photophobia ptosis, retinal hemorrhage, taste loss, visual field defect. ***Urogenital System:*** *infrequent:* amenorrhea, breast pain, cystitis, dysuria, hematuria, menorrhagia, nocturia, pyuria, polyuria, urinary incontinence, urinary retention, urinary urgency, vaginitis; *rare:* abortion, breast atrophy, breast enlargement, endometrial disorder, epididymitis, female lactation, fibrocystic breast, kidney calculus, kidney pain, leukorrhea, mastitis, metrorrhagia, nephritis, oliguria, salpingitis, urethritis, urinary casts, uterine spasm, urolith, vaginal hemorrhage, vaginal moniliasis. **Postmarketing Reports:** Voluntary reports of adverse events in patients taking paroxetine that have been received since market introduction and not listed above that may have no causal relationship with the drug include acute pancreatitis, elevated liver function tests (the most severe cases were deaths due to liver necrosis, and grossly elevated transaminases associated with severe liver dysfunction), Guillain-Barré syndrome, toxic epidermal necrolysis, priapism, syndrome of inappropriate ADH secretion, symptoms suggestive of prolactinemia and galactorrhea, neuroleptic malignant syndrome-like events; extrapyramidal symptoms which have included akathisia, bradykinesia, cogwheel rigidity, dystonia, hypertonia, oculogyric crisis which has been associated with concomitant use of pimozide, tremor and trismus; serotonin syndrome, associated in some cases with concomitant use of serotonergic drugs and with drugs which may have impaired paroxetine metabolism (symptoms have included agitation, confusion, diaphoresis, hallucinations, hyperreflexia, myoclonus, shivering, tachycardia and tremor), status epilepticus, acute renal failure, pulmonary hypertension, allergic alveolitis, anaphylaxis, eclampsia, laryngismus, optic neuritis, porphyria, ventricular fibrillation, ventricular tachycardia (including torsade de pointes), thrombocytopenia, hemolytic anemia, events related to impaired hematopoiesis (including aplastic anemia, pancytopenia, bone marrow aplasia, and agranulocytosis), and vasculitic syndromes (such as Henoch-Schönlein purpura). There has been a case report of an elevated phenytoin level after 4 weeks of paroxetine and phenytoin co-administration. There has been a case report of severe hypotension when paroxetine was added to chronic metoprolol treatment.

DATE OF ISSUANCE: 01/2006

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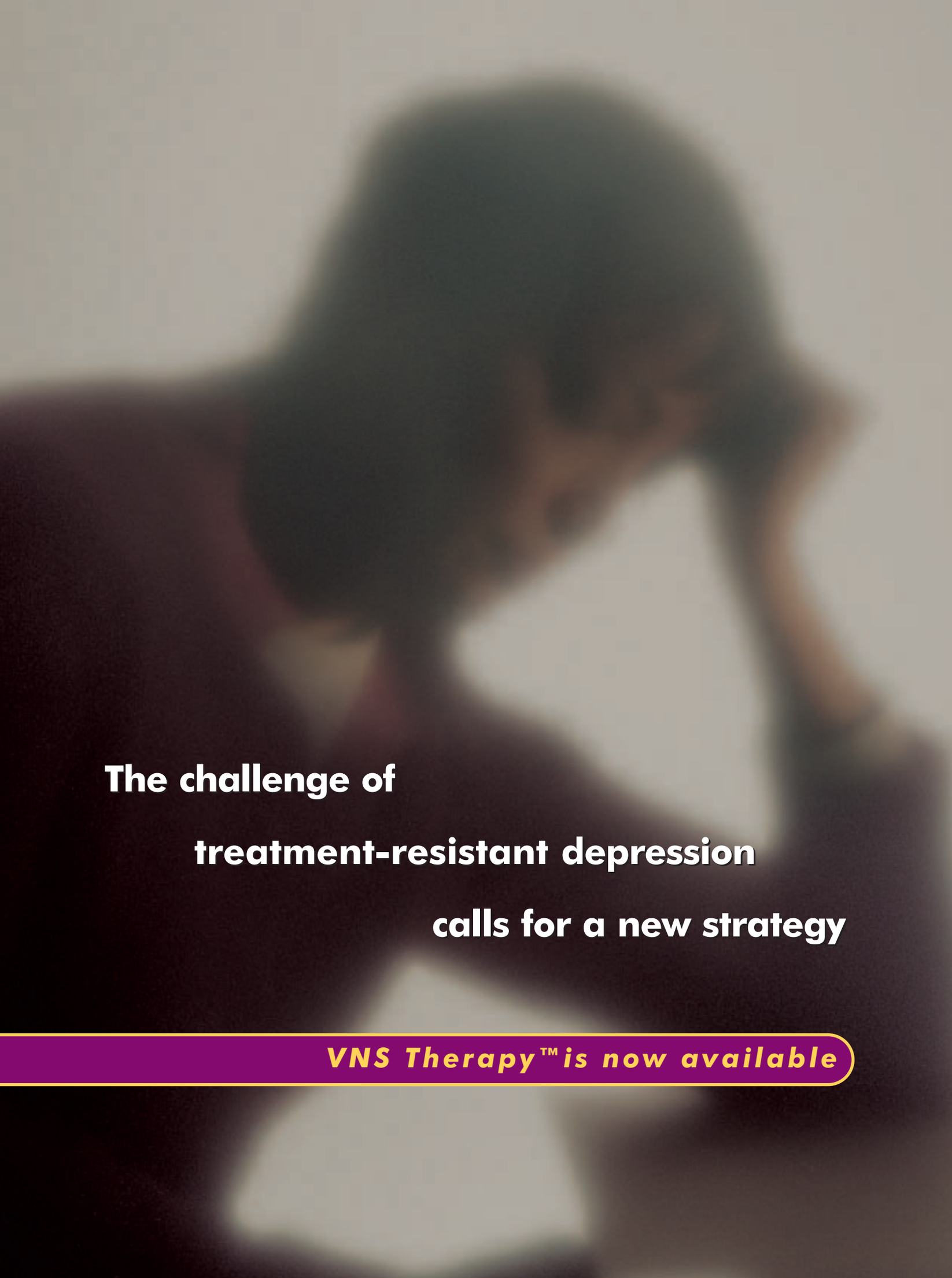

The challenge of
treatment-resistant depression
calls for a new strategy
VNS Therapy™ is now available

NEW *for treatment-resistant depression*

Lauri, VNS Therapy
since 1999

Introducing VNS Therapy

Discover sustained efficacy and help her reconnect

Adding VNS Therapy has been shown to provide sustained efficacy and clinical benefits that improve over time[1]

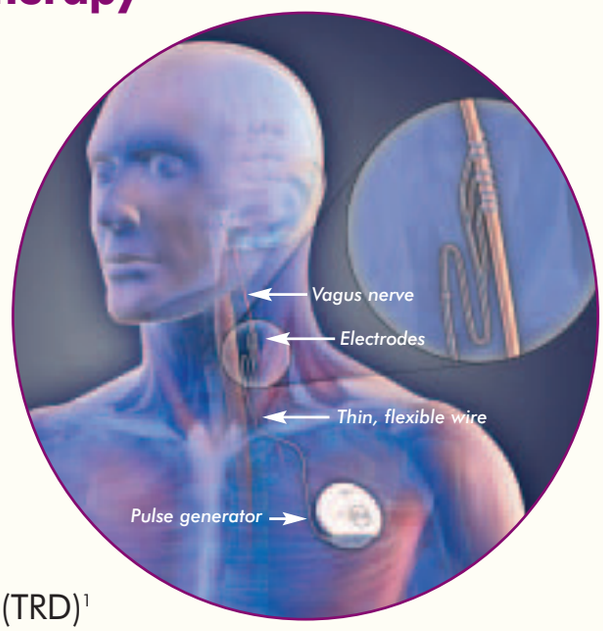
- A unique mechanism of action[2]
- Efficacy that improves over time and is sustained long term[1]
- Quality-of-life benefits that improve over time[1]
- Safety and tolerability, with side effects that typically decrease over time[1]
- High continuation and adherence rates[1]

VNS THERAPY™

VAGUS NERVE STIMULATION

NEW for treatment-resistant depression

Vagus nerve stimulation (VNS) Therapy involves a straightforward procedure



- The VNS Therapy System consists of an implanted pacemaker-like pulse generator and nerve stimulation electrodes, which deliver intermittent stimulation to the patient's left vagus nerve
- Implant procedure takes approximately 1 hour, and the procedure does not involve the brain
- VNS Therapy may be added to any regimen for treatment-resistant depression (TRD)[1]

Adding VNS Therapy has been shown to succeed where other treatments have failed[1,3]

Average Baseline Characteristics of Patients in Clinical Study	
Baseline $HAMD_{24}$* score	**28**
Duration of lifetime illness	**26 years**
Duration of current episode	**50 months**
Number of failed treatments, current episode	**10**
Number of adequate failed treatments,† current episode	**4**

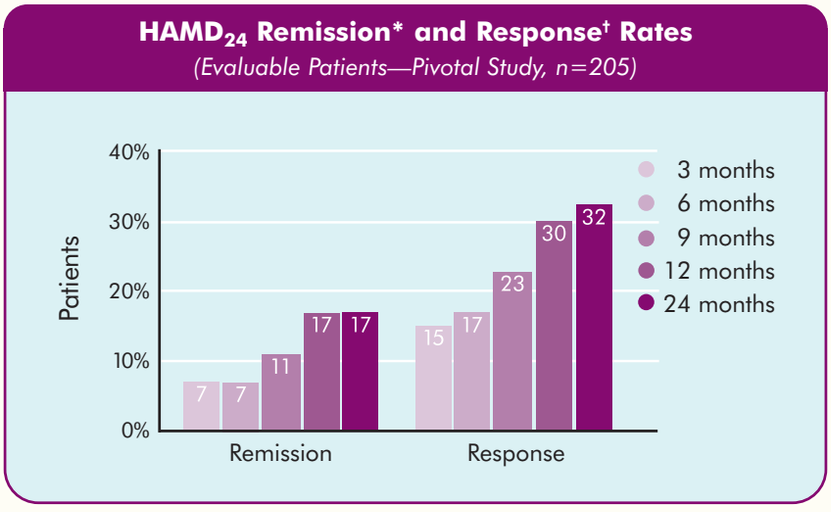
*Hamilton Rating Scale for Depression, 24 items.

†All treatments met ATHF (Antidepressant Treatment History Form) criteria for adequate dose, duration, and peer-reviewed published data from a randomized controlled trial.

PLEASE REFER TO THE ACCOMPANYING BRIEF SUMMARY FOR PRESCRIBING AND SAFETY INFORMATION.

VNS Therapy efficacy improves over time[1]

$HAMD_{24}$ Remission* and Response† Rates
(Evaluable Patients—Pivotal Study, n=205)



*"Remission" defined as $HAMD_{24}$ score ≤9 (symptom-free).
†"Response" defined as ≥50% reduction in $HAMD_{24}$ score.

At 24 months...

- 17% of patients with TRD achieved remission ($HAMD_{24} \leq 9$)[1]
- 32% of patients with TRD achieved clinical response (≥50% reduction in $HAMD_{24}$ score)[1]
- 70% of patients who responded acutely maintained their response[1]

VNS Therapy offers a unique safety profile

- Sleep disturbance and weight gain (commonly reported with other antidepressant treatments) have been reported by <2% of patients receiving VNS Therapy[3]
- VNS Therapy has not been associated with sexual dysfunction[1]
- VNS Therapy has shown no evidence of deterioration in any neurocognitive measures[4]
- Stimulation-related side effects include hoarseness, cough, neck pain, and shortness of breath; are mild to moderate; and decrease over time[1]
- Adding VNS Therapy has been shown to provide sustained efficacy and clinical benefits that improve over time[1]

VNS THERAPY™
VAGUS NERVE STIMULATION

For more information, visit www.VNSTherapy.com.

Brief Summary* of Safety Information for the VNS Therapy™ System May 2005

1. INTENDED USE / INDICATIONS: DEPRESSION (USA)
The VNS Therapy System is indicated for the adjunctive long-term treatment of chronic or recurrent depression for patients 18 years of age or older who are experiencing a major depressive episode and have not had an adequate response to four or more adequate antidepressant treatments.

2. CONTRAINDICATIONS
The VNS Therapy System cannot be used in patients after a bilateral or left cervical vagotomy.
Do not use short-wave diathermy, microwave diathermy, or therapeutic ultrasound diathermy on patients implanted with a VNS Therapy System. Diagnostic ultrasound is not included in this contraindication.

3. WARNINGS
Physicians should inform patients about all potential risks and adverse events discussed in the *Physician's Manual (Depression)*. This document is not intended to serve as a substitute for the complete *Physician's Manual (Depression)*.
Physicians should warn patients that VNS Therapy has not been determined to be a cure for depression.
The safety and efficacy of the VNS Therapy System have not been established for uses not covered in the "Intended Use/Indications" section of the *Physician's Manuals (Depression and Epilepsy)*.
Patients being treated with adjunctive VNS Therapy should be observed closely for clinical worsening and suicidality, especially at the time of VNS Therapy stimulation parameter changes or drug or drug dose changes.
The safety and effectiveness of the VNS Therapy System in patients with predisposed dysfunction of cardiac conduction systems (re-entry pathway) have not been established. Postoperative bradycardia can occur among patients with certain underlying cardiac arrhythmias. Post-implant electrocardiogram and Holter monitoring are recommended if clinically indicated.
It is important to follow recommended implantation procedures and intraoperative product testing described in the *Physician's Manual (Depression)*. During the intraoperative System Diagnostics (Lead Test), infrequent incidents of bradycardia and/or asystole have occurred. If asystole, severe bradycardia (heart rate <40 bpm), or a clinically significant change in heart rate is encountered during a System Diagnostics or during initiation of stimulation, physicians should be prepared to follow guidelines consistent with Advanced Cardiac Life Support (ACLS).
Difficulty swallowing (dysphagia) may occur with active stimulation, and aspiration may result from the increased swallowing difficulties. Patients with pre-existing swallowing difficulties are at greater risk for aspiration.
Shortness of breath (dyspnea) may occur with active VNS Therapy. Any patient with underlying pulmonary disease or insufficiency such as chronic obstructive pulmonary disease or asthma may be at increased risk for dyspnea.
Patients with obstructive sleep apnea (OSA) may have an increase in apneic events during stimulation. Lowering stimulus frequency or prolonging "OFF" time may prevent exacerbation of OSA. Vagus nerve stimulation may also cause new onset sleep apnea in patients who have not previously been diagnosed with this disorder.
Device malfunction could cause painful stimulation or direct current stimulation. Either event could cause nerve damage.
Patients should be instructed to use the Magnet to stop stimulation if they suspect a malfunction, and then to contact their physician immediately for further evaluation.
Patients with the VNS Therapy System or any part of the VNS Therapy System implanted should not have full body MRI.

Use of the Magnet to activate stimulation is not recommended for patients with depression.
Excessive stimulation at an excess duty cycle has resulted in degenerative nerve damage in laboratory animals.
Patients who manipulate the Pulse Generator and Lead through the skin may damage or disconnect the Lead from the Pulse Generator and/or possibly cause damage to the vagus nerve.

4. PRECAUTIONS
Physicians should inform patients about all potential risks and adverse events discussed in the *Physician's Manual (Depression)*.
Prescribing physicians should be experienced in the diagnosis and treatment of depression and should be familiar with the programming and use of the VNS Therapy System.
Physicians who implant the VNS Therapy System should be experienced performing surgery in the carotid sheath; physicians should be familiar with vagus nerve anatomy, particularly the cardiac branches; and they should be trained in the surgical technique relating to the implantation of the VNS Therapy System. See the section "Physician Training/Information" in the *Physician's Manual (Depression)*.
The safety and effectiveness of the VNS Therapy System have not been established for use during pregnancy. VNS Therapy should be used during pregnancy only if clearly needed.
The VNS Therapy System is indicated for use only in stimulating the left vagus nerve in the neck area (inside the carotid sheath).
The VNS Therapy System is indicated for use only in stimulating the left vagus nerve below where the superior and inferior cervical cardiac branches separate from the vagus nerve.
It is important to follow infection control procedures. Infections related to any implanted device are difficult to treat and may require that the device be explanted. The patient should be given antibiotics preoperatively. The surgeon should ensure that all instruments are sterile prior to the procedure.
The VNS Therapy System may affect the operation of other implanted devices, such as cardiac pacemakers and implanted defibrillators. Possible effects include sensing problems and inappropriate device responses. If the patient requires concurrent implantable pacemaker, defibrillatory therapy or other types of

stimulators, careful programming of each system may be necessary to optimize the patient's benefit from each device.
Reversal of Lead polarity has been associated with an increased chance of bradycardia in animal studies. It is important that the electrodes are attached to the left vagus nerve in the correct orientation. It is also important to make sure that Leads with dual connector pins are correctly inserted (white marker band/serial number to + connection) into the Lead receptacles.
Do not program the VNS Therapy System to an "ON" or periodic stimulation treatment for at least 14 days after the initial or replacement implantation.
Patients who smoke may have an increase risk of laryngeal irritation.

5. ENVIRONMENTAL AND MEDICAL THERAPY HAZARDS
Patients should exercise reasonable caution in avoiding devices that generate a strong electric or magnetic field. (For examples, see the "Other Environmental Hazards" section of the *Physician's Manual (Depression)*.) If a Pulse Generator ceases operation while in the presence of electromagnetic interference (EMI), moving away from the source may allow it to return to its normal mode of operation.
VNS Therapy System operation should always be checked by performing device diagnostics after any of the procedures mentioned in the *Physician's Manual (Depression)*.
For chest imaging, patients may need to be specially positioned for mammography procedures because of the location of the Pulse Generator in the chest. (Most routine diagnostic procedures, such as fluoroscopy and x-radiography, are not expected to affect system operation.)
Therapeutic radiation may damage the Pulse Generator's circuitry, although no testing has been done to date and no definite information on radiation effects is available. Sources of such radiation include therapeutic radiation, cobalt machines, and linear accelerators. The radiation effect is cumulative, with the total dosage determining the extent of damage. The effects of exposure to such radiation can range from a temporary disturbance to permanent damage, and may not be detectable immediately.
External defibrillation may damage the Pulse Generator. Please refer to the *Physician's Manual (Depression)* for complete instructions for external defibrillation.
Use of electrosurgery (electrocautery or radio frequency (RF) ablation devices) may damage the Pulse Generator. Please refer to the *Physician's Manual (Depression)* for complete instructions for use during electrosurgery.
Magnetic resonance imaging (MRI) should not be performed with a magnetic resonance body coil in the transmit mode. The heat induced in the Lead by an MRI body scan can cause injury. If an MRI should be done, use only a transmit-and-receive type of head coil. MRI compatibility was demonstrated using a 1.5T General Electric Signa Imager with a Model 100 only. When other MRI systems are used, adverse events may occur because of different magnetic field distributions.
Please refer to the *Physician's Manual (Depression)* for complete information for MRI procedures.
Procedures in which the radiofrequency (RF) is transmitted by a body coil should not be done on a patient who has the VNS Therapy System. Thus, protocols must not be used which utilize local coils that are RF-receive only, with RF-transmit performed by the body coil. Note that some RF head coils are receive only, and that most other local coils, such as knee and spinal coils, are also RF-receive only. These coils must not be used in patients with the VNS Therapy System.
Extracorporeal shockwave lithotripsy may damage the Pulse Generator. If therapeutic ultrasound is required, avoid positioning the area of the body where the Pulse Generator is implanted in the water bath or in any other position that would expose it to ultrasound therapy. If that positioning cannot be avoided, program the Pulse Generator output to 0 mA for the treatment, and then after therapy, reprogram the Pulse Generator to the original parameters.
If the patient receives medical treatment for which electric current is passed through the body (such as from a TENS unit), either the Pulse Generator output should be set to 0 mA or function of the Pulse Generator should be monitored during initial stages of treatment.
Routine therapeutic ultrasound could damage the Pulse Generator and may be inadvertently concentrated by the device, causing harm to the patient.
For information related to home occupational environments, cellular phones, other environmental hazards, other devices, and ECG monitors, please refer to the *Physician's Manual (Depression)* for complete information.

6. ADVERSE EVENTS
Implant-related adverse events reported during clinical studies in ≥5% of patients are listed in order of decreasing occurrence: incision pain, voice alteration, incision site reaction, device site pain, device site reaction, pharyngitis, dysphagia, hypesthesia, dyspnea, nausea, headache, neck pain, pain, paresthesia, and cough increased.
Stimulation-related adverse events reported during the acute phase of clinical studies in ≥5% of patients are listed in order of decreasing occurrence: voice alteration, cough increased, dyspnea, neck pain, dysphagia, laryngitis, paresthesia, pharyngitis, nausea, and incision pain.

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*The information contained in this Brief Summary for Physicians represents partial excerpts of important prescribing information taken from the *Physician's Manual (Depression)*. (Copies of *VNS Therapy Physician's and Patient's Manuals* are posted at www.VNSTherapy.com/manuals). The information is not intended to serve as a substitute for a complete and thorough understanding of the material presented in all of the *Physician's Manuals* for the VNS Therapy System and its component parts, nor does this information represent full disclosure of all pertinent information concerning the use of this product, potential safety complications, or efficacy outcomes.

USA Depression Summary 26-0806-1100/1

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A. Pharmacologic Treatment of Schizophrenia: The State of the Art *John M. Kane, M.D.*

B. From Dopamine to Delusions: Understanding Psychosis From the Bench to the Bedside *Shitij Kapur, M.D.*

C. Cognitive Functioning in Schizophrenia: Cognitive Impairments as Clues for Treatment Development *Robert M. Bilder, Ph.D.*

D. Metabolic Risks of Second-Generation Antipsychotic Medications *Christoph U. Correll, M.D.*

IS15. Vital Signs in Psychiatry: A Perspective on Sleep Across the Life Cycle *Supported by Sepracor Inc.*

A. Sleep in Infancy, Childhood, and Adolescence: Normal Sleep Patterns, Developmental Issues, and Sleep Problems *Jodi Mindell, M.D.*

B. Insomnia in Adulthood: Causes, Consequences, and Treatment *Ned H. Kalin, M.D.*

C. Insomnia Secondary to Medical or Psychiatric Comorbidity: Implications for Evaluation and Management *Matthias K. Lee, M.D.*

D. Sleep in Women Across the Life Cycle: How the Reproductive Cycle Impacts Sleep *Meir Kryger, M.D.*

E. Sleep in the Elderly: Is Poor Sleep a Normal Concomitant of Advancing Age? *Sanford Finkel, M.D.*

IS16. Interrupting the Cycle of Vascular Disease and Depression *Supported by Forest Pharmaceuticals Inc.*

A. Vascular Disease: Mechanisms Underlying the Relationship *Dominique L. Musselman, M.D.*

B. The Bidirectional Relationship Between Diabetes and Depression *Sanjay Mathew, M.D.*

C. Post-Stroke Depression and the Vascular Depression Hypothesis *David C. Steffens, M.D.*

D. Vascular Disease and Depression: Challenges in Management and Treatment *Christopher M. O'Connor, M.D.*

E. Clinical Treatment Perspectives: A Focus on Diagnosis and Safety *J. Craig Nelson, M.D.*

IS17. Update on Insights From and Future Course of the Collaborative Depression Study *Supported by Wyeth Pharmaceuticals*

A. The Pernicious Course of Depression and the Impact of New Insights From Imaging, Genomics, Neurobiology, and Learning *Martin B. Keller, M.D.*

B. Update on the Clinical Course of Major Depression *Audrey R. Tyrka, M.D.*

C. Using Pharmacogenetics in Practice *Alan F. Schatzberg, M.D.*

D. Biological and Imaging Changes in Depression *K. Ranga R. Krishnan, M.B.*

E. Review of the Current State of Evidence-Based Treatment of Depression *Madhukar H. Trivedi, M.D.*

IS18. Misdiagnosis of Bipolar II: Methods for Screening Patients at Risk for Bipolar Disorder *Supported by GlaxoSmithKline*

A. Diagnosing Bipolar Disorder and the Role of Screening Instruments *Terence A. Ketter, M.D.*

B. Antidepressants and the Bipolar Spectrum *S. Nassir Ghaemi, M.D.*

C. Major Depression: Clues to Bipolarity *Hagop S. Akiskal, M.D.*

D. Characteristics and Treatment of Bipolar II Disorder *Ross J. Baldessarini, M.D.*

E. Depression and the Affective Spectrum: The Role of Mood Stabilizers *Frederick K Goodwin, M.D.*

IS19. Advances in the Understanding of the Dementia Spectrum *Supported by Eisai Inc. and Pfizer Inc.*

A. The Neurobiology of Alzheimer's Disease *David A. Bennett, M.D.*

B. Therapeutic Options in the Management of Vascular Dementia *David Wilkinson, M.B.*

C. Evolution in the Understanding and Treatment of Mild Cognitive Impairment *Gregory A. Jicha, M.D.*

D. Improving Outcomes for Patients With Advanced Dementia *Howard Feldman, M.D.*

E. Optimizing Behavioral Outcomes Across the Dementia Spectrum *Jeffrey L. Cummings, M.D.*

2:30 p.m.-4 p.m.

Lecture

L1. The Challenge of Employment-Related Psychiatric Evaluations *Liza H. Gold, M.D., AAPL/APA's Manfred S. Guttmacher Award Lecture*

5 p.m.-6:30 p.m.

Opening Session and Presidential Address

7 p.m.-10 p.m.

Industry-Supported Symposia

IS20. Alzheimer's Disease: Challenging the Practice Paradigm *Supported by Forest Pharmacueticals Inc.*

A. Variability in the Clinical Presentation of Alzheimer's Disease *M. Saleem Ismail, M.D.*

B. Treatment Initiation in Alzheimer's Disease *Pierre N. Tariot, M.D.*

C. Individualizing Alzheimer's Disease Therapy Over the Disease Course *Constantine Lyketsos, M.D.*

D. Neuropsychiatric Symptoms in Alzheimer's Disease: Preventing Emergence and Decreasing Severity *Jeffrey L. Cummings, M.D.*

IS21. Effectiveness of Antipsychotic Drugs in Chronic Schizophrenia: Complete Results of the CATIE Trial *Supported by Eli Lilly and Co.*

A. Comparison of the Primary Outcome Measures of Efficacy and Safety *Jeffrey A. Lieberman, M.D.*

B. Comparison of Clozapine Versus Other Atypical Drugs in Prospectively Defined, Unresponsive Patients *Joseph P. McEvoy, M.D.*

C. Comparison of Ziprasidone Versus Other Atypical Drugs in Prospectively Defined, Unresponsive Patients *Thomas S. Stroup, M.D.*

D. Comparison of Treatment Effects on Cognition *Richard S.E. Keefe, Ph.D.*

E. Comparison of Treatments on Health Service Utilization and Cost-Effectiveness Measures *Robert A. Rosenheck, M.D.*

IS22. Pseudobulbar Affect: A Common Syndrome That Is Underrecognized, Misdiagnosed, and Undertreated *Supported by Avanir Pharmaceuticals*

A. The Differential Diagnosis of Pseudobulbar Affect *David B. Arciniegas, M.D.*

B. The Pathophysiology of Pseudobulbar Affect *Edward C. Lauterbach, M.D.*

C. Treatment Options for Pseudobulbar Affect *Michael C. Graves M.D.*

IS23. Advances in the Neurobiology and Therapeutics of ADHD *Supported by Cephalon Inc.*

A. Sleep and ADHD *Eric Mick, Sc.D.*

B. New Therapeutic Developments in ADHD *Joseph Biederman, M.D.*

C. Defining Executive Function Deficits in ADHD *Ronna Fried, Ed.D.*

D. Advances in f-MRI Research in ADHD *George Bush, M.D.*

IS24. Atypical Depression: Merging Evidence and Public Policy *Supported by Bristol-Myers Squibb Co.*

A. The Neurobiology of Depression: Bringing the Latest in Science to Clinicians *Charles B. Nemeroff, M.D.*

B. Phenomenology of Atypical Depression *Hans-Juergen Moeller, M.D.*

C. An Evidence-Based Approach to Managing the Disabilities of Atypical Depression *Justine M. Kent, M.D.*

D. Future Directions in the Treatment of Atypical Depression *Michael E. Thase, M.D.*

IS25. Insomnia From the Inside Out: From Neuroscience to Clinical Experience to Public Policy *Supported by Pfizer Inc. and Neurocrine Biosciences Inc.*

A. The Science of Insomnia *Phyllis C. Zee, M.D.*

B. Putting the Science to Work *Daniel J. Buysse, M.D.*

C. Insomnia: Symptom, Syndrome, or Disorder *Martin B. Keller, M.D.*

D. Insomnia: Cost of Illness, Public Policy, and Medicolegal Issues *Alan W. Newman, M.D.* ■

Foundation Offers Opportunities for Education, Entertainment, and Philanthropy

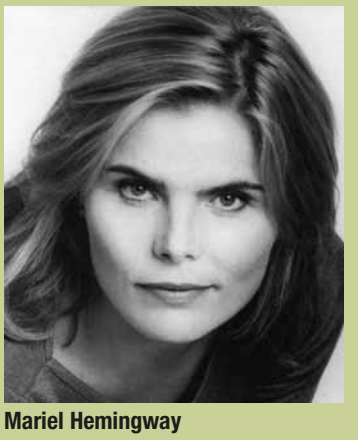
By Tara Burkholder

The American Psychiatric Foundation is hosting four events at APA's 2006 annual meeting that will provide opportunities for learning, relaxation, and supporting the foundation's programs that advance public understanding of mental illness.

The foundation will kick off the meeting with its annual benefit, which this year is titled **"Toronto Tapestry."** It will be held at the Royal Ontario Museum on Saturday, May 20, from 7 p.m. to 10 p.m. The event will feature the museum's historic art collections, international cuisine, live music, and the presentation of the Awards for Advancing Minority Mental Health. Proceeds support the foundation's programs. Tickets are $100 per person if purchased by April 1 and $125 thereafter. Tickets can be ordered by phone at (703) 907-8512 or online at <www.psychfoundation.org>. The benefit is supported by AstraZeneca Pharmaceuticals, Bristol-Myers Squibb Co., Janssen Pharmaceutica Products, Pfizer, Shire, Wyeth Pharmaceuticals, Abbott Laboratories, Cyberonics, Forest Laboratories, Otsuka America Pharmaceutical, and Professional Risk Management Services.

On Monday, May 22, the Golfers of APA will engage in friendly competition at its annual **golf tournament,** which will be held at Angus Glen Golf Club. The event will begin at 7:30 a.m. with a shotgun start. Registration is $250, which includes transportation, greens fees, carts, and prizes. All proceeds benefit the foundation. More information on the course is posted at <www.angusglen.com>. To enter the tournament, contact Stan Jennings at mbears@comcast.net or (804) 320-7881.

The foundation's fifth annual **"Conversations"** event will be Tuesday, May 23. This year's guest is **Mariel Hemingway,** a successful model, actress, author, and mother who will discuss her family connection with mental illness and its impact on future generations. "Conversations" is an interactive discussion series that offers psychiatrists an opportunity to hear unique perspectives on mental illness. The event is supported by an unrestricted educational grant from AstraZeneca Pharmaceuticals.



Mariel Hemingway

Baseball fans can enjoy an evening at the ball park and simultaneously support the foundation's philanthropic work on Tuesday, May 23, or Wednesday, May 24. First-rate field-level baseline tickets are available through a special discount offer to watch the **Toronto Blue Jays** and **Tampa Bay Devil Rays** play in two games. A portion of the cost of each ticket sold is contributed to the foundation. To order tickets, call Harry Einbinder at (888) 654-6529, ext.1666, or send an e-mail to harry.einbinder@bluejays.com. A seating chart and order form are posted at <www.psychfoundation.org>.

The foundation is APA's philanthropic and educational arm. Its mission is to advance public understanding that mental illnesses are real and can be effectively treated.

Tara Burkholder is the foundation's marketing and communications manager.

7 a.m.-8:30 a.m.
Industry-Supported Breakfast Symposia
IS26. Clinical Implications of Choices of Atypical Antipsychotics: Realities and Myths (Part 1) *Supported by Bristol-Myers Squibb Co.*
A. Impact of Short-Term Decision on Long-Term Outcomes *Stephen R. Marder, M.D.*
B. Neurocognition, Functional Outcomes, and Psychopharmacology *Michael Green, M.D.*

IS27. Evidence, Outcomes, and Advocacy: Shaping the Management of GAD (Part 1) *Supported by Cephalon Inc.*
A. Evidence-Based Advocacy: A Data-Driven Look at the Somatic Expression of GAD *Philip R. Muskin, M.D.*
B. Comorbidity in GAD: A Public Health Challenge *John L. Beyer, M.D.*

IS28. Attaining and Sustaining Remission in Treatment of Depression With Comorbid or Residual Anxiety (Part 1) *Supported by Wyeth Pharmaceuticals*
A. Impact of Associated Anxiety Symptoms on Depression *Peter P. Roy-Byrne, M.D.*
B. Collaborative Management Strategies for Patients With Comorbid Anxiety With Depression *Wayne J. Katon, M.D.*
C. Strategies to Achieve and Sustain Remission *Shaily Jain, M.D.*

Residents Session
Meet the Experts: Sunny-Side Up

7:30 a.m.-5:30 p.m.
Registration/Course Enrollment Open

8 a.m.-Noon
CME Courses 38-43

8 a.m.-5 p.m.
CME Course 44

9 a.m.-10:30 a.m.
Clinical Case Conferences
1. Honorable Discharge: Severe Brain-Injured Psychological Symptoms in the Female Veteran *Susan Stabinsky, M.D., Michael Blumenfield, M.D., Capt. Frances Stewart, M.D., Maria Tiamson, M.D.* **(for APA members only)**
2. Sealed With a Kiss: Using the Sexual History in Psychodyamic Psychotherapy *Jennifer I. Downey, M.D., Richard C. Friedman, M.D., Diane McLean, M.D., Ph.D.* **(for APA members only)**

Debate
1. **Resolved: Does CATIE Really Inform the Practice of Psychotherapy?** *Moderator: Richard E. D'Alli, M.D.*

Discussion Groups
1. *Laura Roberts, M.D., on* TBD **(Meet the Authors)**
2. *Donna E. Stewart, M.D., on* Why Women's Mental Health **(Meet the Authors)**
3. *Jesse H. Wright, M.D., on* TBD **(Meet the Authors)**
4. *Michelle B. Riba, M.D., M.S., on* TBD **(Meet the Authors)**

Focus Live Session 1. *Presenter: Glen O. Gabbard, M.D., on* Personality Disorders

Lectures
L2. Culture, Spirituality, and Psychiatry: A Psycho-Historical Study of King Saul *Albert C. Gaw, M.D., APA's Kun-Po Soo Award Lecture*
L3. Rediscovering Our Place in the World *David T. Suzuki, Ph.D., Frontiers of Science Lecture Series*
L4. The Search for Quality and Equity in Care for Psychiatric Disorders: A Story of Opportunity, Evidence, and Partners *Kenneth B. Wells, M.D., APA's Research in Psychiatry Award Lecture*

Master Educator Clinical Consultations
1. *Renato Alarçon, M.D., on* Clinical Dimensions of Cultural Psychiatry
2. *Laura J. Miller, M.D., on* Psychiatric Disorders Across the Female Reproductive Cycle
3. *Meera Narasimhan, M.D., on* Refractory Depression: Diagnostic and Treatment Implications

New Research Young Investigators' Poster Session 1

Component Workshops
CW1. Disaster Psychiatry: Practical Skills to Help District Branches Develop Disaster Plans for Their Communities *APA Committee on Psychiatric Dimensions of Disasters; Co-Chairpersons: Lisa A. Catapano, M.D., Christina V. Mangurian, M.D.*
CW2. Pay for Performance: Linking Incentives to Provider Performance on Quality Measures *APA Council on Quality Care and APA Council on Healthcare Systems and Financing; Co-Chairpersons: Richard C. Hermann, M.D., Bruce J. Schwartz, M.D.*
CW3. Career Choices in Psychiatry: Exploring Fellowship Training *APA Assembly Committee of Area Member-in-Training Representatives; Chairperson: Vincent J. Blanch, M.D.*
CW4. Severely Mentally Ill Persons in Jails and Prisons: Who Should Stay? *APA Corresponding Committee on Jails and Prisons; Chairperson: Henry C. Weinstein, M.D.*
CW5. Crime and Cruel, Not Unusual Punishment: The Need for Juvenile Justice Mental Health Care Reform *APA Alliance; Chairperson: Louis J. Kraus, M.D.*
CW6. Closing a Practice: What Every Psychiatrist's Office and Their Family Should Know *APA Corresponding Committee on Physician Health, Illness, and Impairment; Chairperson: John A. Fromson, M.D.*
CW7. Conquering the Shame, Secrecy, and Stigma of Suicide in Young Asian-American Adults *APA Committee of Asian-American Psychiatrists; Chairperson: Surinder S. Nand, M.D.*
CW8. CPT Coding and Documentation Update *APA Committee on RBRVS, Codes, and Reimbursements; Chairperson: Chester W. Schmidt Jr., M.D.*
CW9. New Developments in APA Practice Guidelines on Bipolar Disorder, MDD, and Panic Disorder *APA Steering Committee on Practice Guidelines; Chairperson: Jack S. McIntyre, M.D.*

Issue Workshops
IW1. A Dimension of Mind: Simulations/Emulations of Psychiatric Symptoms Using the Performing Art of Magic *Chairperson: Bruce C. Ballon, M.D.*
IW2. What Do You Do With a Patient Who Has Access to a Gun? *Chairperson: Donna M. Norris, M.D.*
IW3. Managing Complex Comorbid Psychiatric and Alcohol Use Disorders in Psychiatric Practice *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism; Chairperson: Mark L. Willenbring, M.D.*
IW4. Extrapyramidal Side Effects and Tardive Dyskinesia in the Atypical Antipsychotic Era *Chairperson: Thomas E. Hansen, M.D.*
IW5. Neurocybernetics: Novel Approach in the Treatment of Psychiatric Disorders *Chairperson: Alan L. Summers, M.D.*
IW6. Treatment of Pregnancy-Related Mood Disorders: From Psychiatry to Pediatrics *Co-Chairpersons: Janet A. Martin, M.D., Syed S. A. Naqvi, M.D.*
IW7. Risk Management Issues in Psychiatric Practice *Chairperson: Alan I. Levenson, M.D.*
IW8. But Can We Do It Here? Challenges of Implementing Cognitive-Behavior Therapy for Schizophrenia Programs in the U.S. *Co-Chairpersons: Page Burkholder, M.D., Peter J. Weiden, M.D.*
IW9. Religious and Spiritual Assessment in Clinical Practice *Co-Chairpersons: Francis G. Lu, M.D., Christina M. Puchalski, M.D.*
IW10. Early Detection and Treatment of Bipolar Illness *Chairperson: Eric R Marcus, M.D.*
IW11. What Is a Mood Stabilizer? *Chairperson: Eduard Vieta, M.D.*
IW12. Reinventing Careers: Transitions and Later-Life Strategies for Psychiatrists *Co-Chairpersons: Carolyn B. Robinowitz, M.D., Abram M. Hostetter, M.D.*
IW13. American Board of Psychiatry and Neurology Update: Certification and Maintenance of Certification in Psychiatry and Its Subspecialties *Chairperson: Stephen C. Scheiber, M.D.*
IW14. New Research Advances in Ethnopsychopharmacology *Co-Chairpersons: Pedro Ruiz, M.D., William B. Lawson, M.D.*
IW15. Online Peer Support Groups and Support Group Members *Chairperson: Robert C. Hsiung, M.D.*

9 a.m.-Noon
Media Workshops
MW1. "*Go*": A Triple-Take in the World of Drugs *Co-Chairpersons: Petros Levounis, M.D., Jose P. Vito, M.D.*
MW2. "*Do I Look Fat?*" Eating Disorder Pathology in Gay Men *Chairperson: Daniel Garza, M.D.*

9 a.m.-4 p.m.
CME Courses 45-50

10 a.m.-5:30 p.m.
Exhibits Open
APA Member Center Open
Publishers' Bookfair Open

11 a.m.-12:30 p.m.
Discussion Groups
5. *Jack Drescher, M.D., on* The Psychology of the Closet
6. *Nathan Strahl, M.D., on* TBD (Meet the Authors)
7. *John Oldham, M.D., on* TBD
8. *Ashwin Patkar, M.D., on* TBD
9. *Marian I. Butterfield,M.D., on* Challenges Unique to Women Psychiatrists **(for residents only)**

Focus Live Session 2. *Presenters: Joel Yager, M.D., and Stephen B. Levine, M.D., on* Eating Disorders and Sexual Disorders

Lectures
L5. TBD *Pedro L. Delgado, M.D., APA's Simon Bolivar Award Lecture*
L6. Emotional Processing and Schizophrenia: Neuropsychiatric Perspectives *Raquel Gur, M.D., Distinguished Psychiatrist*
L7. The Discourse on Human Sexuality and AIDS *Anke Ehrhardt, Ph.D., Frontiers of Science Lecture Series*

Master Educator Clinical Consultations
4. *Shaila Misri, M.D., on* Perinatal Psychiatric Disorders on Current Issues in Pregnant and Postpartum Mothers **(for APA members only)**
5. *Marion Goldstein, M.D., on* Late Life Aging Processes and Mental Illness **(for APA members only)**
6. *David Baron, D.O., Geetha Jayaram, M.D., on* Clinical Research Across Geographic Borders: Challenges and Opportunities **(for APA members only)**

Medical Update 1. *Heather Ross, M.D., on* Congestive Heart Failure

Research Consultation 1. *Mark L. Willenbring, M.D., on* Clinical Research on Alcohol Use Disorders *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

Scientific and Clinical Reports
Session 1. Presidential Theme: From

continued on page 16

Have You Received Your Medallion Yet?

APA members who were elected to APA distinguished fellowship in prior years but never attended an annual meeting Convocation to receive their medallion are invited to participate in the Convocation ceremony at this year's meeting on Monday, May 22, from 5:30 p.m. to 7:30 p.m. in Exhibit Hall A, North Level 300, at the Toronto Convention Centre. These distinguished fellows are asked to notify the APA Membership Department that they plan to attend so that they can be sent further details.

The Membership Department may be contacted by mail at 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209-3901; by phone at (888) 35-PSYCH, ext. 7351; by fax at (703) 907-1085; or by e-mail at ppardee@psych.org. ■

Interactive debate-style format!

Sunday, May 21, 2006
1:00 PM – 1:30 PM Lunch
1:30 PM – 4:30 PM CME Symposium

The Fairmont Royal York
Canadian Room, Convention Floor
Toronto, Ontario, Canada

VITAL SIGNS IN PSYCHIATRY:
A PERSPECTIVE ON SLEEP ACROSS THE LIFE CYCLE

A CME Symposium to be held during the 2006 American Psychiatric Association (APA) Annual Meeting

TARGET AUDIENCE
This activity has been designed to meet the educational needs of psychiatrists involved in the management of sleep dysfunction and insomnia.

LEARNING OBJECTIVES
At the conclusion of the symposium, the participant should be able to:

- Understand normal sleep patterns, sleep architecture, and sleep behaviors as they develop and change from infancy through adolescence
- Discuss the epidemiology, impact, evaluation, and general approaches to treatment of insomnia in the adult population
- Review medical and psychiatric comorbidities associated with insomnia and discuss the importance of addressing underlying conditions when managing sleep dysfunction
- Describe gender-related differences in sleep architecture and the development of sleep-related disorders
- Identify changes in the pattern of normal sleep that occur with advancing age

REGISTRATION
Attendees must be registered for the APA Annual Meeting to attend this symposium. Seating is limited and will be based on a first-come, first-served basis. For more information about the meeting, please visit the APA Web site at www.psych.org, or contact the APA toll-free at 1-888-357-7924 (within the US or Canada) or 703-907-7300.

ACCREDITATION STATEMENT
The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The APA designates this educational activity for a maximum of 3 category 1 credits toward the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those credits that he/she actually spent in the activity.

CREDIT DESIGNATION
The APA is approved by the American Medical Association (AMA) to award category 1 credit toward the Physician's Recognition Award.

FACULTY DISCLOSURE STATEMENTS
All faculty participating in industry-supported symposia must sign and submit the Disclosure of Financial Interests or Other Affiliations form. Additionally, faculty must disclose to the audience any financial interests or commercial relations.

AGENDA

1:00 PM-1:30 PM	**Lunch**
1:30 PM-1:40 PM	**Introduction and Overview** ***Eric A. Nofzinger, MD (Chair)*** **University of Pittsburgh School of Medicine** **Pittsburgh, Pennsylvania**
1:40 PM-2:05 PM	**Sleep in Infancy, Childhood, and Adolescence: Normal Sleep Patterns, Developmental Issues, and Sleep Problems** ***Jodi A. Mindell, PhD*** **Saint Joseph's University** **Philadelphia, Pennsylvania**
2:05 PM-2:30 PM	**Insomnia in Adulthood: Causes, Consequences, and Treatment** ***Ned H. Kalin, MD*** **University of Wisconsin Medical School** **Madison, Wisconsin**
2:30 PM-2:55 PM	**Insomnia Secondary to Medical or Psychiatric Comorbidity: Implications for Evaluation and Management** ***Matthias K. Lee, MD*** **Virginia Mason Sleep Disorders Center** **Seattle, Washington**
2:55 PM-3:20 PM	**Sleep in Women Across the Life Cycle: How the Reproductive Cycle Impacts Sleep** ***Meir H. Kryger, MD, FRCPC*** **University of Manitoba** **Winnipeg, Manitoba**
3:20 PM-3:45 PM	**Sleep in the Elderly: Is Poor Sleep a Normal Concomitant of Advancing Age?** ***Sanford I. Finkel, MD*** **University of Chicago Medical School** **Chicago, Illinois**
3:45 PM-4:30 PM	**Audience Questions/Panel Discussion** ***Eric A. Nofzinger, MD (Chair)*** **University of Pittsburgh School of Medicine** **Pittsburgh, Pennsylvania**

SEPRACOR

Supported by an educational grant from Sepracor Inc.
Sponsored by the American Psychiatric Association

Science to Public Policy: Advocacy for Patients and the Profession

1. The Impact of an Integrated Community Arts Studio on Stigmatizing Beliefs and Experiences *Thomas C. Zelnik, M.D.*
2. Health Policies and the *Diagnostic and Statistical Manual Roger Peele, M.D.*
3. The System for Classification of Inpatient Psychiatry: A New Case-Mix Methodology for Mental Health *John P. Hirdes, Ph.D.*

Session 2. Ethics and Human Rights

4. Ethics and Psychobiological Research *Cherise Rosen, Ph.D.*
5. Terrorism and Medical Ethics: Conflicting Loyalties for American Psychiatrists *David A. Rothstein, M.D.*
6. A New Mental Health Act: An Australian Experience *Darryl P. Watson, M.D.*

Session 3. Attention Spectrum Disorders

7. Transdermal Methylphenidate Versus Placebo in Pediatric ADHD *Robert L. Findling, M.D.*
8. Effects of Transdermal Methylphenidate in a Laboratory Classroom Study *James J. McGough, M.D.*
9. Modafinil-ADHD: Long-Term Efficacy and Safety in Children and Adolescents With ADHD *Samuel W. Boellner, M.D.*

Session 4. Current Trends in Schizophrenia

10. Recurring Psychosis in Schizophrenia: A 20-Year Multi, Follow-Up Study *Martin Harrow, Ph.D.*
11. Identifying the Neurobiological Basis for Schizophrenia *Zeinab S. Elbaz, M.D.*
12. Key Findings From the Intercontinental Schizophrenia Outpatients Health Outcomes Study (IC-SOHO): Disease Burden and Clinical Outcomes Associated With Antipsychotic Treatment for Schizophrenia *Martin Dossenbach*

Session 5. Medication Response in MDD

13. Duloxetine Versus Escitalopram and Placebo in the Long-Term Treatment of Patients With MDD *Teresa A. Pigott, M.D.*
14. Conditional Probability of Response to Placebo in MDD *Jennifer Covino, M.P.A.*
15. Addition of Atomoxetine for Depression Incompletely Responsive to Sertraline: A Randomized, Double-Blind, Placebo-Controlled Study *David Michelson, M.D.*

Session 6. Treatment Management and Outcomes in Mood Disorders

16. Management of Side Effects Associated With New Treatments for Bipolar Depression *Joseph R. Calabrese, M.D.*
17. Treatment-Resistant Depression: Changes in Symptoms and Functioning in a Clinical Sample *Alex A. Cardoni, M.S.*
18. Specificity of Effect of Quetiapine in Bipolar Depression *Robert M. A. Hirschfeld, M.D.*

Session 7. Diagnostic Issues

19. Screening for History of Physical, Emotional, and Sexual Abuse: How Do We Ask About Abuse? *Brett D. Thombs, Ph.D.*
20. Kennedy Axis V: The Next Step for Axis V? *James A. Kennedy, M.D.*
21. Dimensional Approaches to *DSM* and the Impact on Diagnostic Instruments *Maritza Rubio-Stipec, Sc.D.*

Session 8. Consultation-Liaison Psychiatry

22. Teaching of Psychiatry in Primary Care Residencies: Do Training Directors of Primary Care and Psychiatry See Eye to Eye? *Hoyle Leigh, M.D.*
23. Unrecognized Post-Traumatic Symptoms Triggered by Routine Hospital Care in Patients With Previous Trauma Histories *Sarah Birmingham, M.D.*
24. Is Asthma Severity Related to Current Major Depressive Episode and Generalized Anxiety Disorder? A Case-Control Study *Claudia Meneses, M.D.*

Session 9. Psychiatric Education

25. Psychiatric CMEs and Commercial Bias: Are New ACCME Standards Effective? *Daniel J. Carlat, M.D.*
26. Relationships Between Self-Assessment Skills, Test Performance, and Other Variables in Psychiatry Residents *David J. Lynn, M.D.*
27. Coaching Communication Using Standardized Patient Encounters: An Educational Research Study *Paula Ravitz, M.D.*

Session 10. Biological Psychiatry and Neuroscience

28. From Synapse to Psychotherapy: The Fascinating Evolution of Neuroscience *Bernadette Grosjean, M.D.*
29. Can Neurological Soft Signs Discriminate Between Four Axis-I Diagnostic Categories in the Prison Population? *Seyed Mohammad Assadi, M.D.*
30. An Association Study of a Brain-Derived Neurotrophic Factor Val66Met Polymorphism and Zotepine Response of Inpatients With Acute Schizophrenia *Ching-Hua Lin, M.D.*

Session 11. Geriatric Psychiatry

31. The Influence of Dementia on the Treatment of Depression in Geriatric Inpatients *John W. Goethe, M.D.*
32. Overall Efficacy and Time to Response for Duloxetine 60 mg Once Daily Versus Placebo in Elderly Patients With MDD *Joel Raskin, M.D.*
33. Safety and Efficacy of Intra-Muscular Ziprasidone Treatment of Acute Psychotic Agitation in Elderly Patients With Schizophrenia *Alex Aviv*

Component Workshops

CW10. The Gift of Life: A Psychiatric Perspective on Living Hepatic Organ Donation *APA Council on Psychosomatic Medicine; Co-Chairpersons: Philip R. Muskin, M.D., Silvia Hafliger, M.D.*

CW11. Toward a Better Understanding of Cultural Issues in Clinical Practice: Residents' Perspective of a Model Curriculum for Residency Training Programs *APA/AstraZeneca Minority Fellows; Chairperson: Angel A. Caraballo, M.D.*

continued on page 18

A different choice in ADHD therapy.

Focalin XR is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in adults, adolescents, and children 6 years and older. Focalin XR is indicated as an integral part of a total treatment program for ADHD that may include other measures (eg, psychological, educational, social) for patients with this syndrome.

Important safety information: The most common adverse events seen with Focalin XR were dyspepsia, decreased appetite, headache, and anxiety in pediatric studies; and dry mouth, dyspepsia, feeling jittery, dizziness, headache, and anxiety in adult studies.

Focalin XR is contraindicated in patients with marked anxiety, tension, and agitation, since the drug may aggravate these symptoms; in patients known to be hypersensitive to methylphenidate or other components of the product; in patients with glaucoma; in patients with motor tics or with a family history or diagnosis of Tourette's syndrome; and during or following treatment with monoamine oxidase inhibitors.

Focalin XR should not be used to treat severe depression or for the prevention or treatment of normal fatigue states. Focalin XR should be used with caution in patients with psychosis, a prior history of seizures or EEG abnormalities, or hypertension. Focalin XR should generally not be used in those who have structural cardiac abnormalities. Focalin XR has been associated in rare cases with visual disturbances. Difficulty with visual accommodation and blurred vision have been reported with methylphenidate. Suppression of growth has been reported with long-term use of stimulants. (See **WARNINGS**.)

Focalin XR should be given cautiously to patients with a history of drug dependence or alcoholism. Chronic abusive use can lead to marked tolerance and psychological dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. (See Boxed Warning.)

Prescribe Focalin XR—
QD ADHD treatment that starts working by 1 hour

- Aproduct of single-isomer science approved for adults, adolescents, and children
- Lowdiscontinuation rates, with no discontinuations due to adverse events in a pediatric study (versus 2.1% for placebo)[1]
- Availablein 3 convenient dosage strengths (5 mg, 10 mg, and 20 mg); capsule can be opened and contents sprinkled on applesauce for easy administration

Reference: 1. Greenhill LL, Muniz R, Pestreich L, et al. Effective control of pediatric ADHD symptoms using once-daily dexmethylphenidate. Poster presented at: 51st Annual Meeting of the American Academy of Child and Adolescent Psychiatry; October 19-24, 2004; Washington, DC.

For more information, visit www.FocalinXR.com.

Please see brief summary of prescribing information, including ***Boxed Warning****, on adjacent page.*

ONCE-DAILY
Focalin XR™
dexmethylphenidate HCl Extended-Release Capsules 5mg, 10mg, 20mg

Fast start. Once a day.

Focalin™ XR

(dexmethylphenidate hydrochloride)

extended-release capsules

Rx only

BRIEF SUMMARY: Please see package insert for full prescribing information.

INDICATIONS AND USAGE

Focalin™ XR (dexmethylphenidate hydrochloride) extended-release capsules is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients aged 6 years and older.

The effectiveness of Focalin XR in the treatment of ADHD in patients aged 6 years and older was established in two placebo-controlled studies in patients meeting DSM-IV criteria for ADHD *(see CLINICAL STUDIES in the full prescribing information).*

A diagnosis of Attention Deficit Hyperactivity Disorder (ADHD; DSM-IV) implies the presence of hyperactive-impulsive or inattentive symptoms that caused impairment and were present before age 7 years. The symptoms must cause clinically significant impairment, e.g., in social, academic, or occupational functioning, and be present in two or more settings, e.g., school (or work) and at home. The symptoms must not be better accounted for by another mental disorder. For the Inattentive Type, at least six of the following symptoms must have persisted for at least 6 months: lack of attention to details/careless mistakes; lack of sustained attention; poor listener; failure to follow through on tasks; poor organization; avoids tasks requiring sustained mental effort; loses things; easily distracted; forgetful. For the Hyperactive-Impulsive Type, at least six of the following symptoms must have persisted for at least 6 months: fidgeting/squirming; leaving seat; inappropriate running/climbing; difficulty with quiet activities; "on the go"; excessive talking; blurting answers; can't wait turn; intrusive. The Combined Types requires both inattentive and hyperactive-impulsive criteria to be met.

Special Diagnostic Considerations

Specific etiology of this syndrome is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but of special psychological, educational, and social resources. Learning may or may not be impaired. The diagnosis must be based upon a complete history and evaluation of the child and not solely on the presence of the required number of DSM-IV characteristics.

Need for Comprehensive Treatment Program

Focalin XR is indicated as an integral part of a total treatment program for ADHD that may include other measures (psychological, educational, social) for patients with this syndrome. Drug treatment may not be indicated for all children with this syndrome. Stimulants are not intended for use in the child who exhibits symptoms secondary to environmental factors and/or other primary psychiatric disorders, including psychosis. Appropriate educational placement is essential and psychosocial intervention is often helpful. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the child's symptoms.

Long-Term Use

The effectiveness of Focalin XR for long-term use, i.e., for more than 7 weeks, has not been systematically evaluated in controlled trials. Therefore, the physician who elects to use Focalin XR for extended periods should periodically reevaluate the long-term usefulness of the drug for the individual patient *(see DOSAGE AND ADMINISTRATION in the full prescribing information).*

CONTRAINDICATIONS

Agitation

Focalin™ XR (dexmethylphenidate hydrochloride) extended-release capsules is contraindicated in patients with marked anxiety, tension, and agitation, since the drug may aggravate these symptoms.

Hypersensitivity to Methylphenidate

Focalin XR is contraindicated in patients known to be hypersensitive to methylphenidate, or other components of the product.

Glaucoma

Focalin XR is contraindicated in patients with glaucoma.

Tics

Focalin XR is contraindicated in patients with motor tics or with a family history or diagnosis of Tourette's syndrome. *(See ADVERSE REACTIONS.)*

Monoamine Oxidase Inhibitors

Focalin XR is contraindicated during treatment with monoamine oxidase inhibitors, and also within a minimum of 14 days following discontinuation of treatment with a monoamine oxidase inhibitor (hypertensive crises may result).

WARNINGS

Depression

Focalin™ XR (dexmethylphenidate hydrochloride) extended-release capsules should not be used to treat severe depression.

Fatigue

Focalin XR should not be used for the prevention or treatment of normal fatigue states.

Long-Term Suppression of Growth

Sufficient data on the long-term effects on growth of dexmethylphenidate in children are not yet available. Although a causal relationship has not been established, suppression of growth (i.e., weight gain, and/or height) has been reported with the long-term use of stimulants in children. Therefore, patients requiring long-term therapy should be carefully monitored. Patients who are not growing or gaining weight as expected should have their treatment interrupted. In the 7-week double-blind placebo-controlled study of Focalin XR, the mean weight gain was greater for patients receiving placebo (+0.4 kg) than for patients receiving Focalin XR (-0.5 kg).

Psychosis

Clinical experience suggests that in psychotic patients, administration of methylphenidate may exacerbate symptoms of behavior disturbance and thought disorder.

Seizures

There is some clinical evidence that methylphenidate may lower the convulsive threshold in patients with prior history of seizures, in patients with prior EEG abnormalities in the absence of a history of seizures, and, very rarely, in patients without a history of seizures and no prior EEG evidence of seizures. Safe concomitant use of anticonvulsants and methylphenidate has not been established. In the presence of seizures, Focalin XR should be discontinued.

Sudden Death and Pre-Existing Structural Cardiac Abnormalities

Sudden death has been reported in association with CNS stimulant treatment at usual doses in children with structural cardiac abnormalities. Although some structural cardiac abnormalities alone may carry an increased risk of sudden death, stimulant products generally should not be used in children, adolescents, or adults with known structural cardiac abnormalities.

Hypertension and Other Cardiovascular Conditions

Caution is indicated in treating patients whose underlying medical conditions might be compromised by increases in blood pressure or heart rate, e.g., those with preexisting hypertension, heart failure, recent myocardial infarction, cardiac arrhythmia or hyperthyroidism. Blood pressure should be monitored at appropriate intervals in patients taking Focalin XR, especially patients with hypertension. Studies of Focalin XR and methylphenidate have shown small, mean, dose-related, increases of resting pulse and blood pressure in both pediatric patients and adults.

Visual Disturbance

Symptoms of visual disturbances have been encountered in rare cases. Difficulties with accommodation and blurring of vision have been reported with methylphenidate.

Use in Children Under Six Years of Age

Focalin XR should not be used in children under 6 years of age, since safety and efficacy in this age group have not been established.

Drug Dependence

Focalin XR should be given cautiously to patients with a history of drug dependence or alcoholism. Chronic abusive use can lead to marked tolerance and psychological dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during withdrawal from abusive use, since severe depression may occur. Withdrawal following chronic therapeutic use may unmask symptoms of the underlying disorder that may require follow-up.

PRECAUTIONS

Hematologic Monitoring

Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

Information for Patients

To assure safe and effective use of Focalin™ XR (dexmethylphenidate hydrochloride) extended-release capsules, the patient information should be discussed with patients.

Drug Interactions

Focalin XR should not be used in patients being treated (currently or within the preceding two weeks) with MAO Inhibitors *(see CONTRAINDICATIONS, Monoamine Oxidase Inhibitors).*

Because of possible effects on blood pressure, Focalin XR should be used cautiously with pressor agents.

Methylphenidate may decrease the effectiveness of drugs used to treat hypertension.

Dexmethylphenidate is metabolized primarily to *d*-ritalinic acid by de-esterification and not through oxidative pathways.

The effects of gastrointestinal pH alterations on the absorption of dexmethylphenidate from Focalin XR have not been studied. Since the modified release characteristics of Focalin XR are pH dependent, the coadministration of antacids or acid suppressants could alter the release of dexmethylphenidate.

Human pharmacologic studies have shown that racemic methylphenidate may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (e.g., phenobarbital, phenytoin, primidone), and tricyclic drugs (e.g., imipramine, clomipramine, desipramine). Downward dose adjustments of these drugs may be required when given concomitantly with methylphenidate. It may be necessary to adjust the dosage and monitor plasma drug concentration (or, in the case of coumarin, coagulation times), when initiating or discontinuing methylphenidate.

Serious adverse events have been reported in concomitant use with clonidine, although no causality for the combination has been established. The safety of using methylphenidate in combination with clonidine or other centrally-acting alpha-2-agonists has not been systematically evaluated.

Carcinogenesis, Mutagenesis, and Impairment of Fertility

Lifetime carcinogenicity studies have not been carried out with dexmethylphenidate. In a lifetime carcinogenicity study carried out in B6C3F1 mice, racemic methylphenidate caused an increase in hepatocellular adenomas, and in males only, an increase in hepatoblastomas at a daily dose of approximately 60 mg/kg/day. Hepatoblastoma is a relatively rare rodent malignant tumor type. There was no increase in total malignant hepatic tumors. The mouse strain used is sensitive to the development of hepatic tumors, and the significance of these results to humans is unknown.

Racemic methylphenidate did not cause any increase in tumors in a lifetime carcinogenicity study carried out in F344 rats; the highest dose used was approximately 45 mg/kg/day.

In a 24-week study of racemic methylphenidate in the transgenic mouse strain p53+/-, which is sensitive to genotoxic carcinogens, there was no evidence of carcinogenicity. Mice were fed diets containing the same concentrations as in the lifetime carcinogenicity study; the high-dose group was exposed to 60-74 mg/kg/day of racemic methylphenidate.

Dexmethylphenidate was not mutagenic in the *in vitro* Ames reverse mutation assay, the *in vitro* mouse lymphoma cell forward mutation assay, or the *in vivo* mouse bone marrow micronucleus test.

Racemic methylphenidate was not mutagenic in the *in vitro* Ames reverse mutation assay or the *in vitro* mouse lymphoma cell forward mutation assay, and was negative *in vivo* in the mouse bone marrow micronucleus assay. However, sister chromatid exchanges and chromosome aberrations were increased, indicative of a weak clastogenic response, in an *in vitro* assay of racemic methylphenidate in cultured Chinese Hamster Ovary (CHO) cells.

Racemic methylphenidate did not impair fertility in male or female mice that were fed diets containing the drug in an 18-week Continuous Breeding study. The study was conducted at doses of up to 160 mg/kg/day.

Pregnancy

Pregnancy Category C

In studies conducted in rats and rabbits, dexmethylphenidate was administered orally at doses of up to 20 and 100 mg/kg/day, respectively, during the period of organogenesis. No evidence of teratogenic activity was found in either the rat or rabbit study; however, delayed fetal skeletal ossification was observed at the highest dose level in rats. When dexmethylphenidate was administered to rats throughout pregnancy and lactation at doses of up to 20 mg/kg/day, postweaning body weight gain was decreased in male offspring at the highest dose, but no other effects on postnatal development were observed. At the highest doses tested, plasma levels (AUCs) of dexmethylphenidate in pregnant rats and rabbits were approximately 5 and 1 times, respectively, those in adults dosed with 20 mg/day.

Racemic methylphenidate has been shown to have teratogenic effects in rabbits when given in doses of 200 mg/kg/day throughout organogenesis.

Adequate and well-controlled studies in pregnant women have not been conducted. Focalin XR should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers

It is not known whether dexmethylphenidate is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised if Focalin XR is administered to a nursing woman.

Pediatric Use

The safety and efficacy of Focalin XR in children under 6 years old have not been established. Long-term effects of Focalin in children have not been well established *(see WARNINGS).*

In a study conducted in young rats, racemic methylphenidate was administered orally at doses of up to 100 mg/kg/day for 9 weeks, starting early in the postnatal period (Postnatal Day 7) and continuing through sexual maturity (Postnatal Week 10). When these animals were tested as adults (Postnatal Weeks 13-14), decreased spontaneous locomotor activity was observed in males and females previously treated with 50 mg/kg/day (approximately 6 times the maximum recommended human dose [MRHD] of racemic methylphenidate on a mg/m^2 basis) or greater, and a deficit in the acquisition of a specific learning task was seen in females exposed to the highest dose (12 times the racemic MRHD on a mg/m^2 basis). The no effect level for juvenile neurobehavioral development in rats was 5 mg/kg/day (half the racemic MRHD on a mg/m^2 basis). The clinical significance of the long-term behavioral effects observed in rats is unknown.

ADVERSE REACTIONS

Focalin™ XR (dexmethylphenidate hydrochloride) extended-release capsules was administered to 46 children and 7 adolescents with ADHD for up to 7 weeks and 206 adults with ADHD in clinical studies. During the clinical studies, 101 adult patients were treated for at least 6 months.

Adverse events during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of events into a smaller number of standardized event categories. In the tables and listings that follow, MedDRA terminology has been used to classify reported adverse events. The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation.

Adverse Events in Acute Clinical Studies with Focalin™ XR – Children

Adverse Events Associated with Discontinuation of Treatment

Overall, 50 of 684 children treated with Focalin immediate-release formulation (7.3%) experienced an adverse event that resulted in discontinuation. The most common reasons for discontinuation were twitching (described as motor or vocal tics), anorexia, insomnia, and tachycardia (approximately 1% each). None of the 53 Focalin XR-treated pediatric patients discontinued treatment due to adverse events in the 7-week placebo-controlled study.

Adverse Events Occurring at an Incidence of 5% or More Among Focalin™ XR-Treated Patients

Table 1 enumerates treatment-emergent adverse events for the placebo-controlled, parallel-group study in children and adolescents with ADHD at flexible Focalin XR doses of 5-30 mg/day. The table includes only those events that occurred in 5% or more of patients treated with Focalin XR and for which the incidence in patients treated with Focalin XR was at least twice the incidence in placebo-treated patients. The prescriber should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied.

Table 1

Treatment-Emergent Adverse Events[1] Occurring During Double-Blind Treatment – Pediatric Patients

	Focalin™ XR N=53	Placebo N=47
No. of Patients with AEs		
Total	76%	57%
Primary System Organ Class/ Adverse Event Preferred Term		
Gastrointestinal Disorders	38%	19%
Dyspepsia	8%	4%
Metabolism and Nutrition Disorders	34%	11%
Decreased Appetite	30%	9%
Nervous System Disorders	30%	13%
Headache	25%	11%
Psychiatric Disorders	26%	15%
Anxiety	6%	0%

[1]Events, regardless of causality, for which the incidence for patients treated with Focalin XR was at least 5% and twice the incidence among placebo-treated patients. Incidence has been rounded to the nearest whole number.

Adverse Events in Clinical Studies with Focalin™ XR – Adults

Adverse Events Associated with Discontinuation of Treatment

In the adult placebo-controlled study, 10.7% of the Focalin XR-treated patients and 7.5% of the placebo-treated patients discontinued for adverse events. Among Focalin XR-treated patients, insomnia (1.8%, n=3), feeling jittery (1.8%, n=3), anorexia (1.2%, n=2), and anxiety (1.2%, n=2) were the reasons for discontinuation reported by more than 1 patient.

Adverse Events Occurring at an Incidence of 5% or More Among Focalin™ XR-Treated Patients

Table 2 enumerates treatment-emergent adverse events for the placebo-controlled, parallel-group study in adults with ADHD at fixed Focalin XR doses of 20, 30, and 40 mg/day. The table includes only those events that occurred in 5% or more of patients in a Focalin XR dose group and for which the incidences in patients treated with Focalin XR appeared to increase with dose. The prescriber should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do

Please see adjacent page for continued brief summary of prescribing information.

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4/06 FCL-AD-0111-B

Photos courtesy of the Ontario Science Centre

Opened in 1969, the Ontario Science Centre pioneered the concept of the interactive science museum.

Uncover Mysterious Life Of Creatures Large, Small

Adventures await at the Ontario Science Centre, which has an Amazing Aging Machine and electricity demonstrations that will make your hair stand on end.

BY JOAN AREHART-TREICHEL

For 114 days, a team of explorers encountered dangerous rapids, deadly crocodiles and hippos, gunfire from bandits, malaria, and the fierce Sahara sun as they descended the world's longest river—the Nile.

You and your family can join them in this chilling descent when you visit the Ontario Science Centre in Toronto in conjunction with APA's 2006 annual meeting. The trip has been captured in an IMAX film shown at the center's OMNIMAX Theatre.

If crocodiles and hippos aren't your style, you can view another IMAX film called "Bugs! A Rainforest Adventure." It provides extraordinary images of those "creepy crawlies," whether they are evolving to maturity or preying or being preyed upon.

Or if insects aren't your passion, you might take in an IMAX film called "The Human Body." It offers film footage of bodily dramas that you never viewed in medical school. For instance, you can view a tomato being blended by the stomach and a red cell zipping through 100 miles of veins and arteries. The film is a combination of live action, computer-generated graphics, microscopy, the latest medical imaging, and cutting-edge cinematic techniques.

Still other titillating adventures await you and your family if you visit the Centre's Weston Family Innovation Centre, Phase One, which opened in March 2005.

It is sort of a scientific Times Square where visitors can explore current science issues—say, avian flu or tsunamis—through multimedia presentations and live updates presented on a stage. Among the more popular displays are "electricity demonstrations with the Van de Graaff generator Hot Spots that are hosted by our science hosts throughout the day," Ellen Flowers, media relations officer for the Ontario Science Centre, told *Psychiatric News*. These demonstrations will literally make your hair stand on end.

In the Weston Family Innovation Centre, you can also read field diaries from scientists working in various countries. For example, Mike Quinn reported on November 11, 2005, from Zambia, where he was helping sorghum farmers improve their harvests: "On the upside. . . I get to bomb around on my motorbike," he explained, "but on the flipside, it's hot. . . and life moves very, very slowly. A meeting scheduled at 9 a.m. happens at 10:30 because time in the rural areas is pretty meaningless, and much of my day consists of sitting under a tree trying not to die from thirst or heat or hunger."

But perhaps the most unusual undertaking you can embark on in the Ontario Science Centre is to enter the Amazing Aging Machine. Located in the Human Body Hall, the machine will show you what you will look like a few years hence. The shock is tempered, however, by the reminder that computer-software aging is not inevitably destiny—that how people care for their bodies over the years can make a big difference as far as the course of aging is concerned.

Altogether the Ontario Science Centre has some 800 interactive exhibits in 10 gargantuan halls, *Frommer's 2005 Guide to Toronto* points out. So in order to see and enjoy everything, it is a good idea to arrive at the center at opening time.

"It has been called a museum of the 21st century, but it's much more than that," *Fodor's 2006 Guide to Toronto* declared. "Where else can you stand at the edge of a black hole, work hand-in-clamp with a robot, or land on the moon?"

The Ontario Science Centre is located at 770 Don Mills Road (at the corner of Eglinton Avenue East), about seven miles northeast of downtown Toronto. More information is available by phone at (416) 696-1000; e-mail at call_centre@osc.on.ca; or online at <www.ontariosciencecentre.ca>. ■

Photos courtesy of the Ontario Science Centre

The Ontario Science Centre offers hair-raising adventure for kids.

CW12. Ethnicity and Caregiving Across the Psychiatric Spectrum *APA Committee on Ethnic Minority Elderly; Co-Chairpersons: Iqbal Ahmed, M.D., Warachal E. Faison, M.D.*

CW13. Sexuality and Its Impact on the HIV Pandemic *APA Committee on HIV/AIDS; Chairperson: Marshall Forstein, M.D.*

CW14. Psychiatric Ethics in the United States and Throughout the World *APA Ethics Committee; Co-Chairpersons: Spencer Eth, M.D., George Christodoulou, M.D.*

CW15. Teaching the Working Alliance as a Core Process Across the Psychotherapies *APA Committee on Psychotherapy by Psychiatrists; Chairperson: Eric M. Plakun, M.D.*

CW16. Scales in the Clinical Practice of Geriatric Psychiatry *APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly; Chairperson: Allan A. Anderson, M.D.*

CW17. Winning the Fight for Mental Health Benefits: Partnering With Employers *APA Committee on APA/Business Relationships; Chairperson: Dauda A. Griffin, M.D.*

CW18. Culture as a Rationalization for Violence Against Women *APA Committee on Family Violence and Abuse; Chairperson: Gail E. Robinson, M.D.*

CW19. Facilitating Minorities to Excel in Academic Psychiatry *APA Assembly Committee of Representatives of Minority/Underrepresented Groups; Chairperson: Jagannathan Srinivasaraghavan, M.D.*

Issue Workshops

IW16. Assessment of Capacity: Developments, DVDs, and Defense Organizations *Chairperson: M.E. Jan Wise, M.R.C. Psych.*

IW17. Biopsychosocial and Spiritual Aspects of Treating Our Physician Colleagues *Co-Chairpersons: Monisha R. Vasa, M.D., Syed S. A. Naqvi, M.D.*

IW18. Oral Boards Boot Camp: 2006 *Chairperson: Elyse D. Weiner, M.D.*

IW19. The Other Desperate Housewives: Hidden Violence in the Home *Chairperson: Susan J. Hatters-Friedman, M.D.*

IW20. Treating First- and Second-Generation Immigrants With Psychotherapy During Residency Training *Chairperson: Anu A. Matorin, M.D.*

IW21. Physician Heal Thyself: Workplace Burnout Among Psychiatrists *Co-Chairpersons: John Sharkey, M.D., Steve Choong Kam Chong, M.D.*

IW22. Psychotherapy Training and International Medical Graduates: The Influence of Cultural Factors *Chairperson: Nyapati R. Rao, M.D.*

IW23. Cognitive-Behavior Therapy for Psychosis: Basic Techniques for Psychiatrists *Chairperson: Shanaya Rathod, M.D.*

IW24. Teaching Cognitive-Behavior Therapy to Residents *Co-Chairpersons: Judith S. Beck, Ph.D., Donna M. Sudak, M.D.*

IW25. Establishing a Women's Mental Health Program in an Academic or Private Setting *Co-Chairpersons: Catherine A. Birndorf, M.D., Nehama Dresner, M.D.*

IW26. Secrets in Family Therapy: To Tell or Not to Tell *Co-Chairpersons: Eva C. Ritvo, M.D., Michael Hughes, M.D.*

IW27. Virtual Reality and Video Games in the Treatment of Mental Health Disorders and Addictions: An Evidence-Based Analysis *Co-Chairpersons: William Huang, M.D., Jeffery N. Wilkins, M.D.*

IW28. Multidisciplinary Treatment of Adults With Asperger's Syndrome and Related Disorders: Lessons From the University of Pennsylvania Social Learning Disorders Program *Co-Chairpersons: Anthony L. Rostain, M.D., Edward S. Brodkin, M.D.*

Noon-1:30 p.m.

Forums

1. Harry Potter and the Half-Blood Prince: Harry Grows Up *Chairperson: JoAnne Isbey, A.B.D.*

2. *DSM-V* *Chairperson: Darrel Regier, M.D.*

3. Mozart at 250: The Mind and Music of a Genius *Chairperson: Richard Kogan, M.D.*

4. Women and Alcohol Use Disorders, *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism; Chairperson: Shelly F. Greenfield, M.D.*

5. The Theory and Practice of Apology *Chairperson: Aaron Lazare, M.D.*

1 p.m.-2:30 p.m.

New Research Young Investigators' Oral/Slide Sessions 2-4

1 p.m.-5 p.m.

CME Courses 51-57

2 p.m.-3:30 p.m.

Focus Live Session 3. *Presenter: Jerald Kay, M.D., on* Psychotherapy

Lectures

L8. Heart Rate Variability and Psychiatry: Beyond Heart-Mind Link *Krishnamachari Srinivasan, M.D., International Lecture*

L9. New Advances in Cognitive Therapy *Aaron T. Beck, M.D., APA's Adolf Meyer Award Lecture*

2 p.m.-5 p.m.

Presidential Symposium 1. The Public Mental Health System: Critical Issues *APA Committee on Family Vio-*

continued on page 22

Psychiatry on the World Stage

The APA Office of International Activities and its components, the Council on Global Psychiatry, Committee on Psychiatric Dimensions of Disasters, and Corresponding Committee on Misuse and Abuse of Psychiatry, will present several timely symposia and workshops at this year's annual meeting. Among them:

Monday, May 22

2 p.m.-5 p.m. **Symposium: "Science, Diagnoses, and the Clinician"**
Cosponsored by APA and the WPA and chaired by Rodrigo Muñoz, M.D.
Royal York, Mezzanine Floor, Alberta Room,

Tuesday, May 23

11 a.m.-12:30 p.m. **Component Workshop and Europe Discussion Group: "European Psychiatry: Health and Mental Health Policy After the Helsinki Summit"**
Cosponsored by the Council on Global Psychiatry and the WPA's Conflict Management and Conflict Resolution Section and co-chaired by Rodrigo Muñoz, M.D., and Eliot Sorel, M.D.
Toronto Convention Centre, South, Level 700, Room 703

2 p.m.-5 p.m. **APA-WPA Presidential Symposium: "International Advocacy Towards a Psychiatry for the Person"**
Cosponsored and co-chaired by APA President Steven Sharfstein, M.D., and WPA President Juan Mezzich, M.D., Ph.D.
Toronto Convention Centre, South, Level 700, Room 701A,

2 p.m.-5 p.m. **Symposium: "APA/APAL: Addressing Psychiatric Patients Needs in Latin America"**
Cosponsored by the Council on Global Psychiatry and the Asociación Psiquiátrica de América Latina (APAL) and co-chaired by Rodrigo Muñoz, M.D., and Pedro Ruiz, M.D.
Toronto Convention Centre, South, Level 700, Room 714B,

Wednesday, May 24

11 a.m.-12:30 p.m. **Component Workshop: "Global Psychiatry: Establishing Formal and Informal Mental Health Exchanges"**
Chaired by Samuel Okpaku, M.D.
Toronto Convention Centre, North, Level 100, Room 104A

Noon-1:30 p.m. **"South Asian Forum"**
Co-chaired by Rodrigo Muñoz, M.D., and Pedro Ruiz, M.D.
Toronto Convention Centre, South, Level 800, Room 801B

Thursday, May 25

9 a.m.-10:30 a.m. **Issue Workshop: "International South Asian Forum: A Model for Improved Psychiatric Services in Developing Countries"**
Chaired by Jagannathan Srinivasaraghavan, M.D.
Toronto Convention Centre, North, Level 200, Room 201D

2 p.m.-5 p.m. **Symposium: "Global Mental Health Disparities: A Cultural Perspective and the Potential for Formal and Informal International Exchanges"**
Sponsored by the Council on Global Psychiatry and co-chaired by Rodrigo Muñoz, M.D., and Samuel Okpaku, M.D.
Toronto Convention Centre, North, Level 200, Room 206C/D,

Other activities include five discussion groups that will examine current issues in psychiatry pertinent to Europe, Latin America, South Asia, Africa, and the Middle East.

- **Africa Discussion Group:** Sunday, May 21, 3 p.m.-5 p.m., Renaissance Toronto Hotel Downtown, Aurora Room, Second Floor
- **South Asia Discussion Group:** Monday, May 22, noon-2 p.m., Renaissance Toronto Hotel Downtown, Club Room, Lobby Level
- **Europe Discussion Group and Council on Global Psychiatry Component Workshop:** "European Psychiatry: Health and Mental Health Policy After the Helsinki Summit," Tuesday, May 23, 11 a.m.-12:30 p.m., Toronto Convention Centre, South, Level 700, Room 703
- **Latin America Discussion Group and Council on Global Psychiatry Symposium:** "APA/APAL: Addressing Psychiatric Patients' Needs in Latin America," Tuesday, May 23, 2 p.m.-5 p.m., Toronto Convention Centre, South, Level 700, Room 714 B
- **Middle East Discussion Group:** Wednesday, May 24, 9 a.m.-11 a.m., Renaissance Toronto Hotel Downtown, Club Room, Lobby Level

In addition to the many international activities, and in response to Hurricane Katrina's devastation on the Gulf Coast and the subsequent need for disaster psychiatry services, the Committee on Psychiatric Dimensions of Disaster will host two important sessions:

- **Course: "Psychiatric Interventions in Disasters and Public Health Emergencies: Theory to Practice":** Sunday, May 21, 1 p.m.-5 p.m. (advance registration required)
- **Component Workshop: "Disaster Psychiatry: Practical Skills to Help District Branches Develop Disaster Plans for Their Communities":** Monday, May 22, 9 a.m.-10:30 a.m., Toronto Convention Centre, North, Level 100, Room 104A

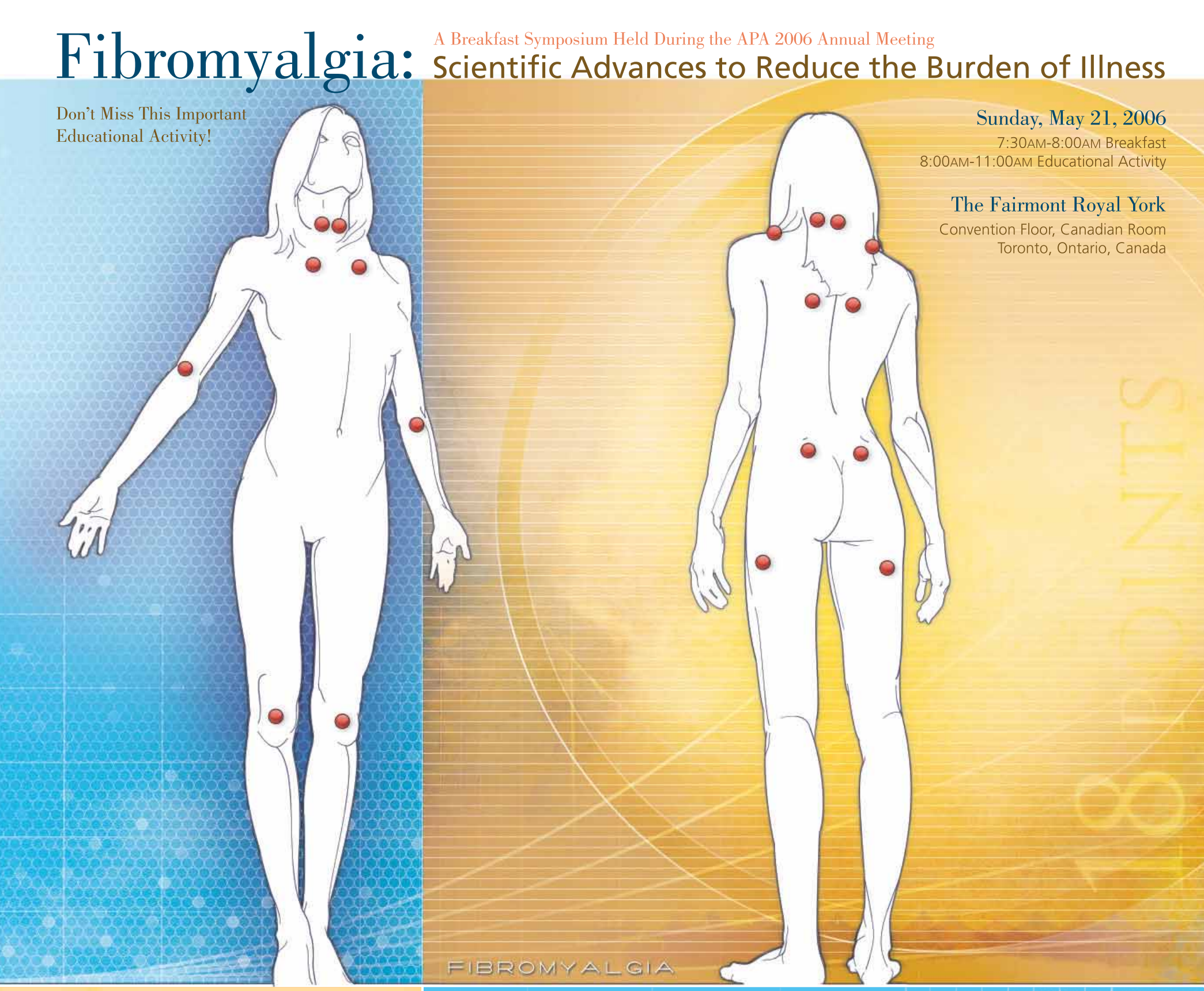
The goals of the Office of International Activities are to strengthen APA's international membership base and carry on APA's long tradition of international collaboration with related organizations devoted to furthering the mission of psychiatry.

Information about the Office of International Activities is posted at <www.psych.org/research/dor/international/index.cfm> or can be obtained by e-mail to internationaloffice@psych.org.

Fibromyalgia:

A Breakfast Symposium Held During the APA 2006 Annual Meeting
Scientific Advances to Reduce the Burden of Illness

Don't Miss This Important Educational Activity!



Sunday, May 21, 2006
7:30AM-8:00AM Breakfast
8:00AM-11:00AM Educational Activity

The Fairmont Royal York
Convention Floor, Canadian Room
Toronto, Ontario, Canada

AGENDA

7:30AM-8:00AM
Breakfast

8:00AM
Welcome and Introduction
Lesley M. Arnold, MD
Program Chairperson
Associate Professor of Psychiatry,
Director, Women's Health Research Program
University of Cincinnati College of Medicine
Cincinnati, Ohio

8:15AM
The Socioeconomic Burden of Fibromyalgia
Sharon B. Stanford, MD
Assistant Professor of Psychiatry and Family Medicine,
Assistant Director,
Women's Health Research Program
University of Cincinnati College of Medicine
Cincinnati, Ohio

8:45AM
New Evidence for the Pathophysiological Basis of Fibromyalgia
Lesley M. Arnold, MD
Program Chairperson

9:15AM
Current and Emerging Strategies for the Pharmacologic Management of Fibromyalgia
Leslie J. Crofford, MD
Gloria W. Singletary Professor of Women's Health Research,
Department of Internal Medicine
Chief, Division of Rheumatology
University of Kentucky
Lexington, Kentucky

9:45AM
Living With Fibromyalgia: A Patient's Perspective
Lesley M. Arnold, MD
Program Chairperson

10:15AM
Question and Answer Session

11:00AM
Program Adjournment

Who Should Participate
This symposium is intended for psychiatrists and other mental health care providers interested in working to improve the medical and psychiatric outcomes of patients with fibromyalgia.

Overview
Fibromyalgia is a syndrome characterized by chronic widespread pain and tenderness at 11 or more of 18 specific points on the body. It afflicts approximately 2% of the population, and it significantly impacts social functioning and contributes to work-related disability for those who suffer from the illness. It is associated with a variety of other pain syndromes as well as mood and anxiety disorders, which may suggest a common pathophysiology. Although the exact cause of fibromyalgia is unknown, there is evidence that physical and psychological trauma may be a predisposing factor in the development of this illness. There is also evidence for the role of various neurotransmitters, including serotonin and norepinephrine, as well as dysregulated hormonal stress responses in the pathophysiology of fibromyalgia. Until recently, treatment of fibromyalgia has been fairly limited; however, new studies show a significant role for antidepressants, anticonvulsants, and cognitive-behavioral therapy in improving pain and functioning in patients suffering from this illness. Fibromyalgia is an often misunderstood illness due to its lack of objective findings, leading to lack of access to effective long-term care and treatment. Given that many of the treatments available to patients with fibromyalgia involve medications and modalities familiar to psychiatrists, there may be an expanded role for psychiatrists to become involved in treating patients afflicted with fibromyalgia.

Learning Objectives
Upon completion of the activity, participants should be able to
1. Recognize the significant morbidity associated with fibromyalgia.
2. Recognize the impact on social functioning and work-related disability in those suffering from fibromyalgia.
3. Recognize the psychiatrist's potential role in easing the socioeconomic burden of fibromyalgia.
4. Recognize the role of stressful life events, trauma, and disturbances in the stress-response system in the pathophysiology of fibromyalgia.
5. Explain the rationale for selection of therapeutic agents for treatment of fibromyalgia.
6. Discuss the data from clinical trials of drugs used in the treatment of fibromyalgia.
7. Develop an algorithm for the treatment of patients with fibromyalgia.
8. Discuss how physician accessibility, perceptions, and patient experience influence access to care and effective treatment of fibromyalgia and how this can impact a patient's life.

Accreditation Statement
The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement
The APA designates this educational activity for a maximum of 3 category 1 credits toward the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those credits that he/she actually spent in the activity.

Faculty Disclosure Statement
All faculty are required to disclose to the audience any real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of the educational activity. The faculty disclosure statements will be listed in the course syllabus and at the beginning of each slide presentation.

Sponsored by the American Psychiatric Association

Supported by an educational grant from Eli Lilly and Company Lilly

Attendees must be registered for the APA Annual Meeting to attend this symposium. Seating is limited and will be based on first-come, first-served. For more information about the meeting, please visit the APA Web site at www.psych.org or contact the APA toll free at 1.888.357.7924 (within the US or Canada) or 317.208.4262.

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Cure That Puckish Feeling At Toronto's Shrine to Hockey

The fast and furious history and heroes of ice hockey await visitors at the Hockey Hall of Fame in Toronto.

BY AARON LEVIN

Photos courtesy of the Hockey Hall of Fame

Originally built as a bank in 1885, this ornate stone building at the corner of Yonge and Front streets was restored and renovated, and opened as the Hockey Hall of Fame in 1993.

Canadians are born into a society that lives and bleeds ice hockey. They start young and stay with it forever, even beyond the grave.

The late Canadian novelist Mordecai Richler was a sportswriter manqué and such passionate fan of the long-dismal Montreal Canadiens that his obituary suggested memorial donations to aid the desperate: the Canadian Cancer Society, Medicins sans Frontieres, or "the Canadiens hockey team, a real lost cause."

Or take the less-extreme case of Montreal psychiatrist Albert Plante, M.D. He began playing at age 6 and swears he hung up his skates four years ago at 61. He wasn't too old to be ridden into the boards by fearsome, stick-wielding opponents, he maintained. His schedule just got too busy to let him practice during the week, "and you can't just play on the weekends."

The game's hold on the big nation may rest on culture, tradition, or maybe the climate, said Plante: "Hockey is Canada's premier sport because the winters are so long."

"Either you embraced the hockey culture and played the game, or you sat out the winter alone in your room, banned from society," recalled Bruce Bell, author (with photographer Elan Penn) of *Toronto: A Pictorial Celebration* (Sterling, 2006). Neighborhood rinks and flooded, frozen backyards resounded each winter to the sound of pucks whacking the boards, said Bell. Dreams of glory on ice were never far away. Everyone seems to know someone who became a star.

Bell grew up in Sudbury, Ontario, next door to one National Hockey League star and down the street from another. Plante coached current New Jersey Devils and Canada's 2006 Olympic goalie Martin Brodeur when Brodeur was 6. An unpromising player as a tyke, young Brodeur appears to have improved since, Plante said.

Hockey is Canada's official winter sport—lacrosse gets the nod in warm weather—and if it occupies a place in the hearts of Canadians closer to religion than sport, then Toronto is home to its chief pilgrimage site, the Hockey Hall of Fame.

More Shrine Than Museum

The Hall of Fame even looks the part of a shrine. Surrounded by glass-and-steel office buildings, the hall is nestled into the former Bank of Montreal building, an ornate 1886 structure three blocks from the Toronto Convention Centre.

The hall was founded in 1941 and moved to its present site in 1993. The main room of the old bank is a quiet sanctuary, lined with plaques citing the sport's heroes, where the "honoured members," as these heroes are formally called, are inducted into the Hall of Fame.

The induction ceremonies are intimate affairs, since the space has room to seat only 200 people. Yet so great is the sense of tradition that even Wayne Gretzky, possibly the game's greatest player, whose induction might have filled any arena in the country, insisted on holding the ceremony inside the old bank.

No Longer Small Potatoes

The Hall of Fame contains 56,000 square feet of space showing the game's evolution from frozen ponds to a global business, said spokesperson Kelly Massey. Besides the plaques of the 300-plus honored members, there's a reconstructed Montreal Canadiens' locker room, the actual Stanley Cup, and the "Lucky Loonie" that some say brought Canada its double victories in men's and women's hockey in the 2002 Olympics.

The "loonie," for the benefit of U.S. citizens, is the unofficial term for Canada's one dollar coin, named for the image of a loon stamped on the reverse. A Canadian who supervised installation of the ice at the Salt Lake City Olympics used the coin to mark center ice before flooding the rink. Only a select few of the Canadian hockey players got the word in advance, but apparently that was enough inspiration—or ice magic—to guarantee a victory for the Canadians.

The hall also features adventures for hockey fans that go beyond the usual interactive computer games. Visitors can take up real hockey sticks and take real shots on a real goal to test their skills, for instance.

Hockey's origins are obscure and subject to debate. Some trace its beginnings to a version of lacrosse played on ice. Others hint at European origins, pointing to 17th century Dutch paintings showing youths playing a game on ice with sticks and balls. Several towns in Nova Scotia claim to be the home of the game before 1800, but a recent report by the Society for International Hockey Research says the question of hockey's origins "may never be conclusively answered."

Whatever its beginnings, the game spread across Canada and into the United States by the mid-19th century. Student teams at Montreal's McGill University substituted the puck for a ball and are credited with playing the first games under standardized rules in the 1870s. Women have played for over a century, and the first recorded game between women's teams was played in 1891.

Toronto has another shrine to hockey, although one not in the pristine condition of the Hall of Fame. Maple Leaf Gardens, home for more than 65 years to the local NHL team, now stands empty, awaiting either the wrecking ball or conversion into a large supermarket that might preserve its art moderne exterior.

Conn Smythe, the team owner who built the Gardens in 1931, was responsible for one of the major innovations of 20th century hockey. Smythe changed what began as a gentleman's game at McGill into something memorialized by Rodney Dangerfield: "I went to see a fight the other night and a hockey game broke out."

"If you can't beat them in the alley, you can't beat them on the ice," Smythe allegedly told his players. After witnessing one fight on the ice, he was heard saying: "We'll have to stamp out that kind of thing or the people are going to keep buying tickets."

The pugnacious attitude and love for the game seems to have rubbed off on other members of Canada's literary firmament.

"As in the world of literature, sometimes hockey's not pretty," said novelist Margaret Atwood, decked out on the ice in goalie's pads and mask for a satiric Canadian television show. "I don't like to hotdog, but if the puck carrier's really putting lumber on it, then Momma can get nasty!" ■

Photos courtesy of the Hockey Hall of Fame

Lord Stanley's Vault, a refurbished bank vault, houses the original Stanley Cup bowl donated by Lord Stanley of Preston in 1892.

Olympians May Be In Italy, But Their Spirit Lives in Toronto

If you want to get some exercise while attending the annual meeting, put on your jogging shoes and head for Olympic Spirit Toronto. There, you can work out while pretending to be an Olympic champ.

BY JOAN AREHART-TREICHEL

True, you can get an idea of what the Olympic Games are all about in the United States—at, for example, the Utah Olympic Park near Salt Lake City or the Olympic Visitor Center in Colorado Springs, Colo.

But if you want to really immerse yourself in the world of the Olympics and vicariously participate in the Olympic Games, then visit Olympic Spirit Toronto. It is the world's first permanent entertainment complex themed around the Olympic Games.

For example, the initial thrust that starts a bobsled can mean the difference between victory and defeat. So one of the exhibits features a bobsled on tracks where you can experience the challenge of starting a fully weighted bobsled in a race against the clock.

In another exhibit, you can try to recreate the record-setting Olympic long jump of nearly 30 feet. It was achieved by an American Olympian at the 1968 Olympics in Mexico City. Here, you grasp what the Canadians call a "flying fox." It is a bar suspended from the ceiling like a trapeze, but is capable of moving forward. You grab the bar, take a few running strides, and then, while still holding the bar, leap forward. Whether you and the bar will be able to move forward 30 feet depends on your height and weight. Most adults can manage it. Of course, the Olympian who made the gargantuan leap of 30 feet did so without a mechanical aid such as the flying fox.

In yet a third exhibit, a sprint simulator allows you to test your speed against an Olympic record in the 100-meter sprint. Before you take your mark, a virtual Olympic sprinter will offer you tips.

You can also challenge yourself on a cycling-training simulator, a rowing-training simulator, or a cross-country-skiing simulator. You can pit yourself against a virtual ice hockey goalie. And thanks to another simulator, you can even experience the visual and tactile thrill of ski jumping—a discipline that requires power, rapidity, sensitivity, precision, equilibrium, and concentration, and one where even the most minuscule of errors can compromise the entire jump.

The center, however, is not just about exercise and entertainment, but also about learning. For example, one display compares ancient and modern Olympic sports and shows how Olympia in Greece looks today. Another display informs visitors about what kinds of nutrition various sports require. Athletes have likewise been hired by the center to answer visitors' questions.

And the center is about inspiration as well. Visitors can watch emotionally charged films capturing the passion, pride, and spirit of Olympic contenders. You can see whether the Olympic creed, introduced at the Olympic Games a century ago, may have an impact on your own life. The creed states: "The most important thing in the Olympic Games is not to win, but to take part, just as the most important thing in life is not the triumph, but the struggle. The essential thing is not to have conquered, but to have fought well."

Olympic Spirit Toronto is in downtown Toronto at Dundas and Victoria streets. More information is available by phone at (888) 466-9991 or online at <www.OlympicSpirit.ca>. ■

lence and Abuse and Council on Social Issues and Public Psychiatry; Chairperson: Yvonne B. Ferguson, M.D.

Symposia

S1. HIV Prevention Interventions With Psychiatric Patients From Around the World: Turning Research Into Practice

A. SMI HIV Research Trajectory and Needs *Karen McKinnon M.A.*

B. Ethnography of HIV Risk in Two Psychiatric Settings *Paulo E. Mattos*

C. Severe Mental Illness and HIV Risk in India With an Emphasis on the Special Threats to Women *Prabha S. Chandra, M.D.*

D. HIV Prevention and People With Mental Illness in South Africa: Prevalence, Policies, and Practice *Pamela Y. Collins*

E. HIV Risk and Risk-Reduction Efforts Among Persons Having Serious Mental Illness and Substance Use Issues in the U.S. *Laura Otto-Salaj, Ph.D.*

S2. Therapeutic Misconception in Clinical Research

A. Therapeutic Misconception: An Overview of the Phenomenon *Paul S. Appelbaum, M.D.*

B. How Prevalent Is Therapeutic Misconception? *Charles W. Lidz, Ph.D.*

C. Assessment of Therapeutic Misconception in Older Patients With Schizophrenia *Laura B. Dunn, M.D.*

D. Reaching Consensus on the Conceptual Definition of Therapeutic Misconception *Gail Henderson*

E. The Ethical Significance of the Therapeutic Misconception *Franklin G. Miller, Ph.D.*

S3. Migration and Mental Illness Around the World *Royal College of Psychiatrists*

A. Refugee Mental Health Challenges in Africa *Frank G. Njenga, M.D.*

B. Mental Health of Sudanese Refugees: An Egyptian Perspective *Nasser F. Loza, M.D.*

C. PTSD Among a Group of Afghan Refugees Attending a Psychiatric Service in Peshawar, Pakistan *Khalid A. Mufti, M.D.*

D. Immigration-Repatriation and Mental Health: The Case of Greece *George G. Christodoulou, M.D.*

E. Raised Incidence of Psychosis in Ethnic Minority Groups in the U.K.: The AESOP Study *Paul Fearon*

F. Migration and Mental Health in Canada: Can Provincial Policy Help? *Stephen R. Kisely, M.D.*

S4. Psychosocial Intervention and Cancer Survival

A. Supportive-Expressive Group Therapy and Survival in Patients With Metastatic Breast Cancer: A Randomized Clinical Intervention Trial *David Spiegel, M.D.*

B. RCT of Supportive-Expressive Group Therapy in Advanced Breast Cancer: Survival, Psychosocial, and Anti-Cancer Treatment Adherence Outcomes *David W. Kissane, M.D.*

C. Treatment Outcomes of Group Supportive-Expressive Therapy for Women With Metastatic Breast Cancer *Molyn Leszcz, M.D.*

D. Impact of Psychotherapeutic Support on Gastrointestinal Cancer Patients Undergoing Surgery: 10-Year Follow-Up Survival Results of a Randomized Trial *Thomas Kuechler, Ph.D.*

E. Malignant Melanoma: Effects of a Brief, Structured Psychiatric Intervention on Survival and Recurrence at 10-Year Follow-Up *Fawzy I. Fawzy, M.D.*

S5. Sexual Orientation and Sports *International Society for Sport Psychiatry*

A. Being Gay in Sports *Eric D. Morse, M.D.*

B. Gender Role Conflict in Female Athletes *Altha J. Stewart, M.D.*

C. Suicide and the Homosexual Athlete *Antonia L. Baum, M.D.*

S6. Insomnia: What Is It?

A. Insomnia: Diagnosis and Treatment Challenges *Thomas W. Uhde, M.D.*

B. Epidemiology of Chronic Insomnia *Edward Bixler, Ph.D.*

C. Chronic Insomnia: Cause-Effect Relationship to Depression and Anxiety Disorders *Ravi K. Singareddy, M.D.*

D. A Vgontzas Biological Model of Chronic Insomnia: Clinical Implications *Alexandros Vgontzas, M.D.*

E. Health Correlates of Insomnia in Young Adults *Antonio Vela-Bueno, M.D.*

S7. The African Diaspora: Identifying and Eliminating Barriers to Mental Health

A. African Belief Systems and Corresponding Healing Practices *Samuel O. Okpaku, M.D.*

B. Why Is Stigma so Rife in Nigeria? *Oye Gureje*

C. The Haitian Diaspora: Barriers in Accessing Mental Health Services *Mary Titus-Villedrouin*

D. Barriers to Mental Health Service Delivery to Ethiopian Immigrants and Refugees in the U.S.: How Should We Tackle This Problem? *Yeshashwork Kibour*

E. The Postcolonial Challenge to the Stigma of Mental Illness in Jamaica *Frederick W. Hickling, M.D.*

F. Stigma and Mental Health: A South African Perspective *Solomon Rataemane*

continued on page 24

A Dinner Symposium Held During the APA 2006 Annual Meeting

Effectiveness of Antipsychotic Drugs in Chronic Schizophrenia:

Complete Results of the CATIE Trial

Sunday, May 21, 2006

6:30PM-7:00PM
Dinner

7:00PM-10:00PM
Educational Activity

The Fairmont Royal York

Convention Floor, Canadian Room

Toronto, Ontario, Canada

7:00PM
Welcome and Introduction
Jeffrey A. Lieberman, MD
Program Chairperson
Chairman, Department of Psychiatry
Columbia University College of Physicians and Surgeons
Director, New York State Psychiatric Institute
Director, Lieber Center for Schizophrenia Research
Psychiatrist-in-Chief,
New York Presbyterian Hospital
Columbia University Medical Center
New York, New York

7:10PM
Comparison of Primary Outcome Measures of Efficacy and Safety
Jeffrey A. Lieberman, MD
Program Chairperson

7:35PM
Comparison of Clozapine vs Other Atypical Drugs in Prospectively Defined Unresponsive Patients
Joseph P. McEvoy, MD
Associate Professor,
Department of Biological Psychiatry
Duke University School of Medicine
Durham, North Carolina

8:00PM
Comparison of Ziprasidone vs Other Atypical Drugs in Prospectively Defined Unresponsive Patients
T. Scott Stroup, MD, MPH
Associate Professor of Psychiatry,
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

8:25PM
Comparison of Treatment Effects on Cognition
Richard S.E. Keefe, PhD
Associate Professor of Psychiatry and Behavioral Sciences,
Duke University Medical Center
Durham, North Carolina

8:50PM
Comparison of Treatments on Health Service Utilization and Cost-Effectiveness Measures
Robert A. Rosenheck, MD
Director, VA Northeast Program Evaluation Center
Professor of Psychiatry, Public Health, and the Child Study Center
Yale School of Medicine
West Haven, Connecticut

9:15PM
Question and Answer Session

10:00PM
Program Adjournment

Don't Miss This Important Educational Activity!

Overview
This symposium will inform the audience of the most complete set of results of the landmark NIMH-sponsored CATIE study that will have been presented to date. The CATIE study was a randomized comparison of several marketed atypical antipsychotics and a representative first-generation drug involving 1500 patients with chronic schizophrenia. Patients were followed for 18 months to assess long-term outcome and cost-effectiveness. If the assigned medication was ineffective, patients were rerandomized in other treatment pathways. Data collection in the study was completed in December 2004. Data analyses are being carried out through 2005, and the results will be presented in their entirety at the 2006 APA meeting. The presentations will include: 1) comparison of the primary outcome measures of efficacy and safety; 2) comparison of treatment effects on cognition; 3) comparison of clozapine vs other atypical drugs in prospectively defined unresponsive patients; 4) comparison of ziprasidone vs other atypical drugs in prospectively defined treatment-intolerant patients; and 5) comparison of treatments on health service utilization and cost-effectiveness measures.

Learning Objectives
Upon completion of the activity, participants should be able to
1. Identify the primary outcome measures used to measure safety and efficacy in the CATIE Trial.
2. Evaluate the impact of antipsychotics on cognitive function in schizophrenia.
3. Compare differences in the efficacy of antipsychotics in defined unresponsive patients.
4. Differentiate antipsychotics in measures of healthcare utilization and cost-effectiveness.

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Supported by an educational grant from Eli Lilly and Company

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S8. Treatment Issues in Schizophrenia With Comorbid Disorders *American Association of Practicing Psychiatrists*

A. TBD *Robert R. Conley*

B. Treatment of Schizophrenia With Obsessive-Compulsive Disorder *Michael Y. Hwang, M.D.*

C. Substance Abuse Among Patients With Schizophrenia Spectrum Disorders *Douglas Noordsy, M.D.*

D. Cognitive Functioning and Outcome in Schizophrenia *Philip D. Harvey, Ph.D.*

E. Schizophrenia and Comorbid Aggressive Behavior: Update 2006 *Leslie L. Citrome, M.D.*

F. Eating Disorders in Schizophrenia *Sun Young Yum, M.D.*

S9. Rehabilitation in France, Canada, and the U.S.: From Science to Recovery: A Joint Meeting With the French Psychiatric Association: Vive la Difference

A. Neuropsychological Therapy Protocol on Young Schizophrenia Patients in Day Hospitals *Christine Germain*

B. Implementing Innovative Rehabilitation Modules: The Case of IPT in a Canadian Province Site *Alain D. Lesage, M.D.*

C. Recovery From Schizophrenia: Current Research *Robert P. Liberman, M.D.*

D. Evidence-Based Practices and Recovery in Schizophrenia *Alan S. Bellack, Ph.D.*

E. A New Rehabilitation Program for Schizophrenia Patients: Development and Preliminary Results *Christophe Lancon*

S10. Model Curricula on Religion and Spirituality for Psychiatry Residency Training Programs

A. Development of a Departmental-Based Curriculum of Spirituality in Health Care for Psychiatry Residents, Other Health Care Professionals, and Clergy/Pastoral Care Professionals *Joan M. Collison, M.D.*

B. Incorporating a Spiritual World View Within Psychiatry in the Bible Belt: University of South Carolina/Palmetto Health Curriculum on Spirituality *Nioaka N. Campbell, M.D.*

C. Bridging the Gap: Science and Spirituality *Patricia E. Murphy, Ph.D.*

D. The Interface Between Spirituality, Religion, and Psychiatry: A Course for Psychiatry Residents at the University of British Columbia *Andrea D. Grabovac, M.D.*

E. Spirituality and Psychiatry: The Harvard Longwood Course Psychiatry Residency Course: Eight Years Later *John R. Peteet, M.D.*

S11. The Long-Term Care and Treatment of Elderly Patients With Bipolar Disorder *APA Council on Aging*

A. The Impact of Elderly Patients With Bipolar Disorder on the Health Care System *Helen H. Kyomen, M.D.*

B. Predictors of Functioning and Treatment of Community Dwelling Older People With Bipolar Disorder *Sarah Pratt, Ph.D.*

C. Treatment Interventions for Elderly Patients With Bipolar Disorder *Melanie T Gentry, M.D.*

D. Ethnic and Cultural Issues in the Care of Elderly Patients With Bipolar Disorder *Iqbal Ahmed, M.D.*

S12. When Usual Treatments Fail: Augmentation Strategies for Refractory Schizophrenia

A. Herbal Medicinal Strategies in Refractory Schizophrenia *Richard P. Brown, M.D.*

B. NMDA Intervention Strategies in Refractory Schizophrenia *Guochuan E. Tsai, M.D.*

C. Augmentation Strategies for the Patient With Treatment-Refractory Schizophrenia *Peter F. Buckley, M.D.*

S13. Substance Use Disorders in the U.S. *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. Prevalence and Correlates of Prescription Drugs Nonmedical Use and Use Disorders in the U.S.: 1991-1992 and 2001-2002 *Carlos Blanco-Jerez, M.D.*

B. Alcohol and Drug Dependence and the Specificity of Family History *Deborah S. Hasin, Ph.D.*

C. Prevalence, Correlates, and Comorbidity of *DSM-IV* Drug Use Disorders *Bridget F. Grant, Ph.D.*

D. Lifetime Comorbidity of *DSM-IV* Mood and Anxiety Disorders and Specific Drug Use Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions *Kevin Conway, Ph.D.*

E. The Relationship of Family History to Cocaine and Cannabis First Use and Dependence *Gary Heiman, Ph.D.*

S14. The Mid-Life Crisis as Interpreted in Film and Television

A. Depression and Other Psychopathology at Mid-Life *Anton C. Trinidad, M.D.*

B. The Mind of the Mid-Life TV Addict *Robert J. Boland, M.D.*

C. TBD *Josepha A. Cheong, M.D.*

S15. First-Episode Schizophrenia: How Can We Improve Treatment Outcome?

A. Measures to Prevent Relapse in Long-Term Treatment: Results From the German Research Network on Schizophrenia *Wolfgang Gaebel, M.D.*

B. The European First Episode Schizophrenia Trial *René S Kahn, M.D.*

C. Management of Impaired Cognition *Stephen R. Marder, M.D.*

D. Social Cognition in Schizophrenia: Impairments and Psychological Treatment *Wolfgang Woelwer, Ph.D.*

E. Effects of Pharmacolgical Treatment on the Quality of Life *George Awad, M.D.*

S16. Adolescent Brain Development: Implications for Psychiatric Treatment *National Institute on Drug Abuse*

A. Adolescent Brain Development: A Period of Vulnerabilities and Opportunities *Ronald E. Dahl, M.D.*

B. Interacting Effects of Cannabis and Tobacco Use on Brain Function in Adolescents *Leslie K. Jacobsen*

C. Prefrontal-Limbic Brain Maturation and Risk for Psychopathology in Adolescence *Isabelle M. Rosso, Ph.D.*

D. The Immature Adolescent Brain and Cognitive Control *Beatriz Luna, Ph.D.*

S17. Ethnicity, Age, and Gender as Factors in the Management of Anxiety and Depression

A. A Clinical Update on Response Rates in Psychiatric Disorders and Ethnicity *DiAnne Bradford, M.D.*

B. Identifying and Treating Depressive and Anxiety Disorders in Children and Adolescents *Melissa P. DelBello, M.D.*

C. Treatment Considerations in Special Populations: Sex Differences *Diana O. Perkins, M.D.*

D. New Pharmacologic Approaches in Treating Depression and Anxiety *David E. Adson, M.D.*

S18. Personality Disorders and Comorbidity: Predictive Factors and Clinical Implications

A. Personality Disorders and Affective Disorders: Ploughing the Sands or Fertile Soil? Predictors and Clinical Implications *Simone Kool, M.D.*

B. Efficacy of Depression Treatment in Patients With or Without Comorbid Personality Disorders: Does Clinical Lore Reflect the Findings From the Literature? *Robert A. Schoevers, M.D.*

C. The Relation Between Personality Pathology and Pathological Gambling *R. Michael Bagby, Ph.D.*

D. Gender Differences in Personality Disorders Among Depressed Outpatients as Compared to the General Population *Cecilia M.T. Gijsbers Van Wijk, Ph.D.*

E. Drug Treatment of Personality Disorder: A Critical Review *Thomas Rinne, M.D.*

S19. Toward a Developmental Trauma Disorder

A. Childhood Abuse, Regional Brain Development, and Psychiatric Vulnerabilities: Evidence for Sensitive Periods *Martin H. Teicher, M.D.*

B. Developmental Trauma Disorder: Evidence From the Adolescent Years *Marylene Cloitre, Ph.D.*

C. Empirical Foundations for a Developmental Trauma Disorder *Bessel A. Van Der Kolk, M.D.*

D. Developmental Trauma Disorder: A Missing Link in Child Psychiatric Nosology and Treatment Planning *Julian Ford*

E. Child Trauma History Profile, Interference With Developmental Competencies, and Influence on Other Major Psychiatric Disorders in Children and Adolescents *Robert S. Pynoos, M.D.*

S20. Borderline Mothers and Infant Interactions: Chaotic Contingency

A. Neurobiological Insights Into the Consequences of Early Nurturing Experience *Cort A. Pedersen, M.D.*

B. Distortion of Borderline Mothers and Infant Interaction and Emotional Regulation at Three Months *Gisèle Apter-Danon, M.D.*

C. Practical Applications of Treating Women in the Postpartum Period *Samantha E. Meltzer-Brody, M.D.*

D. Interventions for New Mothers With PTSD and BPD *Marian I. Butterfield, M.D.*

S21. Criminalization of Mental Illness: Getting In and Out in New York *American Association for Social Psychiatry*

A. Only Some People With Mental Illness Are Criminalized *Zebulon C. Taintor, M.D.*

B. Substance Abuse, Spirituality, and Deviant Behavior *Marc Galanter, M.D.*

C. Mental Health Treatment in New York State Prisons and Outcome *Abraham L. Halpern, M.D.*

D. Alternatives to Incarceration: Assisted Outpatient Treatment and Drug Courts *Gary R. Collins, M.D.*

S22. Psychocultural Foundations of Political Terrorism *APA Council on Global Psychiatry and International Society of Political Psychology*

A. Combating the Virus of Islamist Militancy: A Public Health Perspective *Jerrold M. Post M.D.*

B. Toward a Scientific Revolution in the Application of Behavioral Sciences to the Study of the Deep Roots of Terrorism *Jeff Victoroff, M.D.*

C. The Appeal of Radical Islam for Young British Muslims *Amy Waldman*

D. Terrorism and Diasporas *Stevan M. Weine, M.D.*

E. Religion and Terrorism in U.S. Prisons: Crucible for Commitment or Contagion? *Gregory B. Saathoff, M.D.*

F. Moral Agents, Immoral Violence: Mechanisms of Moral Disengagement in Islamic Suicide Missions *Mohammad Hafez*

S23. Science, Diagnoses, and the Clinician *World Psychiatric Association*

A. A Proposal to Include a Dimensional Component in *DSM-V John E. Helzer*

B. Dualism and the *DSM*: Emerging from the Shadow of the 17th Century *G. Scott Waterman, M.D.*

C. *DSM* in the 21st Century and Beyond: The Interface of Genomics and Neuroscience With Our Diagnostic System *James J. Hudziak, M.D.*

D. Improving the Validity of *DSM* Categories *Lee N. Robins, D. Phil.*

S24. The Effective Psychotherapist: The Role of Common and Specific Factors

A. Factors Common to All Evidence-Based Psychotherapies *John Manring, M.D.*

B. Cognitive-Behavioral Therapy for Anxiety Disorders: Common and Specific Aspects *Edna B. Foa, Ph.D.*

C. Integrating Common and Specific Factors in Psychotherapy Training: McMaster and Syracuse Models *Priyanthy Weerasekera, M.D.*

D. TBD *Scott P. Stuart, M.D.*

S25. Developing Strategies in Psychotherapy Research

A. Assessing the Quality of Randomized, Controlled Trials of Psychotherapy *Andrew J. Gerber, M.D.*

B. Long-Term Outcome in Psychotherapy Research *James H. Kocsis, M.D.*

C. An Outcome Study for Psychoanalysis *Steven P. Roose, M.D.*

D. Comparison and Combination of

continued on page 26

Eclectic Neighborhood Offers Round-the-World Trip

From the first spicy smells, visitors to Kensington Market know they have entered a part of Toronto where people do the business of living, as well as selling.

BY RICH DALY

Are you wondering where to go for a bushel of fresh crabs and quality vintage clothing? Or maybe you just want to people watch in a place where people do both? If eclectic and authentic are your watchwords then Kensington Market is a must-do Toronto destination.

You'll know you have found the market when you are immersed in a maze of narrow streets and alleys, bustling with shops and lined with brightly painted Victorian houses.

The labyrinthine streets on the western side of the city's Chinatown are home to not only some great prices but also some of the best local produce and fresh meat in the city. Among its many appeals, Kensington Market draws most of its visitors because its dozens of tiny shops and produce stands make it a haven of fresh fruit, vegetables, and dry-goods stores.

Photo: Leo Wong

Open for over 20 years, Exile has been a fixture in Toronto's eclectic Kensington Market neighborhood. The store carries mostly vintage and funky new clothes and baubles.

The shops reflect Toronto's rich, multicultural mix. The many small stores are packed with items from Europe, the Caribbean, the Middle East, South America, and Asia. Among the foods the locals search out at the market: great cheeses, coffee, nuts, and international delicacies. Visitors describe the market as a sensory trip around the world because of the different foods and spices that fill the air with their tantalizing aromas.

The ambience comes complete with fishmongers, street musicians, impromptu speechmakers, and shoppers. The sidewalk music can range from sitar, funk, and reggae to punk music.

It's also a trove of vintage clothing shops, tucked in among eclectic restaurants and cafés.

The market area, loosely defined by the borders of College and Dundas streets and Augusta and Spadina avenues, is also home to a variety of tiny cafés

Market Moves Through History

Kensington has been reinventing itself since the 1880s, when houses were built on small plots for Irish and Scottish immigrant laborers. Many of these houses still stand, and the inexpensive homes have housed successive waves of immigrants.

By the early 1900s, the area had become home to more than 80 percent of the city's Jewish community. Shut out of the city's mainstream commercial areas, many residents began selling goods from the back of their homes or from carts in front of their houses. The successful "Jewish Market"—as it is still known to some today—sold a diverse array of items imported from the homelands of the various immigrant communities. These successful immigrants later moved to wealthier suburban areas and were replaced by new immigrants.

By the 1950s the market had become more diversified, with a post-war immigrant influx. Today the area represents more than 30 cultures, including Portuguese, East Indian, Ethiopian, and Caribbean.

The market has achieved fame throughout Canada by lending its name to CBC television shows and a sitcom. A 1960s band called Kensington Market helped shape its image as a hippie enclave.

Today the neighborhood is a welcoming tourist attraction and a center of Toronto's cultural life as artists and writers moved into the area. Although its land values have risen in recent years, Kensington remains a predominantly working class, immigrant community.

Locals suggest visitors take public transportation to the market because parking is difficult. The city's subway, the TTC, has a nearby stop at Queen's Park Station.

Hit the Highlights

Saturdays may be the best time to appreciate the bustle of the market's narrow streets. Some Kensington Market landmarks visitors should see include Bellevue Square Park, Tom's Place, St. Stephen's Community House, and the Number 10 Fire Station.

There are still other highlights in the market.The owners of the Free Times Café describe it as a 25-year home of alternative Canadian/Jewish culture, food, and drink. The café features nightly concerts of original Canadian folk music, art shows, poetry, and theater. Rancho Relaxo is an authentic Mexican restaurant with live music. Kolbeh restaurant offers Persian dishes, a great beer selection, and a belly dancer on the weekends. My Market Bakery is known for great bread, Portuguese custard tarts, and cheesecake.

Additional information about the market is posted at <www.toronto.com/attractions/listing/000-213-802>. ■

Revisit Time When $3 Million Bought a Real Castle

Though its heyday is long past, Sir Henry Pellatt's medieval castle on the hill offers visitors a glimpse of what it life was like for Canada's rich and famous in the early 1900s.

BY EVE BENDER

When in 1911 business magnate Sir Henry Pellatt commissioned famed Toronto architect E.J. Lennox to build a medieval-style castle overlooking the city of Toronto for himself and his wife, he planned to spend $250,000—a lot in those days.

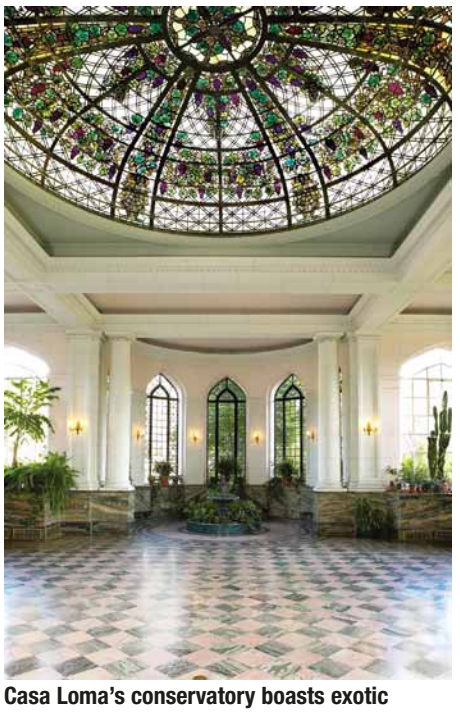

Photo: Tourism Toronto

Casa Loma's conservatory boasts exotic plants and an imported stained-glass dome.

As it turned out, they would spend that much just on the stone wall surrounding Casa Loma, which is Spanish for "house on the hill." Construction of Casa Loma took 300 men nearly three years to complete.

The castle ended up costing Pellatt around $3.5 million, and plans for indoor rifle range, swimming pool, and three bowling alleys in the basement had to be discarded due to the mounting costs.

At age 23, Pellatt became a full partner in his father's brokerage firm, Pellatt and Pellatt, and made his fortune by investing in Northwest Land Company and the Canadian Pacific Railway. He also founded the Toronto Electric Light Company in 1883, which in the years to come eventually monopolized street lighting throughout the city.

However, Pellatt went into debt when ownership of electricity became public and the economy slumped after World War I.

The Pellatts lived in the 98-room castle for only 10 years before financial hardship caused them to auction off its furnishings for a fraction of their original cost and move to more humble lodgings.

Photo: Tourism Toronto

Casa Loma is known for its massive towers, intricate wood carvings, gardens, and hidden passageways. Though its original owners could not afford to live there for long, today anyone can enjoy its opulence.

Casa Loma stood empty for about a decade, and various schemes for the property, such as one that converted the castle into a hotel, failed.

Thanks to the conservation efforts of the city of Toronto, which assumed ownership of the site in the 1930s, and the Kiwanis Club of Casa Loma, which operates it, Casa Loma is open to visitors and has become a popular venue for weddings and other events.

Visitors have plenty at which to marvel. Just across from the main entrance stands the grand library, with its herringbone hardwood floors. Grand glass and wood cabinets can store 10,000 books, which during Pellatt's stay consisted mostly of those on gardening and military history.

The Pellatt family crest is molded on the Elizabethan-style ceiling and reads, "Devant Si Je Puis," or "Foremost If I Can."

The conservatory is a sort of oasis standing at the end of Peacock Alley, the main hallway on the first floor of the castle. Here, Pellatt spared no expense. He imported Italian marble for the floor and fashioned each of the two $10,000 bronze and glass doors after those in an Italian villa he visited.

please see ***Castle*** *on page 62*

Psychotherapy and Medication in Outcome Trials *Michael E. Thase, M.D.*

S26. Taking Science to Policy: Efforts to Reduce Harms Related to Alcohol Misuse *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. The Magnitude and Prevention of Underage Drinking Problems *Ralph Hingson*

B. Pragmatic Science: The New NIAAA Clinician's Guide *Mark L. Willenbring, M.D.*

C. Alcohol Interventions in Trauma Centers Reduce Reinjury Rates: State Laws and Insurance Regulations Prevent Their Implementation *Larry Gentilello*

D. Implementing Alcohol Treatment for People With Co-Occurring Disorders in Pychiatric Treatment Settings *Robert Drake*

E. What Kind of Treatment System Is Necessary to Implement Evidence-Based Practices? *A. Thomas McLellan, Ph.D.*

S27. Not Just Dopamine any More: Emerging Glutamatergic Therapies for Schizophrenia

A. Endogenous Modulators of Glutamatergic Neurotransmission and the Pathophysiology of Schizophrenia *Joseph T. Coyle Jr.*

B. AMPA Agonists Agonists (Ampakines) in Schizophrenia *Donald C. Goff, M.D.*

C. The PCP Model of Schizophrenia: 45 Years and Counting *Daniel Javitt, M.D.*

D. NMDA Glycine Site Agonists in the Treatment of the Schizophrenia Prodome *Scott W. Woods, M.D.*

S28. CANMAT Guidelines for the Management of Bipolar Disorder: An Effort Toward International Consensus

A. Foundations of Management: Applying Chronic Disease Models and Psychosocial Interventions to Bipolar Disorder *Sagar V. Parikh, M.D.*

B. CANMAT Guidelines for Acute and Continuation Treatment of Mania *Lakshmi N. Yatham, M.D.*

C. Acute Management of Bipolar Depression *Sidney H. Kennedy, M.D.*

D. Bipolar II Disorder: Emerging Guidelines for Treatment *Claire M. O'Donovan, M.B.*

E. U.S. and International Perspective on CANMAT Guidelines for Bipolar Disorder *Joseph R. Calabrese, M.D.*

S29. Dementia in Patients With Down Syndrome: Risk Factors, Biomarkers, Diagnosis, and Treatment

A. Risk Factors and Biomarkers for Dementia in Adults With Down Syndrome *Nicole Schupf, Ph.D.*

B. Cognitive Assessment of Aging Persons With Down Syndrome *Arthur Dalton, Ph.D.*

C. Trials to Assess Treatment Strategies for Dementia in Down Syndrome *Mary Sano, Ph.D.*

S30. Geriatric Psychiatry: New Ideas and New Practices for the 21st Century

A. Pharmacogenomics in Clinical Practice and Research *Larry Ereshefsky, Pharm.D.*

B. The Future of Magnetic and Electrical Stimulation Therapies in Geriatrics *Sarah H. Lisanby, M.D.*

C. New Pharmaceuticals *Sandra A. Jacobson, M.D.*

D. Best New Technologies for Improved Patient Care *Myron L. Pulier, M.D.*

continued on page 28

Patient-Safety Issues To Be in Spotlight

The APA Committee on Patient Safety is sponsoring the symposium "Patient Safety: To Err Is Human, To Be Safe Is Divine" at APA's 2006 annual meeting. The symposium, chaired by Geetha Jayaram, M.D., and Al Herzog, M.D., will be presented from 2 p.m. to 5 p.m. on Tuesday, May 24, in Room 717 A, Level 700, in the Toronto Convention Centre South.

The session should be of interest to all psychiatrists, but several segments pay particular attention to teaching medical students, residents, and faculty.

Presentations will focus on examining critical concepts such as "collective mindfulness," "error-prone institutions," and the "code of silence," with particular attention to the presentation, disclosure, and resolution of medical mistakes; problems that arise (and potential solutions) when patients with psychiatric disorders have long lengths of stay in an emergency room; prescribing errors; high-risk prescribing situations; ways to prevent errors when ordering medications that have look-alike or sound-alike names; concerns about suicidal risk, including the integration of risk-profile assessments into daily practice; understanding diverse cultural norms; applying accurate medication-related and psychotherapeutic interventions to render care safely; and an increased awareness of the complexities of patient safety, practicing safer medicine at the solo and system level, and becoming a patient-safety advocate in one's practice community. ■

MAINTAINING WELLNESS IN PATIENTS WITH BIPOLAR DISORDER

2006 APA ANNUAL MEETING

MOVING BEYOND EFFICACY TO EFFECTIVENESS

DATE SATURDAY, MAY 20TH **TIME** 12:30 PM — 3:30 PM

ACTIVITY CHAIRPERSON GARY SACHS, MD

THE FAIRMONT ROYAL YORK ■ CANADIAN ROOM ■ TORONTO, CANADA

TARGET AUDIENCE

This educational activity is intended for psychiatrists and other mental health care professionals attending the 2006 Annual Meeting of the American Psychiatric Association.

LEARNING OBJECTIVES

After attending this symposium, participants should be better able to:

- Discuss basic neurobiologic and genetic factors underlying the pathophysiology of bipolar disorder
- Differentiate between bipolar disorder and unipolar disorder, based on clinical presentation and other factors
- Evaluate the most recent clinical trial data assessing the efficacy of behavioral and pharmacologic therapies for bipolar disorder

ACCREDITATION STATEMENT

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

DESIGNATION STATEMENT

The APA designates this educational activity for a maximum of 3 category 1 credits toward the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those credits that he/she actually spent in the activity.

DISCLAIMER STATEMENT

The opinions or views expressed in this CME activity are those of the presenters and do not necessarily reflect the opinions or recommendations of the APA or the commercial supporters. Attendees should critically appraise the information presented and are encouraged to consult appropriate resources for information surrounding any product or device mentioned.

Attendees must be registered for the APA 2006 Annual Meeting to attend this symposium. Seating is limited and will be based on a first-come, first-served basis. For more information about the meeting, please visit the APA web site at **www.psych.org** or contact APA toll free at **1-888-357-7924** (within the US or Canada) or **1-703-907-7300**.

AGENDA

SATURDAY, MAY 20TH, 2006

12:00 PM — 12:30 PM	LUNCH
12:30 PM — 12:35 PM	WELCOME AND INTRODUCTION Gary Sachs, MD
12:35 PM — 1:05 PM	IMPACT OF MISDIAGNOSIS OF BIPOLAR DISORDER ON PATIENT OUTCOMES Claudia F. Baldassano, MD
1:05 PM — 1:35 PM	BRAINS AND GENES: IMPLICATIONS FOR THE TREATMENT OF BIPOLAR DISORDER Kiki Chang, MD
1:35 PM — 2:05 PM	EVALUATION OF CLINICAL TRIALS IN BIPOLAR DISEASE Gary Sachs, MD
2:05 PM — 2:35 PM	IMPACT OF PATIENT SATISFACTION ON TREATMENT OUTCOMES Holly A. Swartz, MD
2:35 PM — 3:25 PM	PANEL DISCUSSION Moderator: Gary Sachs, MD
3:25 PM — 3:30 PM	CLOSING REMARKS Gary Sachs, MD

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Sponsored by the American Psychiatric Association

Supported by an educational grant from Bristol-Myers Squibb Company and Otsuka America Pharmaceutical, Inc.

S31. Nancy Andreasen: Festschrift for Her 13 Years as Journal Editor

A. Scientific Journals and the Transmission of Knowledge to Clinicians *Floyd E. Bloom, M.D.*

B. Interaction Between Gene Expression and Social Behavior *Leon Eisenberg, M.D.*

C. Brain Imaging and the Human Brain at Work *Marcus Raichle, M.D.*

D. The History of Episodic Memory *Endel Tulving, Ph.D.*

S32. A Spanish Language Update on the Assessment and Management of Depression *American Society of Hispanic Psychiatry*

A. Update on the Neurobiology of Depression *Pedro L. Delgado, M.D.*

B. Suicide *Maria A. Oquendo, M.D.*

C. Treatment of Depression in Parkinson's Disease *Humberto Marin, M.D.*

D. Depression in Cognitive-Intact and Cognitive-Impaired Elderly Persons *Jacobo E. Mintzer, M.D.*

S33. Recent Advances in Clinical Care and Clinical Research in BPD

A. Course of Acute and Temperamental Symptoms of Borderline Personality Disorder Over 10 Years of Prospective Follow-Up *Mary C. Zanarini, Ed.D.*

B. Affective Instability and Suicidality in Borderline Personality *Paul S. Links, M.D.*

C. Effectiveness of Inpatient Dialectical Behavioral Therapy for Borderline Personality Disorder: A Controlled Trial and Follow-Up Data *Martin Bohus, M.D.*

D. Empirical Observations on the Relationship of Borderline Personality Disorder and Bipolar Disorders *John G. Gunderson, M.D.*

E. Randomized Control Trial of Psychodynamic Treatments Compared With DBT for Borderline Personality Disorder *John F. Clarkin, Ph.D.*

2 p.m.-5:30 p.m.

Advances in Psychopharmacology *Alan F. Schatzberg, M.D.*

3 p.m.-5 p.m.

New Research Poster Session 5

5:30 p.m.-6:30 p.m.

Convocation of Distinguished Fellows

Lecture

L10. Connecting the Dots: The Interacting Problems of Poverty *David K. Shipler; William C. Memorial Lecture*

7 p.m.-10 p.m.

Industry-Supported Symposia

IS29. Pharmacotherapy of Psychotic and Mood Disorders With Co-Existing Medical Illness *Supported by AstraZeneca Pharmaceuticals*

A. Optimal Selection of Pharmacotherapy in Psychotic and Mood Disorders With Co-Existing Metabolic Disorders *Henry A. Nasrallah, M.D.*

B. Patients With Mental Illness and Cancer *Diana O. Perkins, M.D.*

C. Pharmacotherapy of Psychotic and Mood Disorders in the Context of Thromboembolic Disease *Quinton E. Moss, M.D.*

D. When Mental Illness Is Complicated by Respiratory Symptoms: Management Implications *Peter J. Weiden, M.D.*

E. When HIV Complicates Psychosis or Mood Disorder: Pharmacotherapeutic Considerations and Drug Interactions *Glenn J. Treisman, M.D.*

IS30. Helping Depressed Patients Achieve Remission: Advocacy for Improvement *Supported by Bristol-Myers Squibb Co.*

A. Heterogeneity in Response and Remission: Implications for Optimizing Treatment *A. John Rush, M.D.*

B. Switching Treatments: For Whom and to What Effect? *Maurizio Fava, M.D.*

C. Optimizing Antidepressant Treatments: Use of Augmentations and Combinations to Achieve Remission *Andrew A. Nierenberg, M.D.*

D. Psychotherapy: For Whom and To What Effect? *Michael E. Thase, M.D.*

E. Pharmacogenetics: Can We Customize the Treatments of Depression? *Roy H. Perlis, M.D.*

IS31. Understanding and Managing the Transition of ADHD From Adolescence to Young Adulthood: The Maturation of the Disorder *Supported by Shire US Inc.*

A. Imaging the Brains of ADHD Adults: New Findings *George Bush, M.D.*

B. ADHD "Not Otherwise Specified": Conceptual Issues *Stephen V. Faraone, Ph.D.*

C. ADHD Behind the Wheel: Driving With ADHD *Craig B.H. Surman, M.D.*

D. ADHD Goes to College: Planning, Protecting, and Prospering *Sharon B. Wigal, Ph.D.*

E. Emerging Therapies in the Treatment of ADHD *Timothy E. Wilens, M.D.*

IS32. The Cognition, Neurocircuitry, and Disability Interface: Bringing Evidence to Practice *Supported by Cephalon Inc.*

A. The Neurocircuitry of Cognition *John H. Krystal, M.D.*

B. Cognition: What Is the Role of Genetics? *Daniel R. Weinberger, M.D.*

C. Cognition, Attention, and Executive Function: How Do They Translate in Our Patients? *Philip D. Harvey, Ph.D.*

D. From Brain to Bedside: Understanding the Clinical Interface of Cognition and Neurocircuity of Depression *Boadie W. Dunlop, M.D.*

E. Novel Treatments for Cognitive Enhancement: Can Drugs Make People Smarter? *Trevor Robbins, Ph.D.*

IS33. Taking Control of Negative Symptoms: The Next Step for Improved Patient Outcomes in Schizophrenia *Supported by Organon USA Inc. and Pfizer Inc.*

A. Recognizing Negative Symptoms and Their Importance *Joseph M. Pierre, M.D.*

B. Psychosis Circuits, Negative Symptoms, and Brain Imaging *Steven G. Potkin, M.D.*

C. Treatment of Negative Symptoms *Hans-Juergen Moeller, M.D.*

D. Positive Outcomes With Negative Symptoms: Measuring and Monitoring Your Patients *Dawn I. Velligan, Ph.D.* ■

Photo: Tourism Toronto

PsychiatryOnline to Showcase New Features, Updates

Visit the APPI Bookstore in the exhibit area of the Toronto Convention Centre and see this Web site in action.

Since its launch in April 2005, the portal Web site PsychiatryOnline.com, from American Psychiatric Publishing Inc. (APPI), has seen substantial increases in the number of subscribers, features, and content.

"The site was a hit with early subscribers," according to Bob Pursell, APPI's director of sales and marketing. "As word of mouth spreads about the richness of the site, it's gaining momentum among a wider array of psychiatrists and mental health professionals."

Libraries have been enthusiastic supporters from the beginning. Site licenses, which provide access for an entire institution for one fee, open the door to APA/APPI books and journals for a huge universe of users. Institutional subscribers are as wide ranging as university systems, medical schools, hospital libraries, individual medical practices, pharmaceutical companies, and state and federal government agencies.

The number of visitors to PsychiatryOnline.com has grown each month, reaching 60,000 in December 2005. And hits—the number of requests for a file—recently topped the million mark. The site has a global audience, logging visitors from North America, Europe, Asia, Australia, South America, and Africa.

Opportunities to test-drive the site will be offered in the APPI Bookstore at APA's 2006 annual meeting. And a video demonstration is available on the site itself; click "Take a Guided Tour of the Site" from the homepage at <www.psychiatryonline.com>.

A popular new feature at PsychiatryOnline.com is the Book of the Month. Subscribers are given electronic access (in pdf) to the full text of a different book each month from the APPI collection. This feature gives subscribers a peek inside popular titles so they can better evaluate whether they would like to purchase the print book.

The site currently offers access to *DSM-IV-TR*, differential diagnostic advice and case examples, APA's practice guidelines (including new guidelines and revisions as they are released by APA), Hales and Yudofsky's *Textbook of Clinical Psychiatry* (with interactive self-assessment), and the *American Journal of Psychiatry* and other journals published by APA and APPI.

Just how is the diverse content from these books and journals integrated within the site? "It's hard to explain just how dynamic the PsychiatryOnline.com Web site is," said Pam Harley, APPI's director of e-publishing. "It's something you really need to see in action. As a result of semantic tags added by indexers and the National Library of Medicine, new connections among related pieces of content are always being generated, allowing readers to discover relevant information they didn't even know existed." ■

one more day

Lilly

Important Safety Information for ZYPREXA® (olanzapine)

Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. ZYPREXA is not approved for the treatment of elderly patients with dementia-related psychosis.

Safety experience in elderly patients with dementia-related psychosis

In placebo-controlled clinical trials of elderly patients with dementia-related psychosis, the incidence of death in olanzapine-treated patients was significantly greater than placebo-treated patients (3.5% vs 1.5%, respectively). Risk factors that may predispose this patient population to increased mortality when treated with olanzapine include age ≥80 years, sedation, concomitant use of benzodiazepines, or presence of pulmonary conditions (eg, pneumonia, with or without aspiration). ZYPREXA is not approved for the treatment of patients with dementia-related psychosis.

Cerebrovascular adverse events (CVAE), including stroke, in elderly patients with dementia

Cerebrovascular adverse events (eg, stroke, transient ischemic attack), including fatalities, were reported in patients in trials of ZYPREXA in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was a significantly higher incidence of CVAE in patients treated with ZYPREXA compared to patients treated with placebo. ZYPREXA is not approved for the treatment of patients with dementia-related psychosis.

Hyperglycemia and diabetes mellitus

Hyperglycemia, in some cases associated with ketoacidosis, coma, or death, has been reported in patients treated with atypical antipsychotics including ZYPREXA. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. All patients taking atypicals should be monitored for symptoms of hyperglycemia. Persons with diabetes who are started on atypicals should be monitored regularly for worsening of glucose control; those with risk factors for diabetes should undergo baseline and periodic fasting blood glucose testing. Patients who develop symptoms of hyperglycemia during treatment should undergo fasting blood glucose testing.

Orthostatic hypotension

In premarketing schizophrenia trials, some patients taking ZYPREXA may have experienced orthostatic hypotension associated with dizziness,* tachycardia,* and, in some cases, syncope (15/2500, 0.6%).

Transient, asymptomatic elevations of hepatic transaminase

In placebo-controlled schizophrenia trials, clinically significant ALT (SGPT) elevations (≥3 times the upper limit of the normal range) were observed in 2% (6/243) of patients exposed to ZYPREXA compared to none (0/115) of the placebo patients. None of these patients developed jaundice. Periodic assessment of transaminases is recommended in patients with significant hepatic disease.

Drug interactions

Coadministration of diazepam or ethanol with ZYPREXA may potentiate orthostatic hypotension. Lower doses of ZYPREXA should be considered in patients receiving concomitant therapy with fluvoxamine.

Effect on prolactin

Modest elevations of prolactin were seen with ZYPREXA in acute-phase schizophrenia trials (incidence 34% vs 13% with placebo), although mean changes from baseline to endpoint were not statistically significantly different between ZYPREXA and placebo. Some patients may have persisting modest prolactin elevations.

Special populations—elderly

Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. In 5 studies in elderly patients with dementia-related psychosis, adverse events observed at a greater incidence with olanzapine than with placebo were falls, somnolence, peripheral edema, abnormal gait, urinary incontinence, lethargy, increased weight, asthenia, pyrexia, pneumonia, dry mouth, and visual hallucinations. As with other CNS-active drugs, ZYPREXA should be used with caution in elderly patients with dementia. Olanzapine is not approved for the treatment of patients with dementia-related psychosis.

Medication dispensing and prescribing errors have occurred between ZYPREXA® (olanzapine) and Zyrtec® (cetirizine HCl). These errors could result in unnecessary adverse events or potential relapse in patients suffering from schizophrenia or bipolar disorder. To reduce the potential for dispensing errors, please write ZYPREXA clearly.

As with all antipsychotic medications, the following considerations should be taken into account when prescribing ZYPREXA:

Neuroleptic malignant syndrome (NMS)—as with all antipsychotic medications, a rare condition known as NMS has been reported with olanzapine. If signs and symptoms appear, immediate discontinuation is recommended.

Tardive dyskinesia (TD)—as with all antipsychotic medications, prescribing should be consistent with the need to minimize the risk of TD. If its signs and symptoms appear, discontinuation should be considered.

Seizures—occurred infrequently in premarketing clinical trials (22/2500, 0.9%). Confounding factors may have contributed to many of these occurrences. ZYPREXA should be used cautiously in patients with a history of seizures or with conditions that lower the seizure threshold. Such conditions may be more prevalent in patients age 65 years or older.

The most common treatment-emergent adverse event associated with ZYPREXA (vs placebo) in 6-week acute-phase schizophrenia trials was somnolence (26% vs 15%). Other common events were dizziness (11% vs 4%), weight gain (6% vs 1%), personality disorder† (8% vs 4%), constipation (9% vs 3%), akathisia (5% vs 1%), and postural hypotension (5% vs 2%).

The most common treatment-emergent adverse event associated with ZYPREXA (vs placebo) in 3- and 4-week bipolar mania trials was somnolence‡ (35% vs 13%). Other common events were dry mouth‡ (22% vs 7%), dizziness‡ (18% vs 6%), asthenia‡ (15% vs 6%), constipation (11% vs 5%), dyspepsia (11% vs 5%), increased appetite (6% vs 3%), and tremor (6% vs 3%).

* In acute-phase schizophrenia trials with oral olanzapine (n=366), dizziness (11% vs 4%) and tachycardia (4% vs 1%) were reported; these events were not always associated with hypotension.

† COSTART term for nonaggressive objectionable behavior.

‡ In bipolar mania trials, 4 adverse events occurred with statistically significantly higher incidence with olanzapine than with placebo; none of these resulted in discontinuation.

ZYPREXA®
Olanzapine

I fight

for one more day with my daughter

I have bipolar disorder.
But I won't let it have me.

If I have to fight it the rest of my life,
with the help of my doctor, and my family,
and my friends, I will do it.

Because I am the most important
thing in her world, and being her
mother is the most important
thing in mine.

ZYPREXA is approved for the treatment of schizophrenia, for acute bipolar mania, and for maintenance treatment in bipolar disorder.

For important safety information, including boxed warning, see adjacent pages and Brief Summary of Prescribing Information.

Lilly

ZYPREXA® (Olanzapine Tablets)
ZYPREXA® ZYDIS® (Olanzapine Orally Disintegrating Tablets)
ZYPREXA® IntraMuscular (Olanzapine for Injection)
Brief Summary: Please consult package insert for complete prescribing information.

WARNING: Increased Mortality in Elderly Patients with Dementia-Related Psychosis—Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. ZYPREXA is not approved for the treatment of patients with dementia-related psychosis.

INDICATIONS AND USAGE: ZYPREXA and ZYPREXA Zydis are indicated for short- and long-term treatment of schizophrenia, for acute manic and mixed episodes of bipolar I disorder, and for maintenance treatment in bipolar disorder. The use of ZYPREXA for extended periods should be periodically re-evaluated as to the long-term usefulness of the drug for the individual patient. ZYPREXA IntraMuscular is indicated for treatment of agitation associated with schizophrenia and bipolar I mania.

CONTRAINDICATIONS: Known hypersensitivity to olanzapine.

WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis—Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. ZYPREXA is not approved for the treatment of patients with dementia-related psychosis (*see* BOX WARNING).

In placebo-controlled clinical trials of elderly patients with dementia-related psychosis, the incidence of death in olanzapine-treated patients (3.5%) was significantly greater than placebo-treated patients (1.5%).

Cerebrovascular Adverse Events, Including Stroke, in Elderly Patients with Dementia—Cerebrovascular adverse events (eg, stroke, transient ischemic attack), including fatalities, were reported in patients in trials of olanzapine in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was a significantly higher incidence of cerebrovascular adverse events in patients treated with olanzapine compared to patients treated with placebo. Olanzapine is not approved for the treatment of patients with dementia-related psychosis.

Hyperglycemia and Diabetes Mellitus—Hyperglycemia, in some cases associated with ketoacidosis, coma, or death, has been reported in patients treated with atypical antipsychotics including olanzapine. Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Patients diagnosed with diabetes who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes who are starting treatment with atypicals should have fasting blood glucose (FBG) testing at baseline and periodically during treatment. Any patient treated with atypicals should be monitored for symptoms of hyperglycemia. Patients who develop symptoms of hyperglycemia during treatment with atypicals should undergo FBG testing.

Neuroleptic Malignant Syndrome (NMS)—Potentially fatal NMS has been reported in association with administration of antipsychotic drugs, including olanzapine. See complete prescribing information for information on management of NMS. Patients requiring antipsychotic drug treatment after recovery from NMS should be carefully monitored since recurrences have been reported.

Tardive Dyskinesia (TD)—Potentially irreversible TD may develop in patients treated with antipsychotic drugs. Although the prevalence of TD appears to be highest among the elderly, especially elderly women, it is impossible to predict which patients are more likely to develop the syndrome. If signs and symptoms of TD appear, consider drug discontinuation.

PRECAUTIONS: Hemodynamic Effects—Olanzapine may induce orthostatic hypotension associated with dizziness; tachycardia; and in some patients, syncope. Hypotension, bradycardia with/without hypotension, tachycardia, and syncope were also reported during the clinical trials with intramuscular olanzapine for injection. Incidence of syncope was 0.6%, 15/2500 with oral olanzapine in phase 2-3 trials and 0.3%, 2/722 with intramuscular olanzapine for injection in clinical trials. Three normal volunteers in phase 1 studies with intramuscular olanzapine experienced hypotension, bradycardia, and sinus pauses of up to 6 seconds that spontaneously resolved (in 2 cases the events occurred on intramuscular olanzapine, and in 1 case, on oral olanzapine). The risk for this sequence of events may be greater in nonpsychiatric patients compared to psychiatric patients who are possibly more adapted to certain effects of psychotropic drugs. Patients should remain recumbent if drowsy or dizzy after injection with intramuscular olanzapine for injection until examination has indicated they are not experiencing postural hypotension, bradycardia, and/or hypoventilation. Olanzapine should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemia, heart failure, or conduction abnormalities), cerebrovascular disease, and conditions which would predispose patients to hypotension (dehydration, hypovolemia, and treatment with antihypertensive medications) where the occurrence of syncope, or hypotension and/or bradycardia might put them at increased medical risk. Caution is necessary in patients receiving treatment with other drugs having effects that can induce hypotension, bradycardia, respiratory or CNS depression (*see* Drug Interactions). Concomitant administration of intramuscular olanzapine and parenteral benzodiazepine has not been studied and is not recommended. If such combination treatment is considered, careful evaluation of clinical status for excessive sedation and cardiorespiratory depression is recommended.

Seizures—During premarketing testing, seizures occurred in 0.9% (22/2500) of olanzapine-treated patients, regardless of causality. Use cautiously in patients with a history of seizures or with conditions that potentially lower the seizure threshold.

Hyperprolactinemia—Like other drugs that antagonize dopamine D2 receptors, olanzapine elevates prolactin levels; a modest elevation persists during chronic administration. Tissue culture experiments indicate that approximately one third of human breast cancers are prolactin dependent in vitro. However, neither clinical nor epidemiologic studies have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is inconclusive.

Transaminase Elevations—In placebo-controlled studies, clinically significant ALT (SGPT) elevations (≥3 times the upper limit of normal) were observed in 2% (6/243) of patients exposed to olanzapine compared to no (0/115) placebo patients. None of these patients experienced jaundice. Among about 2400 patients with baseline SGPT ≤90 IU/L, 2% (50/2381) had asymptomatic SGPT elevations to >200 IU/L. Most were transient changes that tended to normalize while olanzapine treatment was continued. Among 2500 patients in oral olanzapine trials, about 1% (23/2500) discontinued treatment due to transaminase increases. Exercise caution in patients who have signs and symptoms of hepatic impairment; preexisting conditions associated with limited hepatic functional reserve; or concomitant treatment with potentially hepatotoxic drugs (*see* Laboratory Tests, below).

Potential for Cognitive and Motor Impairment—Somnolence was a commonly reported, dose-related adverse event in premarketing trials (olanzapine 26% vs placebo 15%). Somnolence led to discontinuation in 0.4% (9/2500) of patients in the oral premarketing database.

Body Temperature Regulation—Use appropriate care when prescribing olanzapine for patients who will be experiencing conditions that may contribute to an elevation in core body temperature.

Dysphagia—Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in patients with advanced Alzheimer's disease. Olanzapine and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia.

Suicide—The possibility of a suicide attempt is inherent in schizophrenia and in bipolar disorder, and close supervision of high-risk patients should accompany drug therapy. Prescriptions for olanzapine should be written for the smallest quantity of tablets consistent with good patient management.

Use in Patients with Concomitant Illnesses—Olanzapine should be used with caution in patients with clinically significant prostatic hypertrophy, narrow angle glaucoma, or a history of paralytic ileus.

In 5 placebo-controlled studies in elderly patients with dementia-related psychosis (n=1184), these treatment-emergent adverse events were reported with olanzapine at an incidence of ≥2% and significantly greater than with placebo: falls, somnolence, peripheral edema, abnormal gait, urinary incontinence, lethargy, increased weight, asthenia, pyrexia, pneumonia, dry mouth, visual hallucinations. Discontinuation due to adverse events was significantly greater with olanzapine than placebo (13% vs 7%). Elderly patients with dementia-related psychosis treated with olanzapine are at an increased risk of death compared to placebo. Olanzapine is not approved for treatment of patients with dementia-related psychosis. If the prescriber elects to treat this patient population, vigilance should be exercised (*see* BOX WARNING *and* WARNINGS).

Because of the risk of orthostatic hypotension with olanzapine, use caution in cardiac patients (*see* Hemodynamic Effects).

Information for Patients—See full prescribing information for information to discuss with patients taking olanzapine.

Laboratory Tests—Periodic assessment of transaminases is recommended in patients with significant hepatic disease.

Drug Interactions—Use caution when olanzapine is taken in combination with other centrally acting drugs and alcohol. Olanzapine may enhance the effects of certain antihypertensive agents. Olanzapine may antagonize the effects of levodopa and dopamine agonists. Agents that induce CYP1A2 or glucuronyl transferase enzymes (e.g., omeprazole, rifampin) may cause an increase in olanzapine clearance. Inhibitors of CYP1A2 could potentially inhibit olanzapine clearance. Although olanzapine is metabolized by multiple enzyme systems, induction or inhibition of a single enzyme may appreciably alter olanzapine clearance. A dosage adjustment may need to be considered with specific drugs.

Activated charcoal (1 g) reduced the C_{max} and AUC of oral olanzapine by about 60%. Single doses of cimetidine (800 mg) or aluminum- and magnesium-containing antacids did not affect the oral bioavailability of olanzapine. Carbamazepine (200 mg bid) causes an approximately 50% increase in the clearance of olanzapine. Higher daily doses of carbamazepine may cause an even greater increase in olanzapine clearance. Neither ethanol (45 mg/70 kg single dose) nor warfarin (20 mg single dose) had an effect on olanzapine pharmacokinetics. Fluoxetine at 60 mg (single or multiple doses) causes a small increase in the C_{max} of olanzapine and a small decrease in olanzapine clearance; however, the impact of this factor is small in comparison to the overall variability between individuals, and dose modification is not routinely recommended. Fluvoxamine decreases the clearance of olanzapine; lower doses of olanzapine should be considered in patients receiving fluvoxamine concomitantly. In vitro data suggest that a clinically significant pharmacokinetic interaction between olanzapine and valproate is unlikely.

Olanzapine is unlikely to cause clinically important drug interactions mediated by the enzymes CYP1A2, CYP2C9, CYP2C19, CYP2D6, and CYP3A. Single doses of olanzapine did not affect the pharmacokinetics of imipramine/desipramine or warfarin. Multiple doses of olanzapine did not influence the kinetics of diazepam/N-desmethyldiazepam, lithium, ethanol, or biperiden. However, coadministration of either diazepam or ethanol potentiated the orthostatic hypotension observed with olanzapine. Multiple doses of olanzapine did not affect the pharmacokinetics of theophylline or its metabolites. Co-administration of intramuscular lorazepam and intramuscular olanzapine for injection added to the somnolence observed with either drug alone (*see* Hemodynamic Effects).

Carcinogenesis, Mutagenesis, Impairment of Fertility—The incidence of liver hemangiomas and hemangiosarcomas in female mice was significantly increased in one carcinogenicity study at 2 times the maximum human daily oral dose (MHDOD) but not in another study at 2-5 times the MHDOD (mg/m^2 basis). In this study there was a high incidence of early mortalities in males in the 30/20 mg/kg/d group. The incidence of mammary gland adenomas and adenocarcinomas was significantly increased in female mice and rats given olanzapine at 0.5 and 2 times the MHDOD respectively (mg/m^2 basis). In other studies, serum prolactin measurements of olanzapine showed elevations up to 4-fold in rats at the same doses used in the carcinogenicity studies. The relevance for human risk of the finding of prolactin mediated endocrine tumors in rodents is unknown. No evidence of mutagenic potential for olanzapine has been found.

In rats, fertility (females) and mating performance (males and females) were affected at doses 1.5-11 times the MHDOD (mg/m^2 basis). Diestrous was prolonged and estrous delayed at 0.6 times the MHDOD (mg/m^2 basis); therefore, olanzapine may produce a delay in ovulation.

Pregnancy Category C—There are no adequate and well-controlled studies in pregnant women. Olanzapine should be used in pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor and Delivery, Nursing Mothers—Parturition in rats was not affected by olanzapine; its effect on labor and delivery in humans is unknown. In a study in lactating, healthy women, olanzapine was excreted in breast milk. Mean infant dose at steady state was estimated to be 1.8% of the maternal dose. It is recommended that women receiving olanzapine should not breast-feed.

Use in Pediatric and Geriatric Patients—Safety and effectiveness in pediatric patients have not been established. In premarketing clinical trials in patients with schizophrenia, there was no indication of any different tolerability of olanzapine in the elderly compared to younger patients. Studies in elderly patients with dementia-related psychosis have suggested there may be a different tolerability profile in these patients. Elderly patients with dementia-related psychosis treated with olanzapine are at an increased risk of death compared to placebo. Olanzapine is not approved for treatment of patients with dementia-related psychosis. If the prescriber elects to treat these patients, vigilance should be exercised. Consider a lower starting dose for any geriatric patient in the presence of factors that might decrease pharmacokinetic clearance or increase the pharmacodynamic response to olanzapine (*see* BOX WARNING, WARNINGS, *and* PRECAUTIONS).

ADVERSE REACTIONS: The following findings are based on a clinical trial database consisting of 8661 patients with approximately 4165 patient-years of exposure to oral olanzapine and 722 patients with exposure to intramuscular olanzapine for injection, including patients with schizophrenia, bipolar mania, or Alzheimer's disease (oral olanzapine trials) and patients with agitation associated with schizophrenia, bipolar I disorder (manic or mixed episodes), or dementia (intramuscular olanzapine for injection trials). See the full prescribing information for details on these trials. Certain portions of the discussion below relating to dose-dependent adverse events, vital sign changes, weight gain, laboratory changes, and ECG changes are derived from studies in patients with schizophrenia and have not been duplicated for bipolar mania or agitation; however, this information is also generally applicable to bipolar mania and agitation.

Associated with Discontinuation—Overall there was no difference in discontinuations due to adverse events in placebo-controlled oral olanzapine trials (olanzapine vs placebo: schizophrenia, 5% vs 6%; bipolar mania monotherapy, 2% vs 2%; bipolar mania cotherapy, 11% [olanzapine plus lithium or valproate] vs 2% [lithium or valproate alone]); or in placebo-controlled intramuscular olanzapine for injection trials (olanzapine for injection, 0.4%; placebo 0%). Discontinuations in oral schizophrenia trials due to increases in SGPT were considered to be drug related (olanzapine 2% vs placebo 0%; *see* PRECAUTIONS).

Commonly Observed Adverse Events—In 6-week, placebo-controlled, premarketing schizophrenia trials, the most common treatment-emergent adverse events associated with oral olanzapine (incidence ≥5% and olanzapine incidence at least twice that for placebo) were: postural hypotension, constipation, weight gain, dizziness, personality disorder (COSTART term for nonaggressive objectionable behavior), and akathisia. In 3- and 4-week placebo-controlled bipolar mania monotherapy trials, the most common treatment-emergent adverse events associated with oral olanzapine were: asthenia, dry mouth, constipation, dyspepsia, increased appetite, somnolence, dizziness, and tremor. In short-term bipolar mania combination therapy trials, the most common treatment-emergent adverse events observed with olanzapine plus lithium or valproate were dry mouth, weight gain, increased appetite, dizziness, back pain, constipation, speech disorder, increased salivation, amnesia, and paresthesia. In 24-hour placebo-controlled trials of intramuscular olanzapine for injection for agitation associated with schizophrenia or bipolar mania, somnolence was the one adverse event observed at an incidence of ≥5% and at least twice that for placebo (olanzapine for injection 6%, placebo 3%).

Adverse Events with an Incidence ≥2% in Oral Monotherapy Trials—The following treatment-emergent events were reported at an incidence of ≥2% with oral olanzapine (doses ≥2.5 mg/d), and at a greater incidence with olanzapine than with placebo in short-term placebo-controlled trials (olanzapine N=532, placebo N=294): ***Body as a Whole***—accidental injury, asthenia, fever, back pain, chest pain; ***Cardiovascular***—postural hypotension, tachycardia, hypertension; ***Digestive***—dry mouth, constipation, dyspepsia, vomiting, increased appetite; ***Hemic and Lymphatic***—ecchymosis; ***Metabolic and Nutritional***—weight gain, peripheral edema; ***Musculoskeletal***—extremity pain (other than joint), joint pain; ***Nervous System***—somnolence, insomnia, dizziness, abnormal gait, tremor, akathisia, hypertonia, articulation impairment; ***Respiratory***—rhinitis, cough increased, pharyngitis; ***Special Senses***—amblyopia; ***Urogenital***—urinary incontinence, urinary tract infection.

Adverse Events with an Incidence ≥2% in Oral Combination Therapy Trials—The following treatment-emergent events were reported at an incidence of ≥2% with oral olanzapine (doses ≥5 mg/d) plus lithium or valproate (N=229), and at a greater incidence than with placebo plus lithium or valproate (N=115) in short-term placebo-controlled trials: ***Body as a Whole***—asthenia, back pain, accidental injury, chest pain; ***Cardiovascular***—hypertension; ***Digestive***—dry mouth, increased appetite, thirst, constipation, increased salivation; ***Metabolic and Nutritional***—weight gain, peripheral edema, edema; ***Nervous System***—somnolence, tremor, depression, dizziness, speech disorder, amnesia, paresthesia, apathy, confusion, euphoria, incoordination; ***Respiratory***—pharyngitis, dyspnea; ***Skin and Appendages***—sweating, acne, dry skin; ***Special Senses***—amblyopia, abnormal vision; ***Urogenital***—dysmenorrhea, vaginitis.

Adverse Events with an Incidence ≥1% in Intramuscular Trials—The following treatment-emergent adverse events were reported at an incidence of ≥1% with intramuscular olanzapine for injection (2.5 -10 mg/injection) and at incidence greater than placebo in short-term, placebo-controlled trials in agitated patients with schizophrenia or bipolar mania: ***Body as a Whole***—asthenia; ***Cardiovascular***—hypotension, postural hypotension; ***Nervous System***—somnolence, dizziness, tremor.

Dose Dependency of Adverse Events in Short-Term, Placebo-Controlled Trials—*Extrapyramidal Symptoms*—In an acute-phase controlled clinical trial in schizophrenia, there was no significant difference in ratings scales incidence between any dose of oral olanzapine (5+2.5, 10+2.5, or 15+2.5 mg/d) and placebo for parkinsonism (Simpson-Angus Scale total score >3) or akathisia (Barnes Akathisia global score ≥2). In the same trial, only akathisia events (spontaneously reported COSTART terms akathisia and hyperkinesia) showed a statistically significantly greater adverse events incidence with the 2 higher doses of olanzapine than with placebo. The incidence of patients reporting any extrapyramidal event was significantly greater than placebo only with the highest dose of oral olanzapine (15+2.5 mg/d). In controlled clinical trials of intramuscular olanzapine for injection, there were no statistically significant differences from placebo in occurrence of any treatment-emergent extrapyramidal symptoms, assessed by either rating scales incidence or spontaneously reported adverse events.

Other Adverse Events—Dose-relatedness of adverse events was assessed using data from a clinical trial involving 3 fixed oral dosage ranges compared with placebo. The following treatment-emergent events showed a statistically significant trend: asthenia, dry mouth, nausea, somnolence, tremor.

Vital Sign Changes—Oral olanzapine was associated with orthostatic hypotension and tachycardia in clinical trials. Intramuscular olanzapine for injection was associated with bradycardia, hypotension, and tachycardia in clinical trials (*see* PRECAUTIONS).

Weight Gain—In placebo-controlled 6-week schizophrenia studies, weight gain was reported in 5.6% of oral olanzapine patients (average 2.8-kg gain) compared to 0.8% of placebo patients (average 0.4-kg loss); 29% of olanzapine patients gained >7% of their baseline weight, compared to 3% of placebo patients. During continuation therapy (238 median days of exposure), 56% of patients met the criterion for having gained >7% of their baseline weight. Average gain during long-term therapy was 5.4 kg.

Laboratory Changes—Olanzapine is associated with asymptomatic increases in SGPT, SGOT, and GGT and with increases in serum prolactin and CPK (*see* PRECAUTIONS). Asymptomatic elevation of eosinophils was reported in 0.3% of olanzapine patients in premarketing trials. There was no indication of a risk of clinically significant neutropenia associated with olanzapine in the premarketing database.

In clinical trials among olanzapine-treated patients with baseline random triglyceride levels of <150 mg/dL (N=659), 0.5% experienced triglyceride levels of ≥500 mg/dL anytime during the trials. In these same trials, olanzapine-treated patients (N=1185) had a mean triglyceride increase of 20 mg/dL from a mean baseline of 175 mg/dL. In placebo-controlled trials, olanzapine-treated patients with baseline random cholesterol levels of <200 mg/dL (N=1034) experienced cholesterol levels of ≥240 mg/dL anytime during the trials more often than placebo-treated patients (N=602; 3.6% vs 2.2% respectively). In these same trials, olanzapine-treated patients (N=2528) had a mean increase of 0.4 mg/dL in cholesterol from a mean baseline of 203 mg/dL, which was significantly different compared to placebo-treated patients (N=1415) with a mean decrease of 4.6 mg/dL from a mean baseline of 203 mg/dL.

ECG Changes—Analyses of pooled placebo-controlled trials revealed no statistically significant olanzapine/placebo differences in incidence of potentially important changes in ECG parameters, including QT, QTc, and PR intervals. Olanzapine was associated with a mean increase in heart rate of 2.4 BPM compared to no change among placebo patients.

Other Adverse Events Observed During Clinical Trials—The following treatment-emergent events were reported with oral olanzapine at multiple doses ≥1 mg/d in clinical trials (8661patients, 4165 patient-years of exposure). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. *Frequent* events occurred in ≥1/100 patients; *infrequent* events occurred in 1/100 to 1/1000 patients; *rare* events occurred in <1/1000 patients. ***Body as a Whole***—*Frequent:* dental pain, flu syndrome; *Infrequent:* abdomen enlarged, chills, face edema, intentional injury, malaise, moniliasis, neck pain, neck rigidity, pelvic pain, photosensitivity reaction, suicide attempt; *Rare:* chills and fever, hangover effect, sudden death. ***Cardiovascular***—*Frequent:* hypotension; *Infrequent:* atrial fibrillation, bradycardia, cerebrovascular accident, congestive heart failure, heart arrest, hemorrhage, migraine, pallor, palpitation, vasodilatation, ventricular extrasystoles; *Rare:* arteritis, heart failure, pulmonary embolus. ***Digestive***—*Frequent:* flatulence, increased salivation, thirst; *Infrequent:* dysphagia, esophagitis, fecal impaction, fecal incontinence, gastritis, gastroenteritis, gingivitis, hepatitis, melena, mouth ulceration, nausea and vomiting, oral moniliasis, periodontal abscess, rectal hemorrhage, stomatitis, tongue edema, tooth caries; *Rare:* aphthous stomatitis, enteritis, eructation, esophageal ulcer, glossitis, ileus, intestinal obstruction, liver fatty deposit, tongue discoloration. ***Endocrine***—*Infrequent:* diabetes mellitus; *Rare:* diabetic acidosis, goiter. ***Hemic and Lymphatic***—*Infrequent:* anemia, cyanosis, leukocytosis, leukopenia, lymphadenopathy, thrombocytopenia; *Rare:* normocytic anemia, thrombocythemia. ***Metabolic and Nutritional***—*Infrequent:* acidosis, alkaline phosphatase increased, bilirubinemia, dehydration, hypercholesteremia, hyperglycemia, hyperlipemia, hyperuricemia, hypoglycemia, hypokalemia, hyponatremia, lower extremity edema, upper extremity edema; *Rare:* gout, hyperkalemia, hypernatremia, hypoproteinemia, ketosis, water intoxication. ***Musculoskeletal***—*Frequent:* joint stiffness, twitching; *Infrequent:* arthritis, arthrosis, leg cramps, myasthenia; *Rare:* bone pain, bursitis, myopathy, osteoporosis, rheumatoid arthritis. ***Nervous System***—*Frequent:* abnormal dreams, amnesia, delusions, emotional lability, euphoria, manic reaction, paresthesia, schizophrenic reaction; *Infrequent:* akinesia, alcohol misuse, antisocial reaction, ataxia, CNS stimulation, cogwheel rigidity, delirium, dementia, depersonalization, dysarthria, facial paralysis, hypesthesia, hypokinesia, hypotonia, incoordination, libido decreased, libido increased, obsessive compulsive symptoms, phobias, somatization, stimulant misuse, stupor, stuttering, tardive dyskinesia, vertigo, withdrawal syndrome; *Rare:* circumoral paresthesia, coma, encephalopathy, neuralgia, neuropathy, nystagmus, paralysis, subarachnoid hemorrhage, tobacco misuse. ***Respiratory***—*Frequent:* dyspnea; *Infrequent:* apnea, asthma, epistaxis, hemoptysis, hyperventilation, hypoxia, laryngitis, voice alteration; *Rare:* atelectasis, hiccup, hypoventilation, lung edema, stridor. ***Skin and Appendages***—*Frequent:* sweating; *Infrequent:* alopecia, contact dermatitis, dry skin, eczema, maculopapular rash, pruritus, seborrhea, skin discoloration, skin ulcer, urticaria, vesiculobullous rash; *Rare:* hirsutism, pustular rash. ***Special Senses***—*Frequent:* conjunctivitis; *Infrequent:* abnormality of accommodation, blepharitis, cataract, deafness, diplopia, dry eyes, ear pain, eye hemorrhage, eye inflammation, eye pain, ocular muscle abnormality, taste perversion, tinnitus; *Rare:* corneal lesion, glaucoma, keratoconjunctivitis, macular hypopigmentation, miosis, mydriasis, pigment deposits lens. ***Urogenital***—*Frequent:* vaginitis*; *Infrequent:* abnormal ejaculation,* amenorrhea,* breast pain, cystitis, decreased menstruation,* dysuria, female lactation,* glycosuria, gynecomastia, hematuria, impotence,* increased menstruation,* menorrhagia,* metrorrhagia,* polyuria, premenstrual syndrome,* pyuria, urinary frequency, urinary retention, urinary urgency, urination impaired, uterine fibroids enlarged,* vaginal hemorrhage*; *Rare:* albuminuria, breast enlargement, mastitis, oliguria. (*Adjusted for gender.)

The following treatment-emergent events were reported with intramuscular olanzapine for injection at one or more doses ≥2.5 mg/injection in clinical trials (722 patients). This list may not include events previously listed elsewhere in labeling, those events for which a drug cause was remote, those terms which were so general as to be uninformative, and those events reported only once or twice which did not have a substantial probability of being acutely life-threatening. ***Body as a Whole***—*Frequent:* injection site pain; *Infrequent:* abdominal pain, fever. ***Cardiovascular***—*Infrequent:* AV block, heart block, syncope. ***Digestive***—*Infrequent:* diarrhea, nausea. ***Hemic and Lymphatic***—*Infrequent:* anemia. ***Metabolic and Nutritional***—*Infrequent:* creatine phosphokinase increased, dehydration, hyperkalemia. ***Musculoskeletal***—*Infrequent:* twitching. ***Nervous System***—*Infrequent:* abnormal gait, akathisia, articulation impairment, confusion, emotional lability. ***Skin and Appendages***—*Infrequent:* sweating.

Postintroduction Reports—Reported since market introduction and temporally (not necessarily causally) related to olanzapine therapy: allergic reaction (eg, anaphylactoid reaction, angioedema, pruritus or urticaria), diabetic coma, pancreatitis, priapism, rhabdomyolysis, and venous thromboembolic events (including pulmonary embolism and deep venous thrombosis). Random cholesterol levels of ≥240 mg/dL and random triglyceride levels of ≥1000 mg/dL have been rarely reported.

DRUG ABUSE AND DEPENDENCE: Olanzapine is not a controlled substance.

Literature revised September 30, 2005

PV 5194 AMP

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7 a.m.-8:30 a.m.
Industry-Supported Breakfast Symposia
IS26. Clinical Implications of Choices of Atypical Antipsychotics: Realities and Myths (Part 2) *Supported by Bristol-Myers Squibb Co.*
A. Bridging Pharmacology and Clinical Effectiveness in Schizophrenia *Anissa Abi-Dargham, M.D.*
B. Advances in Pharmacotherapy for Maintenance Treatment in Bipolar Disorder *Terence A. Ketter, M.D.*

IS27. Evidence, Outcomes, and Advocacy: Shaping the Management of GAD (Part 2) *Supported by Cephalon Inc.*
A. The Cognitive Expression of GAD *David J. Nutt, M.D.*
B. Gender Differences in GAD From Menarche to Menopause *Marlene P. Freeman, M.D.*
C. The Evidence Supporting Targeted Pharmacotherapy in GAD *David V. Sheehan, M.D.*

IS28. Attaining and Sustaining Remission in Treatment of Depression With Comorbid or Residual Anxiety (Part 2) *Supported by Wyeth Pharmaceuticals*
A. New Strategies to Address Anxiety and Resistant Somatic Symptoms *Mark H. Rapaport, M.D.*
B. How to Monitor Progress of Treatment of Depression With Anxiety *Madhukar H. Trivedi, M.D.*

7:30 a.m.-6 p.m.
Registration/Course Enrollment Open

8 a.m.-Noon
CME Courses 58-64

9 a.m.-10:30 a.m.
Clinical Case Conferences
3. Rocking the Cradle: A Case of Postpartum Infanticide *Nicole F. Wolfe, M.D., Diana Dell, M.D., Alyson Kuroski-Mazzei, D.O., Donna M. Norris, M.D.* **(for APA members only)**
Continuous Clinical Case Conference
1. *R. Rao Gogineni, M.D., Sheila Judge, M.D., Richard P. Kluft, M.D., Robert Michels, M.D., on* 20 Therapies Later: Addressing Tranference Resistance **(for APA members only)**

Debate 2. Medications in Pregnancy and Lactation: What Have We Learned? *Moderator: Linda L.M. Worley, M.D.*

Discussion Groups
10. *Eric Hollander, M.D., on* New Developments in Impulse-Control Disorders and Autism
11. *Vivien Burt, M.D., on* TBD **(Meet the Authors)**
12. *Robert Cabaj, M.D., on* Gay Men and Crystal Meth Abuse
13. *Carol Bernstein, M.D., on* TBD

Lectures
L11. Personality Disorders: Psychiatry's Stepchildren Come of Age *Joel Paris, M.D. Distinguished Psychiatrist Lecture Series*
L12. Prevention, Early Intervention, and Elimination *Loretta E Duvall, APA's Patient Advocacy Award Lecture*
L13. What Have We Learned About Alcoholism From Animal Models? *Tiang Kai Li, M.D., Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

Master Educator Clinical Consultations
7. *Ronald O Rieder, M.D., on* Building a Research Career in Psychiatry **(for APA members only)**
8. *Michael Myers, M.D., on* Treating Physicians and Their Families: Clinical Dilemmas **(for APA members only)**
9. *Zebulon Taintor, M.D., on* TBD **(for APA members only)**

Component Workshops
CW20. The End of Hospitalization? Trends in Intensive Mental Health Services for Children and Adolescents *APA Council on Children, Adolescents, and Their Families; Co-Chairpersons: Brady G. Case, M.D., Harold Alan Pincus, M.D.*
CW21. Bridge Suicide: The Prince Edward Viaduct in Toronto and the Golden Gate Bridge in San Francisco *APA Northern California Psychiatric Society; Chairperson: Mel Blaustein, M.D.*
CW22. You Can Be Leaders Too: A Workshop for IMGs and Minorities *APA Committee on International Medical Graduates; Chairperson: Josie L. Olympia, M.D.*
CW23. Managed Pharmacy and Pay for Performance: The New Managed Care *APA Committee on Managed Care; Chairperson: Paul H. Wick, M.D.*
CW24. Doing It in Public: Opportunities in Public Sector Psychiatry *APA Council on Social Issues and Public Psychiatry; Co-Chairpersons: Cassandra F. Newkirk, M.D., Matthew O. Hurford, M.D.*
CW25. It Takes a Village: Assessing Behavioral and Psychiatric Disorders in Mentally Retarded Individuals *APA Committee on Developmental Disabilities; Chairperson: Roxanne Dryden-Edwards, M.D.*
CW26. Media Outreach to Latinos: Enhancing Access and Reducing Stigma *APA Committee of Hispanic Psychiatrists; Co-Chairpersons: Andres J. Pumariega, M.D., Ana E. Campo, M.D.*
CW27. Buprenorphine: Clinical Issues and Managing More Complicated Patients *APA Corresponding Committee on Training and Education in Addiction Psychiatry; Chairperson: John A. Renner Jr., M.D.*
CW28. 10 Ways to Stay Out of Trouble: Ethics and Etiquette *APA Ethics Committee and APA Ethics Appeal Board; Chairperson: Spencer Eth, M.D.*

Issue Workshops
IW29. Pharmaceutical Bias in Presentations: Dos and Don'ts for Educators *Association for Academic Psychiatry; Co-Chairpersons: Donald M. Hilty, M.D., Kelli J. R. Harding, M.D.*
IW30. When Psychiatrists Get Cancer *Chairperson: Michelle B. Riba, M.D., Leah J. Dickstein, M.D.*
IW31. The Creation and Function of a Mental Health Court *Co-Chairpersons: Lawrence K. Richards, M.D., Roger Peele, M.D.*
IW32. Metabolic Screening of Patients on Antipsychotic Medications: Development of a Quality Improvement Program in an Urban Training Clinic; *Co-Chairpersons: Diane B. Gottlieb, M.D., Karen Melendez, M.D.*
IW33. The Difficult-to-Treat Bulimia Nervosa *Chairperson: Jennifer L. McLain, M.D.*
IW34. Initiating Couples Therapy Today *Chairperson: Ian E. Alger, M.D.*
IW35. Legal Issues in Consultation-Liaison Psychiatry *Chairperson: Renee M. Sorrentino, M.D.*
IW36. Compulsive Hoarding: Conceptualization and Treatment *Chairperson: Jose A. Yaryura-Tobias, M.D.*
IW37. Cognitive Therapy for Personality Disorders *Chairperson: Judith S. Beck, Ph.D.*
IW38. Evidence-Supported, Risk-Minimizing, and Cost-Conscious Approaches in Psychopharmacology *Chairperson: David N. Osser, M.D.*
IW39. Murder Mysteries, Games, and Psychiatric Education: How and Why to Do a "Who Done It?" *Chairperson: Andrea E. Waddell, M.D.*
IW40. Practical Pharmacotherapy for the Treatment of Alcohol Dependence *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism; Chairperson: Robert M. Swift, M.D.*
IW41. How to Launch a Successful Private Practice: Part 1 *Co-Chairpersons: William E. Callahan Jr., M.D., Keith W. Young, M.D.*
IW42. Grassroots Advocacy for Patients and for the Psychiatric Profession: How Medical Students, Residents, and Early Career Psychiatrists Can Affect the Legislative, Regulatory, and Political Process *Co-Chairpersons: Jose P. Vito, M.D., Tony B. Shivers*

9 a.m.-11 a.m.
Research Advances in Medicine
Aging, Longevity, and Neurological Disorders *Chairperson: Anand Pandya, M.D.*

9 a.m.-Noon
Media Workshop
MW3. "*Crash*": A Portrait of Multicultural America at the Flashpoint *APA Council on Minority Mental Health and Health Disparities; Co-Chairpersons: Francis G. Lu, M.D., Heather M. Hall, M.D.*

9 a.m.-12:30 p.m.
Advances in Personality Disorders
John M. Oldham, M.D.

Continuous Clinical Case Conference
1. *R. Rao Gogineni, M.D., Sheila Judge, M.D., Richard P. Kluft, M.D., Robert Michels, M.D., on* 20 Therapies Later: Addressing Tranference Resistance **(for APA members only)**

9 a.m.-4 p.m.
CME Courses 65-70

10 a.m.-6 p.m.
Exhibits Open
APA Member Center Open
Publishers' Bookfair Open

11 a.m.-12:30 p.m.
Discussion Groups
14. *David McDowell, M.D., on* The Clinical Use of Buprenorphine
15. *Nada Stotland, M.D., on* Emerging Issues in Women's Mental Health Care
16. *Avram Mack, M.D., on* Killer Adolescents: Drugs, School, and the Courts
17. *Mary Jane Massie, M.D., on* Psychotherapy With Women With Breast Cancer
18. TBD **(for residents only.)**

Lectures
L14. History of Mental Health Care Disparities and Corrective Proposals *Milton C. Hollar, M.D., APA's Solomon Carter Fuller Award Lecture*
L15. Priorities, Initiatives, and Women's Health Research *Vivian Pinn, M.D.*
L16. Psychiatric Implications of Displacement: The Emotional Costs of Losing Human Habitat *Mindy J. Fullilove, M.D. Distinguished Psychiatrist Lecture Series*

Master Educator Clinical Consultations
10. *Prakash S. Masand, M.D., on* Atypical Antipsychotics: 2006 and Beyond **(for APA members only)**
11. *John Livesley, M.D., on* Current Issues in the Treatment of Personality Disorder **(for APA members only)**
12. *Robin Hurley, M.D., on* Neuropsychiatric Aspects of Traumatic Brain Injury **(for APA members only)**

Medical Update 2. *Richard P. Brown, M.D., on* ADD Kids Get Smart Naturally: Complementary Treatments for ADD

Research Consultation With 2. *Paul S. Links, M.D., on* Clinical Research Into Suicide

Scientific and Clinical Reports
Session 12. Gender Differences in Child and Adolescent Behaviors
34. Prediction of Suicidality and Violence in Hospitalized Adolescents: Comparisons by Gender *Daniel F. Becker, M.D.*
35. Daily Cigarette Smoking Among Colombian High School Students: Gender Related Factors *Jorge A. Martínez-Mantilla*
36. Subtypes of Aggression: Incidence and Gender Differences in Adolescents *Melissa McMullin, B.A.*

Session 13. Violence, Trauma, and Victimization
37. Terrorism: A Phenomenon at the Interface Between Individual and Group Psychology *David A. Rothstein, M.D.*
38. The Role of the Psychiatrist in Hospital Emergency Planning *Julia B. Frank, M.D.*
39. Psychopathological Effects of Workplace Harassment *Jose L. Gonzalez de Rivera, M.D.*

Session 14. Emotionality, Gender, and Life Satisfaction in Adolescents
40. The Role of Subjective Emotional Reactivity to Affective Pictures in Predicting Emotional-Behavior Disorders Over a One-Year Period in an Unselected Community Sample of Children Between the Ages of 7 and 11 *Carla Sharp, Ph.D.*

continued on page 34

41. Life Satisfaction in Young Urban Adolescents *Maribeth Pender, Ph.D.*
42. Effectiveness of Group Interventions for Parents of Gender-Variant Children *Edgardo J. Menvielle, M.D.*

Session 15. Neurobiology and Psychoimmunology
43. Lymphocyte and Platelet Alteration of the 5HT Transporter in Patients With Psychosis *Donatella Marazziti, M.D.*
44. Potential Role of Interleukin-6 and HPA Axis in Breast Cancer Patients With MDD *Haldun Soygur, M.D.*
45. NMDA Receptors and BPD: A Critical Mediator *Bernadette M. Grosjean, M.D.*

Session 16. Medication Response in Bipolar Disorder
46. Galantamine-CR for Cognitive Dysfunction in Bipolar Disorder: Efficacy and Biological Correlates *Dan V. Iosifescu, M.D.*
47. Rate of Improvement With Quetiapine Across Different Symptoms and Symptom Clusters in Bipolar Disorder *Terence A. Ketter, M.D.*
48. Efficacy of the Antipsychotics in Anxiety Symptoms With or Without Bipolar Disorder *Keming Gao, M.D.*

Session 17. Prescription and Compliance in Bipolar Disorder
49. Prescription Patterns for Latin Americans Treated for MDD in Naturalistic Clinical Practice Settings *Hector J. Duenas, M.D.*
50. Nonadherence in Bipolar Disorder: A Qualitative Study Exploring Perceptual and Practical Barriers to Taking Medication *Jane Clatworthy*
51. Patient Dissatisfaction With Information Received About Medicines Prescribed for Bipolar Disorder *Richard Bowskill*

Session 18. Special Populations and Mood Disorders
52. Juvenile Bipolar Disorder: Toward a Validation of the Episodic-Chronic Distinction *Giulio Perugi, M.D.*
53. Treatment of SAD With a Carbohydrate-Rich Nutrient Mixture *David Mischoulon, M.D.*
54. Impaired Mood and Social Functioning Among Adult Children of Parents With Depression *Christine Timko, Ph.D.*

Session 19. Brain Imaging
55. fMRI of the Brain Reward System: Manipulation of Risk and Reward Value *Juliana Yacubian, Ph.D.*
56. Brain Structure and Outcome in Schizophrenia: The Northern Finland 1966 Birth Cohort *Erika Lauronen, M.D.*
57. Progressive Glutamatergic and Gray Matter Changes in First-Episode Patients With Schizophrenia and High Field Proton MRS *Peter C. Williamson, M.D.*

Session 20. Medical Issues in the Treatment of Schizophrenia
58. Metabolic Syndrome in Thai Patients With Schizophrenia: Prevalence and Incidence *Manit Srisurapanont, M.D.*
59. The Swedish Study of Metabolic Risks in Psychiatry *Urban P. Osby, M.D.*
60. Olanzapine Treatment Does Not Increase 10-Year Cardiovascular Risk: Comparison With Haloperidol in Patients With Schizophrenia *Yoram Barak, M.D.*

Session 21. Neuropsychiatry
61. Psychosocial Treatment of Depression in Parkinson's Disease *Amy Farabaugh, Ph.D.*
62. Frequency of EEG Abnormalities and Results of Antiepileptic Drug Therapy in Unstable Mood Disorders *Drake Duane, M.D.*
63. Juvenile Epilepsy and Bipolar Disorder: Clinical Challenges *Smadar Celestin-Westreich, Ph.D.*

Session 22. International Epidemiology
64. Mental Health in Iranian Medical Students and Doctors *Seyed M. Assadi, M.D.*
65. Three-Year, Follow-Up Study of the Psychosocial Predictors of Delayed and Unresolved Post-Traumatic Stress Symptoms of Geriatric Earthquake Survivors in Yu-Chi, Taiwan *Frank H. Chou, M.D.*
66. Three-Year, Follow-Up Study of the Relationship Between Post-Traumatic Stress Symptoms and Quality of Life Among Geriatric Earthquake Survivors in Yu-Chi, Taiwan *Kuan-Yi Tsai, M.D.*

Component Workshops

CW29. Advances in the Treatment of Intimate Partner Violence *APA Rhode Island Psychiatric Society's Committee on Women; Chairperson: Alison M Heru, M.D.*

CW30. Employment in the Post-Residency Years: Getting What You Want *APA Committee of Residents and Fellows; Chairperson: William C. Wood, M.D.*

CW31. Can We Talk? A Model for Constructive Conversation Between Opponents and Advocates of Same-Sex Relationships *APA Corresponding Committee on Religion, Spirituality, and Psychiatry; Co-Chairpersons: John R. Peteet, M.D., Allan M. Josephson, M.D.*

CW32. From Diagnosis to Treatment of Infants and Young Children *APA Corresponding Committee on Infancy and Early Childhood; Chairperson: Irene Chatoor, M.D.*

CW33. Moving the Psychiatric Agenda in the House of Medicine *APA/AMA Delegation Section Council on Psychiatry; Chairperson: Jack S. McIntyre, M.D.*

CW34. European Psychiatry: Health and Mental Health Policy After the Helsinki Summit *APA Council on Global Psychiatry and the World Psychiatric Association Conflict Management and Conflict Resolution Section; Co-Chairpersons: Eliot Sorel, M.D., Rodrigo A. Muñoz, M.D.*

CW35. From Fantasy to Reality: Recruitment of Minorities in Clinical Research *APA Council on Minority Mental Health and Health Disparities; Co-Chairpersons: Annelle B. Primm, M.D., Sanjay Dube, M.D.*

CW36. Integrating Evidence-Based Psychiatry With Clinical Intelligence *APA Lifers; Co-Chairpersons: Abram M. Hostetter, M.D., Sheila H. Gray, M.D.*

Issue Workshops

IW43. The Psychiatry Resident as Educator: Implementation of a Teaching Curriculum *Co-Chairpersons: Ruth M. Lamdan, M.D., Autumn Ning, M.D.*

IW44. Teaching on the Fly: Practical Tips for Teaching Medical Students One-to-One *Co-Chairpersons: Andrea E. Waddell, M.D., Jodi S. Lofchy, M.D.*

IW45. Infertility: From Patient Care to Advocacy and Public Policy *Chairperson: Roxanne Dryden-Edwards, M.D.*

IW46. An Integrative Approach to Cultural Competence Training for Resident and Staff Psychiatrists *Co-Chairpersons: Kenneth P. Fung, M.D., Ted Lo, M.D.*

IW47. Career Advancement in Academic Psychiatry for Early Career Psychiatrists *Co-Chairpersons: Dimitri D Markov, M.D., Elisabeth J.S. Kunkel, M.D.*

IW48. How to Launch a Successful Private Practice: Part 2 *Chairperson: William E. Callahan Jr., M.D.*

IW49. Does Beauty Equal Happiness? *Co-Chairpersons: Stephanie M. Stewart, M.D., Alicia R. Ruelaz, M.D.*

IW50. Teaching Boundaries to Practicing Clinicians *Chairperson: Werner Tschan, M.D.*

IW51. Multidisciplinary Treatment of Chronic Pain *Co-Chairpersons: Vladimir Bokarius, M.D., Steven H. Richeimer, M.D.*

IW52. Are There Limits to Boundary Limits? *Chairperson: Malkah T. Notman, M.D.*

IW53. Sexual History: The Art and the Science *Co-Chairpersons: Shahrad R. Amiri, M.D., Danni Z. Michaeli, M.D.*

IW54. The Psychiatry Resident as Advocate: Practical Steps From the Clinic to the Capitol *Co-Chairpersons: Joan M. Anzia, M.D., James L. Griffith, M.D.*

Noon-1:30 p.m.

Forums

6. To Understand and Assess the Complex Issues of Addiction to Prescription Medication *National Institute on Drug Abuse; Chairperson: Nora Volkow, M.D.*

7. Hot Topics in Psychiatric Drug Safety *APA Scientific Program Committee and APA Council on Research; Chairperson: P. Murali Doraiswamy, M.D.*

8. Worldwide Interpersonal and Group Terrorism Toward Women *Chairperson: Leah Dickstein, M.D.*

9. Alcohol Related Research by Psychiatry Residents *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism; Chairperson: Mark Willenbring, M.D.*

Noon-2 p.m.

New Research Poster Session 6

1 p.m.-5 p.m.

CME Courses 71-78

2 p.m.-3:30 p.m.

Lectures

L17. Changing the Landscape of American Psychiatry: An African-American Perspective on Feminine Expansive Personality *Altha J. Stewart, M.D., APA's Alexandra Symonds Award Lecture*

L18. Pharmacogenetics of Alcohol: Are We There Yet? *Henry R. Kranzler, M.D., Frontiers of Science Lecture Series; Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

L19. An Evidence-Based Clinician's Guide to the New Pharmacotherapies for Alcoholism *Barbara J. Mason, Ph.D., Frontiers of Science Lecture Series*

2 p.m.-5 p.m.

Presidential Symposium 2. International Advocacy Toward a Psychiatry for the Person *World Psychiatric Association; Chairperson: Steven S. Sharfstein, M.D.*

Symposia

S34. Predictors of Outcome and Treatment Response in Eating Disorders: Results From New Research on Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder
A. Fluoxetine Versus Placebo to Prevent Relapse in Anorexia Nervosa *B. Timothy Walsh, M.D.*
B. Fluoxetine Versus Placebo to Prevent Relapse in Anorexia Nervosa: Predictors of Outcome After One Year of Treatment *Allan S. Kaplan, M.D.*
C. Fluoxetine Versus Placebo to Prevent Relapse in Anorexia Nervosa: Body Composition Predicts Outcome After One Year of Treatment *Laurel Mayer, M.D.*
D. Early Response to Medication Among Women With Bulimia Nervosa *Robyn Sysko, M.S.*
E. Long-Term Outcome of Psychotherapy and Medication for Binge-Eating Disorder *Michael J. Devlin, M.D.*

S35. Impulsivity in Axis I and Axis II: Common Substrates, Different Presentations?
A. Compulsive Shopping: Epidemiology, Comorbidity, and Treatment *Donald W. Black, M.D.*
B. Pathological Gambling: From Neurobioloby to Evidence-Based Treatment *Carlos Blanco-Jerez, M.D.*
C. Borderline Personality Disorder: Affective or Impulse Control Disorder? *S. Charles Schulz, M.D.*
D. Kleptomania: Clinical Presentation, Neuroimaging, and Treatment *Jon E. Grant, M.D.*

S36. Diagnostic Criteria in Alzheimer's Disease and Dementia: Future Challenges
A. Neuroimaging as a Surrogate Marker of Dementia *Gary W. Small, M.D.*
B. Neuropsychological Testing in the Diagnosis of Dementia *Mary Sano, Ph.D.*
C. The Search for Biomarkers as Diagnostic Aides in Alzheimer's Disease *Trey Sunderland, M.D.*

S37. Bullying in the Workplace: Psychiatric and Public Health Perspectives
A. Setting the Stage: Prevalence, Antecedents, and Effects of Workplace Bullying *Loraleigh Keashly, Ph.D.*
B. Bullying at Work: Psychiatric Issues *Renato Gilioli, M.D.*
C. Workplace Bullying, Alcohol Use, Abuse, and Service Utilization *Judith A. Richman, Ph.D.*
D. Workplace Bullying and Employee

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VERGING ON REALITY

2006 APA ANNUAL MEETING

EMERGENT THERAPEUTIC APPROACHES FOR SCHIZOPHRENIA

DATE SATURDAY, MAY 20TH **TIME** 6:00 PM – 9:00 PM

ACTIVITY CHAIRPERSON PETER F. BUCKLEY, MD

THE FAIRMONT ROYAL YORK ■ CANADIAN ROOM ■ TORONTO, CANADA

TARGET AUDIENCE

This educational activity is intended for psychiatrists and other mental health care professionals attending the 2006 Annual Meeting of the American Psychiatric Association.

LEARNING OBJECTIVES

After attending this symposium, participants should be better able to:

- Identify the role of genetic effects on brain physiology and treatment response in schizophrenia
- Recognize insights from neuroimaging on the physiology of pharmacotherapy and the implications for drug development
- Discuss the differential adverse event profiles of and subjective tolerability to atypical antipsychotics with regard to patient-centered treatment outcomes

ACCREDITATION STATEMENT

The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

DESIGNATION STATEMENT

The APA designates this educational activity for a maximum of 3 category 1 credits toward the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those credits that he/she actually spent in the activity.

DISCLAIMER STATEMENT

The opinions or views expressed in this CME activity are those of the presenters and do not necessarily reflect the opinions or recommendations of the APA or the commercial supporters. Attendees should critically appraise the information presented and are encouraged to consult appropriate resources for information surrounding any product or device mentioned.

Attendees must be registered for the APA 2006 Annual Meeting to attend this symposium. Seating is limited and will be based on a first-come, first-served basis. For more information about the meeting, please visit the APA web site at **www.psych.org** or contact APA toll free at **1-888-357-7924** (within the US or Canada) or **1-703-907-7300**.

AGENDA

SATURDAY, MAY 20TH, 2006

5:30 PM – 6:00 PM	DINNER
6:00 PM – 6:05 PM	WELCOME AND INTRODUCTION Peter F. Buckley, MD
6:05 PM – 6:35 PM	FUNCTIONAL GENOMICS AND THERAPEUTIC EFFECTS OF ANTIPSYCHOTICS Anil Malhotra, MD
6:35 PM – 7:05 PM	INSIGHTS FROM NEUROIMAGING TO GUIDE DRUG CHOICE AND DEVELOPMENT Carol A. Tamminga, MD
7:05 PM – 7:35 PM	THE SCIENCE OF SUBJECTIVE TOLERABILITY: "WELLNESS" AS A TREATMENT OUTCOME Meera Narasimhan, MD
7:35 PM – 8:05 PM	RECOVERY AND REMISSION: DEFINITIONS, DILEMMAS, AND THE EMERGENT ROLE OF PEER SUPPORT Peter F. Buckley, MD
8:05 PM – 8:50 PM	PANEL DISCUSSION Moderator: Peter F. Buckley, MD
8:50 PM – 9:00 PM	CLOSING REMARKS Peter F. Buckley, MD

ACTIVITY CHAIRPERSON

PETER F. BUCKLEY, MD
Professor and Chairman
Department of Psychiatry and Health Behavior
Medical College of Georgia
Augusta, Georgia

FACULTY

ANIL MALHOTRA, MD
Associate Professor of Psychiatry
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Graduate School of Biomedical Sciences
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MEERA NARASIMHAN, MD
Clinical Assistant Professor
Neuropsychiatry & Behavioral Science
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Columbia, South Carolina

Sponsored by the American Psychiatric Association

Supported by an educational grant from Bristol-Myers Squibb Company and Otsuka America Pharmaceutical, Inc.

Benefits: Enabling the Traumatized Worker to Seek Help for Psychiatric Illness *David Yamada, J.D.*

E. Syndrome of Morbidity Associated With School Bullying: Implications for Adulthood *Jorge C. Srabstein, M.D.*

S38. Screening, Diagnosis, and Management of Alcohol Use Disorders in Psychiatric Practice *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. Screening, Assessment, and Management Using the NIAAA Clinicians Guide *Mark L. Willenbring, M.D.*

B. Motivational Enhancement Strategies to Address Substance Use Disorders *Douglas M. Ziedonis, M.D.*

C. Integrating Pharmacotherapy for Alcohol Dependence Into General Psychiatric Practice *Hugh Myrick, M.D.*

D. Meeting the Addiction Medicine Needs of Patients in a General Psychiatric Practice *Michael M. Miller, M.D.*

S39. Therapeutic Neuromodulation: Methods and Mechanisms

A. Therapeutic Neuromodulation: The Arrival of a Paradigm Shift *Mark Demitrack, M.D.*

B. Vagus Nerve Stimulation: A Review of the Evidence *Philip G. Janicak, M.D.*

C. Repetitive Transcranial Magnetic Stimulation at 10 Hz in the Treatment of Pharmacoresistant Major Depression: Results From a Controlled Multicenter Clinical Trial *John P. O'Reardon, M.D.*

D. Therapeutic Neuromodulation Mechanisms of Action *Elliott Richelson, M.D.*

S40. APA Research Agenda for *DSM-V* Personality Disorders

A. Alternative Dimensional Models: Toward an Integration *Thomas A. Widiger, Ph.D.*

B. Issues and Challenges in Developing an Etiologically Based Dimensional Classification of Personality Disorder *Kerry L. Jang, Ph.D.*

C. Toward A Developmental View of Personality Pathology *Rebecca L. Shiner, Ph.D.*

D. The Major Dimensions of Personality: Cross-Cultural Evidence Based on the Lexical Approach *Michael C. Ashton, Ph.D.*

E. Clinical Application of a Dimensional Model of Personality Disorder *John Livesley*

S41. Sleep, Fatigue, and Depression in Medically Ill Patients

A. Sleep and Fatigue in Breast Cancer *Sonia Ancoli-Israel, Ph.D.*

B. Sleep, Fatigue, Pain, and Depression in Patients With Diabetes Mellitus *Wayne J. Katon, M.D.*

C. Insomnia, Depression, Quality of Life, and Survival in Patients With End-Stage Renal Disease and Following Renal Transplantation *Marta Novak, M.D.*

D. Sleep Disruption, Fatigue, and Depression in the Medically Ill *Colin M. Shapiro, Ph.D.*

S42. Scaling Up Against HIV/AIDS: A Culturally Sensitive and Comprehensive Approach

A. Understanding the Linkages Between HIV/AIDS and Development *Scholastica Kimaryo*

B. Culture, Indigenous Knowledge, and Information and Communications Technology in the Response to the HIV/AIDS Challenge *Joseph Okpaku, M.D.*

C. Defining and Describing a Modern Epidemic: The Case of HIV/AIDS in Sub-Sahara Africa *Samuel O. Okpaku, M.D.*

D. Challenges to Implement Culturally Adapted HIV/AIDS Programs in Haiti *Vladimir Berthaud*

S43. Suicide Research in Canada

A. Neurobiological Studies of Suicide Completers *Gustavo Turecki, Ph.D.*

B. Prospective Community Study of Suicidality in Young Adults *Joel F. Paris, M.D.*

C. Affective Instability and Suicidality in Borderline Personality Disorder *Paul S. Links, M.D.*

D. Clinical Guidelines for Suicidality *Isaac Sakinofsky, M.D.*

S44. Neurobiological Basis for Co-Occurring Substance Abuse and Other Psychiatric Disorders *National Institute on Drug Abuse*

A. Smoking and Schizophrenia: Does Comorbidity of Substance Abuse and Disease Suggest Self-Medication? *Sherry Leonard, Ph.D.*

B. Insights From Animal Models of Dual Diagnosis: How Common Neurocircuit Abnormalities Underlie Both Mental Illness and Addiction Vulnerability *Robert A. Chambers, M.D.*

C. Nicotine-Induced Sensitization and ADHD *Jean King, Ph.D.*

D. Effects of Nicotine and Other Drugs of Abuse on Cognitive Dysfunction in Individuals With Schizophrenia *Tony P. George, M.D.*

S45. Bipolar Disorder and the U.S. Legal System

A. Bipolar Disorder and the Legal System *Mark A. Frye, M.D.*

B. Clinical and Legal Characteristics of Inmates With Bipolar Disorder *Cameron D. Quanbeck, M.D.*

C. An Epidemiologic Perspective on Forensic History in Bipolar I Disorder *Benjamin I. Goldstein, M.D.*

D. Can Psychiatry Reduce the Criminalization of the Severely Mentally Ill? *Elizabeth Walsh, M.D.*

S46. APA/APAL: Addressing Psychiatric Patients' Needs in Latin America *APA Council on Global Psychiatry*

A. APA/APAL Addressing Psychiatric Patients' Needs in Latin America *Angel Valmaggia, M.D.*

B. Future Perspectives With Respect to APA/APAL *Cesar M. Mejias, M.D.*

C. Structure of Strategic Collaboration Between APA and APAL *Edgard Belfort, M.D.*

D. Improving Mental Health Care in Latin America: The Role of International Cooperation *Jose M. Caldas de Almeida, Ph.D.*

S47. Helping Returning Veterans: Veterans Affairs Community Collaborations

A. The Public Health Approach in Department of Defense/Veteran Affairs Outreach to Service Members/Veterans and Their Families *Harold Kudler, M.D.*

B. A Model for Interagency Collaborative Care of Stress Disorders Related to Military Deployment *Miles McFall, Ph.D.*

C. Collaborative Interventions Addressing Sexual Trauma in Female Veterans Post-Deployment *Marian I. Butterfield, M.D.*

D. The Ohio Cares Initiative *Col. Terry C. Washam, L.I.S.W.*

S48. Substance Use Disorders: Planning a Research Agenda for *DSM-V* *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. Adolescents and Substance-Related Disorders: Research Agenda to Guide Decisions on *DSM-V Thomas J. Crowley, M.D.*

B. Methods for *DSM-V* Research Workgroups to Address Key Diagnostic Issues for Substance Use Disorders *Linda B. Cottler, Ph.D.*

C. Substance Use Disorder Comorbidity and *DSM-V Deborah S. Hasin, Ph.D.*

D. What Can Human Brain Imaging Tell Us About Addiction? *Anna R. Childress, M.D.*

S49. The Use of Atypical Antipsychotics in Elderly Patients With Dementia: What Next?

A. Use of Antipsychotics in Elderly Patients With Dementia: What's Next? *Soo Borson, M.D.*

B. Pharmacological Strategies for the Management of Behavior Disorders in Dementia *Bruce G. Pollock, M.D.*

C. Thinking Outside the Black Box: Risk Management for Using Atypical Antipsychotic Medications With the Elderly *Patricia R. Recupero, M.D.*

S50. Prevention of Common Mental Disorders: Is It Time to Start?

A. Cost-Effectiveness of Preventing Depression in Primary Care Patients: randomized Trial *Filip E Smit M.S.C.*

B. Prevention of New Cases of Mental Disorders: Problems and Solutions *Prof. Pim Cuijpers*

C. Prevention of Late-life Depression: Do We Know Where to Begin? *Robert A. Schoevers, M.D.*

S51. How to Launch a Successful Private Practice: Part 3

A. Personal Factors Leading to a Successful Private Practice *William E. Callahan Jr., M.D.*

B. Office Location and Design for Efficiency and Success *Keith W. Young, M.D.*

C. Streamlining Overhead and Managing Your Business in Private Practice *Keith W. Young, M.D.*

D. Marketing Your Unique Private Practice *William E. Callahan Jr., M.D.*

S52. Choosing the Right Treatment for Substance Abuse

A. Choosing the Right Treatment for Cocaine Dependence *Adam M. Bisaga, M.D.*

B. Treatment of Comorbid Conditions *Frances R. Levin, M.D.*

C. Marijuana and Club Drugs: Cutting-Edge Developments, New and Potential Treatments *David M. McDowell, M.D.*

D. Behavioral Treatments for Substance Dependence and Integrating Behavioral Therapy With Medication *Edward V. Nunes, M.D.*

E. Choosing the Right Treatment for Opioid Dependence *Herbert D. Kleber, M.D.*

S53. Stress-Induced and Fear Circuitry Disorders: Planning the Research Agenda for *DSM-V*

A. The Role of Cognition in Stress-Induced and Fear Circuitry Disorders *Edna B. Foa, Ph.D.*

B. Overlap and Distinctiveness Among Stress-Induced and Fear-Circuitry Disorders *Abby Fyer, M.D.*

C. Neurochemisry/Neuroendocrine Signals and Noise in Anxiety Disorders *Rachel Yehuda, M.D.*

D. Serotonin, the Hippocampus, and Emotional Behavior *Rene Hen, M.D.*

S54. The Methamphetamine Epidemic in the U.S. National Institute on Drug Abuse

A. Neurobiological Effects of Methamphetamine Abuse: Acute and Long Term *Linda Chang, M.D.*

B. Methamphetamine Use, Abuse, Dependence, and Treatment: Survey Findings, 2002-2004 *James D. Colliver, Ph.D.*

C. The Epidemiolgy of Methampetamine Use in NYC: Prevention and Intervention Implications *Perry Halkitis*

S55. Preventing Schizophrenia: Opportunities and Challenges

A. Reducing the Damage of the First Psychosis Onset *Ingrid Melle, M.D.*

B. Treatment of the Schizophrenia Prodrome: Update 2006 *Scott Woods, M.D.*

C. Predicting Schizophrenia: Early Risk Factors *Barbara A. Cornblatt, Ph.D.*

D. Psychological Interventions for Those at Ultra High Risk of Psychosis *Jean Addington, Ph.D.*

E. Prevention Research in Psychosis: Current State of the Art *Thomas H. McGlashan, M.D.*

continued on page 39

For Great Shopping, Follow the Geese

A mobile of a flock of geese flying across the glass ceiling of The Eaton Centre is a Toronto landmark.

BY MARK MORAN

Serious shoppers won't need to be told where to go when they arrive in Toronto for APA's annual meeting in May. Stretching two full city blocks, the Toronto Eaton Centre is a historical landmark and with more than 250 retailers is today one of Canada's best-known retail shopping destinations, attracting approximately 50 million visitors annually.

The Toronto Eaton Centre is a six-story, glass-ceilinged structure named after Timothy Eaton, an Irish immigrant whose four-story flagship department store at the corner of Queen and Yonge streets was built in 1883. In the 1960s, Eaton's department store moved to the corner of Yonge and Dundas, and its competitor, Simpsons, opened at Yonge and Queen. Today, these stores have been replaced by Sears (Eaton's) and the Bay (Simpsons).

According to the Eaton Centre's Web site at <www.torontoeatoncentre.com>, the complex is modeled after Milan's Galleria Vittorio Emanuele. The Eaton Centre's architect, Eb Zeilder, created the retail portion of the complex to feature a four-level shopping center with a glass-domed ceiling running the length of the complex. Hanging from the ceiling is a mobile of a flock of Canadian geese, "Flight Stop," designed by artist Michael Snow.

"The whole complex is becoming the center of the city, as well as the epicenter of shopping in Toronto," said Andrew Weir, a spokesperson for the Toronto Convention and Visitors Association.

Here are some of the shops and stores at Eaton Centre:

- **Hollister Co.,** located on level one, is a southern California lifestyle retailer.
- **Pinstripe Menswear** offers a combination of classic and contemporary clothing styles for men. It is located on the concourse level by the North Food Court.
- **Mango,** on the third level at the south end of the complex, is a Spanish retailer dedicated to the design, manufacture, and marketing of clothing garments and accessories for women.
- **Bebe Sport** is part of a distinctive line of contemporary women's apparel that was founded in 1976. Bebe Sport is located on the second level by the Queen Street entrance.
- **Pink Paw** offers animal lovers a variety of pet accessories for animal lovers, such as colorful leashes, stylish hair accessories, and entertaining beds. They are in a second-level kiosk by Tip Top Tailors.
- **lululemon athletica** is a Yoga-inspired athletic apparel company. Authentic to its West Coast roots, lululemon continues to focus on a healthy, balanced, fun-filled way of life.

The Eaton Centre is bordered by Dundas Street (north), Yonge Street (east), Queen Street (south), and Bay Street (west) and is accessible in several ways. To take the subway, ride the Yonge Line to either Dundas or Queen Station. To take the streetcar, ride the Dundas line to Yonge and Dundas or the Queen line to Yonge and Queen. ■

Photo: Tourism Toronto

The sculpture "Flight Stop" hangs from the ceiling of the Toronto Eaton Centre, a multilevel shopping complex that is one of Toronto's most visited attractions.

Photo: Tourism Toronto

Sessions Offer Window Into *DSM-V* Development Process

The state-of-the-science in several diagnostic areas looking toward *DSM-V* will be illuminated at APA's 2006 annual meeting.

BY JENNIFER SHUPINKA
PAUL SIROVATKA

With anticipated publication of *DSM-V* now only five years away, APA's 2006 annual meeting will feature numerous sessions that will highlight scientific, clinical, and methodological issues being explored to improve diagnosis, according to Darrel Regier, M.D., M.P.H, director of APA's Division of Research and executive director of the American Psychiatric Institute for Research and Education (APIRE).

"Since the publication of *DSM-IV* in 1994, there has been extraordinary progress in research in so many areas—brain circuitry, genetics, family studies, and new data analysis techniques—that could potentially help us to make unprecedented leaps in the way we diagnose our patients," Regier noted.

APIRE has an NIH-funded, five-year research planning conference grant designed to engage work groups representing the global research community in recommending what research needs to be conducted to incorporate these scientific leaps into a diagnostic reality. Titled "The Future of Psychiatric Diagnosis: Refining the Research Agenda," the project comprises 12 research work groups, 10 focused on specific diagnostic topics and two on methodologic issues. At the annual meeting, four of these work groups will review their recommendations and describe research now under way to implement them.

At noon on Monday, May 22, Regier will chair the forum "Research Planning for the *DSM-V*," which will provide an overview of the progress to date on this dynamic project.

"The research planning work groups, which consist of expert scientists and clinicians throughout the world from various disciplines, were challenged to focus their collective knowledge on three questions: What are the strengths and weaknesses of the current *DSM* criteria? What research findings currently exist that might justify changes in criteria? And what research needs to be done that could be tested within the next couple of years to make the classification more valid and useful?," explained William Narrow, M.D., M.P.H., associate director for diagnosis and classification in the Division of Research and a co-principal investigator with Regier for the conference grant.

Beyond stimulating the field to conduct needed research, the recommendations generated through the conferences will serve as resources for future *DSM-V* work groups and, at the discretion of the WHO leadership, for the pending *ICD-11* revision.

In addition to the forum, four symposia will review in greater detail evidence arising from conferences on personality disorders, substance use disorders, stress-induced and fear circuitry disorders, and dementia. All of these symposia will take place on Tuesday, May 23, at 2 p.m.

A principal focus of the work group on personality disorders has been to examine the scientific rationale and prospects for integrating alternative dimensional models into currently used categorical approaches to the diagnosis of personality disorders. The symposium will be chaired by John Livesley, Ph.D., and co-chaired by Thomas Widiger, Ph.D., who also co-chaired the research planning conference on personality disorders.

"Substance Use Disorders: Planning a Research Agenda for *DSM-V*" will highlight research opportunities that could facilitate evidence for changes in substance use disorder definitions and criteria: Should dependence criteria be tailored to specific substances? How might a research focus on withdrawal help validate orthogonal concepts of dependence and abuse? Presentations will review these and other research priorities generated from this research planning group's efforts. Marc Schuckit, M.D., and Bridget Grant, Ph.D., will co-chair the symposium.

Dennis Charney, M.D., dean for research at Mt. Sinai School of Medicine, will lead the symposium "Stress-Induced and Fear Circuitry Disorders." The research planning work group on this topic questioned whether future research on selected current anxiety disorder classifications could be improved or changed by building from brain-based phenotypes. The presentation will review highlights of state-of the-science findings, including neural mechanisms of fear and anxiety, the role of cognitions,

please see ***DSM*** *on page 62*

Jennifer Shupinka is the *DSM* program manager in APA's Division of Research, and Paul Sirovatka is director of policy analysis in the Division of Research.

DSM-V Research Planning Sessions

Monday, May 22

Noon-1:30 p.m.
Research Planning for the *DSM-V*
Chair: Darrel Regier, M.D.
Presenters: Dennis Charney, M.D., Wilson Compton, M.D., Norman Sartorius, M.D., Trey Sunderland, M.D., Carol Tamminga, M.D.

Tuesday, May 23

2 p.m.-5 p.m
Diagnostic Criteria in Alzheimer's Disease and Dementia: Research Challenges and Implications for *DSM-V*
Chair: Trey Sunderland, M.D.

Substance Use Disorders: Planning a Research Agenda for *DSM-V*
Co-chairs: Marc Schuckit, M.D., Bridget Grant, Ph.D.

Stress-Induced and Fear Circuitry Disorders: Planning the Research Agenda for *DSM-V*
Chair: Dennis Charney, M.D.

APA Research Agenda for *DSM-V:* Personality Disorders
Co-chairs: John Livesley, Ph.D., Thomas Widiger, M.D.

CLINICAL IMPLICATIONS OF CHOICE OF ATYPICAL ANTIPSYCHOTIC

2006 APA ANNUAL MEETING
REALITIES AND MYTHS

DATE MONDAY, MAY 22ND — **TIME** 7:00 AM — 8:30 AM
TUESDAY, MAY 23RD — 7:00 AM — 8:30 AM

ACTIVITY CHAIRPERSON ROBERT E. HALES, MD, MBA
CO-CHAIR STUART C. YUDOFSKY, MD

THE FAIRMONT ROYAL YORK ■ CANADIAN ROOM ■ TORONTO, CANADA

TARGET AUDIENCE
This educational activity is intended for psychiatrists and other mental health care professionals attending the 2006 Annual Meeting of the American Psychiatric Association.

LEARNING OBJECTIVES
After attending this symposium, participants should be better able to:

- Discuss the differential pharmacology of atypical antipsychotics and the clinical implications in patients with psychotic disorders
- Differentiate between atypical antipsychotics and mood stabilizers with respect to efficacy, safety, and tolerability
- Consider the impact of sedation on functionality and cognition in patients with psychotic disorders

ACCREDITATION STATEMENT
The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

DESIGNATION STATEMENT
The APA designates this educational activity for a maximum of 3 category 1 credits toward the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those credits that he/she actually spent in the activity.

DISCLAIMER STATEMENT
The opinions or views expressed in this CME activity are those of the presenters and do not necessarily reflect the opinions or recommendations of the APA or the commercial supporters. Attendees should critically appraise the information presented and are encouraged to consult appropriate resources for information surrounding any product or device mentioned.

Attendees must be registered for the APA 2006 Annual Meeting to attend this symposium. Seating is limited and will be based on a first-come, first-served basis. For more information about the meeting, please visit the APA web site at **www.psych.org** or contact APA toll free at **1-888-357-7924** (within the US or Canada) or **1-703-907-7300**

AGENDA

MONDAY, MAY 22ND, 2006

6:30 AM – 7:00 AM	BREAKFAST
7:00 AM – 7:05 AM	WELCOME AND INTRODUCTION Robert E. Hales, MD, MBA | Stuart C. Yudofsky, MD
7:05 AM – 7:30 AM	IMPACT OF SHORT-TERM TREATMENT ON LONG-TERM PATIENT OUTCOMES Stephen R. Marder, MD
7:30 AM – 7:55 AM	NEUROCOGNITION, FUNCTIONAL OUTCOMES, AND PSYCHOPHARMACOLOGY Michael F. Green, PhD
7:55 AM – 8:25 AM	PANEL DISCUSSION Discussant: Claudia F. Baldassano, MD
8:25 AM – 8:30 AM	CLOSING REMARKS Robert E. Hales, MD, MBA | Stuart C. Yudofsky, MD

TUESDAY, MAY 23RD, 2006

6:30 AM – 7:00 AM	BREAKFAST
7:00 AM – 7:05 AM	WELCOME AND INTRODUCTION Robert E. Hales, MD, MBA | Stuart C. Yudofsky, MD
7:05 AM – 7:30 AM	BRIDGING PHARMACOLOGY AND CLINICAL EFFECTIVENESS IN SCHIZOPHRENIA Anissa Abi-Dargham, MD
7:30 AM – 7:55 AM	ADVANCES IN PHARMACOTHERAPY FOR MAINTENANCE TREATMENT IN BIPOLAR DISORDER Terence A. Ketter, MD
7:55 AM – 8:25 AM	PANEL DISCUSSION Discussant: Claudia F. Baldassano, MD
8:25 AM – 8:30 AM	CLOSING REMARKS Robert E. Hales, MD, MBA | Stuart C. Yudofsky, MD

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Sponsored by the American Psychiatric Association

Supported by an educational grant from Bristol-Myers Squibb Company and Otsuka America Pharmaceutical, Inc.

S56. HIV Update for Psychiatric Care *APA Committee on AIDS*

A. HIV Medical Update *Milton L. Wainberg, M.D.*

B. Hepatitis C and HIV Infection *Antoine B. Douaihy, M.D.*

C. Club Drugs and HIV *Khakasa H. Wapenyi, M.D.*

D. Body Image and HIV *Marshall Forstein, M.D.*

S57. Voting by Persons With Cognitive Impairment

A. Voting by Persons With Cognitive Impairment: Overview of the Issues *Richard Bonnie, J.D.*

B. Voting By Persons With Cognitive Impairments: The Legal Issues *Pamela Karlan*

C. Assessing Competence to Vote in a Cognitively Impaired Population *Paul S. Appelbaum, M.D.*

D. Respecting Rights and Preserving The Integrity of Elections: The Challenges of Voting in Long-Term-Care Facilities *Jason Karlawish, M.D.*

S58. Not Your Parents' EEG: Clinical Applications of Auditory and Visual Event-Related Potentials

A. Event-Related Potential Abnormalities in Schizophrenia *Daniel C. Javitt, M.D.*

B. Probing the Cognitive, Clinical, and Functional Impairments of Schizophrenia Patients With Mismatch Negativity *Gregory A. Light, Ph.D.*

C. Event-Related Potential P300 and Mismatch Negativity Abnormalities in Patients at Ultra-High Risk for Schizophrenia *Daniel H. Mathalon, M.D.*

D. Use of Auditory Event-Related Potentials and Other Quantitative Measures in an Evidence-Based, Person-Centered Psychosis Treatment Program *Steven B. Schwarzkopf, M.D.*

S59. Genetic Findings Related to Alcohol Dependence and Related Conditions *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. Genetic Susceptibility for Alcohol Dependence: Recent Findings *Howard J. Edenberg, Ph.D.*

B. At-Risk Families: A Multigenerational Study of Alcoholism *Laura J. Bierut, M.D.*

C. Further Characterization of the Risk Associated With GABA-A Receptor Genes *Danielle M. Dick, Ph.D.*

D. Neurophysiological Endophenotypes and the Risk for Alcohol Dependence and Related Disorders *Bernice Porjesz, Ph.D.*

E. Prediction of Alcohol Problems Using a Prospective Longitudinal Design Including Genotype *John I. Nurnberger Jr., M.D.*

S60. The Meanings of Medication: Issues in Patients' Compliance With Psychotropic Drugs *American Academy of Psychoanalysis and Dynamic Psychiatry*

A. Medication Management: A Clinical Misnomer *Leah Davidson, M.D.*

B. Compliance as Accord, Not Submission *Eve Leeman M.D.*

C. Transferences to Medication and Implications for the Structure of the Ego *Eric R. Marcus, M.D.*

D. Poison or Cure: Meanings of Medication in Schizophrenia *Paul J. Rosenfield, M.D.*

E. The Meanings of Medication: Issues in Patients' Compliance With Psychotropic Drugs: Be Careful What You Wish for *Jeffrey Rubin, M.D.*

S61. Pharmacogenetics and Drug Abuse Research *National Institute on Drug Abuse*

A. Allele Specific Gene Expression in Addiction Genes *Wolfgang Sadee*

B. Assaying Functional SNPs for Psychiatric Disease *Robert K. Moyzis, M.D.*

C. Pharmacogenetics and Smoking Cessation With Nicotine Replacement Therapy *Caryn Lerman, Ph.D.*

D. Pharmacogenetics of Smoking Cessation Using Non-Nicotine Replacement Therapies *Huijun Z. Ring, Ph.D.*

E. Pharmacogenetics of Alcohol Treatment *David W. Oslin, M.D.*

S62. Eating Disorders 2006: From Science to Practice

A. Altered Dopamine and Optimal Stimulus Response in Anorexia Nervosa *Walter H. Kaye, M.D.*

B. Gender Difference Comparisons of Eating Difference Comparisons of Eating and Other Psychiatric Disorders in Course of Illness *Katherine A. Halmi, M.D.*

C. Federal Advocacy for Eating Disorders *David B. Herzog, M.D.*

D. Night Eating Syndrome *James E. Mitchell III, M.Ed.*

E. The 2006 APA Practice Guidelines for Eating Disorders *Joel Yager, M.D.*

S63. Vascular Depression: Measurement and Treatment Issues of a Proposed Diagnostic Entity

A. Vascular Risk Factors, Frontolimbic Dysfunction, and Course of Geriatric Depression *George S. Alexopoulos, M.D.*

B. Treatment of Vascular Depression Including New Data on rTMS *Robert G. Robinson, M.D.*

C. Neuroimaging of Cerebrovascular Disease *David C. Steffens, M.D.*

D. Vascular Depression: A Distinct Diagnostic Entity? *Joel R. Sneed, Ph.D.*

S64. Deep Brain Stimulation for Treatment-Resistant Psychiatric Disorders

A. History and Ethics of Neurosurgery for Treatment-Refractory Psychiatric Disorders *George E. Tesar, M.D.*

B. Deep Brain Stimulation Surgery for Treatment of Intractable Psychiatric Disorders *Ali R. Rezai, M.D.*

C. DBS for OCD: Targeting and Clinical Results *Benjamin D. Greenberg, M.D.*

D. Deep-Brain Stimulation in Psychiatric Disorders: Surgical Candidates and Preliminary Results in Major Depression *Donald A. Malone Jr., M.D.*

S65. Complex Depression: The Interface Between Personality Disorders and Major Depression

A. The Neurobiology of the Links Between Personality Traits and Depression *Glenda M. MacQueen, M.D.*

B. Patient Personality as a Differential Predictor of Treatment Outcome to Psychotherapy Versus Pharmacotherapy *R. Michael Bagby, Ph.D.*

C. Managing Patients With Complex Depression *Sidney H. Kennedy, M.D.*

D. Key Psychotherapy Issues in Complex Depression: Patients With Major Depression and Personality Psychopathology *Michael B. Rosenbluth, M.D.*

2 p.m.-5:30 p.m.

Advances in Psychodynamic Psychotherapy: The State of the Art *Glen O. Gabbard, M.D.*

3 p.m.-5 p.m.

New Research Poster Session 7

7 p.m.-10 p.m.

Industry-Supported Symposia

IS34. Management of Psychosis in the Elderly: The Science and the Art *Supported by Solvay Wyeth Pharmaceuticals*

A. Management of Psychosis in the Elderly: The Science and the Art *Carl Salzman, M.D.*

B. Efficacy and Effectiveness of Antipsychotics for Dementia *Lon S. Schneider, M.D.*

C. Safety of Antipsychotics in Elderly Patients *Dilip V. Jeste, M.D.*

D. Novel Antipsychotic Strategies: Implications for Biology and Future Treatment *P. Murali Doraiswamy, M.D.*

E. Nonpharmacologic Interventions for Psychosis in the Elderly *Warachal E. Faison, M.D.*

IS35. Multiple and Complex Presentations of Bipolar Disorder *Supported by Abbott Laboratories*

A. Presentations of Bipolar Disorder in Children and Adolescents *Kiki D. Chang, M.D.*

B. The Impulsive-Aggression Symptom Domain in Personality Disorders *Eric Hollander, M.D.*

C. Bipolar II Disorder and Suicidal Behaviors *William H. Coryell, M.D.*

D. Predicting Maintenance Response From the Acute Episode *Charles L. Bowden, M.D.*

IS36. Treating the Early Stages of Schizophrenia *Supported by AstraZeneca Pharmaceuticals*

A. Genetic and Clinical Risk Factors for Schizophrenia: Predicting the Onset and Outcomes of the Illness and Treatment Response *Dolores Malaspina, M.D.*

B. Treatment of First Episode Schizophrenia: Tolerability and Adherence *Delbert G. Robinson, M.D.*

C. Pharmacologic Strategies for the Treatment of Prodromal Schizophrenia *Daniel C. Javitt, M.D.*

D. Treatment of the Early Stages of Schizophrenia: The Possibility of Neuroprotection *Jeffrey A. Lieberman, M.D.*

E. Evaluation of Prodromal Schizophrenia *Cheryl Corcoran, M.D.*

IS37. Advocating for Change Through Evidence-Based Medicine: A Focus on ADHD *Supported by Cephalon Inc.*

A. Neurocircuitry of ADHD *James J. Hudziak, M.D.*

B. Phenomenology and Diagnosis of ADHD *Christopher J. Kratochvil, M.D.*

C. The Impact of Sleep/Wake Disturbances in ADHD *Judith Owens, M.D.*

D. Evidence-Based Pharmacotherapy of ADHD *Timothy E. Wilens, M.D.*

E. Role of Family and Social Support Systems in the Management of ADHD *Scott Kollins, Pharm.D.*

IS38. The Maze of Mood and Anxiety in the Elderly Patient: A Case Series *Supported by GlaxoSmithKline*

A. The Impact of Medical Comorbidity on Mood and Anxiety Disorders in the Elderly Patient *Prakash S. Masand, M.D.*

B. Achieving a Better Understanding of the Neurobiology of Mood and Anxiety Disorders in the Elderly *Eric J.Lenze, M.D.*

C. An Evidence-Based Approach to the Acute Management of Mood and Anxiety Disorders in the Elderly Population *Warren D. Taylor, M.D.*

D. Deciphering the Maze of Mood and Anxiety Symptoms in the Elderly Patient *Charles F. Reynolds III, M.D.* ■

Hellenic Association To Meet

APA members are invited to attend the Seventh Annual Meeting of the Hellenic American Psychiatric Association (HAPA), which is being held in conjunction with APA's 2006 annual meeting in Toronto.

The meeting has been scheduled for Tuesday, May 23, from 7 p.m. to 10 p.m. at the Westin Harbor Castle. The meeting includes dinner and a scientific presentation.

More information can be obtained by sending an e-mail to office@hellenic-psych.org. Registration information is posted on HAPA's Web site at <www.hellenic-psych.org>. ■

Do I Need a Passport?

U.S. citizens traveling to and from Canada must have proof of U.S. citizenship, such as a U.S. passport (preferred) or ***certified*** copy of their birth certificate, and photo identification, such as a current, valid driver's license. Naturalized citizens should travel with their naturalization certificate. A driver's license, voter's registration card, or Social Security card is ***not*** valid proof of citizenship. Alien permanent residents of the U.S. must present their Alien Registration Card, also known as a "green card."

More information is posted at <http://travel.state.gov/> and <www.cic.gc.ca/english/visit/index.html>. Additional information for individuals with a J-1 visa is posted at <www.nih.gov/od/ors/dirs/isb/j1_travelcanada.htm>. Information about entry requirements, health insurance, and customs is posted at <http://travel.state.gov/travel/tips/regional/regional_1170.html>.

7 a.m.-8:30 a.m.

Industry-Supported Breakfast Symposia

IS39. Emerging Evidence in the Treatment of Bipolar Depression (Part 1) *Supported by AstraZeneca Pharmaceuticals*

A. The Clinical Management of Bipolar Disorder *Frederick K. Goodwin, M.D.*

B. How Guidelines Influence Acute and Long-Term Treatment of Bipolar Depression *Robert M.A. Hirschfeld, M.D.*

C. Treatment of Alcohol and Drug Abuse in Bipolar Disorder *Kathleen T. Brady, M.D.*

IS40. Bipolar Illness: The Road to Remission (Part 1) *Supported by Bristol-Myers Squibb Co.*

A. Is Remission Achievable in Bipolar Disorder? *John L. Beyer, M.D.*

B. Roadblocks to Remission in the Bipolar Patient *Prakash S. Masand, M.D.*

IS41. New Frontiers in Depression: Providing Solutions to Unmet Needs (Part 1) *Supported by Solvay Wyeth Pharmaceuticals*

A. Genetic Mechanisms of Mood and Temperament *Daniel R. Weinberger, M.D.*

B. Chronic Pain and Major Depression *Alan F. Schatzberg, M.D.*

IS42. What the Psychiatrist Needs to Know About Sleep-Related Movement Disorders (Part 1) *Supported by GlaxoSmithKline*

A. Diagnosis, Epidemiology, and Natural History of Restless Legs Syndrome and Periodic Limb Movements of Sleep *Philip M. Becker, M.D.*

B. Sleep, Health, and Quality of Life Consequences *R. Robert Auger, M.D.*

C. Diagnostic Challenges and Initial Treatment Strategies *Cynthia L. Comella, M.D.*

7:30 a.m.-5 p.m.

Registration/Course Enrollment Open

8 a.m.-12 p.m.

CME Courses 79-84

9 a.m.-10:30 a.m.

Clinical Case Conferences

4. Crossing the Line: Determining Your Patient Is Too Dangerous to Drive *Carl B. Greiner, M.D., Laura W. Roberts, M.D., Steven P. Wengel, M.D., Nicole F. Wolfe, M.D.* **(for APA members only)**

Discussion Groups

19. *Marc Galanter, M.D., on* How to Retain Addicted Patients in Ongoing Ambulatory Therapy

20. *Marcia Goin, M.D., on* Borderline Personality Disorder: Talking With Patients About Their Illness "What Do You Say?"

Lectures

L20. Psychiatry and Aging: Contributions of the International Medical Graduates *Dilip V. Jeste, M.D., APA's George Tarjan Award Lecture*

L21. Combining Neuroimaging and Pharmacology to Better Treat Alcoholism *Karl Mann, M.D., International Lecture Series, Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

L22. Psychiatry and Education: When the Twain Meet *James Comer, M.D.*

Master Educator Clinical Consultations

13. *James L. Griffith, M.D., Christina Puchalski, M.D., on* The Role of Spirituality in the Care of Patients

14. *Robert P. Cabaj, M.D., on* Sexual Orientation and Gender Identity in Clinical Care

15. *Helga Hannesdottir, M.D., on* Doing a Residency Training in Psychiatry in the U.S. and Returning Home to Practice

Roundtable

Child and Adolescent Bipolar Disorder: Out of a Diagnostic Quandry *Moderator: Richard E. D'Alli, M.D.*

Component Workshops

CW37. Data Coupled With Advocacy Shaping Public Policy *APA Illinois Psychiatric Society; Co-Chairpersons: Jagannathan Srinivasaraghavan, M.D., Daniel W. Hardy, M.D.*

CW38. Disasters, Disparities, and Cultural Psychiatry APA/SAMHSA Minority Fellows *Chairperson: Niranjan S. Karnik, M.D.*

CW39. Doing More With Less: Challenges and Rewards of Becoming a Psychiatrist Executive *APA Committee on Psychiatric Administration and Management; Chairperson: Sy A. Saeed, M.D.*

CW40. Teaching the History of Psychiatry to Students and Residents: A Workshop Discussion on Content, Methods, and Ideals *APA Corresponding Committee on History and Library; Chairperson: Avram H. Mack, M.D.*

CW41. How to Be a More Creative Teacher: Winning Strategies for Residents and Faculty *APA Council on Medical Education and Lifelong Learning; Co-Chairpersons: Joan M. Anzia, M.D., Lowell D. Tong, M.D.*

CW42. The National Health Information Network and Psychiatry: How Will the Coming National Electronic Health Record Impact Our Patients

and Our Practice? *APA Corresponding Committee on Electronic Health Records; Chairperson: John J. Boronow, M.D.*

CW43. Novel Careers in Psychiatry: Women Who Have Made Their Own Way *APA Committee on Women; Co-Chairpersons: Marisa A. Giggie, M.D., Melva I. Green, M.D.*

Issue Workshops

IW55. Supervising the Supervisors: See One, Do One, Teach One Model Shattered! An Innovative Group to Train Faculty to Teach Medical Students *Co-Chairpersons: Joseph M. Garbely D.O., Javed A. Joy, M.D.*

IW56. Psycho-Killers: Mental Illness and Homicide *Chairperson: Renee M. Sorrentino, M.D.*

IW57. Psychiatric Aspects of Deep Brain Stimulation for Parkinson's Disease *Chairperson: Valerie Voon, M.D.*

IW58. Dynamic Therapy With Self-Destructive Borderlines *Co-Chairpersons: Eric M. Plakun, M.D., Edward R. Shapiro, M.D.*

IW59. Training Psychiatric Residents in the Cognitive Therapy of Schizophrenia *Chairperson: Page Burkholder, M.D.*

IW60. The Mirror Has a Reflection: Teaching and Modeling Cultural Competency to General Psychiatry Residents *Co-Chairpersons: Dionne A. Hart, M.D., Renato D. Alarçon, M.D.*

IW61. Assisted Outpatient Treatment and Its Role in the Fabric of the Mental Health System *Chairperson: Daniel Garza, M.D.*

IW62. Psychiatrists in the Dean's Office: Career Opportunities and Career Development *Chairperson: Carolyn B. Robinowitz, M.D.*

IW63. Detection of Malingering; *Chairperson: Alan R. Hirsch, M.D.*

IW64. The Quality Information System: A New System for Measuring Progress in the Doctor-Patient Relationshi; *Chairperson: Victor J. Buwalda, M.D.*

IW65. Connection Is the Cure: Treating Relational Disorders *Co-Chairpersons: Glenn N. Siegel, M.D., Mary Pittman, M.S.*

9 a.m.-Noon

Media Workshops

MW4. I Used. I Am Sorry. Can I Come Back? *"Sister Helen"* Says: Piss Off *APA Corresponding Committee on Treatment Services for Patients With Addictive Disorders; Co-Chairpersons: Petros Levounis, M.D., Marjorie E. Waldbaum, M.D.*

MW5. The Movie *"Fun"* as a Framework for Exploring Conduct Disorder in Adolescent Girls *Chairperson: Jessica C. Morgan, M.D.*

MW6. Carter's Addiction: Substance Use Disorders in Physicians *Collaborative Session With the National*

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Excitement, Relaxation Just A Ferry Ride Away

With a little bit of everything for everyone, Toronto Island Park is the perfect retreat to take you away from the hustle and bustle of a busy annual meeting.

BY JIM ROSACK

Photo: Tourism Toronto

Toronto Island Park offers many peaceful places to enjoy the great outdoors.

Whether it is rest and relaxation or a wide array of recreational activities you are seeking between all of those symposia, lectures, and courses you'll be attending at APA's 2006 annual meeting, plan some time to follow Toronto's city dwellers across the inner harbor to Toronto Island Park.

A short ferry ride across the harbor from the mainland Ferry Terminal (located at the base of Yonge Street at Queen's Quay), Toronto Island Park actually consists of several islands home to just about every outdoor recreational activity imaginable. Ferries depart every 15 minutes from the docks to three points on Toronto Island Park.

Something for Everyone

Whether you're looking for golfing, boating, yachting, swimming, volleyball, tennis, softball, or something more sedate such as a bicycle ride or leisurely walk, you'll find it all at Toronto Island Park. Indeed, if you just want to relax on the beach, Toronto Island Park has you covered—or uncovered, as it were—yes, clothing is optional at Hanlan's Point Beach.

History buffs will delight in Gibraltar Point Lighthouse. Built in 1809, the lighthouse is the oldest landmark in Toronto. With walls nearly six feet thick at the base, the structure stands over 63 feet tall. Today many believe the structure is haunted by the ghost of the first lightkeeper, who is said to have met an untimely and suspicious death.

Children and kids at heart alike will find great pleasure at Centreville Amusement Park, which has more than 30 rides and 14 food outlets on the park's 600 acres. The park's carousel is an original Dentzell (circa 1905) and is the only operating Dentzell carousel in Canada. Centreville boasts a flume ride, antique cars, train and pony rides, and an antique windmill Ferris wheel. Centerville will be open May 20 to 23 daily from 10:30 a.m. to 8 p.m.

Youngsters will also be fascinated by Franklin Children's Garden, inspired by the character Franklin the Turtle in the Paulette Bourgeois series of children's books. The garden is a great place to play and to learn. In addition, storytelling abounds, with some of Canada's best children's performers reading.

Nature Did Its Work

The islands were originally a peninsula formed by a series of continuously moving sandbars. By the early 1800s Lake Ontario's currents had extended the bars some nine kilometers (about five and a half miles), forming a natural harbor between the lake and the mainland. In 1858, however, a fierce storm permanently separated the peninsula from the mainland.

First surveyed by the British Navy in 1792, Europeans established permanent settlements beginning in the 1830s. By the 1920s Toronto's wealthier citizens were retreating to the islands each summer, and soon crowds were attending baseball games at an island stadium (where Babe Ruth hit his first professional home run—a statue and plaque still mark the spot) and spending the weekends at the amusement park. With the advent of World War II the stadium and original amusement park were demolished to make way for Toronto Island Airport, where the Royal Norwegian Air Force once trained.

Of the nine actual islands, two—Wards (the largest) and Algonquin—are the only ones today with full-time permanent residents. Beautiful Victorian summerhouses, built by some of Toronto's wealthiest families, still line Lake Shore Avenue along with St. Andrew-by-the-Lake Anglican Church.

More information on Toronto Island Park is posted at <www.toronto.ca/parks/island/index.htm> and at <http://torontoisland.org>. ■

Institute on Alcohol Abuse and Alcoholism; Chairperson: Christopher J. Welsh, M.D.

9 a.m.-12:30 p.m.
Advances in Mood Disorders *David J. Kupfer, M.D.*

Continuous Clinical Case Conference 1, Part 2. *R. Rao Gogineni, M.D., Sheila Judge, M.D., Richard P. Kluft, M.D., Robert Michels, M.D., on* 20 Therapies Later: Addressing Tranference Resistance **(for APA members only)**

9 a.m.-4 p.m.
CME Courses 85-91

10 a.m.-3 p.m.
Exhibits Open (last day)
APA Member Center Open (last day)
Publishers' Bookfair Open (last day)

11 a.m.-12:30 p.m.
Discussion Groups
21. *Michelle B. Riba, M.D., on* The Role of the Psychiatrist in End-of-Life Care
22. *Patricia Ordorica, M.D., on* The Future of Psychiatry: What the Resident Should Know **(for residents only)**

Lectures
L23. High on Neurosteroids: Mechanisms and Therapeutic Relevance *A. Leslie Morrow, Ph.D., Frontiers of Science Lecture Series*
L24. I Am All in Favor of Research But I Need Help Tomorrow or Next Week: The Plaint of a University President on the Firing Line of Leadership in an Alcohol-Saturated Peer Culture *Edward Malloy, Ph.D., Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*
L25. Medications That Act at Ion Channels as Treatment for Alcohol Dependence *Bankole Johnson, M.D., Distinguished Psychiatrist Lecture Series, Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

Master Educator Clinical Consultations
16. *David Baron, D.O., on* Performance-Enhancing Drug Use in Adolescent Athletes: A Sports Psychiatry Perspective
17. *Ellen Haller, M.D., on* Working With Lesbian, Gay, Bisexual, and Transgendered Patients: What Do You Need to Know?


Photo: tourism toronto

Toronto's Old Town neighborhood features historic sites dating to 1793.

Medical Update 3. *Jerald Bain, M.D. on* Testosterone Replacement Therapy in the Aging Male: Implications for Psychiatry and Other Disciplines

Research Consultation 3. *Howard Goldman, M.D., on* Mental Health Policy Research

Scientific and Clinical Reports Session 23. Sleep Disorders
67. Effect of Armodafinil on Reducing Fatigue in Patients With Narcolepsy *Russell Rosenberg, Ph.D.*
68. Effect of Armodafinil on Attention in Patients With Excessive Sleepiness As-

continued on page 49

Annual Meeting Events For Residents, Fellows

APA has planned a full schedule of events for psychiatry residents and fellows so they can meet and socialize with one another, ask questions, share information, and learn more about their chosen profession. A number of events will also help residents meet leaders in psychiatry and become more involved in APA. More information about annual meeting opportunities for residents is available by contacting Nancy Delanoche at (703) 907-8635 or ndelanoche@psych.org.

Sunday, May 21

10 a.m.-11:30 a.m. **"How to Survive the Annual Meeting"**
Orientation for Medical Students and Residents
Niagara Room, Lower Level, Intercontinental Hotel

Noon-2 p.m. **Roeske and Bland Award Luncheon for Educators, Medical Students, and Residents**
Imperial Room, Main Level, Royal York Hotel

2 p.m.-4:30 p.m. **Global Psychosomatic Medicine: A Session for U.S. and International Residents**
Kingsway Room, Main Level, Intercontinental Hotel

Monday, May 22

7 a.m.-8:30 a.m. **"Meet the Experts: Sunny-Side Up" Breakfast**
Ballroom B, Lower Level, Intercontinental Hotel
Nationally recognized experts meet informally over breakfast in small groups with residents to discuss career issues and opportunities in psychiatry. This year's topics include addiction psychiatry, child and adolescent psychiatry, cultural competency, forensic psychiatry, geriatric psychiatry, psychodynamic psychotherapy, psychosomatic medicine, public and community psychiatry, and many more.

9 a.m.-10:30 a.m. **Component Workshop: "Career Choices in Psychiatry: Exploring Fellowship Training"**
Room 205 A, Level 200, Toronto Convention Centre, North

Issue Workshop: "ABPN Update: Certification and Maintenance of Certification in Psychiatry and its Subspecialties"
Room 801 A, Level 800, Toronto Convention Centre, South

11 a.m.-12:30 p.m. **Issue Workshop: "Oral Boards Boot Camp: 2006"**
Toronto Convention Centre, South Level 700, Room 713 A/B

Component Workshop: "Toward a Better Understanding of Cultural Issues in Clinical Practice: Residents' Perspective of a Model Curriculum for Residency Training Programs" by the APA/AstraZeneca Minority Fellows
Room 205 B, Level 200, Toronto Convention Centre, North

Tuesday, May 23

9 a.m.-10:30 a.m. **Issue Workshop: "Grassroots Advocacy for Patients and for the Psychiatric Profession: How Medical Students, Residents, and Early Career Psychiatrists Can Affect the Legislative, Regulatory, and Political Process"**
Room 810, Level 800, Toronto Convention Centre, South

Issue Workshop: "How to Launch a Successful Private Practice, Part 1"
Room 801 A, Level 800, Toronto Convention Centre, South

11 a.m.-12:30 p.m. **Issue Workshop: "The Psychiatry Resident as Educator: Implementation of a Teaching Curriculum"**
Room 709, Level 700, Toronto Convention Centre, South

Issue Workshop: "The Psychiatry Resident as Advocate: Practical Steps From the Clinic to the Capitol"
Salon A, Convention Floor, Royal York Hotel

Issue Workshop: "How to Launch a Successful Private Practice, Part 2"
Room 801 A, Level 800, Toronto Convention Centre, South

Component Workshop: "Employment in the Post-Residency Years: Getting What You Want" by the APA Committee of Residents and Fellows
Room 205 B, Level 200, Toronto Convention Centre, North

2 p.m.-5 p.m. **Symposium: "How to Launch a Successful Private Practice, Part 3"**
Room 801 A, Level 800, Toronto Convention Centre, South

Wednesday, May 24

9 a.m.-10:30 a.m. **Component Workshop: "Disasters, Disparities, and Cultural Psychiatry" by the APA/SAMHSA Minority Fellows**
Room 104 D, Level 100, Toronto Convention Centre, North

Component Workshop: "How To Be a More Creative Teacher: Winning Strategies for Residents and Faculty" by the APA Council on Medical Education and Lifelong Learning
Room 205 B, Level 200, Toronto Convention Centre, North

11 a.m.-12:30 p.m. **Component Workshop: "Welcome to the Jungle: The Dynamics Between Residents and Industry" by the APA/GlaxoSmithKline Fellows**
Room 205 D, Level 200, Toronto Convention Centre, North

Component Workshop: "Trauma of Hearts and Minds: Racism and Psychiatry in the 21st Century" by the APA/SAMHSA and APA/AstraZeneca Minority Fellows
Room 206 C/D, Level 200, Toronto Convention Centre, North

Issue Workshop: "Countertransference and Boundary Issues of Residents Treating Medical Students, Fellow Residents, and Attendings"
Room 707, Level 700, Toronto Convention Centre, South

2 p.m.-4 p.m. **Department of Minority/National Affairs "Film Fest 2006"**
Humber Room, Main Level, Intercontinental Hotel

American Psychiatric Foundation
Advancing public understanding of mental illnesses

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Join the American Psychiatric Foundation for four special events at the 2006 APA Annual Meeting.

2006 Annual Benefit "Toronto Tapestry"

Saturday, May 20, 2006
7:00 – 10:00 p.m.
The Royal Ontario Museum
100 Queen's Park
Toronto, Ontario

You are invited to an exciting special evening featuring the Royal Ontario Museum's historic art collections, a menu of eclectic and delicious international cuisine, live music and the presentation of the Awards for Advancing Minority Mental Health. Event proceeds support the foundation's programs that advance public understanding that mental illnesses are real and treatable.

Tickets:
$100 USD per person if purchased by April 1 or $125 USD per person thereafter. To order tickets, please call (703) 907-8512 or visit **www.psychfoundation.org**.

Supported By:

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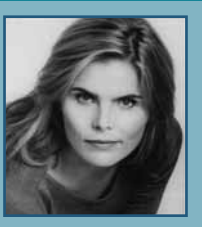
"Conversations" featuring Mariel Hemingway



Tuesday, May 23, 2006 - 5:30 – 6:30 p.m.
Hall A of the Toronto Convention Center
Open to all annual meeting attendees

Don't miss our 5th annual "Conversations" event, an interactive series that offers psychiatrists an opportunity to hear unique perspectives on mental illness. Mariel Hemingway, a successful model, actress, author and mother, will be our guest. Hemingway will discuss her family connection with mental illness and its impact on future generations.

Supported by an unrestricted educational grant from:

Take Me Out to the Ball Game

Tuesday, May 23, 2006 – 7:00 p.m. $22 CAD per ticket ($7 to the foundation) – Ticket value of $29
Wednesday May 24, 2006 – 7:00 p.m. $30 CAD per ticket ($10 to the foundation) – Ticket value of $39

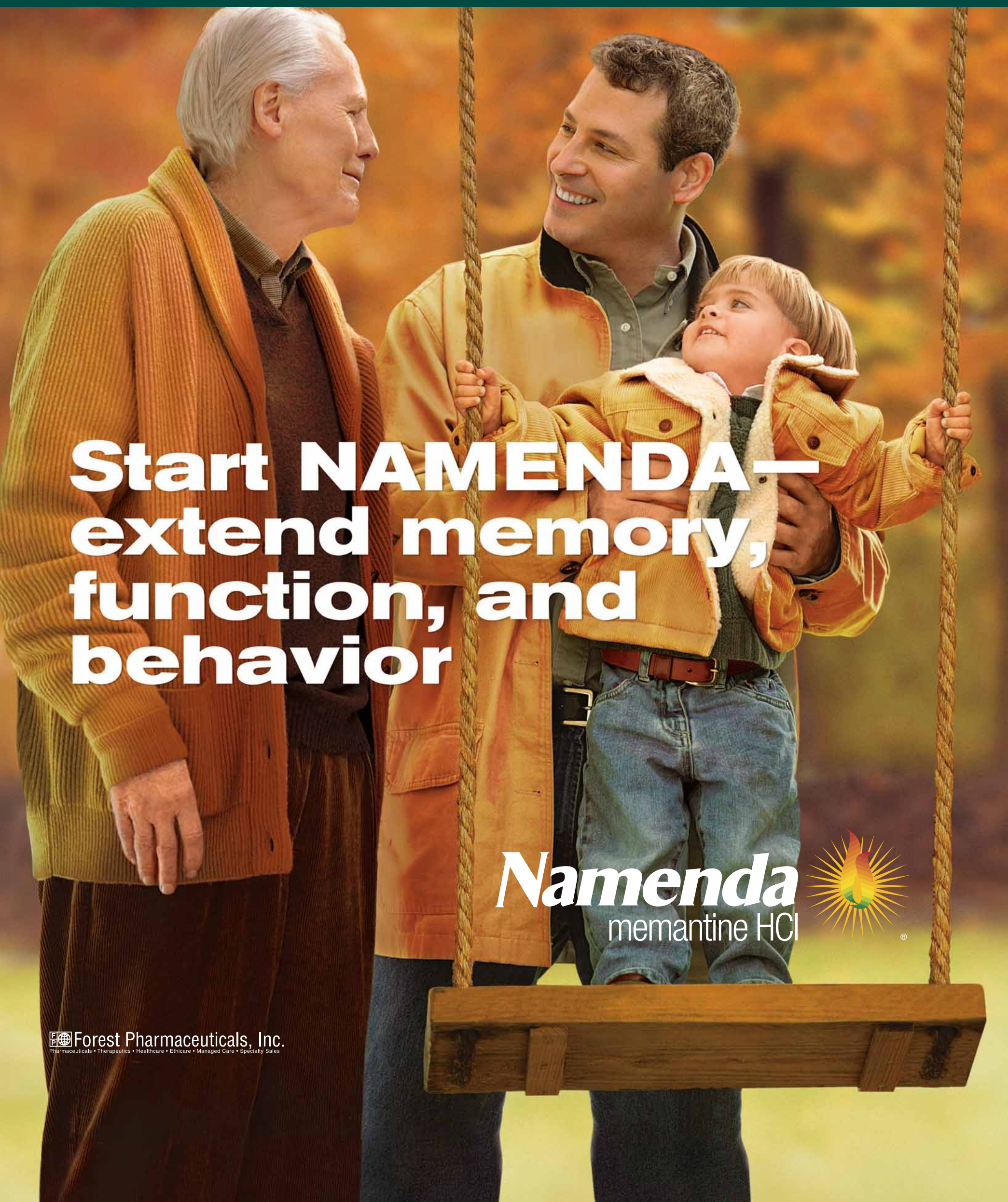
Enjoy a spring evening at the ball park (directly across from the convention center) while supporting the philanthropic work of the foundation. First-rate, field level baseline tickets are available for two Toronto Blue Jays vs. the Tampa Bay Devil Rays games through a special discount offer. A portion of each ticket sold is contributed to the foundation. To order tickets, call Harry Einbinder at (888) 654-6529 ext.1666 or harry.einbinder@bluejays.com. For a seating chart and order form, visit **www.psychfoundation.org**.

Golfers of the APA 2006 Annual Golf Tournament

Monday, May 22, 2006
7:30 a.m. with a shotgun start
Angus Glen Golf Club

Enjoy friendly competition and 18 holes of golf at the north course of Angus Glen, site of the 2007 Canadian Open. $250 USD includes transportation, greens fees, carts and prizes. All event proceeds will benefit the foundation. For more information on the course, visit **www.angusglen.com**. To enter the tournament, contact Stan Jennings at mbears@comcast.net or (804) 320-7881.

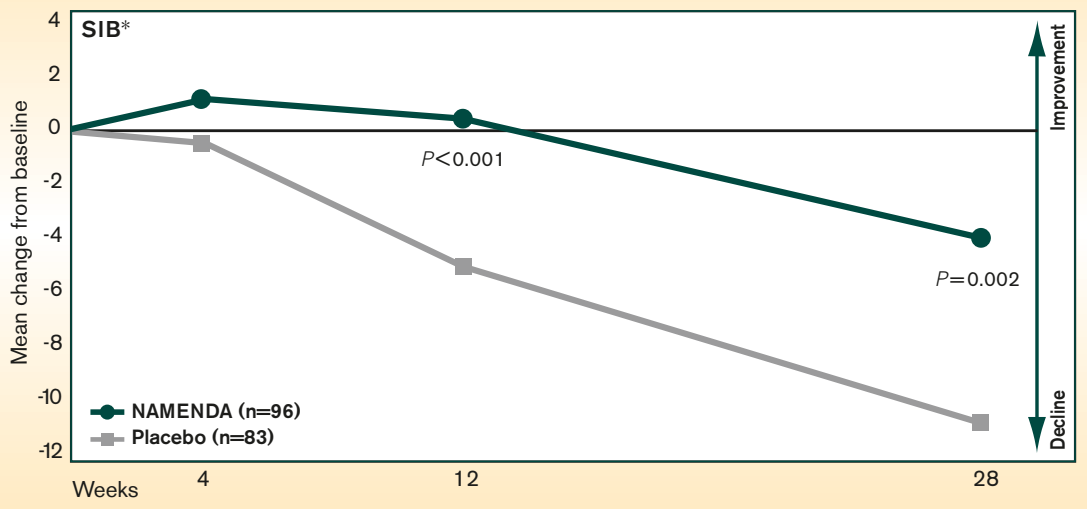
At the first sign of moderate Alzheimer's disease



Extend cognition with NAMENDA

First-line—for newly diagnosed moderate or severe patients and those who do not tolerate AChEIs

Significantly superior cognitive benefits vs placebo[1,2]



Results from a randomized, multicenter, double-blind, parallel-group, placebo-controlled U.S. study investigating the efficacy and safety of NAMENDA in 175 outpatients with moderate to severe Alzheimer's disease (AD). Results shown are from observed cases (OC) analysis. Patients received treatment with NAMENDA (10 mg BID) or placebo BID for 28 weeks.[1]

*SIB=Severe Impairment Battery. Evaluates cognitive performance in moderate to severe AD. It is a 40-item scale that assesses attention, language, praxis, visuospatial ability, construction, memory, orientation, orienting to name, and social interaction. The test is scored from 0 (greatest impairment) to 100.[3]

† Separate placebo-controlled cost analysis.

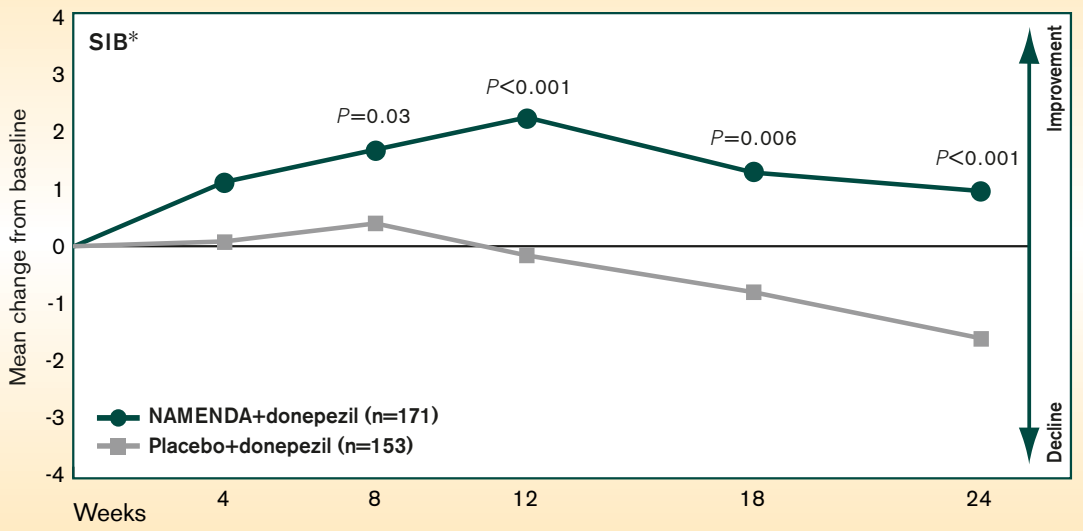
- NAMENDA provided a significantly superior effect on cognition vs placebo over the first 28 weeks of the study period (P=0.002)[1]

NAMENDA significantly:

- ***Reduced monthly caregiving time by 46 hours*** *(P=0.02)*
- ***Reduced monthly costs by $824*** *(P=0.03)*[4†]

In combination—for patients taking AChEIs

Improved cognitive benefits with NAMENDA+donepezil[5]



Results from a randomized, multicenter, double-blind, parallel-group, placebo-controlled U.S. study investigating the efficacy of NAMENDA plus donepezil in patients with moderate to severe AD. Results shown are from OC analysis. The study involved 404 outpatients ≥50 years of age with a Mini-Mental State Examination (MMSE) score of 5 to 14 points. Patients were randomized to treatment with NAMENDA (10 mg BID) or placebo added to a stable regimen of donepezil (5 mg-10 mg/day) for 24 weeks.[5]

‡ Donepezil therapy could have been 6 months or longer.

§ Alzheimer's Disease Cooperative Study Activities of Daily Living$_{19}$ (ADCS-ADL$_{19}$) Inventory. Autonomy subscale included: using a telephone, watching television, traveling, and being left alone; higher-level functions subscale included: conversing, finding belongings, obtaining a beverage, and turning a light off.[2]

- NAMENDA in combination with donepezil significantly improved and sustained cognitive performance above baseline for 6 months vs progressive decline seen with donepezil+placebo (P<0.001)[5‡]

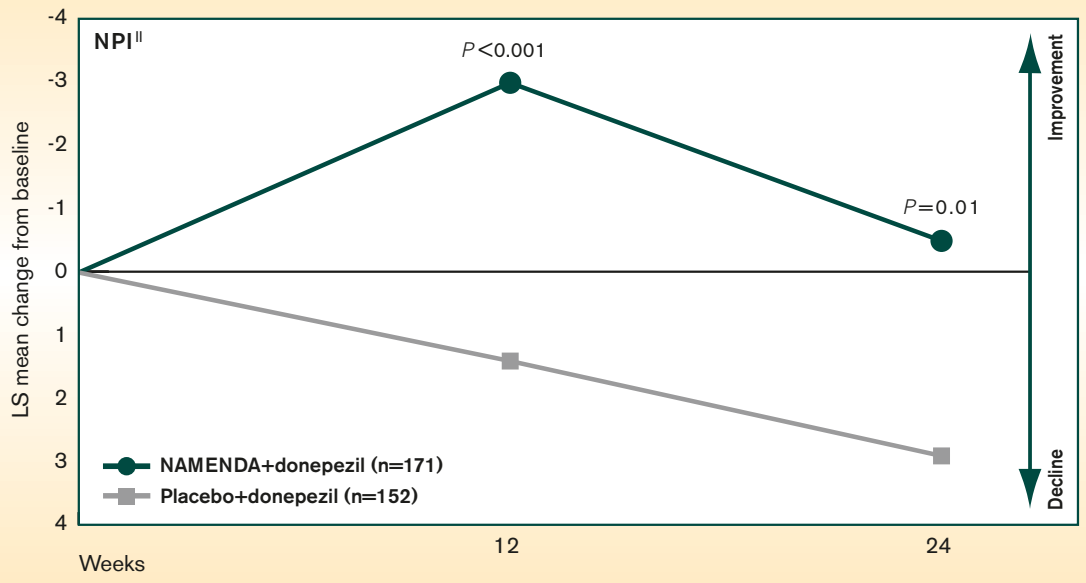
NAMENDA-treated patients also maintained significantly more autonomy and higher-level functioning than patients taking donepezil+placebo (P<0.05)[2]

- Autonomy and higher-level function are subscales derived from the ADCS-ADL$_{19}$[§]

Improve behavioral symptoms

In combination—for patients taking AChEIs

NAMENDA+donepezil sustains behavior above baseline[5,6]



Results from a randomized, multicenter, double-blind, parallel-group, placebo-controlled U.S. study investigating the efficacy of NAMENDA plus donepezil in patients with moderate to severe AD. Results shown are from OC analysis. The study involved 404 outpatients ≥50 years of age with an MMSE score of 5 to 14 points. Patients were randomized to treatment with NAMENDA (10 mg BID) or placebo added to a stable regimen of donepezil (5 mg-10 mg/day) for 24 weeks.[5]

‖ NPI=Neuropsychiatric Inventory. The NPI is designed to assess behavioral disturbances occurring in patients with Alzheimer's disease or other dementias. It is particularly relevant because it is based on scripted questions administered to caregivers.[7]

- As measured by caregivers, NAMENDA+donepezil significantly improved behavioral function for 6 months compared with the progressive decline seen with patients taking donepezil+placebo (P=0.01)[5,6]

NAMENDA® (memantine HCl) is contraindicated in patients with known hypersensitivity to memantine HCl or any excipients used in the formulation. The most common adverse events reported with NAMENDA vs placebo (≥5% and higher than placebo) were dizziness, confusion, headache, and constipation. In patients with severe renal impairment, the dosage should be reduced.

References: 1. Reisberg B, Doody R, Stöffler A, Schmitt F, Ferris S, Möbius HJ, for the Memantine Study Group. Memantine in moderate-to-severe Alzheimer's disease. *N Engl J Med.* 2003;348:1333-1341. **2.** Data on file. Forest Laboratories, Inc. **3.** Saxton J, McGonigle KL, Swihart A, Boller F. The Severe Impairment Battery. Bury St Edmunds, England: Thames Valley Test Company; 1993. **4.** Wimo A, Winblad B, Stöffler A, Wirth Y, Möbius HJ. Resource utilisation and cost analysis of memantine in patients with moderate to severe Alzheimer's disease. *Pharmacoeconomics.* 2003;21:327-340. **5.** Tariot PN, Farlow MR, Grossberg GT, Graham SM, McDonald S, Gergel I, for the Memantine Study Group. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004;291:317-324. **6.** Cummings JL, Schneider E, Tariot PN, Graham SM, for the Memantine Study Group. Effect of memantine on behavioral outcomes in moderate to severe Alzheimer's disease. Poster presented at: Annual Meeting of the American College of Neuropsychopharmacology; December 12-16, 2004; San Juan, Puerto Rico. **7.** Cummings JL, Mega M, Gray K, Rosenberg-Thompson S, Carusi DA, Gornbein J. The Neuropsychiatric Inventory: comprehensive assessment of psychopathology in dementia. *Neurology.* 1994;44:2308-2314.

AChEIs=acetylcholinesterase inhibitors.

Please see brief summary of Prescribing Information on the last page of this advertisement.

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Brief Summary of Prescribing Information.

For complete details, please see full Prescribing Information for Namenda.

INDICATIONS AND USAGE
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

CONTRAINDICATIONS
Namenda (memantine hydrochloride) is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation.

PRECAUTIONS
Information for Patients and Caregivers: Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).

Neurological Conditions
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.

Genitourinary Conditions
Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

Special Populations
Hepatic Impairment
Namenda undergoes partial hepatic metabolism, with about 48% of administered dose excreted in urine as unchanged drug or as the sum of parent drug and the N-glucuronide conjugate (74%). The pharmacokinetics of memantine in patients with hepatic impairment have not been investigated, but would be expected to be only modestly affected.

Renal Impairment
No dosage adjustment is needed in patients with mild or moderate renal impairment. A dosage reduction is recommended in patients with severe renal impairment.

Drug-Drug Interactions
N-methyl-D-aspartate (NMDA) antagonists: The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.
Effects of Namenda *on substrates of microsomal enzymes: In vitro* studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isoenzymes CYP1A2, CYP2C9, CYP2E1, and CYP3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.
Effects of inhibitors and/or substrates of microsomal enzymes on Namenda: Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.
Acetylcholinesterase (AChE) inhibitors: Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.
Drugs eliminated via renal mechanisms: Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®.
Drugs that make the urine alkaline: The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate) and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

Carcinogenesis, Mutagenesis and Impairment of Fertility
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m^2 basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m^2 basis, respectively) through 128 weeks.
Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro S. typhimurium* or *E. coli* reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivocal in an *in vitro* gene mutation assay using Chinese hamster V79 cells.
No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m^2 basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

Pregnancy
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m^2 basis).
Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m^2 basis.
There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

Pediatric Use
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

ADVERSE REACTIONS
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.

Adverse Events Leading to Discontinuation: In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.

Adverse Events Reported in Controlled Trials: The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-treated Patients.

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
Body as a Whole		
Fatigue	1	2
Pain	1	3
Cardiovascular System		
Hypertension	2	4
Central and Peripheral Nervous System		
Dizziness	5	7
Headache	3	6
Gastrointestinal System		
Constipation	3	5
Vomiting	2	3
Musculoskeletal System		
Back pain	2	3
Psychiatric Disorders		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
Respiratory System		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, inflicted injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.

The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

Vital Sign Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure, and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

Laboratory Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

ECG Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

Other Adverse Events Observed During Clinical Trials
Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment.
Treatment emergent signs and symptoms that occurred during 8 controlled clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using WHO terminology, and event frequencies were calculated across all studies.
All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused, e.g., because they are common in the study population. Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events - those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

Body as a Whole: *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

Cardiovascular System: *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

Central and Peripheral Nervous System: *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hypertonia, tremor, aphasia, hypoesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

Gastrointestinal System: *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

Hemic and Lymphatic Disorders: *Frequent:* anemia. *Infrequent:* leukopenia.

Metabolic and Nutritional Disorders: *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

Psychiatric Disorders: *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoid reaction, thinking abnormal, crying abnormal, appetite increased, paroniria, delirium, depersonalization, neurosis, suicide attempt.

Respiratory System: *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

Skin and Appendages: *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

Special Senses: *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, blepharitis, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retinal detachment.

Urinary System: *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US
Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, claudication, colitis, dyskinesia, dysphagia, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatic failure, hyperlipidemia, hypoglycemia, ileus, impotence, malaise, neuroleptic malignant syndrome, acute pancreatitis, aspiration pneumonia, acute renal failure, prolonged QT interval, restlessness, Stevens-Johnson syndrome, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, and thrombocytopenia.

ANIMAL TOXICOLOGY
Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV of the posterior cingulate and retrosplenial neocortices in rats, similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine. In a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m^2 basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

DRUG ABUSE AND DEPENDENCE
Controlled Substance Class: Memantine HCl is not a controlled substance.
Physical and Psychological Dependence: Memantine HCl is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

OVERDOSAGE
Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug. As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine. In a documented case of an overdosage with up to 400 mg of memantine, the patient experienced restlessness, psychosis, visual hallucinations, somnolence, stupor and loss of consciousness. The patient recovered without permanent sequelae.

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sociated With Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, and Shift Work Sleep Disorder *Keith Wesnes, Ph.D.*

69. Armodafinil Improves Wakefulness in Patients With Excessive Sleepiness Associated With Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, and Shift Work Sleep Disorder *Milton Erman, M.D.*

Session 24. ECT

70. Predictors of Referral for ECT *Bonnie L. Szarek, R.N.*

71. ECT Stimulus Dose as Physiological Volume of Seizure Foci *Conrad M. Swartz, M.D.*

72. The Efficacy and Outcome of Combining ECT and Atypical Antipsychotics for Treatment-Resistant Depression *Randall T. Espinoza, M.D.*

Session 25. Health, Nutrition, and Weight in Schizophrenia

73. Assessing Health and Nutrition Status of Urban Psychiatric Outpatients *David J. Hellerstein, M.D.*

74. Are Females at Special Risk for Obesity if They Become Psychotic? The Longitudinal Northern Finland 1966 Birth Cohort Study *Hannu J. Koponen, M.D.*

75. A 12-Week Open-Label Trial of Topiramate for Limiting Weight Gain During Olanzapine Treatment in Patients With Schizophrenia *Jin-Hun Kim Papakostas, M.D.*

Session 26. Developmental Issues in Schizophrenia

76. Altered Developmental Trajectories in Schizophrenia *Matti K. Isohanni, Dr. Med. Sc.*

77. Characteristics of the Interpersonal Distance of Patients With Schizophrenia in the Virtual Environment *Sung-Hyouk Park, M.D.*

78. Familial Risk of Psychosis and Prodromal Features of Psychosis at the Age of 15-16 Years *Juha M. Veijola, M.D.*

Session 27. Treatment of Schizophrenia

79. An Effectiveness Trial of a Brief Cognitive-Behavioral Intervention by Mental Health Nurses in Schizophrenia: Clinically Important Outcomes in the Medium Term *Shanaya Rathod, M.D.*

80. Efficacy and Tolerability of Olanzapine, Quetiapine, and Risperidone in the Treatment of First-Episode Psychosis: A Randomized, Double-Blind, 52-Week Comparison *Joseph P. McEvoy, M.D.*

81. Quetiapine for Bipolar Disorder and Schizophrenia: Appropriate Dose for Optimal Response *Arthur L. Lazarus, M.D.*

Session 28. Recent Research on SSRIs

82. Early Symptomatic Worsening During Treatment With Fluoxetine in MDD: A Replication Study *Cristina Cusin, M.D.*

83. Meta-Analysis of Efficacy of Paroxetine Versus Placebo Utilizing the GlaxoSmithKline Clinical Trials Registry *Lawrence W. Adler, M.D.*

84. Resolution of Sleepiness and Fatigue in the Treatment of MDD: A Comparison of Bupropion and SSRIs *George I. Papakostas, M.D.*

Session 29. Epidemiological Studies of Adverse Events in Institutionalized Populations

85. Death by Unnatural Causes During Childhood and Early Adulthood in Offspring of Psychiatric Inpatients *Roger T. Webb, M.S.C.*

86. The Incidence and Prevalence of Diabetes Mellitus Among Inpatients in State-Operated Psychiatric Hospitals in New York State 1997-2004 *Leslie L. Citrome, M.D.*

87. Associations Between Psychiatric Disorder and Commitment Criteria in Acute Involuntarily Admitted Patients in the Netherlands *Cornelis Mulder, M.D.*

Session 30. Treatment of Adverse Events

88. PDE5I Sildenafil Treatment of Serotonergic Antidepressant Associated Sexual Dysfunction in Women With MDD in Remission: An Eight-Week Randomized, Double-Blind, Placebo-Controlled Trial With Eight-Week Open-Label Continuation *H. George Nurnberg, M.D.*

89. Theoretical Implications of Improved Depression Severity by PDE5I Sildenafil Treatment of Erectile Dysfunction Associated With Treated or Untreated MDD for Endothelial Dysfunction Mediation *Richard L. Siegel, M.D.*

90. Efficacy of Sildenafil for the Treatment of Erectile Dysfunction in Men Taking Antidepressant Medication: Meta-Analysis of Randomized, Double-Blind, Placebo-Controlled Studies *Joseph C. Cappelleri, Ph.D.*

Session 31. BPD

91. Structural Brain Abnormalities in BPD *Paul H. Soloff, M.D.*

92. Neurobiological Correlates of Diagnosis and Underlying Traits in Patients With BPD Compared With Normal Controls *Joel F. Paris, M.D.*

93. BPD and Suicide Attempt: Are There Any Correlates Between Attempters and Non-Attempters? *Tavi Thongdy, M.D.*

Session 32. Women's Health Issues

94. Gender Differences in Schizophrenia and Other Psychotic Disorders: A 20-Year Follow-Up Study *Linda S. Grossman, Ph.D.*

95. Severe Personality Disorders in the Offspring of Antenatally Depressed Mothers: A 31-Year Follow-Up of the Northern Finland 1966 Birth Cohort *Pirjo H. Maki, M.D.*

96. Outcome of Prenatal Anxiety, Stress, and Depression *Gisèle Apter-Danon, M.D.*

Session 33. Cross-Cultural and Minority Issues

97. All Equal? Advocating Equity in Mental Health Services in France to Ethnic-Minority Disadvantaged Youth and Their Families Through Evidence-Based Protocols *Leon-Patrice Celestin, M.D.*

98. Stories About Mental Health: A Cross-Cultural Relapse-Prevention Study in Northern Territory Aboriginal Communities *Tricia M. Nagel*

99. Recognizing and Engaging Depressed Chinese Americans in Treatment in a Primary Care Setting *Albert Yeung, M.D.*

Component Workshop

CW44. Global Psychiatry: Establishing Formal and Informal Mental Health Exchanges *APA Council on Global Psychiatry; Co-Chairpersons: Samuel O. Okpaku, M.D., William Lawson, M.D.*

CW45. School-Based Suicide Prevention: Evidence-Based Strategies and New Approaches *APA Corresponding Committee on Mental Health and Schools; Co-Chairpersons: Eugenio M. Rothe, M.D., Daniel Castellanos, M.D.*

CW46. A Research Agenda for *DSM-V*: Mental Health in the Gay, Lesbian, and Bisexual Populations *APA Committee on Gay, Lesbian, and Bisexual Issues; Co-Chairpersons: Benjamin H. McCommon, M.D., Jack Drescher, M.D.*

CW47. Welcome to the Jungle: The Dynamics Between Residents and Industry *APA/GlaxoSmithKline Fellows; Co-Chairpersons: Lisa A. Catapano, M.D., Itai Danovitch, M.D.*

CW48. Trauma of Hearts and Minds: Racism and Psychiatry in the 21st Century *APA/SAMHSA and APA/AstraZeneca Minority Fellowships; Co-Chairpersons: Napoleon B. Higgins Jr., M.D., Jean-Marie E. Alves-Bradford, M.D.*

CW49. Current Issues in Psychiatry and Law *APA Council on Psychiatry and Law; Chairperson: Paul S. Appelbaum, M.D.*

Issue Workshops

IW66. Psychiatry Training for Primary Care Physicians: An Ongoing Challenge *Chairperson: Hoyle Leigh, M.D.*

IW67. When Therapeutic Lifestyle Changes Fail: Pharmacologic Management of Metabolic Syndrome in Psychiatry *Co-Chairpersons: Peter Manu, M.D., Raymond E. Suarez, M.D.*

IW68. Countertransference and Boundary Issues of Residents Treating Medical Students, Fellow Residents, and Attendings *Chairperson: Benjamin D. Lederer, M.D.*

IW69. Applying for National Institute of Alcohol Abuse and Alcoholism Research Money: Some Things You Didn't Learn in Graduate School *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism; Chairperson: Robert Huebner, Ph.D.*

IW70. The Nature of Nurture: The Long-Lasting Impacts of Early Adverse Life Events *Co-Chairpersons: Mireya Nadal-Vicens, M.D., Stacy S. Drury, M.D.*

IW71. Maintenance of Certification for Diplomates of the American

continued on page 52

Learn the Latest on HIV Psychiatry

More than a million people are infected with HIV in the United States, and most of them will experience a psychiatric disorder during the course of their illness. The Office of HIV Psychiatry and the APA Committee on AIDS offer annual meeting programs to provide you with what you need to know to deliver quality care to your HIV-infected patients. Geared to psychiatrists with varying levels of experience, this year's sessions in Toronto will provide useful clinical information on HIV-related complications and treatments.

Residents Training

Sunday, May 21, 12:30 p.m.-4:30 p.m.

The Committee on AIDS will present a program for psychiatry residents on assessing and treating patients with HIV-related psychiatric and neuropsychiatric disorders. The workshop will provide practical information including "10 Things You Need to Know About HIV Psychiatry." The program is designed to be interactive, with plenty of time for case discussion. A box lunch will be provided, but **you must RSVP by May 7** by calling (703) 907-8641 or e-mailing aids@psych.org.

Sexuality and Its Impact on the HIV Pandemic

Monday, May 22, 11 a.m.-12:30 p.m.

In this highly interactive component workshop, panelists will discuss sexuality across a variety of cultures and communities, cultural attitudes toward sexual practices, sexual behaviors that place individuals at risk for contracting HIV, and the role of the psychiatrist in prevention education. Participants are asked to bring clinical problems, countertransference issues, and ethical dilemmas to discuss during the workshop.

HIV Update for Psychiatric Care

Tuesday, May 23, 2 p.m.-5 p.m.

In this symposium, psychiatrists will offer a snapshot of trends in the HIV epidemic in the United States. A medical update will provide information on epidemiology, new clinical challenges, current treatments, patient management, integrated care, and drug interactions and toxicity. Other presentations will cover the effects of hepatitis C co-infection/treatment and its role in cognitive function, liver function, and substance use; club-drug use (including crystal methamphetamine) and its impact on the brain, immune function, and risk behavior; and body image and metabolic complications of treatment and their impact on physical and mental functioning, treatment adherence, and quality of life.

Don't forget to stop by the exhibit in the APA Member Center to pick up HIV-related policy guidelines, training request forms, and clinical materials for your practice and for members of your treatment team.

Technology Training at Meeting To Transform Your Practice

BY JOHN LUO, M.D.

This article will highlight the many informatics offerings at APA's 2006 annual meeting and the annual meeting of the American Association for Technology in Psychiatry (AATP) in Toronto that address some of your informatics needs. Every year there are many workshops, symposia, and courses that cover a range of topics in medical informatics. Due to great popularity, some of the CME courses are repeats of courses presented in past years, so sign up early. Please note that there is an additional fee to attend courses, and you must register in advance.

One of the new features of APA's Web site is the ability to search the scientific program based on topic, keyword, or presenter. In addition, you can create an online account and save your searches to create an itinerary. To access this tool, go to the annual meeting page at <www.psych.org/edu/ann_mtgs/am/06/index.cfm> and scroll down to the gold box labeled "Scientific Program Itinerary Planner, Search for Session Details." A very nice feature of the tool is that it highlights scheduling conflicts you may have created by selecting sessions offered at the same time.

After you have saved your searches into an itinerary, you can either print the page to take with you or save it on your personal digital assistant (PDA). To save the itinerary on your PDA, you must have an account with AvantGo, a mobile content provider that offers no-charge accounts. If you are a Windows user, an alternative to using AvantGo is to create a PDF from the Itinerary using either Adobe Acrobat or another PDF creator along with the Adobe Acrobat Reader for your PDA. If you are using Mac OS X, go to the print menu, click on "Print," then "PDF," and finally, "Save as PDF." For older operating systems, you can use the Mac version of Adobe Acrobat (the creator program, not the reader), but it is expensive. Other options include PrintToPDF for OS 9, which is shareware, and JAWS PDF Creator, which costs $85. If all of that sounds complicated, sign up for one of the three PDA courses offered this year to learn how!

The annual meeting of the AATP is being held in conjunction with APA's annual meeting on Saturday, May 20, from 8 a.m. to 5 p.m., in the Toronto Marriott Eaton Centre.

The AATP's annual meeting will cover a wide range of topics. David Medvedeff, Pharm.D., M.B.A., will discuss how technology plays a vital role in disaster response in the session "Disaster Health Informatics." Alex Young, M.D., will lead the session "The Quality Enhancement Research Initiative," which is an informatics system to support collaborative care for chronic illness. J. David Moore, M.D., will speak on behavioral health care and informatics from his perspective as medical director for Florida Health Partners. Thomas Kim, M.D., has been working with former Surgeon General David Satcher, M.D., on disaster telepsychiatry in response to Hurricane Katrina. APA President Steven Sharfstein, M.D., will speak on psychiatric informatics and public policy, and will provide APA's perspective. Ross Martin, M.D., M.B.A., director of business technology at Pfizer, will provide an overview of recent efforts to develop health care information technology standards for the interoperability of various electronic medical record and information networks with respect to Medicare Part D.

The following sessions are part of the APA annual meeting program:

Course: "Computer-Assisted Diagnostic Interivew"; Sunday, May 21, 1 p.m. to 5 p.m.; Room 717 B, Level 700, Toronto Convention Centre, South

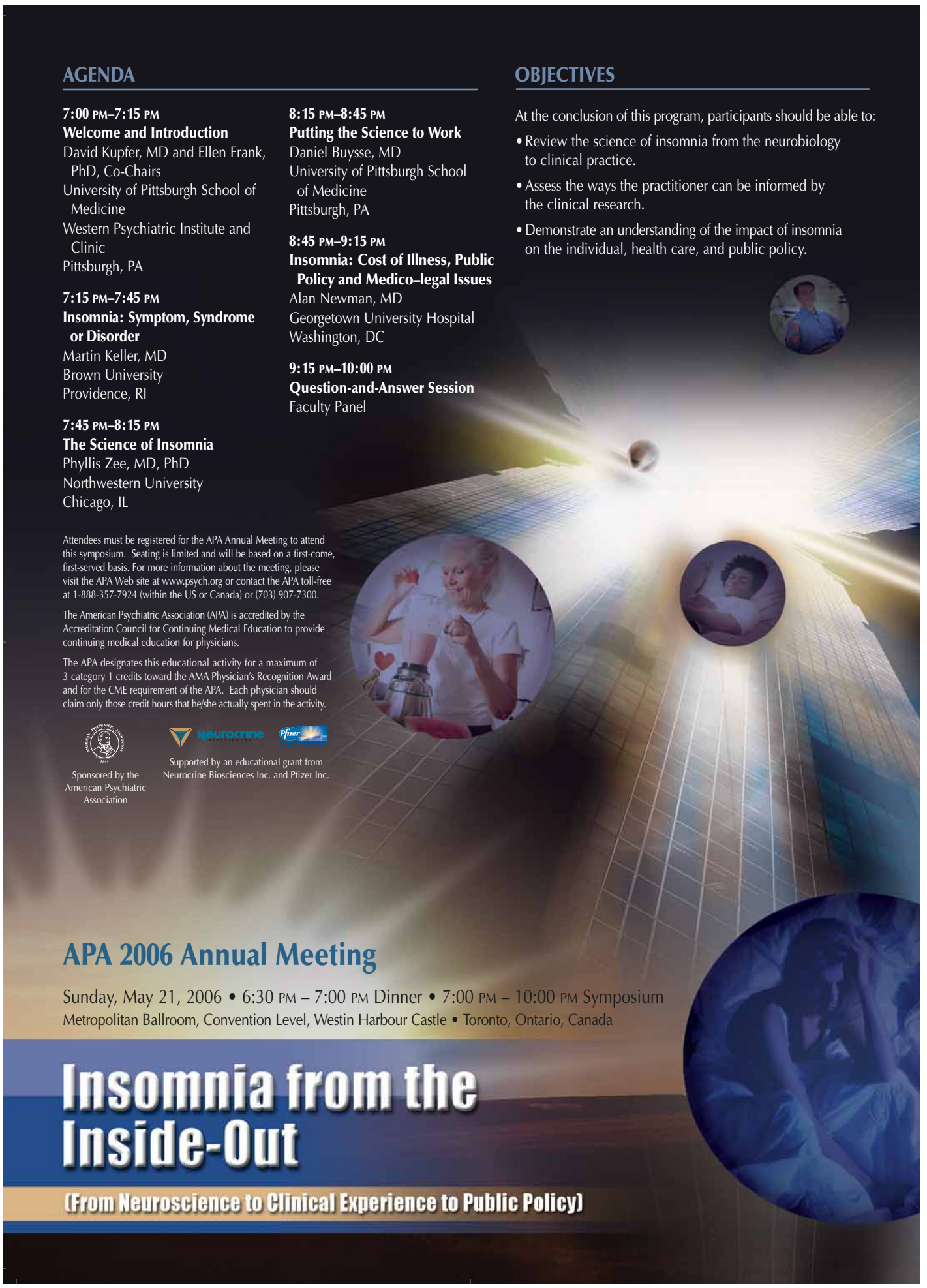
This course demonstrates the use of the CADI Rom, a computer-based program on PCs and PDAs that assists psychiatric diagnosis of adults with guided structured interviews, data collection, and differential-diagnoses generation. CADI Rom diagnostic precision (accuracy, completeness, and reliability) is equal to gold standards (SCID, consensus-diagnosis).

Issue Workshop: "Online Peer Support Groups and Support Group Members"; Monday, May 22, 9 a.m. to 10:30 a.m.; Room 803 A/B, Level 800, Toronto Convention Centre, South

This workshop discusses how the Internet empowers patients by connecting them not only to information, but also to each other via online peer-support groups. Moderators of the groups will explain how the groups function, what their goals are, how group members interact, what topics are discussed, how the moderators moderate, and what the pros and cons of the groups are.

please see ***Connections*** *on page 62*

John Luo, M.D., is an assistant professor of psychiatry at the UCLA Semel Institute for Neuroscience and Human Behavior in Los Angeles and past president of the American Association for Technology in Psychiatry.



BIPOLAR ILLNESS

2006 APA ANNUAL MEETING
THE ROAD TO REMISSION

DATE WEDNESDAY, MAY 24TH **TIME** 7:00 AM – 8:30 AM
THURSDAY, MAY 25TH 7:00 AM – 8:30 AM

ACTIVITY CHAIRPERSON PRAKASH S. MASAND, MD

THE FAIRMONT ROYAL YORK ■ CANADIAN ROOM ■ TORONTO, CANADA

TARGET AUDIENCE
This educational activity is intended for psychiatrists and other mental health care professionals attending the 2006 Annual Meeting of the American Psychiatric Association.

LEARNING OBJECTIVES
After attending this symposium, participants should be better able to:

- Outline a long-term strategy for maintenance therapy that maintains or improves cognitive function and minimizes the risk of metabolic abnormalities in patients with bipolar disorder
- Discuss the different rates of remission associated with various pharmacotherapeutic regimens
- Describe the role of psychosocial therapies in maintaining remission in bipolar disorder

ACCREDITATION STATEMENT
The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

DESIGNATION STATEMENT
The APA designates this educational activity for a maximum of 3 category 1 credits toward the AMA Physician's Recognition Award and for the CME requirement of the APA. Each physician should claim only those credits that he/she actually spent in the activity.

DISCLAIMER STATEMENT
The opinions or views expressed in this CME activity are those of the presenters and do not necessarily reflect the opinions or recommendations of the APA or the commercial supporters. Attendees should critically appraise the information presented and are encouraged to consult appropriate resources for information surrounding any product or device mentioned.

Attendees must be registered for the APA 2006 Annual Meeting to attend this symposium. Seating is limited and will be based on a first-come, first-served basis. For more information about the meeting, please visit the APA web site at **www.psych.org** or contact APA toll free at **1-888-357-7924** (within the US or Canada) or **1-703-907-7300**.

AGENDA

WEDNESDAY, MAY 24TH, 2006

6:30 AM – 7:00 AM	BREAKFAST
7:00 AM – 7:05 AM	WELCOME AND INTRODUCTION Prakash S. Masand, MD
7:05 AM – 7:30 AM	IS REMISSION ACHIEVABLE IN BIPOLAR DISORDER? John L. Beyer, MD
7:30 AM – 7:55 AM	ROADBLOCKS TO REMISSION IN PATIENTS WITH BIPOLAR DISORDER Prakash S. Masand, MD
7:55 AM – 8:25 AM	PANEL DISCUSSION Moderator: Prakash S. Masand, MD
8:25 AM – 8:30 AM	CLOSING REMARKS Prakash S. Masand, MD

THURSDAY, MAY 25TH, 2006

6:30 AM – 7:00 AM	BREAKFAST
7:00 AM – 7:05 AM	WELCOME AND INTRODUCTION Prakash S. Masand, MD
7:05 AM – 7:30 AM	AN EVIDENCE-BASED APPROACH TO ACHIEVING REMISSION IN BIPOLAR DISORDER Roger S. McIntyre, MD, FRCPC
7:30 AM – 7:55 AM	THE ROLE OF NONPHARMACOLOGIC THERAPIES IN ACHIEVING REMISSION Eduardo Vieta, MD, PhD
7:55 AM – 8:25 AM	PANEL DISCUSSION Moderator: Prakash S. Masand, MD
8:25 AM – 8:30 AM	CLOSING REMARKS Prakash S. Masand, MD

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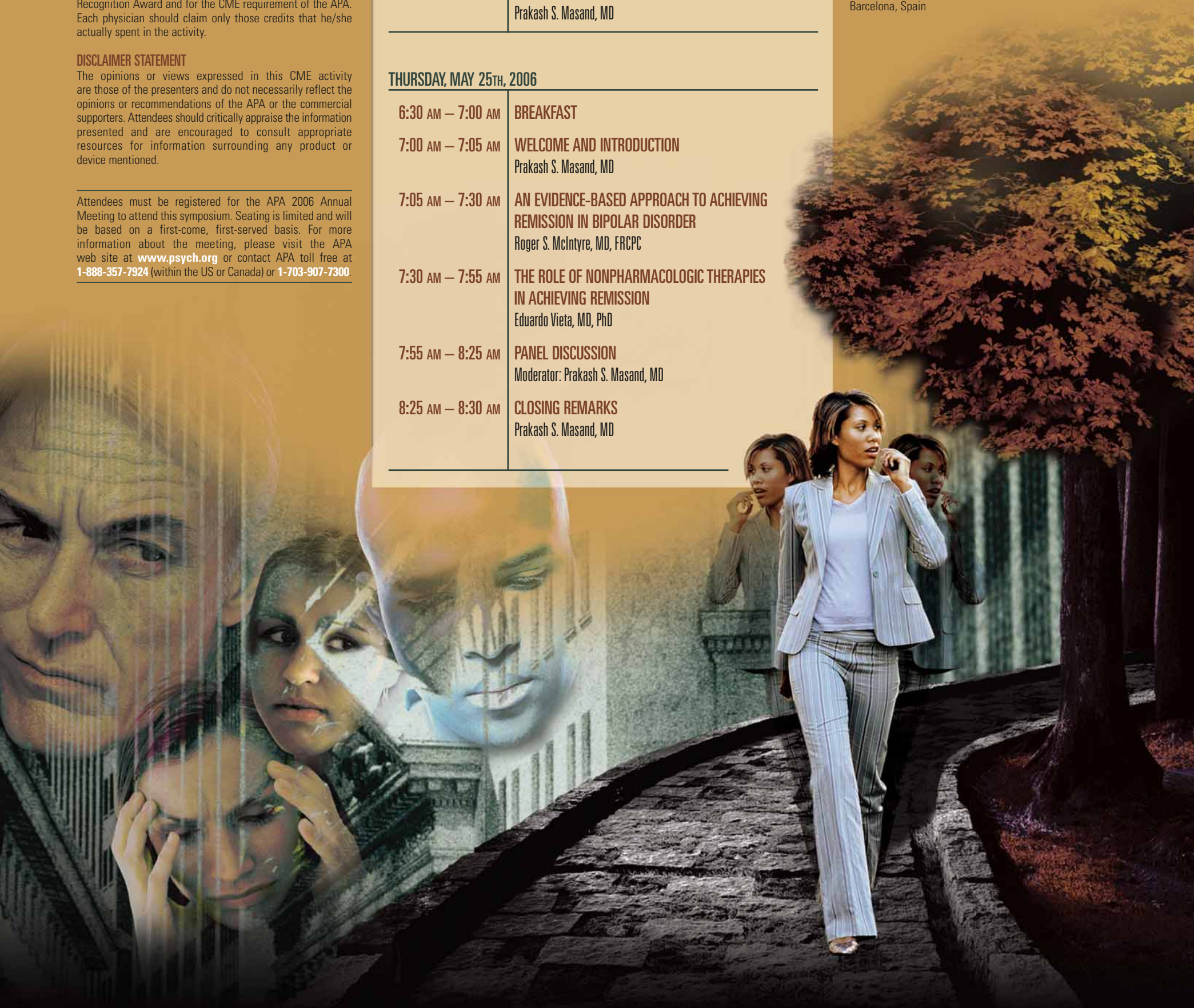

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Supported by an educational grant from Bristol-Myers Squibb Company and Otsuka America Pharmaceutical, Inc.

Board of Psychiatry and Neurology *Chairperson: Stephen C. Scheiber, M.D.*

IW72. Responding to the Impact of Suicide on Clinicians *Chairperson: Eric M. Plakun, M.D.*

IW73. Non-Governmental Organizations: Response to Mental Health Consequences of Asian Tsunami *Chairperson: Jagannathan Srinivasaraghavan, M.D.*

IW74. Approaches to Chronic Disease Management: Opportunities for Psychiatry *Chairperson: Nick Kates, M.B.*

IW75. The Key to Success, Mentorship Matters: A Practical Guide for Trainees and Educators *Chairperson: Anita R. Kishore, M.D.*

IW76. The Evolution of Grandfamilies: The Psychological, Social, and Financial Impact of Grandparents Raising Grandchildren *American Academy of Child and Adolescent Psychiatry; Co-Chairpersons: James E. Lee Jr., M.D., Sandra C. Walker, M.D.*

Noon-1:30 p.m.

Forums

10. Correctional Mental Health Issues: An International Perspective *Chairperson: Jeffrey L. Metzner, M.D.*

11. Katrina: Psychiatric Responses and Care for Individuals and Communities *Chairperson: Robert J. Ursano, M.D.*

12. Addressing Psychiatric Needs in Asia *APA Council on Global Psychiatry; Chairperson: Pedro Ruiz, M.D.*

13. Environmental Psychiatry: From Sick Buildings to the Gulf War *Chairperson: Claudia S. Miller, M.D.*

Noon-2 p.m.

New Research Poster Session 8

1 p.m.-5 p.m.

CME Courses 92-97

2 p.m.-3:30 p.m.

Lecture

L26. Beyond Dopamine: Neuroadaptations, Negative Affect, and Clinically Relevant Treatment Targets in Alcoholism, *Markus Heilig, M.D., Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

2 p.m.-5 p.m.

Presidential Symposia

3. Collaboration in Crisis: Academic Medical Centers' Response to Hurricanes Katrina and Rita *Chairperson: Joseph D. Hamilton, M.D.*

4. Psychiatric Participation in Interrogation of Detainees: Ethical Considerations *Chairperson: Steven S. Sharfstein, M.D.*

Symposia

S66. Risk Factors, Personality Variables, and Addictive Disorders *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. Risk Factors for Addictive Disorders *Maurice Corcos, Ph.D.*

B. Dependency and Suicidality in Addictive Disorders *Gwenole Loas, M.D.*

C. Depressive Psychopathology in Addictive Disorders *Mario Speranza, M.D.*

D. Sensation Seeking and Addictive Disorders *Alexandra Pham-Scottez*

E. Addictive Disorder: Goodman's Concept of Addiction: A Study of 692 Addictive Subjects *Ludovic A. Gicquel, Ph.D.*

S67. Reductionism in Psychiatry: Implications and Limits *Association for the Advancement of Philosophy and Psychiatry*

A. Is Modern Biological Psychiatry Reductionistic or Integrative? *G. Scott Waterman, M.D.*

B. Dr. Chekhov and the Multiplicity of Psychiatric Experience *Bradley E. Lewis*

C. Reduction in Psychiatry *Ian Gold, Ph.D.*

D. Reducing Reductionism: Reclaiming Psychiatry *Wesley E. Sowers, M.D.*

S68. Complex PTSD Across the Lifespan: Implications for *DSM-V*

A. Disorders of Extreme Stress: Results from the *DSM-IV* Field Trial *Bessel A. Van Der Kolk, M.D.*

B. Self-Regulation as a Framework for Conceptualizing and Treating Complex PTSD *Julian Ford, Ph.D.*

C. Early Childhood Trauma, Insecure Attachment, and Complex PTSD *Marylene Cloitre, Ph.D.*

S69. Pharmaceutical Industry Influence in Psychiatry

A. Physicians and Industry: A Review of Commercial Influence on Medical Decision Making *Jerome P. Kassirer, M.D.*

B. Psychiatric CMEs and Commercial Bias: Are New ACCME Standards Effective? *Daniel J. Carlat, M.D.*

C. The ADHD/Psychostimulant Epidemic: The Role of the Pharmaceutical Industry *Lawrence H. Diller, M.D.*

D. Relationship Between Drug Company Funding and Outcomes of Clinical Psychiatric Research *Robert E. Kelly Jr., M.D.*

E. Psychiatric Research as Marketing: Common Distortions of Research Design in Industry-Sponsored Clinical Trials *Daniel J. Safer, M.D.*

S70. New Directions in Community Psychiatry

A. Poverty Reduction Strategies: An Important Focus for Early Intervention Programs *Terry Krupa, Ph.D.*

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In patients with schizophrenia who have been discharged…

50%
are not fully compliant with their antipsychotic medication within 1 year[1]

Up to

25%
are not fully compliant with their antipsychotic medication within 7–10 days[2]

When you recognize these patients...

Consider

RISPERDAL

The **only** long-acting

RISPERDAL CONSTA is indicated for the treatment of schizophrenia.

Increased Mortality in Elderly Patients with Dementia–Related Psychosis
Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10 week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. RISPERDAL® CONSTA® (risperidone) is not approved for the treatment of patients with Dementia-Related Psychosis.

Commonly observed events: Treatment-emergent adverse events with an incidence of 5% or greater in at least one of the RISPERDAL CONSTA groups (25 mg or 50 mg) and at least twice that of placebo were: somnolence, akathisia, parkinsonism, dyspepsia, constipation, dry mouth, fatigue, and weight increase.

Hyperglycemia and diabetes: Hyperglycemia, in some cases extreme and associated with ketoacidosis, hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics (APS), including RISPERDAL CONSTA. Patients starting treatment with APS who have or are at risk for diabetes should undergo fasting blood glucose testing at the beginning of and during treatment. Patients who develop symptoms of hyperglycemia should also undergo fasting blood glucose testing.

Tardive dyskinesia (TD): As with all antipsychotic medications, prescribing should be consistent with the need to minimize the risk of TD; if its signs and symptoms appear, discontinuation of RISPERDAL CONSTA should be considered. In the integrated database of multiple-dose studies, the incidence of TD was 0.6% (9/1499 patients).

Neuroleptic malignant syndrome (NMS): NMS has been reported rarely with this class of medications, including RISPERDAL CONSTA, and appropriate management should be employed.

Cerebrovascular adverse events (CAEs): CAEs, including fatalities, have been reported in elderly patients with dementia-related psychosis taking oral risperidone in clinical trials. The incidence of CAEs with oral risperidone was significantly higher than with placebo. RISPERDAL CONSTA is not approved for treating these patients.

References: 1. Weiden PJ, Zygmunt A. The road back: working with the severely mentally ill. Medication noncompliance in schizophrenia: part 1. Assessment. *J Pract Psychiatry Behav Health.* 1997;3:106–110. **2.** Lam YWF, Velligan D, Ereshefsky L, et al. Intra-individual variability in plasma concentrations as an indicator of adherence in schizophrenia. Poster presented at: 42nd Annual New Clinical Drug Evaluation Unit (NCDEU) Meeting: June 10–13, 2002; Boca Raton, Fla.

Please see brief summary of full Prescribing Information, including Boxed Warning, on adjacent page.

Visit our Web site at risperdalconsta.com

Janssen L.P.

 01-CS-389 Printed in U.S.A. November 2005

CONSTA

atypical antipsychotic

Provides 2 weeks of continuous coverage

- While not guaranteeing compliance, RISPERDAL CONSTA enables you to recognize and intervene when a patient misses a dose

Risperdal® CONSTA®
risperidone Long-Acting Injection

Risperdal® CONSTA®

risperidone Long-Acting Injection

BEFORE PRESCRIBING, PLEASE CONSULT COMPLETE PRESCRIBING INFORMATION OF WHICH THE FOLLOWING IS A BRIEF SUMMARY.

Increased Mortality in Elderly Patients with Dementia–Related Psychosis

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10 week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. RISPERDAL® CONSTA® (risperidone) is not approved for the treatment of patients with Dementia-Related Psychosis.

INDICATIONS AND USAGE: RISPERDAL® CONSTA® (risperidone) is indicated for the treatment of schizophrenia.

CONTRAINDICATIONS: RISPERDAL® CONSTA® (risperidone) is contraindicated in patients with a known hypersensitivity to the product or any of its components.

WARNINGS

Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. RISPERDAL® CONSTA® (risperidone) is not approved for the treatment of dementia-related psychosis (see Boxed Warning).

Neuroleptic Malignant Syndrome (NMS) A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported.

Tardive Dyskinesia A syndrome of potentially irreversible, involuntary, dyskinetic movements may develop in patients treated with antipsychotic drugs. If signs and symptoms of tardive dyskinesia appear in a patient treated with RISPERDAL® CONSTA®, drug discontinuation should be considered. However, some patients may require treatment with RISPERDAL® CONSTA® despite the presence of the syndrome.

Cerebrovascular Adverse Events, Including Stroke, in Elderly Patients with Dementia-Related Psychosis Cerebrovascular adverse events (e.g., stroke, transient ischemic attack), including fatalities, were reported in patients (mean age 85 years; range 73-97) in trials of oral risperidone in elderly patients with dementia-related psychosis. In placebo-controlled trials, there was a significantly higher incidence of cerebrovascular adverse events in patients treated with oral risperidone compared to patients treated with placebo. RISPERDAL® CONSTA® is not approved for the treatment of patients with dementia-related psychosis. (See also **Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis**.)

Hyperglycemia and Diabetes Mellitus Hyperglycemia, in some cases extreme and associated with ketoacidosis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including RISPERDAL®. Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk factors for diabetes mellitus who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment.

PRECAUTIONS - General

Orthostatic Hypotension RISPERDAL® CONSTA® (risperidone) may induce orthostatic hypotension associated with dizziness, tachycardia, and in some patients, syncope, probably reflecting its alpha-adrenergic antagonistic properties. Syncope was reported in 0.8% (12/1499 patients) of patients treated with RISPERDAL® CONSTA® in multiple-dose studies. Patients should be instructed in nonpharmacologic interventions that help to reduce the occurrence of orthostatic hypotension (e.g., sitting on the edge of the bed for several minutes before attempting to stand in the morning and slowly rising from a seated position). RISPERDAL® CONSTA® should be used with particular caution in (1) patients with known cardiovascular disease (history of myocardial infarction or ischemia, heart failure, or conduction abnormalities), cerebrovascular disease, and conditions which would predispose patients to hypotension, e.g., dehydration and hypovolemia, and (2) in the elderly and patients with renal or hepatic impairment. Monitoring of orthostatic vital signs should be considered in all such patients, and a dose reduction should be considered if hypotension occurs. Clinically significant hypotension has been observed with concomitant use of oral RISPERDAL® and antihypertensive medication.

Seizures During premarketing testing, seizures occurred in 0.3% (5/1499 patients) of patients treated with RISPERDAL® CONSTA®. Therefore, RISPERDAL® CONSTA® should be used cautiously in patients with a history of seizures.

Dysphagia Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in patients with advanced Alzheimer's dementia. RISPERDAL® CONSTA® and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia. (See also **Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis**.)

Osteodystrophy and Tumors in Animals RISPERDAL® CONSTA® produced osteodystrophy in male and female rats in a 1-year toxicity study and a 2-year carcinogenicity study at a dose of 40 mg/kg administered IM every 2 weeks. RISPERDAL® CONSTA® produced renal tubular tumors (adenoma, adenocarcinoma) and adrenomedullary pheochromocytomas in male rats in the 2-year carcinogenicity study at 40 mg/kg administered IM every 2 weeks. In addition, RISPERDAL® CONSTA® produced an increase in a marker of cellular proliferation in renal tissue in males in the 1-year toxicity study and in renal tumor-bearing males in the 2-year carcinogenicity study at 40 mg/kg administered IM every 2 weeks.

Neither the renal or adrenal tumors, nor osteodystrophy, were seen in studies of orally administered risperidone. Osteodystrophy was not observed in dogs at doses up to 14 times (based on AUC) the IM MRHD in a 1-year toxicity study.

The renal tubular and adrenomedullary tumors in male rats and other tumor findings are described in more detail under PRECAUTIONS, Carcinogenicity, Mutagenesis, Impairment of Fertility. The relevance of these findings to human risk is unknown.

Hyperprolactinemia As with other drugs that antagonize dopamine D_2 receptors, risperidone elevates prolactin levels and the elevation persists during chronic administration. Neither clinical studies nor epidemiologic studies conducted to date have shown an association between chronic administration of this class of drugs and tumorigenesis in humans; the available evidence is considered too limited to be conclusive at this time.

Potential for Cognitive and Motor Impairment Somnolence was reported by 5% of patients treated with RISPERDAL® CONSTA® in multiple-dose trials. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that treatment with RISPERDAL® CONSTA® does not affect them adversely.

Priapism No cases of priapism have been reported in patients treated with RISPERDAL® CONSTA®. However, rare cases of priapism have been reported in patients treated with oral RISPERDAL®.

Thrombotic Thrombocytopenic Purpura (TTP) A single case of TTP was reported in a 28 year-old female patient receiving oral RISPERDAL® in a large, open premarketing experience (approximately 1300 patients). She experienced jaundice, fever, and bruising, but eventually recovered after receiving plasmapheresis. The relationship to RISPERDAL® therapy is unknown.

Antiemetic Effect Risperidone has an antiemetic effect in animals; this effect may also occur in humans, and may mask signs and symptoms of overdosage with certain drugs or of conditions such as intestinal obstruction, Reye's syndrome, and brain tumor.

Body Temperature Regulation Disruption of body temperature regulation has been attributed to antipsychotic agents.

Suicide The possibility of a suicide attempt is inherent in schizophrenia, and close supervision of high-risk patients should accompany drug therapy.

Use in Patients with Concomitant Illness Clinical experience with RISPERDAL® CONSTA® in patients with certain concomitant systemic illnesses is limited. Patients with Parkinson's Disease or Dementia with Lewy Bodies who receive antipsychotics may be at increased risk of Neuroleptic Malignant Syndrome as well as having an increased sensitivity to antipsychotic medications. Manifestation of this increased sensitivity can include confusion, obtundation, postural instability with frequent falls, in addition to extrapyramidal symptoms. Caution is advisable when using RISPERDAL® CONSTA® in patients with diseases or conditions that could affect metabolism or hemodynamic responses. Increased plasma concentrations of risperidone and 9-hydroxyrisperidone occur in patients with severe renal impairment and seen in patients with severe hepatic impairment. Patients with renal or hepatic impairment should be carefully titrated on oral RISPERDAL® before treatment with RISPERDAL® CONSTA® is initiated (see DOSAGE AND ADMINISTRATION).

Drug Interactions The interactions of RISPERDAL® CONSTA® and other drugs have not been systematically evaluated. Given the primary CNS effects of risperidone, caution should be used when RISPERDAL® CONSTA® is administered in combination with other centrally-acting drugs or alcohol. Because of its potential for inducing hypotension, RISPERDAL® CONSTA® may enhance the hypotensive effects of other therapeutic agents with this potential. RISPERDAL® CONSTA® may antagonize the effects of levodopa and dopamine agonists. Amytriptyline does not affect the pharmocokinetics of risperidone or the active antipsychotic fraction. Cimetidine and ranitidine increased the bioavailability of risperidone, but only marginally increased the plasma concentration of the active antipsychotic fraction. Chronic administration of clozapine with risperidone may decrease the clearance of risperidone.

Carbamazepine and Other Enzyme Inducers In a drug interaction study in schizophrenic patients, 11 subjects received oral risperidone titrated to 6 mg/day for 3 weeks, followed by concurrent administration of carbamazepine for an additional 3 weeks. During co-administration, the plasma concentrations of risperidone and its pharmacologically active metabolite, 9-hydroxyrisperidone, were decreased by about 50%. Plasma concentrations of carbamazepine did not appear to be affected. Co-administration of other known enzyme inducers (e.g., phenytoin, rifampin, and phenobarbital) with risperidone may cause similar decreases in the combined plasma concentrations of risperidone and 9-hydroxyrisperidone, which could lead to decreased efficacy of risperidone treatment. At the initiation of therapy with carbamazepine or other known hepatic enzyme inducers, patients should be closely monitored during the first 4-8 weeks, since the dose of RISPERDAL® CONSTA® may need to be adjusted. A dose increase, or additional oral RISPERDAL®, may need to be considered. On discontinuation of carbamazepine or other hepatic enzyme inducers, the dosage of RISPERDAL® CONSTA® should be re-evaluated and, if necessary, decreased. Patients may be placed on a lower dose of RISPERDAL® CONSTA® between 2 to 4 weeks before the planned discontinuation of carbamazepine therapy to adjust for the expected increase in plasma concentrations of risperidone plus 9-hydroxyrisperidone. For patients treated with the lowest available dose (25 mg) of RISPERDAL® CONSTA®, it is recommended to continue treatment with the 25-mg dose unless clinical judgment necessitates interruption of treatment with RISPERDAL® CONSTA®.

Fluoxetine and Paroxetine Fluoxetine (20 mg QD) and paroxetine (20 mg QD), which inhibits CYP 2D6, have been shown to increase the plasma concentration of risperidone 2.5-2.8 fold and 3-9 fold respectively. Fluoxetine did not affect the plasma concentration of 9-hydroxyrisperidone. Paroxetine lowered the concentration of 9-hydroxyrisperidone an average of 13%. When either concomitant fluoxetine or paroxetine is initiated or discontinued, the physician should re-evaluate the dosage of RISPERDAL® CONSTA®. When initiation of fluoxetine or paroxetine is considered, patients may be placed on a lower dose of RISPERDAL® CONSTA® between 2 to 4 weeks before the planned start of fluoxetine or paroxetine therapy to adjust for the expected increase in plasma concentrations of risperidone. For patients treated with the lowest available dose (25 mg), it is recommended to continue treatment with the 25-mg dose unless clinical judgment necessitates interruption of treatment with RISPERDAL® CONSTA®. The effects of discontinuation of concomitant fluoxetine or paroxetine therapy on the pharmacokinetics of risperidone and 9-hydroxyrisperidone have not been studied.

Lithium Repeated oral doses of risperidone (3 mg BID) did not affect the exposure (AUC) or peak plasma concentrations (C_{max}) of lithium (n=13).

Valproate Repeated oral doses of risperidone (4 mg QD) did not affect the pre-dose or average plasma concentrations and exposure (AUC) of valproate (1000 mg/day in three divided doses) compared to placebo (n=21). However, there was a 20% increase in valproate peak plasma concentration (C_{max}) after concomitant administration of risperidone.

Digoxin RISPERDAL® (0.25 mg BID) did not show a clinically relevant effect on the pharmacokinetics of digoxin.

Drugs that Inhibit CYP 2D6 and Other CYP Isozymes

Risperidone is metabolized to 9-hydroxyrisperidone by CYP 2D6, an enzyme that is polymorphic in the population and that can be inhibited by a variety of psychotropic and other drugs (see CLINICAL PHARMACOLOGY). Drug interactions that reduce the metabolism of risperidone to 9-hydroxyrisperidone would increase the plasma concentrations of risperidone and lower the concentrations of 9-hydroxyrisperidone. Analysis of clinical studies involving a modest number of poor metabolizers (n≈70 patients) does not suggest that poor and extensive metabolizers have different rates of adverse effects. No comparison of effectiveness in the two groups has been made.

In vitro studies showed that drugs metabolized by other CYP isozymes, including 1A1, 1A2, 2C9, 2C19, and 3A4, are only weak inhibitors of risperidone metabolism. There were no significant interactions between risperidone and erythromycin (see CLINICAL PHARMACOLOGY).

Drugs Metabolized by CYP 2D6 *In vitro* studies indicate that risperidone is a relatively weak inhibitor of CYP 2D6. Therefore, RISPERDAL® CONSTA® is not expected to substantially inhibit the clearance of drugs that are metabolized by this enzymatic pathway. In drug interaction studies, oral risperidone did not significantly affect the pharmacokinetics of donepezil and galantamine, which are metabolized by CYP 2D6.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis - Oral Carcinogenicity studies were conducted in Swiss albino mice and Wistar rats. Risperidone was administered in the diet at doses of 0.63, 2.5, and 10 mg/kg for 18 months to mice and for 25 months to rats. These doses are equivalent to 2.4, 9.4, and 37.5 times the oral maximum recommended human dose (MRHD) (16 mg/day) on a mg/kg basis, or 0.2, 0.75, and 3 times the oral MRHD (mice) or 0.4, 1.5, and 6 times the oral MRHD (rats) on a mg/m² basis. A maximum tolerated dose was not achieved in male mice. There was a significant increase in pituitary gland adenomas in female mice at doses 0.75 and 3 times the oral MRHD on a mg/m² basis. There was a significant increase in endocrine pancreatic adenomas in male rats at doses 1.5 and 6 times the oral MRHD on a mg/m² basis. Mammary gland adenocarcinomas were significantly increased in female mice at all doses tested (0.2, 0.75, and 3 times the oral MRHD on a mg/m² basis), in female rats at all doses tested (0.4, 1.5, and 6 times the oral MRHD on a mg/m² basis), and in male rats at a dose 6 times the oral MRHD on a mg/m² basis.

Carcinogenesis - IM RISPERDAL® CONSTA® was evaluated in a 24-month carcinogenicity study in which SPF Wistar rats were treated every 2 weeks with IM injections of either 5 mg/kg or 40 mg/kg of risperidone. These doses are 1 and 8 times the MRHD (50 mg) on a mg/m² basis. A control group received injections of 0.9% NaCl, and a vehicle control group was injected with placebo microspheres. There was a significant increase in pituitary gland adenomas, endocrine pancreas adenomas, and adrenomedullary pheochromocytomas at 8 times the IM MRHD on a mg/m² basis. The incidence of mammary gland adenocarcinomas was significantly increased in female rats at both doses (1 and 8 times the IM MRHD on a mg/m² basis). A significant increase in renal tubular tumors (adenoma, adenocarcinomas) was observed in male rats at 8 times the IM MRHD on a mg/m² basis. Plasma exposures (AUC) in rats were 0.3 and 2 times (at 5 and 40 mg/kg, respectively) the expected plasma exposure (AUC) at the IM MRHD. The relevance for human risk of the findings of prolactin-mediated endocrine tumors in rodents is unknown (see PRECAUTIONS - Hyperprolactinemia).

Mutagenesis No evidence of mutagenic potential for oral risperidone was found. In addition, no evidence of mutagenic potential was found in the *in vitro* Ames reverse mutation test for RISPERDAL® CONSTA®.

Impairment of Fertility Oral risperidone (0.16 to 5 mg/kg) was shown to impair mating, but not fertility, in Wistar rats in three reproductive studies at doses 0.1 to 3 times the oral maximum recommended human dose. No mating and fertility studies were conducted with RISPERDAL® CONSTA®.

Pregnancy - *Pregnancy Category C*

The teratogenic potential of oral risperidone was studied in three embryofetal development studies in Sprague-Dawley and Wistar rats (0.63-10 mg/kg or 0.4 to 6 times the oral maximum recommended human dose [MRHD] on a mg/m² basis) and in one embryofetal development study in New Zealand rabbits (0.31-5 mg/kg or 0.4 to 6 times the oral MRHD on a mg/m² basis). The incidence of malformations was not increased compared to control in offspring of rats or rabbits given 0.4 to 6 times the oral MRHD on a mg/m² basis. In three reproductive studies in rats (two peri/post-natal development studies and a multigenerational study), there was an increase in pup deaths during the first 4 days of lactation at doses of 0.16-5 mg/kg or 0.1 to 3 times the oral MRHD on a mg/m² basis. It is not known whether these deaths were due to a direct effect on the fetuses or pups or to effects on the dams. There was no no-effect dose for increased rat pup mortality. In one peri/post-natal development study, there was an increase in stillborn rat pups at a dose of 2.5 mg/kg or 1.5 times the oral MRHD on a mg/m² basis. In a cross-fostering study in Wistar rats, toxic effects on the fetus or pups, as evidenced by a decrease in the number of live pups and an increase in the number of dead pups at birth (Day 0), and a decrease in birth weight in pups of drug-treated dams were observed. In addition, there was an increase in deaths by Day 1 among pups of drug-treated dams, regardless of whether or not the pups were cross-fostered. Risperidone also appeared to impair maternal behavior in that pup body weight gain and survival (from Days 1 to 4 of lactation) were reduced in pups born to control but reared by drug-treated dams. These effects were all noted at the one dose of risperidone tested, i.e., 5 mg/kg or 3 times the oral MRHD on a mg/m² basis. No studies were conducted with RISPERDAL® CONSTA®. Placental transfer of risperidone occurs in rat pups. There are no adequate and well-controlled studies in pregnant women. However, there was one report of a case of agenesis of the corpus callosum in an infant exposed to risperidone *in utero*. The causal relationship to oral RISPERDAL® therapy is unknown. RISPERDAL® CONSTA® should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor and Delivery

The effect of RISPERDAL® CONSTA® on labor and delivery in humans is unknown.

Nursing Mothers

In animal studies, risperidone and 9-hydroxyrisperidone are excreted in milk. Risperidone and 9-hydroxyrisperidone are also excreted in human breast milk. Therefore, women should not breast-feed during treatment with RISPERDAL® CONSTA® and for at least 12 weeks after the last injection.

Pediatric Use RISPERDAL® CONSTA® has not been studied in children younger than 18 years old.

Geriatric Use In an open-label study, 57 clinically stable, elderly patients (≥65 years old) with schizophrenia or schizoaffective disorder received RISPERDAL® CONSTA® every 2 weeks for up to 12 months. In general, no differences in the tolerability of RISPERDAL® CONSTA® were observed between otherwise healthy elderly and nonelderly patients. Therefore, dosing recommendations for otherwise healthy elderly patients are the same as for nonelderly patients. Because elderly patients exhibit a greater tendency to orthostatic hypotension than nonelderly patients, elderly patients should be instructed in nonpharmacologic interventions that help to reduce the occurrence of orthostatic hypotension (e.g., sitting on the edge of the bed for several minutes before attempting to stand in the morning and slowly rising from a seated position). In addition, monitoring of orthostatic vital signs should be considered in elderly patients for whom orthostatic hypotension is of concern (see CLINICAL PHARMACOLOGY, PRECAUTIONS, and DOSAGE AND ADMINISTRATION).

Concomitant use with Furosemide in Elderly Patients with Dementia-Related Psychosis In placebo-controlled trials in elderly patients with dementia-related psychosis, a higher incidence of mortality was observed in patients treated with furosemide plus oral risperidone (7.3%; mean age 89 years, range 75-97) when compared to patients treated with oral risperidone alone (3.1%; mean age 84 years, range 70-96) or furosemide alone (4.1%; mean age 80 years, range 67-90). The increase in mortality in patients treated with furosemide plus oral risperidone was observed in two of the four clinical trials.

No pathophysiological mechanism has been identified to explain this finding, and no consistent pattern for cause of death observed. Nevertheless, caution should be exercised and the risks and benefits of this combination should be considered prior to the decision to use. There was no increased incidence of mortality among patients taking other diuretics as concomitant medication with risperidone. Irrespective of treatment, dehydration was an overall risk factor for mortality and should therefore be carefully avoided in elderly patients with dementia-related psychosis. RISPERDAL® CONSTA® is not approved for the treatment of patients with dementia-related psychosis. (See also **Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis**.)

ADVERSE REACTIONS

Associated with Discontinuation of Treatment In the 12-week, placebo-controlled trial, the incidence of schizophrenic patients who discontinued treatment due to an adverse event was lower with RISPERDAL® CONSTA® (11%; 22/202 patients) than with placebo (13%; 13/98 patients).

Incidence in Controlled Trials *Commonly Observed Adverse Events in Controlled Clinical Trials*

In the 12 week placebo-controlled trial, spontaneously reported, treatment-emergent adverse events with an incidence of 5% or greater in at least one of the RISPERDAL® CONSTA® groups (25 mg or 50 mg) and at least twice that of placebo were: somnolence, akathisia, parkinsonism, dyspepsia, constipation, dry mouth, fatigue, weight increase. Adverse Events Occurring at an Incidence of 2% or More in Patients Treated with RISPERDAL® CONSTA®: were at least as frequent among patients treated with 25 mg or 50 mg RISPERDAL® CONSTA® as patients treated with placebo in the 12-week, placebo-controlled trial.

Dose Dependency of Adverse Events

Extrapyramidal Symptoms: The overall incidence of EPS-related adverse events (akathisia, dystonia, parkinsonism, and tremor) in patients treated with 25 mg RISPERDAL® CONSTA® was comparable to that of patients treated with placebo; the incidence of EPS-related adverse events was higher in patients treated with 50 mg RISPERDAL® CONSTA®.

Vital Sign Changes: RISPERDAL® is associated with orthostatic hypotension and tachycardia (see PRECAUTIONS). In the placebo-controlled trial, orthostatic hypotension was observed in 2% of patients treated with 25 mg or 50 mg RISPERDAL® CONSTA® (see PRECAUTIONS).

Weight Changes: In the 12-week, placebo-controlled trial, 9% of patients treated with RISPERDAL® CONSTA®, compared with 6% of patients treated with placebo, experienced a weight gain of >7% of body weight at endpoint.

Laboratory Changes: The percentage of patients treated with RISPERDAL® CONSTA® who experienced potentially important changes in routine serum chemistry, hematology, or urinalysis parameters was similar to or less than that of placebo patients. Additionally, no patients discontinued treatment due to changes in serum chemistry, hematology, or urinalysis parameters.

ECG Changes: The electrocardiograms of 202 schizophrenic patients treated with 25 mg or 50 mg RISPERDAL® CONSTA® and 98 schizophrenic patients treated with placebo in a 12-week, double-blind, placebo-controlled trial were evaluated. Compared with placebo, there were no statistically significant differences in QTc intervals (using Fridericia's and linear correction factors) during treatment with RISPERDAL® CONSTA®.

Pain assessment and local injection site reactions: The mean intensity of injection pain reported by patients using a visual analog scale decreased in all treatment groups from the first to the last injection. After the sixth injection (Week 10), investigator ratings indicated that 1% of patients treated with 25 mg or 50 mg RISPERDAL® CONSTA® experienced redness, swelling, or induration at the injection site.

Other Events Observed During the Premarketing Evaluation of RISPERDAL® CONSTA® During its premarketing assessment, RISPERDAL® CONSTA® was administered to 1499 patients in multiple-dose studies. The conditions and duration of exposure to RISPERDAL® CONSTA® varied greatly, and included (in overlapping categories) open-label and double-blind studies, uncontrolled and controlled studies, inpatient and outpatient studies, fixed-dose and titration studies, and short-term and long-term exposure studies. The following reactions were reported: (Note: frequent adverse events are those occurring in at least 1/100 patients. Infrequent adverse events are those occurring in 1/100 to 1/1000 patients; rare events are those occurring in fewer than 1/1000 patients. It is important to emphasize that, although the events reported occurred during treatment with RISPERDAL® CONSTA®, they were not necessarily caused by it.)

Psychiatric Disorders *Frequent:* anxiety, psychosis, depression, agitation, nervousness, paranoid reaction, delusion, apathy. *Infrequent:* anorexia, impaired concentration, impotence, emotional lability, manic reaction, decreased libido, increased appetite, amnesia, confusion, euphoria, depersonalization, paroniria, delirium, psychotic depression.

Central and Peripheral Nervous System Disorders *Frequent:* hypertonia, dystonia. *Infrequent:* dyskinesia, vertigo, leg cramps, tardive dyskinesia[a], involuntary muscle contractions, paraesthesia, abnormal gait, bradykinesia, convulsions, hypokinesia, ataxia, fecal incontinence, oculogyric crisis, tetany, apraxia, dementia, migraine. *Rare:* neuroleptic malignant syndrome.

Body as a Whole/General Disorders *Frequent:* back pain, chest pain, asthenia. *Infrequent:* malaise, choking. ***Gastrointestinal Disorders*** *Frequent:* nausea, vomiting, abdominal pain. *Infrequent:* gastritis, gastroesophageal reflux, flatulence, hemorrhoids, melena, dysphagia, rectal hemorrhage, stomatitis, colitis, gastric ulcer, gingivitis, irritable bowel syndrome, ulcerative stomatitis. ***Respiratory System Disorders*** *Frequent:* dyspnea. *Infrequent:* pneumonia, stridor, hemoptysis. *Rare:* pulmonary edema. ***Skin and Appendage Disorders*** *Frequent:* rash. *Infrequent:* eczema, pruritus, erythematous rash, dermatitis, alopecia, seborrhea, photosensitivity reaction, increased sweating. ***Metabolic and Nutritional Disorders*** *Infrequent:* hyperuricemia, hyperglycemia, hyperlipemia, hypokalemia, glycosuria, hypercholesterolemia, obesity, dehydration, diabetes mellitus, hyponatremia. ***Musculo-Skeletal System Disorders*** *Frequent:* arthralgia, skeletal pain. *Infrequent:* torticollis, arthrosis, muscle weakness, tendinitis, arthritis, arthropathy. ***Heart Rate and Rhythm Disorders*** *Frequent:* tachycardia. *Infrequent:* bradycardia, AV block, palpitation, bundle branch block. *Rare:* T-wave inversion. ***Cardiovascular Disorders*** *Frequent:* hypotension. *Infrequent:* postural hypotension. ***Urinary System Disorders*** *Frequent:* urinary incontinence. *Infrequent:* hematuria, micturition frequency, renal pain, urinary retention. ***Vision Disorders*** *Infrequent:* conjunctivitis, eye pain, abnormal accommodation. ***Reproductive Disorders, Female*** *Frequent:* amenorrhea. *Infrequent:* nonpuerperal lactation, vaginitis, dysmenorrhea, breast pain, leukorrhea. ***Resistance Mechanism Disorders*** *Infrequent:* abscess. ***Liver and Biliary System Disorders*** *Frequent:* increased hepatic enzymes. *Infrequent:* hepatomegaly, increased SGPT. *Rare:* bilirubinemia, increased GGT, hepatitis, hepatocellular damage, jaundice, fatty liver, increased SGOT. ***Reproductive Disorders, Male*** *Infrequent:* ejaculation failure. ***Application Site Disorders*** *Frequent:* injection site pain. *Infrequent:* injection site reaction. ***Hearing and Vestibular Disorders*** *Infrequent:* earache, deafness, hearing decreased. ***Red Blood Cell Disorders*** *Frequent:* anemia. ***White Cell and Resistance Disorders*** *Infrequent:* lymphadenopathy, leucopenia, cervical lymphadenopathy. *Rare:* granulocytopenia, leukocytosis, lymphopenia. ***Endocrine Disorders*** *Infrequent:* hyperprolactinemia, gynecomastia, hypothyroidism. ***Platelet, Bleeding and Clotting Disorders*** *Infrequent:* purpura, epistaxis. *Rare:* pulmonary embolism, hematoma, thrombocytopenia. ***Myo-, Endo-, and Pericardial and Valve Disorders*** *Infrequent:* myocardial ischemia, angina pectoris, myocardial infarction. ***Vascular (Extracardiac) Disorders*** *Infrequent:* phlebitis. *Rare:* intermittent claudication, flushing, thrombophlebitis.

Postintroduction Reports Adverse events reported since market introduction which were temporally (but not necessarily causally) related to oral RISPERDAL® therapy include the following: anaphylactic reaction, angioedema, apnea, atrial fibrillation, cerebrovascular disorder, including cerebrovascular accident, hyperglycemia, diabetes mellitus aggravated, including diabetic ketoacidosis, intestinal obstruction, jaundice, mania, pancreatitis, Parkinson's disease aggravated, pulmonary embolism. There have been rare reports of sudden death and/or cardiopulmonary arrest in patients receiving oral RISPERDAL®. A causal relationship with oral RISPERDAL® has not been established. It is important to note that sudden and unexpected death may occur in psychotic patients whether they remain untreated or whether they are treated with other antipsychotic drugs.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class RISPERDAL® CONSTA® (risperidone) is not a controlled substance.

For more information on symptoms and treatment of overdosage, see full prescribing information.

7519504 - US Patent 4,804,663 Revised April 2005 ©Janssen 2003

01-CS-352BS

JANSSEN PHARMACEUTICA PRODUCTS, L.P.

Titusville, NJ 08560

B. Aiming for the Stars: Refining Recovery in Practice *Helen M. Glover, B.S.W.*

C. You Can Do It. We Can Help *Larry Davidson, Ph.D.*

S71. How to Practice Evidence-Based Medicine

A. Introduction to Evidence-Based Medicine *Kumaraswamy Budur, M.D.*

B. Review of Basic Statistical Concepts *Maju Mathews, M.D.*

C. Critical Appraisal of Systematic Reviews and Meta-Analysis *Babatunde A. Adetunji, M.D.*

D. Critical Appraisal of Randomized, Controlled Studies *Adedapo B. Williams, M.D.*

S72. The Problem of Outcomes With the Difficult-to-Treat Patient

A. Framing the Problem of Outcome With the Difficult-to-Treat Patient *Richard L. Munich, M.D.*

B. Rethinking Outcomes in Mentalization-Based Treatment *Jon G. Allen, Ph.D.*

C. Cognitive-Behavioral Therapy for Treatment Refractory OCD and Other Anxiety Disorders: Outcome Data From a Specialized Hospital Program *Throstur Bjorgvinsson, Ph.D.*

D. The Problem of Outcomes With the Difficult-to-Treat Patient *Norma V. Clarke, M.D.*

E. Future Direction of Specialized Treatment Programs: Mentalizing, Brain Imaging Studies, and Preliminary Outcomes *Efrain Bleiberg, M.D.*

S73. The Art and Science of Brief Psychotherapies

A. Brief Cognitive Therapy *Judith S. Beck, Ph.D.*

B. Interpersonal Psychotherapy *Scott P. Stuart, M.D.*

C. Solution-Focused Brief Therapy *Brett Steenbarger*

D. Common Factors: Essential Ingredients for Successful Psychotherapy *Roger P. Greenberg*

S74. Neuropsychiatric Responses to Burns: Modeling the Developmental Neurobiology of Trauma

A. Neurobiological Responses to Burn Trauma *John B. Levine, M.D.*

B. The Psychology and Physiology of Burn Stress in Very Early Childhood *Jennifer E. Drake, M.A.*

C. Determinants of Traumatic Stress in Older Children *Glenn Saxe, M.D.*

D. Pharmacological and Psychological Prevention of PTSD *Rohini Luthra, Ph.D.*

E. Psychopharmacological Interventions for Stress in Children *Frederick J. Stoddard Jr., M.D.*

Latest Health Care Trends Focus of Workshops

Two workshops at this year's annual meeting will provide excellent opportunities for members and others to learn about the latest developments in key areas that are soon likely to have a major impact on psychiatric practice. One of the workshops will explore pay-for-performance issues, and the other will delve into the shift from paper to electronic medical records.

The workshop titled "Pay for Performance: Linking Incentives to Provider Performance on Quality Measures" is sponsored by APA's Council on Quality Care and Council on Healthcare Systems and Financing in association with the Department of Quality Improvement and Psychiatric Services (QIPS). It will be held on Monday, May 22, from 9 a.m. to 10:30 a.m.

Pay-for-performance initiatives are taking hold in both private and public health plans. The workshop will review the status of pay for performance, its potential impact on clinicians, and the processes by which national bodies are selecting measures of mental health care. Participants will be able to discuss measures that are under consideration, and APA's role in the performance-measurement movement will be reviewed. Presenters will include Richard Hermann, M.D., Bruce Schwartz, M.D., and John Oldham, M.D.

A workshop on the fast-moving trend to adopt electronic health records (EHR) will be sponsored by APA's Corresponding Committee on Electronic Health Records and QIPS. The workshop is titled "The National Health Information Network and Psychiatry: How Will the Coming National Electronic Health Records Impact Our Patients and Our Practice?" and will be held on Wednesday, May 24, from 9 a.m. to 10:30 a.m.

Presenters will detail the latest developments in the national effort toward interoperable EHR and a national health information network. A great deal of activity is now consolidated under the federal Office of the National Coordinator for Health Information Technology. The workshop will review the status of the EHR movement, provide opportunities to discuss issues such as privacy and confidentiality, and describe ways in which psychiatrists can contribute to this rapidly accelerating campaign.

QIPS staff have been following national developments in health information technology, and representatives from the department will be available at the APA Membership Center to discuss these issues. Staff will be distributing a survey to assess current EHR adoption by APA members and to learn what information and services members would like APA to provide in this area. At the end of the annual meeting, a drawing of completed surveys will be held to award the latest edition of the compendium *APA Practice Guidelines for the Treatment of Psychiatric Disorders*. In addition, a new health information technology page will soon be added to the APA Web site at <www.psych.org>.

QIPS staff would like to hear from members about their experiences with health information technology. The department's e-mail address is qips@psych.org. ■

S75. Acute Brief Psychoses: Nosology and Boundaries

A. Acute and Transient Psychotic Disorders *Prof. Andreas Marneros*

B. The Relationship Between Acute and Transient Psychotic Syndromes and Psychotic Symptoms in the General Population: Implications for Causes and Treatment *Peter B. Jones, Dr. Med. Sc.*

C. Panic Attacks With Psychotic Features: A Variant of Nonaffective Acute Remitting Psychoses? *Igor I. Galynker, M.D.*

D. The Place of Nonaffective Acute Remitting Psychoses in *DSM-IV* and *ICD-10 Ramin Mojtabai, M.D.*

S76. Enhancing the Well-Being of Older Persons With Schizophrenia *APA Council on Aging*

A. Assessing Medical Comorbidity and Optimizing Medical Care in Older Patients With Schizophrenia *Ipsit Vahia, M.D.*

B. Enhancing Quality of Life in Older Persons With Schizophrenia *Azziza O. Bankole, M.D.*

C. Diminishing Depression in Older Adults With Schizophrenia: Targets for Intervention *Shilpa P. Diwan, M.D.*

D. Adaptive Functioning in Older Persons With Schizophrenia *Carl I. Cohen, M.D.*

S77. Demoralization and Psychotherapy: A Tribute to Jerome D. Frank, M.D.

A. The Demoralization Hypothesis: Conceptualization, Epidemiology, and Clinical Relevance *John M. de Figueiredo, M.D.*

B. Demoralization in the Experience of Being Ill *David Clarke*

C. Brief Psychotherapy at the Bedside: Countering Demoralization From Medical Illness *James L. Griffith, M.D.*

S78. Use of Quantitative Instruments for Monitoring Depression Severity: Clinical Applications

A. National Depression Management Leadership Initiative: Improving Depression Care *Henry Chung, M.D.*

B. Depression Management Experience in Private Versus Public Psychiatric Practices *Rodrigo A. Muñoz, M.D.*

C. Depression Management Experience in Primary Care *Jack S. McIntyre, M.D.*

D. Depression Screeening and Management in New York City *Lloyd I. Sederer, M.D.*

E. Optimizing the Treatment of Depression: Using Treatment Algorithms in Conjunction With Standardized Instruments in Clinical Care Settings *Madhukar H. Trivedi, M.D.*

S79. Women's Life Cycle and Mental Health

A. The Female Life Cycle: From Childhood to Old Age *G. William Bates, M.D.*

B. Menopausal Management *Esther Eisenberg, M.D.*

C. TBD *Patricia Matthews-Juarez, Ph.D.*

D. Psychosocial Aspects of Infertility *Samuel O. Okpaku, M.D.*

S80. Stalking Offenders and Victims

A. Stalking: An Overview of the Problem *Gail E. Robinson, M.D.*

B. Stalking Victims: A Comprehensive Treatment Approach *Karen M. Abrams,M.D.*

C. Stalking: A Treatment Concept for Offenders *Werner Tschan, M.D.*

S81. Nicotine Dependence and Schizophrenia: Neurobehavioral Pathways *National Institute on Drug Abuse*

A. Nicotine Intake and Blood Levels in Smokers With Schizophrenia *Jill Williams, M.D.*

B. Effects of Biological and Environmental Challenges on Smoking in Schizophrenic Versus Nonpsychiatric Heavy Smokers *Jennifer W. Tidey, Ph.D.*

C. Nicotine Abuse and the Neurobiology of Schizophrenia *Robert Freedman, M.D.*

D. Pharmacological Treatment of Nicotine Dependence in Schizophrenia: Modulation of Outcomes by Atypical Antipsychotic Drugs, Cognitive Function, and Genetic Polymorphisms *Tony P. George, M.D.*

E. Integrating Tobacco Dependence Treatment Into Mental Health Treatment *Douglas M. Ziedonis, M.D.*

S82. Adolescent Alcohol Use Disorders and Psychiatric Comorbidity *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. Trauma and Alcohol Use Disorders in Adolescents: Psychiatric Comorbidity and Adult Outcomes *Duncan B. Clark, M.D.*

B. Assessing Alcohol Problems in Adolescents With Psychiatric Comorbidity *Deborah Deas, M.D.*

C. Treatment of Adolescents With Alcohol Problems and Major Depression *Jack R. Cornelius, M.D.*

D. When ADHD and Substance Use Disorders Collide *Timothy E. Wilens, M.D.*

S83. Educating a New Generation of Physicians in Psychiatry: Focus on Medical Student Education

A. Medical Student Education in Psychiatry: Where We Are and Where We Can Go *Myrl R.S. Manley, M.D.*

B. Medical Student Education in Psychiatry: A Model *Lowell D. Tong, M.D.*

C. Medical Student Education in Psychiatry: Impacting Career Choice and Practice *Brian A. Palmer, M.D.*

D. Medical Student Education in Psychiatry: What We Can Learn From Other Disciplines *Deborah Danoff, M.D.*

S84. Patient Safety: To Err Is Human, To Be Safe Is Divine *APA Committee on Patient Safety*

A. Length of Stay in the Psychiatric Emergency Room of an Urban Teaching Hospital *Patrick T. Triplett, M.D.*

B. A Primer for Prescribing: How to Prevent Medication Errors *Kathryn J. Ednie, M.D.*

C. Educating Faculty and Residents on Patient Safety *Carl B. Greiner, M.D.*

D. Suicide and Patient Safety *Geetha Jayaram, M.D.*

E. Your Role and All of Our Roles in

continued on page 58

Making Patient Safety a Bigger Reality *Alfred Herzog, M.D.*

S85. Relationships Between Axis I and Axis II *Association for Research in Personality Disorders*

A. State and Trait in Personality Disorders *James H. Reich, M.D.*

B. Spectra of Pathology Across Axis I and Axis II Disorders *David P. Bernstein, Ph.D.*

C. Etiological Relationships Among Dimensions of Personality Disorders and Axis I Syndromes *John Livesley, M.D.*

D. A Comparison of Mu-Opioid Receptor Activity in Depressed Subjects and in Subjects With Borderline Personality Disorder *Kenneth R. Silk, M.D.*

E. A Neurobiologic Perspective on the Relationship Between Axis I and Axis II Disorders *Larry J. Siever, M.D.*

S86. Science to Policy: Advancing Women's Mental Health *Association of Women Psychiatrists*

A. Science to Policy: Psychiatric Aspects of Reproductive Health *Nada L. Stotland, M.D.*

B. PTSD in Women Veterans: From Science to Policy *Marian I. Butterfield, M.D.*

C. Premenstrual Dysphoric Disorder: Treatment Update *Tana A. Grady-Weliky, M.D.*

D. Neuroactive Steroids in Men and Women: Investigations in Schizophrenia, Bipolar Disorder, and Alzheimer's Disease *Christine E. Marx, M.D.*

E. Ethnic and Racial Disparities in Women's Mental Health *Annelle B. Primm, M.D.*

S87. Alcohol, Drugs, and Psychiatric Disorders in the U.S. *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. Comorbidity of Pain and Substance Use Disorders in the U.S. *Wilson M. Compton, M.D.*

B. Antisocial Personality Disorder and Lifetime Course of Alcohol Use Disorders in the U.S. General Population *Rise B. Goldstein, Ph.D.*

C. Prevalence, Correlates, and Comorbidity of Alcohol Use Disorders in the U.S. *Frederick S. Stinson, Ph.D.*

D. Prevalence, Correlates, and Comorbidity of Nonmedical Sedative, Tranquilizer, Opioid, and Amphetamine Use, Abuse, and Dependence in the U.S. *Bridget F. Grant, Ph.D.*

E. Cannabis Withdrawal Syndrome in 2,613 Lifetime Heavy Cannabis Users From a National Survey: Symptom Prevalence, Factor Structure, and Correlates *Deborah S. Hasin, Ph.D.*

S88. Sobering Facts: Alcohol Dependence and Treatment Interventions *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism*

A. The Impact of Alcohol Use Disorders *Richard J. Frances, M.D.*

B. Alcohol Dependence: Difficulties in Diagnosis *Kathleen T. Brady, M.D.*

C. Integrating Pharmacotherapy and Psychosocial Support in Treating the Alcohol-Dependent Patient *Roger D. Weiss, M.D.*

D. Pharmacotherapy for the Treat-

How to Obtain Certificate of Attendance

There are now four easy methods for APA members to obtain a personalized or nonpersonalized CME Certificate of Attendance for APA's 2006 annual meeting in Toronto.

- An official certificate of attendance can be found in the front of the annual meeting *Syllabus & Proceedings Summary* book that all registrants receive. This certificate can be filled in and forwarded to other organizations.

- To receive a formal parchment CME Certificate of Attendance, and to provide valuable feedback regarding experiences and opinions of the annual meeting, there is a print evaluation form in the meeting registration packet. Once the General Evaluation Form is completed, return it to the Computerized Evaluation Center or APA Member Center at the annual meeting, and you will receive a blank parchment certificate.

- For the computer fearless, the Evaluation Program is available as a Web-based online form that can be completed at the APA Computerized Evaluation Center, located across from the Internet Village at the Toronto Convention Centre. Computer terminals will provide access to the evaluation form. Registrants who complete the evaluation form will receive a personalized certificate on site.

- The evaluation form can also be completed at the annual meeting in areas with "wireless" access at the convention site or in your hotel room or after the meeting using any remote computer. A personalized CME Certificate of Attendance can then be printed out.

APA's Scientific Program Committee urges all members to provide feedback on the annual meeting so that APA can continue to ensure that the meeting reflects the needs of its members.

ment of Alcohol Dependence: Review of Outcome Data *Robert M. Swift, M.D.*

S89. Pharmacotherapy for Single- and Dual-Diagnosed Substance Abusers *American Academy of Addiction Psychiatry*

A. Comorbidity With Opioid Dependence *Edward V. Nunes, M.D.*

B. Pharmacotherapy of Comorbid Substance Abuse and Schizophrenia *Steven L. Batki, M.D.*

C. Comorbidity of General Psychiatric Disorders and Cocaine Abuse *Thomas R. Kosten, M.D.*

D. The Comorbidity of Bipolar Spectrum Disorders and Substance Use Disorders *Stephen Ross*

S90. Science and Regulation Affecting Private Practice

A. Evidence-Based Medicine in Child and Adolescent Psychiatry: What Is Your Best Guess? *Jeffrey A. Naser, M.D.*

B. Evidence-Based Medicine in Solo Private Practice: What If the Patient Doesn't Fit? *Ronald D. Abramson, M.D.*

C. Missing Resources: Comprehensive Psychiatry for People With Medical Illnesses *John C. Urbaitis, M.D.*

D. Comprehensive Psychiatry in 2006: Confidentiality and Access to Care in Private Practice and in Military Practice *Brian Crowley, M.D.*

E. TBD *Harold I. Eist, M.D.*

S91. Recent Advances in Ethnopsychopharmacological, Ethnic, and Cultural Aspects of Mood and Anxiety Disorders

A. Ethnopsychopharmacology *David C. Henderson, M.D.*

B. Psychiatric Management of Hispanic Patients: Cross-Cultural Issues and Ethnopsychopharmacology *David Mischoulon, M.D.*

C. Impact of Cultural Beliefs on the Treatment of Depressed Chinese Americans *Albert Yeung, M.D.*

D. Challenges in the Diagnosis and Treatment of Mood and Anxiety Disorders in the Asian-Indian Population: Cross-Cultural Factors and Psychopharmacological Considerations *Rajesh M. Parikh, M.D.*

S92. Anxiety and Emotional Dysfunction in Endophenotype of Schizophrenia

A. Schizophrenia and Obsessive-Compulsive Disorder: The Role of Serotonergic and Dopaminergic Systems *Joseph Zohar*

B. Anxiety Comorbidities and Role of Emotion in Endophenotype of Schizophrenia *Stefano Pallanti*

C. Investigating the Cognitive and Emotional Neuropsychology of Schizophrenia Comorbid With Anxiety Disorders *Naomi A. Fineberg, M.A.*

D. Psychophysiological Investigation of Pathological Anxiety and Emotional Dysfunction in Patients With Schizphrenia *Werner Strik, M.D.*

S93. Teaching Psychiatry Residents About Informed Consent

A. Informed Consent in Psychiatry: An Overview *Thomas G. Gutheil, M.D.*

B. Initiation of Psychotherapeutic and Psychopharmacologic Treatment by Psychiatry Residents *Bret R. Rutherford, M.D.*

C. Informed Consent for Psychotherapy *Thomas G. Gutheil, M.D.*

D. Complications of the Informed-Consent Process in Psychotherapy *Glen O. Gabbard, M.D.*

E. Informed Consent in Psychopharmacology *Steven K. Hoge, M.D.*

S94. Sustained Recovery and Healthy Functioning: The Long and Short of It

A. Evidence for Recovery in the Psychotherapy of Personality Disorders *John C. Perry, M.D.*

B. Change in Psychological Risk and Recovery in Recurrent Depression *Elisabeth Banon*

C. Dynamic Recovery in Patients With Treatment-Refractory Disorders *Christopher Fowler*

D. Examining the Sequence of Recovery in Long-Term Dynamic Psychotherapy *Michael P. Bond*

E. A Review of Treatment Evidence on Sustained Recovery and Healthy Functioning *Daniel Frank, M.D.*

S95. Mental Health Disparities: Concepts, Assessment, Evidence-Based Practice, and Advocacy *APA Council on Minority Mental Health and Health Disparities*

A. Estimating Mental Health Disparities for Latinos and Asians Using the National Latino and Asian-American Study *Margarita Alegria, Ph.D.*

B. Strategies for Assessing Mental Health Disparities Using Health Care for Communities *Thomas McGuire, Ph.D.*

C. Addressing Mental Health Disparities in Evidence-Based Mental Health Practices *Steve Leff*

D. Reducing Mental Health Disparities for Racial and Ethnic Minorities: The APA Plan of Action *Francis G. Lu, M.D.*

S96. Fearful Sleep Arousals

A. Does Movement Suppression Index Central Fear System Involvement

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in PTSD Nightmares? *Steve H. Woodward, Ph.D.*

B. Sleep Terrors and Sleepwalking in Children and Adults *Rosalind D. Cartwright, Ph.D.*

C. Nocturnal Panic Attack: An Underrecognized Fearful Arousal *Ravi K. Singareddy, M.D.*

D. Sleep Paralysis: Overlooked Fearful Arousal *Thomas W. Uhde, M.D.*

S97. Translating the Neurobiology of Alcoholism Into Clinical Treatments
Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism

A. Lost in Translation: Preclinical Studies of Genetic Susceptibility and Neuroadaptations Point to a Growing List of Novel Candidate Targets for Treatment of Alcoholism *Markus Heilig, M.D.*

B. Medications for Treating Alcoholism: From Animal Models to Clinical Usefulness *Charles P. O'Brien, M.D.*

C. Animal Models for Novel Medications for Alcoholism: View From the Dark Side *George F. Koob*

D. Alcohol Relapse-Like Behavior in Laboratory Animals: The Nociceptin/Orphanin Fq System: A Potential Target for the Development of New Pharmacotreatments *Roberto Ciccocioppo, Ph.D.*

E. TBD *Barbara J. Mason, Ph.D.*

S98. Same-Sex Civil Marriage: Historical and Mental Health Research Perspectives

A. Gay Marriage in History: New Manifestations of Old Traditions *Robert P. Cabaj, M.D.*

B. Gay Marriage in The Netherlands: The First Five Years *Nicolaas F. Hettinga, M.D.*

C. Leading the Way: Canadian Same-Sex Marriage *Laura M. Chapman, M.D.*

D. Six Weeks of Marriage Vows in San Francisco: Personal Perspectives *Ellen Haller, M.D.*

E. Same-Sex Marriage From a Mental Health Research Perspective *Robert M. Kertzner, M.D.*

S99. Psychiatry in Amsterdam: Acute Psychiatric Services in a Metropolitan Area

A. The Amsterdam Model: Past, Present, and Future *Hans Sanders, M.D.*

B. Urbanization as a Risk Indicator for Psychiatric Disturbances *Jack J. Dekker, Ph.D.*

C. A One-Year Prospective Study of the Temporary Transitional Unit *Wijnand Mulder, M.D.*

D. Controversies and Dilemmas Regarding the Amsterdam Model: Case Histories *Hans Nusselder, M.D.*

E. Community Admission Units in Amsterdam: A Benchmark Study *Cecilia Gijsbers Van Wijk, M.D.*

2 p.m.-5:30 p.m.
Advances in Schizophrenia *Jeffrey Lieberman, M.D.*

3 p.m.-5 p.m.
New Research Poster Session 9

7 p.m.-10 p.m.
Industry-Supported Symposia
IS43. What Is the Role of Somatic and Physical Symptoms in Depression?
Supported by Wyeth Pharmaceuticals

A. The Neurobiology of Somatic and Physical Symptoms in Depression *Pedro L Delgado, M.D.*

B. Pain and Other Somatic Symptoms and Their Relationship to Antidepressant Treatment Outcome *George I. Papakostas, M.D.*

C. Diagnostic Challenges in Medically Ill Patients With Depression *Donna E. Stewart, M.D.*

D. Management Issues in the Treatment of Depression With Comorbid Medical Disorders *Jonathan E. Alpert, M.D.*

E. Are All Antidepressants Equally Effective in the Treatment of Somatic and Physical Symptoms in Depression? *Maurizio Fava, M.D.*

IS44. Diagnosing and Treating Alcohol Dependence in the Office *Supported by Alkermes Inc. and Cephalon Inc.*

A. Alcoholism as a Chronic Disease: Implications for Office-Based Treatment *A. Thomas McLellan, Ph.D.*

B. Screening, Diagnosis, and Early Intervention *Kathleen T. Brady, M.D.*

C. Current and Emerging Treatment Options in Alcoholism *Richard N. Rosenthal, M.D.*

D. Office-Based Treatment of Co-Occurring Psychiatric Disorders *Shelly F. Greenfield, M.D.*

E. Behavioral Therapies for Alcohol Dependence *Grace Hennesy, M.D.*

IS45. Managing Unmet Needs in Psychiatric Illnesses: A Critical Look at Disorders and Public Policy *Supported by Solvay Wyeth Pharmaceuticals*

A. Managing the Unmet Needs in Depression *A. John Rush, M.D.*

B. Managing the Unmet Needs in Bipolar Disorder *Roger S. McIntyre, M.D.*

C. Managing the Unmet Needs in Schizophrenia *Marvin S. Swartz, M.D.*

D. Managing the Unmet Needs in Dementia *K. Ranga R. Krishnan M.B.*

E. Managing the Unmet Needs: A Public Health Dilemma *Junius J. Gonzales, M.D.*

IS46. Remission and Recovery in Schizophrenia: Advocating for Our Patients *Supported by Eisai Inc. and Pfizer Inc.*

A. Defining Remission and Recovery in Schizophrenia *Nancy C. Andreasen, M.D.*

B. Should Functional Outcomes Be a Defining Feature of Remission and Recovery in Schizophrenia? *Stephen R. Marder, M.D.*

C. An Evidence-Based Approach to Achieving Remission and Recovery in Schizophrenia *John M. Kane, M.D.*

D. Barriers to Achieving Remission and Recovery in Schizophrenia *Meera Narasimhan, M.D.* ■

Networking Opportunities for Minority/Underrepresented Members

APA has planned a variety of activities for minority/underrepresented (MUR) psychiatrists attending this year's annual meeting. Among them are meetings of APA's MUR caucuses, which are forums to discuss issues and concerns. The following caucuses will meet during the annual meeting:

- **Caucus of American Indian, Alaska Native, and Native Hawaiian Psychiatrists:** Monday, May 22, 7 a.m.-8:15 a.m., Wellington Room, Intercontinental Hotel
- **Caucus of Asian-American Psychiatrists:** Monday, May 22, 6:30 p.m.-7:30 p.m., Wellington Room, Intercontinental Hotel
- **Caucus of Black Psychiatrists:** Tuesday, May 23, 5:30 p.m.-7 p.m., Humber Room, Intercontinental Hotel
- **Caucus of Gay, Lesbian, and Bisexual Psychiatrists and the Association of Gay and Lesbian Psychiatrists:** Tuesday, May 23, 5:30 p.m.-7 p.m., Carlyle A Room, Delta Chelsea
- **Caucus of Hispanic Psychiatrists:** Monday, May 22, 6:30 p.m.-7:30 p.m., Oakville Room, Intercontinental Hotel
- **Caucus of International Medical Graduates:** Monday, May 22, 6:30 p.m.-8:30 p.m., Grenadier Room, Intercontinental Hotel
- **Caucus of Women Psychiatrists and the Association of Women Psychiatrists:** Monday, May 22, 7 p.m.-9 p.m., Governor General's Suite, Hilton

For a list of sessions and events on diversity-related topics, visit <www.psych.org/downloads/APA_Schedule3.pdf>. More information on these sessions is available from Alison Bondurant by phone at (703) 907-8639 or by e-mail abondurant@psych.org .

APA wants to hear from members who qualify for membership in one of its minority/underrepresented caucuses. This will help APA keep these members informed about news and activities that may be of particular interest to them.

Members who haven't indicated their ethnicity or race on their membership records are encouraged to do so and to join one of the minority/underrepresented group caucuses.

Name _____
Phone _____
E-Mail _____

These are the ethnicities/races listed on the APA membership application:
☐ American Indian/Eskimo/Aleut/Native Hawaiian
☐ Mexican/Mexican American
☐ Puerto Rican
☐ Other Spanish descent (Cuban, Central American, or South American)
☐ Filipino
☐ Indian/Pakistani/Ceylonese/Malay
☐ Japanese/Chinese/Korean/Other Asian
☐ African American/Black

These are the seven APA minority/underrepresented group caucuses:
☐ American Indian/Alaska Native/Native Hawaiian
☐ International Medical Graduates
☐ Gay/Lesbian/Bisexual
☐ Hispanic
☐ Asian American
☐ Black
☐ Women

Members can provide this information to APA's Membership Department by e-mail to apa@psych.org or by phone at (888) 357-7924 or by mailing this form to APA Department of Minority and National Affairs, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209.

Find Your Voice in APA

Are you looking for a forum in which to share your expereinces and concerns? Are you considering changing your practrice setting? Do you want to find out what's going on with other psychiatrists in similar practice settings? If you answered yes to any of these questions, the APA caucus program is for you.

The program highlights topics important to psychiatrists working in specialized treatment settings or with particular patient groups. Each meeting is an open forum to which you can bring your concerns, comments, complaints, or kudos and discuss them with colleagues who may be experiencing similar issues. Several APA caucuses will meet at the annual meeting in Toronto. The schedule and locations for these caucus meetings are as follows:

Monday, May 22

2 p.m.-4 p.m. **Caucus of VA Psychiatrists**
Library, Mezzanine Floor, Royal York Hotel

Tuesday, May 23

9 a.m.-11 a.m. **Caucus of State Hospital Psychiatrists**
Whistler Room, Hospitality Floor, Royal York Hotel

2 p.m.-4 p.m. **Caucus of Psychiatrists Treating Persons With Mental Retardation/Developmental Disabilities**
Banff Room, Hospitality Floor, Royal York Hotel

Caucus of Psychiatrists Working in Correctional Settings
Confederation 3 Room, Mezzanine Floor, Royal York Hotel

7 a.m.-8:30 a.m.
Industry-Supported Breakfast Symposia
IS39. Emerging Evidence in the Treatment of Bipolar Depression (Part 2) *Supported by AstraZeneca Pharmaceuticals*

A. Neurobiology of Bipolar Patients: What Does It Tell Us? *Sophia Frangou, M.D.*

B. Future Treatments: Repetitive Transcranial Magnetic Stimulation and Vagus Nerve Stimulation in Bipolar Depression *Guohua Xia, M.D.*

IS40. Bipolar Illness: The Road to Remission (Part 2) *Supported by Bristol-Myers Squibb Co.*

A. An Evidence-Based Approach to Achieving Remission in Bipolar Illness *Roger S. McIntyre, M.D.*

B. The Role of Non-Pharmacologic Therapies in Achieving Remission *Eduard Vieta, M.D.*

IS41. New Frontiers in Depression: Providing Solutions to Unmet Needs (Part 2) *Supported by Solvay Wyeth Pharmaceuticals*

A. Unipolar Versus Bipolar Depression: Diagnostic and Therapeutic Challenges *James M. Martinez, M.D.*

B. Current and Novel Treatment Options for Treatment-Resistant Depression *Lauren B. Marangell, M.D.*

IS42. What the Psychiatrist Needs to Know About Sleep-Related Movement Disorders (Part 2) *Supported by GlaxoSmithKline*

A. Restless Legs Syndrome and Psychiatric Disorders: Demonstrating a Relationship *John W. Winkelman, M.D.*

B. Current Therapeutic and Management Strategies in Restless Legs Syndrome and Periodic Limb Movements of Sleep *Clete A. Kushida, M.D.*

7:30 a.m.-2 p.m.
Registration/Course Enrollment Open

8 a.m.-Noon
CME Courses 98-101

9 a.m.-10:30 a.m.
Clinical Case Conferences

5. Consultation-Liaison Casebook Challenge: Strategies and Limitations in Establishing Competency *Dimitri D. Markov, M.D., Kenneth M. Certa, M.D., John Paul Gomez, M.D., David H. Lynn, M.D., Jacob Widroff, M.D.* **(for APA members only)**

Issue Workshops

IW77. Direct to Consumer Marketing: Just Who Is the Consumer? *Co-Chairpersons: Nadeem H. Bhanji, M.D., David A. Baron*

IW78. Can I Change? A Journey Through Ex-Gay Ministries and Beyond *Association of Gay and Lesbian Psychiatrists; Co-Chairpersons: Mary E. Barber, M.D., David L. Scasta, M.D.*

IW79. A Model for Improved Psychiatric Services in Developing Countries: South Asian Forum *International South Asian Forum; Chairperson: Jagannathan Srinivasaraghavan, M.D.*

IW80. Use of a Standardized Comprehensive Psychiatric Assessment Tool to Facilitate Evidence-Based Decisions: The InterRAI Mental Health *Co-Chairpersons: Trevor F. Smith, Ph.D., John P. Hirdes, Ph.D.*

IW81. Going to the Heart of the Matter in Patient Interviews *Chairperson: Harold J. Bursztajn, M.D.*

IW82. Fibromyalgia: Current Understanding and Future Directions *Co-Chairpersons: Alan Z. Manevitz, M.D., James P. Halper, M.D.*

IW83. Traumatized Children in Iraq *Chairperson: Sadiq H. Al-Samarrai, M.D.*

IW84. International Medical Graduates in Training and Practice: Professional and Personal Trials *Co-Chairpersons: Michael F. Myers, M.D., Nyapati R. Rao, M.D.*

IW85. Race and Countertransference in the Clinical Setting *Co-Chairpersons: Sherri M. Simpson, M.D., Sandra C. Walker, M.D.*

IW86. Dialectical Behavioral Therapy With Adolescents *Chairperson: Viet Q. Bui, M.D.*

IW87. Mental Health Issues in the Aftermath of Hurricane Katrina *Co-Chairpersons: Philip T. Merideth, M.D., Grayson Norquist, M.D.*

IW88. Size Matters: Teaching Medical Students in Small Groups *Co-Chairpersons: Lana M. Benedek, M.D., Bruce C. Ballon, M.D.*

IW89. So You Want to Be a Clinical Investigator *Chairperson: Arthur Lazarus, M.D.*

IW90. Collaborative Mental Health Care in Canada *Chairperson: Nick Kates, M.B.*

IW91. Psychiatry in the Primary Care Setting: Making It Work for Doctors and Patients *Chairperson: John C. Urbaitis, M.D.*

IW92. Computer Tools for Cognitive-Behavior Therapy: Integrating Technology Into Clinical Practice *Chairperson: Jesse H. Wright, M.D.*

IW93. Cultural Diversity and Psychiatry: Clinical Care, Research, and Education *Chairperson: Niranjan S Karnik, M.D.*

IW94. Cardiovascular Complica-

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Shoes

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with its lid resting slightly askew, which is no accident.

Moriyama is quoted as saying, "When I first viewed the collection [of shoes], I was impressed by the array of shoe boxes that protected the shoes from light and dust."

Two of the museum's outer walls angle inward from roof to sidewalk.

At the museum's entrance, a glass wedge protrudes through the building's limestone and enables passersby to see the lobby, five-story steel staircase, and a 42-foot high window in the rear of the building.

Visitors usually begin their tour with the exhibit "All About Shoes: Footwear Through the Ages," which gives an overview of shoes that have been worn through different periods of history.

The exhibit "Icons of Elegance: Influential Shoe Designers of the 20th Century" features the shoes of Salvatore Ferragamo, Manolo Blahnik, and Christian Louboutin, among others.

The award-winning "Beads, Buckles, and Bows: Four Hundred Years of Embellished Footwear" features 300-year-old Italian dress shoes made of apple-green-colored silk, embroidered ankle boots from 19th century France, and ornately beaded Italian heels from a more modern time, the late 1960s. This exhibit explains how sequins were once made out of beetle wings, fish scales, or mother of pearl. Nowadays, sequins are decorative but were once worn to repel evil and promote fertility, according to museum literature.

Another exhibit opening in March will feature the shoes of Chinese children throughout the ages.

The Bata Shoe Museum is located at 327 Bloor Street West. More information is posted at <www.batashoemuseum.ca/>. ■

Castle

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The conservatory's stained-glass ceiling dome was also imported from Italy. The round room housed a number of exotic plants, and to ensure that they survived, steam pipes were buried in the flower beds.

The Oak Room boasts oak panels carved so intricately that they were first displayed in the Musee Beaux Arts in Montreal in 1913 before being installed in Casa Loma. Italian craftsmen were brought to Toronto to carve the oak panels and the molded plaster ceiling.

The Pellatts' private quarters occupy a large portion of the castle's second floor. Lady Pellatt's bedroom, bathroom, sitting room, and balcony occupy 3,000 square feet. Sir Pellatt's quarters are smaller, but include an 18-inch-diameter showerhead in his bathroom.

Sometimes, the parts of the castle that are hidden are just as fascinating as those that are on display.

For instance, there are hidden stairways that lead from Pellatt's study to a wine cellar in the basement and to a second-floor hallway.

There is also an 800-foot tunnel 18 feet below ground that leads from Casa Loma to the estate's elaborate stables, where gold name plates for the horses used to adorn each of the mahogany stalls. Stable floors are constructed with Spanish tiles.

Due to the gradual deterioration of certain structures, in 1996 an elaborate restoration of the castle and stables began.

The grounds of the estate also feature five acres of gardens.

A self-guided digital audio tour in eight languages (English, French, Japanese, German, Italian, Spanish, Mandarin, and Korean) is available for a $2 surcharge.

Casa Loma is located at 1 Austin Place, a short walk from the Dupont subway stop. It is open daily from 9:30 a.m. to 5 p.m. Admission is $12 for adults aged 18 to 59 $7.50 for those aged 60 and up. There are discount rates for youngsters under age 18. More information about Casa Loma is posted at <www.casaloma.org/>. ■

DSM

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neural circuitry, and neurochemistry/neuroendocrinology.

The symposium "Diagnostic Criteria in Alzheimer's Disease and Dementia," chaired by NIH's Trey Sunderland, M.D., will highlight the work group's recommendations for exploiting recent scientific breakthroughs in a fast-moving field. Presentations will address how diagnostic criteria might be updated to reflect data emerging from novel applications of neuroimaging technologies, how improved assessment of executive function and attention can contribute to a better understanding of the pathology of the dementias, and how prospects for clinically applicable biomarkers in prognosis and diagnosis of Alzheimer's disease and dementia.

The research planning conference series, which APIRE administers with the cosponsorship of WHO and NIH, is nearly halfway complete, with five of the 12 conferences already conducted. Future conferences will focus on psychotic disorders, the spectrum of obsessive-compulsive behavior, somatic presentations of mental disorders, externalizing disorders of childhood, depression and generalized anxiety disorders, and the clinical, forensic, economic, and other implications of a revised classification from a public health perspective. Another conference will assess the overall practicality and utility of incorporating dimensional approaches into the *DSM*.

Each conference is being co-chaired by a senior U.S. investigator and an international colleague, and psychiatrists and others from around the world are being invited to participate.

"The extent of international interest in the *DSM-V* research-planning conferences is very encouraging," Regier said. "Because the manual is used throughout the world, we are making a strenuous effort to ensure that *DSM-V* empirically considers the different ways in which individuals experience mental disorders across cultures, socioeconomic status, and across the globe.

"Members should be aware that a Web site is available at <www.dsm5.org> that provides information about the future conferences and detailed summaries of those that have already taken place. We will use the site to report new developments as they occur over the next several years and to offer researchers and the general public opportunities to offer feedback and suggestions regarding *DSM* development."

He noted that Michael First, M.D., who is a consultant to APIRE and has played a major role in prior revisions of the *DSM*, led the creation of the Web site. ■

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Issue Workshop: "Virtual Reality and Video Games in the Treatment of Mental Health Disorders and Addictions: An Evidence-Based Analysis"; Monday, May 22, 11 a.m. to 12:30 p.m.; Salon A, Convention Floor, Royal York Hotel

Presenters will review the scientific literature regarding various technological therapeutic innovations, such as virtual reality, video games, and other forms of computer-based therapy in terms of therapeutic effectiveness, diagnosis, treatment, and psychoeducation. The workshop will also cover the possible risks of ethical concerns and exacerbation of mental health problems.

Course: "How to Use Your Palm OS PDA in Psychiatric Practice: Basic"; Tuesday, May 23, 8 a.m. to noon; Conference Room F, Mezzanine, Sheraton Centre

This course is for beginners who own a Palm OS PDA. There will be hands-on instruction on how to enter information, use the different built-in programs, synchronize with a desktop computer, install software, and utilize medical software such as ePocrates Rx.

Course: "How to Use Your Palm OS PDA in Psychiatric Practice: Advanced Topics"; Tuesday, May 23, 1 p.m. to 5 p.m.; Conference Room F, Mezzanine, Sheraton Centre

This course is for advanced users who seek to get more out of their Palm OS device. This course is not intended for beginners or for those taking the above basic course until after they have had time to practice the skills mastered in that course. Topics will include how to prepare emergency backup of data, how to create a handheld database, how to capture Web sites for offline viewing, and how to better organize your programs for ease of use. You will learn how to create PDFs and carry them on your PDA here.

Course: "How to Use Your Pocket PC PDA in Psychiatric Practice"; Wednesday, May 24, 8 a.m. to noon; Windsor Room East, Mezzanine, Sheraton Centre

This course will cover basic functions of the Windows Mobile (formerly known as Pocket PC) operating system for PDAs. Participants will learn ways to optimize their device settings, implement security, synchronize data with a desktop computer, install software, and run various medical applications.

Component Workshop: "The National Health Information Network and Psychiatry: How Will the Coming National Electronic Health Record (EHR) Impact Our Patients and Our Practice?"; Wednesday, May 24, 9 a.m. to 10:30 a.m.; Room 205 D, Level 200, Toronto Convention Centre, North

Presenters will discuss the development of the national health information infrastructure in the U.S. under the Office of the National Coordinator for Health Information Technology. They will review the status of the EHR movement, privacy and confidentiality issues, and the processes that are being utilized to develop standards and requirements for a nationally interoperable HER system.

Issue Workshop: "The Quality Information System: A New System for Measuring Progress in the Doctor-Patient Relationship"; Wednesday, May 24, 9 a.m. to 10:30 a.m., Room 714 B, Level 700, Toronto Convention Centre, South

Presenters will demonstrate use of the Quality Information System, a computerized system used in routine clinical practice. This program can implement a short measurement instrument (like the Health of the Nation Outcome Scales) to evaluate the treatment progress of individual patients and groups in a clinical practice, hospital, or health care system.

Course: "Psychiatry and the Internet"; Wednesday, May 24, 1 p.m. to 5 p.m.; Wentworth Room, Second Floor, Sheraton Centre

This course will review some of the many resources available on the Internet, such as Web browsers and search engines, and how to use them efficiently. Participants will learn how to access and find medical information, as well as how to download it. Patient-care issues such as online therapy and its implications will be reviewed.

Issue Workshop: "Computer Tools for CBT: Integrating Technology Into Clinical Practice"; Thursday, May 25, 9 a.m. to 10:30 a.m., Room 711, Level 700, Toronto Convention Centre, South

This workshop will provide a brief overview of the use of computers in treatment and education. Topics covered will include indications for using computer tools in clinical practice, integration of computer and human components of therapy and education, methods of using computer tools for CBT training, and economic issues.

Issue Workshop: "Use of a Standardized Comprehensive Psychiatric Assessment Tool to Facilitate Evidence-Based Decisions: The InterRAI Mental Health"; Thursday, May 25, 9 a.m. to 10:30 a.m., Room 205 A, Level 200, Toronto Convention Centre, North

This workshop will review use of the InterRAI mental health standardized data collection system for mental health, which is designed to include care planning, outcome measurement, quality improvement, and case mix–based funding applications. Workshop participants will learn how to use this comprehensive assessment tool for evidence-based clinical decision making and outcomes evaluation.

Symposium: "Virtual Environments and Convergent Media Technology"; Thursday, May 25, 2 p.m. to 5 p.m., Room 104 D, Level 100, Toronto Convention Centre, North

This symposium will review how virtual reality (VR) environments, created through computerized simulation programs and displays, have become clinically useful in medical and psychological VR applications. The presenters will discuss VR use in assessment, therapy, and rehabilitation, as well as for study of brain functions.

Symposium: "Using Technology to Improve Patient Care"; Thursday, May 25, 2 p.m. to 5 p.m., Room 714 B, Level 700, Toronto Convention Centre, South

This symposium will review how PDAs are playing an expanding role in health care. Clinical decision support, improved quality of care, and even prescription cost savings are some of the ways that technology improves patient care. ■

tions of Second Generation Antipsychotic Drugs *Co-Chairpersons: Peter Manu, M.D., Raymond E. Suarez, M.D.*

IW95. Children of Psychiatrists *Co-Chairpersons: Michelle B. Riba, M.D., Leah J. Dickstein, M.D.*

9 a.m.-Noon

Media Workshop

MW7. *"Bad Education"*: Portraying Transsexualism, Pedophilia, and Addiction *American Academy of Child and Adolescent Psychiatry; Chairperson: Jose P. Vito, M.D.*

11 a.m.-12:30 p.m.

Issue Workshops

IW96. Group Psychotherapy of Substance Abuse *American Group Psychotherapy Association; Co-Chairpersons: David W. Brook, M.D., Henry I. Spitz, M.D.*

IW97. Providing Behavioral Health Treatment Services for Very Young Special-Needs Children and Their Families *Chairperson: Peter D Ganime, M.D.*

IW98. The Impact of Race and Gender on the Interactions Between Female Psychiatry Residents and Their Patients: An Interactive Group Workshop *Co-Chairpersons: Nancy M. Bivens, M.D., Christina V. Mangurian, M.D.*

IW99. Identifying and Managing Patients With Schizophrenia and a Genetic Syndrome *Chairperson: Anne S. Bassett, M.D.*

IW100. Disasters, Public Policy, and Addiction Psychiatry *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism; Chairperson: Richard J. Frances, M.D.*

IW101. Performance-Enhancement Psychological Techniques in Golf *International Society for Sport Psychiatry; Co-Chairpersons: Syed S. A. Naqvi, M.D., Salvador R. del Rosario Jr., M.D.*

IW102. Anorexia and Malnutrition in the Elderly Patient *Chairperson: Jonathan T. Stewart, M.D.*

IW103. Medical Comorbidity in Dual-Diagnosis Patients *Collaborative Session With the National Institute on Alcohol Abuse and Alcoholism; Chairperson: Vasant P. Dhopesh, M.D.*

IW104. Detecting Bipolar Disorder *Co-Chairpersons: Gary E. Miller, M.D., Richard L. Noel, M.D.*

IW105. Simulations and Psychiatric Education: Workshop for Standardized Patient Training *Co-Chairpersons: Nancy L. McNaughton M.Ed., Kerry J. Knickle, B.A.*

IW106. Making It Happen: Implementing the APA Practice Guideline for Major Depressive Disorder in Everyday Practice *Chairperson: Jack S. McIntyre, M.D.*

IW107. Desperate Housewives Survive the War of the Worlds: Therapeutic Perspectives on Women's Health *Chairperson: Richard K. Harding, M.D.*

IW108. Psychiatrists Who Have Faced Mental Illness in Themselves: There Is a Silver Lining *Co-Chairpersons: Michael F. Myers, M.D., Leah J. Dickstein, M.D.*

IW109. Teaching Human Sexuality to Health Science Students Using the Sexual Events Classification System *Association for Academic Psychiatry; Co-Chairpersons: Donald C. Fidler, M.D., Gregg Dwyer, M.D.*

IW110. Improving Access to Healthcare for Homeless Persons Living With HIV/AIDS *Co-Chairpersons: Keith R. Stowell, M.D., Antoine B. Douaihy, M.D.*

Medical Update 4. *Philip Wong, M.D., on* Liver Transplant Update: Current Outcomes and Challenges in 2006

Scientific and Clinical Reports

Session 34. Current Research in Depression and Anxiety

100. Desvenlafaxine: Preclinical Evidence for 5HT and Norepinephrine Reuptake Inhibition, Antidepressant, and Antinociceptive Activity *Terrance H. Andree, Ph.D.*

101. Efficacy and Safety of Desvenlafaxine Succinate in the Treatment of MDD *Nicholas Demartinis, Ph.D.*

102. Panic Disorder Associated With Severe Dizziness: Demographic and Clinical Features and Treatment With Clonazepam *Antonio E. Nardi, M.D.*

Session 35. Panic Disorders

103. A 40-Year Follow-Up Study of Patients With Panic Disorder *Gabriel Rubio, M.D.*

104. Resilience in Anxiety Disorders *Catherine Mancini, M.D.*

105. The Naturalistic Treatment of Panic Disorder in a Real-World Clinical Setting *Eric D. Peselow, M.D.*

Session 36. Family Contributions/Perspectives

106. Family Background and Genius: Nobel Laureates in Science *Albert Rothenberg, M.D.*

107. Familial Psychiatric Disorders and Sudden Infant Death Syndrome: Is There a Significant Relationship? *Jeffrey Sverd, M.D.*

108. The Parent's Perspective on Gender Variant Children and Adolescents: Concerns, Hopes, and Joys *Darryl B. Hill, Ph.D.*

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Session 37. Matching Treatment to Appropriate Populations

109. Patterns of Symptom Response in the Treatment for Adolescents With Depression Study: Do Some Symptoms Respond Better to Certain Treatments? *Jessica L. Murakami, M.S.*

110. Antipsychotics in the Treatment of Delirium: A Review of Prospective Trials *Dallas P. Seitz, M.D.*

111. Treatment Matching in the Post-Hospital Care of Patients With Depression *Gabor I. Keitner, M.D.*

Session 38. Suicide

112. Distinguishing Patients Who Attempt Suicide From Patients With Ideation Only *Stephen B. Woolley, M.P.H.*

113. Hopelessness and Suicidality Three Months Post-Hospital Discharge *John W. Goethe, M.D.*

114. Parent's Socioeconomic Status, Psychiatric Disorders, and Suicidality as Risk Factors of Subsequent Suicide of Offspring: The Northern Finland 1966 Birth Cohort Study *Antti S. Alaräisänen, M.B.*

Session 39. Current Trends and Controversies in Psychiatry

115. A Review of Chemical Castration and Its Use in the U.S. Penal System *Sara G. West, M.D.*

116. Acupuncture and Cognitive-Behavior Therapy for PTSD *Michael Hollifield, M.D.*

117. Pseudoseizures: Interaction of Past Traumatic Stress and Current Suppression of Negative Affects *James L. Griffith, M.D.*

Session 40. Cultural Variations in Psychiatric Illness

118. BPD and Cultures *Bernadette M. Grosjean, M.D.*

119. Patterns of Antidepressant Prescribing and Suicide in Israel *Dov Aizenberg, M.D.*

120. Prevalence of PMDD Among Women in a Primary Care Outpatient Setting in the United Arab Emirates *Ossama T. Osman, M.D.*

Session 41. Lifestyle Issues in Mental Health

121. Lifestyle Issues in Mental Health: Social Support, Diet, Fitness, and Recreation *Henry T. Chuang, M.D.*

122. Alcoholism in Schizophrenia: Systematic Review 2000-2004 *Johanna Koskinen, M.B.*

123. Cigarette Smoking Among Psychiatric Outpatients: A Matched Case-Control Study in Bucaramanga, Colombia *Adalberto Campo-Arias, M.D.*

Session 42. Studies in Addiction

124. Substance Abuse in Bipolar Disorder *E. Sherwood Brown, M.D.*

125. Substance-Related Disorders and Dual Diagnosis in a Random Nation-Wide Sample of 998 Prisoners: Prevalences and Risk Factors *Michael Lukasiewicz, M.D.*

126. Stroop Performance in Pathological Gamblers *Pinhas N. Dannon, M.D.*

Session 43. Complication of Treatments in Psychiatric Disorders

127. Armodafinil Improves Fatigue in Patients With Excessive Sleepiness Due to Obstructive Sleep Apnea/Hypopnea Syndrome *Steven Hull, M.D.*

128. Efficacy, Tolerability, and Safety of Once-Daily Atomoxetine Hydrochloride Versus Placebo in Taiwanese Children and Adolescents With ADHD *Susan Shur-Fen Gau, M.D.*

129. Medication Nonadherence in Bipolar Disorder: The Role of Patients Treatment Perceptions *Rob Horne*

Session 44. Therapeutic Solutions for Caregiving Families

130. Spirituality and Recovery From Depression *Caroline B. Williams, M.D.*

131. Depression and Caregiver Burden in Families of People With Schizophrenia *Lawrence Haber, Ph.D.*

132. Psychodrama Groups for Psychiatric Intervention to Family Members of Patients With Schizophrenia *Derya I. Akbiyik, M.D.*

12 p.m.-1:30 p.m.

Forums

14. Psychotherapy Tools for Disaster-Related Problems *Chairperson: Katherine Shear, M.D.*

15. Improving the Quality of Health Care for Mental and Substance Use Conditions *Chairperson: Mary Jane England, M.D.*

Noon-2 p.m.

New Research Poster Session 10

2 p.m.-5 p.m.

Symposia

S100. Strengthening of Mental Health Systems in Low- and Middle-Income Countries *APA Council on Global Psychiatry*

A. Strengthening of Mental Health Systems in Low and Middle Income Countries: World Health Organization's Current Activities *Shekhar Saxena, M.C.*

B. Strengthening the Mental Health System in Chile *Alberto H. Minoletti, M.D.*

C. Strengthening the Mental Health System in Pakistan *Khalid Saeed, M.D.*

D. Strengthening of Mental Health Services: The Role of NGOs *R. Thara, M.D.*

E. Assessment and Strengthening of the Mental Health System in the Hunan Province of China *Li L. Jiang, M.D.*

E. Activities of the World Psychiatric Association to Strenthen Mental Health in Low- to Middle-Income Countries *M. Parameshvara Deva*

S101. Identifying Subtypes in OCD

A. OCD Subtypes and Drug Treatment Response *Wayne K. Goodman, M.D.*

B. Subtypes of OCD From a Familial Perspective *Gerald Nestadt, M.D.*

C. OCD Subtypes Based on Course of Illness and Clinical Features *Jane L. Eisen, M.D.*

D. Neurobiological Heterogeneity in OCD *Sanjaya Saxena, M.D.*

S102. Virtual Environments and Convergent Media Technology

A. Virtual Reality Assets for Assessment, Therapy, and Rehabilitation *Albert A. Rizzo, Ph.D.*

B. Why Simulate? The Cognitive Neuroergonomics of Virtual Environments *Henry J. Moller, M.D.*

C. Can Virtual Reality Be Useful for the Study of Brain Functions? *Pierre Boulanger, Ph.D.*

D. Music Triggered Avatars: A New Way to Express Emotion in the Virtual World *Robyn Taylor, B.S.C.*

E. The Evolution of Clinical Virtual Reality Simulation Over the Past 10 Years *Ken Graap, M.Ed.*

S103. A Research Agenda for *DSM-V* Concerning Religious and Spiritual Issues in the Diagnostic Process *APA Corresponding Committee on Religion, Spirituality, and Psychiatry*

A. Religious and Spiritual Aspects in the Diagnosis of Depression *Dan G. Blazer II, M.D.*

B. Religious and Spiritual Aspects of the Diagnosis of Anxiety Disorders and Adjustment Disorders *Samuel B. Thielman, M.D.*

C. Substance Dependence and Spirituality *Marc Galanter, M.D.*

D. Religious and Spiritual Aspects of Personality Traits and Disorders *C. Robert Cloninger, M.D.*

E. Religious and Spiritual Aspects of Child and Adolescent Psychiatric Disorders *Mary Lynn Dell, M.D.*

S104. Global Mental Health Disparities: A Cultural Perspective and the Potential for Formal and Informal International Exchanges *APA Council on Global Psychiatry*

A. The Global Treatment Gap in Mental Health Care *Robert Kohn, M.D.*

B. International Cooperation in Regional Psychiatric Programs *Rodrigo A. Muñoz, M.D.*

C. Trauma Treatment at the Child Rescue Center at Bo, Sierra Leone *Michael A. Hollifield, M.D.*

D. Socioeconomic and Environmental Realities and Cultural Factors Affecting Children's Mental Health and Treatment in Africa *Dolores Garcia-Moreno, M.D.*

E. An International Perspective on Disability *Samuel O. Okpaku, M.D.*

S105. Psychiatry on the Silver Screen

A. The Movies, the Mind, and Hollywood Stereotypes *Rudolf A. Feijen, M.D.*

B. Teaching Psychiatry by Movie Clips: How to Overcome Stereotypes *Bastiaan L. Oele, M.D.*

C. Cinema in the Consulting Room: The Silver Screen as a Projection Screen *Josephine M. Caubel, M.D.*

D. The Use of Film in a Psychodynamic Treatment *Willem C. Tuinebreijer, M.D.*

S106. Treatment of Personality Disorders: Preview of TPD IV

A. Treatment of the Narcissistic Personality *Elsa F. Ronningstam, Ph.D.*

B. Treatment of Histrionic Personality Disorder *Glen O. Gabbard, M.D.*

C. Psychotherapy With Cluster A Personality Disorders *Michael H. Stone, M.D.*

D. Treatment of Borderline Personality Disorder *John G. Gunderson, M.D.*

E. Treatment of Cluster C Personality Disorders and Its Empirical Support *John C. Perry, M.D.*

S107. Post-Deployment Mental Health: Translating Research Into Clinical Practice

A. The Veterans Affairs/Department of Defense Response to OIF/OEF Mental Health Challenges *Harold S. Kudler, M.D.*

B. Traumatic Brain Injury in OEF/OIF Veterans: Implications for Health Care *Robin A. Hurley, M.D.*

C. Neuroactive Steroids and Stress in Psychiatric Disorders *Christine E. Marx, M.D.*

D. Multimodal Imaging Assessment of PTSD *Rajendra A. Morey, M.D.*

E. The Amygdala, Stress, and Substance Abuse *Scott D. Moore*

S108. Improving Cross-Cultural Competency in Psychiatric Training

A. Preparing Psychiatrists of the Future to Treat an Increasingly Diverse Population *Annelle B. Primm, M.D.*

B. Asians and Psychiatry: Understanding Their Perspectives *Consuelo C. Cagande, M.D.*

C. Mental Disorders: Hispanics as Patients and Clinicians *Humberto Marin, M.D.*

D. South-Asian Immigrant Physician: American Patient, Cross-Cultural Treatment *R. Rao Gogineni, M.D.*

S109. Bereavement and *DSM-V*

A. Should Bereavement Remain an Exclusion for Major Depression? *Sidney Zisook, M.D.*

B. Complicated Grief and *DSM-V* *Holly G. Prigerson, Ph.D.*

C. Complicated Grief Treatment: Implications for *DSM-V* *M. Katherine Shear, M.D.*

D. Treatment of Bereavement-Related Depression: Implications for *DSM-V* *Paula Hensley, M.D.*

S110. NAMI Doctors Sound Off *National Alliance on Mental Illness*

A. Recovery Programs and Mental Illness *Edward F. Foulks, M.D.*

B. Formulary Roulette: Getting Better Odds With Access to Treatment *Kenneth Duckworth, M.D.*

C. Medication Adherence: Partnering With Your Patients *Stephen M. Goldfinger, M.D.*

D. The Changing Role of Families in Psychiatry *Anand Pandya, M.D.*

E. Recovering Psychiatrists *Elizabeth A. Baxter, M.D.*

S111. Infectious Diseases and Psychiatric Symptomatology

A. SARS: Psychological Consequences for the Patient the Health Care Worker and the General Population *Rima Styra, M.D.*

B. Psychiatric Aspects of HIV/AIDS *Stephen J. Ferrando, M.D.*

C. Hepatitis C Disease Management Patterns in High-Risk Populations: Testing, Infection, and Treatment Rates Among Patients With Serious Mental Illness and Substance Use Disorders *Peter Hauser, M.D.*

D. Delusional Parasitosis: An Infectious Disease Created Within Our Own Minds and Spread as Folie-a-Deux by Primitive Biological Mechanisms *Annette M. Matthews, M.D.*

S112. Using Technology to Improve Patient Care *American Association for Technology in Psychiatry*

A. Personal Digital Assistants in Psychiatric Care *John Luo, M.D.*

B. Quality and Cost Impact of PDA Use in Psychiatry in Florida Medicaid *Naakesh A. Dewan, M.D.*

C. Internet Resources to Assist in Clinical Decision Making *Robert S. Kennedy, M.A.*

D. TBD *Britton A. Arey, M.D.*

S113. Neurofeedback Advances in ADHD: Does the Research Validate Clinical Use?

A. Progress in Efficacy Studies of EEG Biofeedback for ADHD *Roger J. deBeus, Ph.D.*

B. The Scientific Foundation of EEG Biofeedback as an Intervention for ADHD *Laurence M. Hirshberg, Ph.D.*

C. The Interaction Between Neurofeedback Training and Medication in the Treatment of ADHD: Four Case Illustrations *David A. Mitnick, M.D.*

S114. Sleep Deprivation: Theoretical and Practical Implications

A. Sleep Deprivation: Overview of Implications for Mental Health Professionals *Thomas W. Uhde, M.D.*

B. TBD *Andrew D. Krystal M.D.*

C. The Effects of Sleep Deprivation on Stress and Immune Systems *Alexandros Vgontzas, M.D.*

D. Antidepressant Effects of Sleep Deprivation *Robert M. Post, M.D.*

E. Sleep Deprivation and Post-Traumatic Stress Disorder *Bernadette M. Cortese, M.D.*

S115. International Perspective on Quality Improvement Initiatives *World Psychiatric Association*

A. International Issues of Quality Assurance in Mental Health *Julio E. Arboleda-Florez, M.D.*

B. Quality Management in Psychiatry–A Task for the Future *Wolfgang Gaebel, Ph.D.*

C. Recent Advance in the Development and Implementation of Practice Guidelines *Jack S. McIntyre, M.D.*

D. NEED TITLE *J. Richard Ciccone, M.D.*

E. Suicide Prevention in Iceland: Outcome Parameters *Hogni Oskarsson, M.D.*

S116. Armed and Dangerous: Is Your Patient Safe to Return to Work? *APA Corresponding Committee on Psychiatry in the Workplace*

A. Workplace Safety Overview *Marie-Claude Rigaud, M.D.*

B. Physician Heal Yourself: The Impaired Physician *Marilyn Price, M.D.*

C. The Police Problem, Problem Police *Marcia Scott, M.D.*

D. Vulnerable Positions/Defining Roles *Andrea G. Stolar, M.D.*

S117. One Patient/Four Minds: Integrated Treatment for MDD

A. Mind One: Neurobiological Perspective *Guylain Bouchard, M.D.*

B. Mind Two: Interpersonal Psychotherapy for Depression *Simon Patry, M.D.*

C. Mind Three: Afraid to Take Medicine? Targeting the Rational Thinking *Nicole Thibodeau, M.D.*

D. One Patient/Four Minds: Integrated Treatment for Major Depressive Disorder *Marie-Josee Filteau, Dr. Med. Sc.*

E. One Patient/Four Minds: Integrated Treatment Approach for Major Depressive Disorder *Gerard Leblanc, M.D.*

S118. U.S. Military Psychiatry and Operation Iraqi Freedom: An Update

A. Mental Health Impact of Combat Operations in Iraq and Afghanistan: Update and Lessons Learned *Charles W. Hoge, M.D.*

B. The Evolution of Operational Mental Health Care in the United States Navy and Marine Corps From WWI to Operation Iraqi Freedom *James J. Reeves, M.D.*

C. Operation Iraqi Freedom: Walter Reed Army Medical Center Inpatient Psychiatry: An Update *Theodore S. Nam, M.D.*

D. Psychiatric Intervention With Wounded Soldiers: A Consultation-Liaison Approach *Harold J. Wain, Ph.D.*

E. The Challenges to Psychiatric Leadership at a Military Medical Center During Wartime *Stephen J. Cozza, M.D.*

S119. Complementary, Alternative, and Integrative Approaches in Mental Health Care

A. Classical Homeopathy: An Overview for Psychiatrists *Pamela A. Pappas, M.D.*

B. Ayurveda: Ancient Wisdom for Modern Psychiatry *Sudha Prathikanti, M.D.*

C. No Effect of Anonymous Distant Healing on Survival Time for Patients With Glioblastoma Multiforme *Andrew J. Freinkel, M.D.*

D. Select Integrative Medicine Treatments for Depression in Women *Priti Sinha*

E. Meditation for Psychiatric Disorders: A Review of the Evidence *Jeffrey D. Rediger, M.D.*

S120. Suicide on College Campuses: Practical and Ethical Issues

A. The Epidemiology of College Student Suicide *Morton M. Silverman, M.D.*

B. Screening College Students for Suicide Risk *Ann P. Haas, Ph.D.*

C. The University Response to Suicide Prevention and Treatment *Paul J. Barreira, M.D.*

D. Ethical Dilemmas of College Student Suicide *Paul S. Appelbaum, M.D.*

E. Balancing Privacy and Protection Concerns in Suicidal College Students *Barbara H. Stanley* ■

Sessions

continued from page 2

The other lecture, titled "Psychiatry and Education: When the Twain Meet," will be given on Wednesday, May 24, at 9 a.m. by James Comer, M.D., a professor of child psychiatry at Yale University's Child Study Center. Dr. Comer is an inspiring advocate for children and the pioneer of the Comer Method, which bridges child psychiatry and education; it has been disseminated in over 500 schools in the United States. He has written numerous books, most recently *Leave No Child Behind: Preparing Today's Youth for Tomorrow's World.*

Vivian Pinn, M.D., will also deliver an invited lecture, titled "Priorities, Initiatives, and Women's Health Research," in which she will discuss research advances in women's health and their relevance to psychiatry. In 1991 Dr. Pinn, a lifelong advocate for access to health care, was named the first full-time director of the Office of Research on Women's Health at the National Institutes of Health.

This year we are especially honored to have Aaron T. Beck, M.D., present the Adolf Meyer Award lecture. Dr. Beck, who is internationally recognized for his pioneering work in cognitive therapy for depression, will talk on "New Advances in Cognitive Therapy." He is a professor emeritus of psychiatry at the University of Pennsylvania and has written or cowritten more than 450 articles and 17 books.

Always a popular draw at the annual meeting is the session "Advances in Research," originally developed by Herbert Pardes, M.D., president and chief executive officer of New York Presbyterian Hospital and a former APA president and director of the National Institute of Mental Health. In this session, which will be held on Monday, May 22, at 10:30 a.m., psychiatric experts will provide a succinct and relevant update for clinicians on the latest advances in the field. Among the presenters will be Jeffrey Leiberman, M.D., chair of psychiatry at Columbia University, who will discuss the CATIE research outcomes and implications of antipsychotic use for people with schizophrenia.

APA's annual meeting isn't limited to psychiatric topics; the meeting also provides updates in selected areas of general medicine each year. This year's medical update topics are congestive heart failure, psychopharmacological and alternative therapies for children with attention-deficit disorder, testosterone replacement therapy in aging men, and liver transplants.

Take a break from the heavy scientific action by attending the noon forum on Monday, May 22, titled "Harry Potter and the Half-Blood Prince: Harry Potter Grows Up." It will be chaired by JoAnne Isbey, an associate professor of language and literature at the University of Detroit Mercy. And if you want a little fun in a more serious setting, don't miss the "Focus Live" series. No, it's not the set of "Who Wants to Be a Millionaire," but audience members get to use an electronic response system to answer questions posed by the presenters and receive immediate feedback on their knowledge. Deborah Hales, M.D., director of APA's Division of Education and Career Development, has organized sessions on three topics this year: psychotherapy, led by Jerald Kay, M.D.; eating disorders and sexual disorders, led by Joel Yager, M.D., and Steven Levine, M.D.; and personality disorders, led by Glen Gabbard, M.D.

The master educator clinical consultation series provides another interactive format for learning with psychiatry experts who are outstanding educators. Among them: Marion Goldstein, M.D., director of the Division of Geriatric Psychiatry at the University of New York at Buffalo, on geriatric psychiatry, and Prakash Masand, M.D., a professor of psychiatry at Duke University, on treatment refractory depression. All sessions are limited to 30 participants to provide plenty of opportunity to interact with faculty.

Rick D'Ali, M.D., a media expert and child psychiatrist at Duke University, will moderate a follow-up to last year's standing-room-only debate on the safety and efficacy of second-generation antipsychotics as compared with first-generation antipsychotics.

This year we will offer a new format planned collaboratively with Robert Hales, M.D., editor in chief of American Psychiatric Publishing Inc. (APPI), and its Editorial Advisory Board. Experts in their respective areas of psychiatry will review recent advances in psychopharmacology, personality disorders, psychodynamic psychotherapy, mood disorders, and schizophrenia.

Also in collaboration with APPI, we have expanded the "Meet the Author" discussion groups. Several of these are in the area of academic psychiatry and training. For example, Laura Roberts, M.D., chair of psychiatry at the Medical College of Wisconsin, will lead a discussion on career development issues in academic psychiatry. Michele Riba, M.D., immediate past president of APA and a professor of psychiatry at the University of Michigan, will discuss core competency issues in residency training, particularly combining pharmacotherapy and psychotherapy training. Authors and experts in women's mental health, Donna Stewart, M.D., University Professor of Psychiatry and Obstetrics and Gynecology at the University of Toronto, and Vivian Burt, M.D., a professor of psychiatry at UCLA, will discuss their recent advances in understanding menopause and women's mental health, respectively.

The list of don't-miss sessions could go on and on, but you get the idea: something will appeal to you in every time slot in which scientific sessions are scheduled. And when you are not in scientific sessions, you can get to know our host city better. This issue of *Psychiatric News* will introduce you to much that Toronto has to offer and persuade you to register today for the meeting. Registration details appear on page 4. See you there! ■

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The Department of Psychiatry is located near the southern shore of Lake Erie where the University district includes the affordable and historic neighborhoods of Shaker Heights, University Heights, and Cleveland Heights, an outstanding public school system, a world class orchestra, and abundant recreational activities. University Hospitals of Cleveland and Case Western Reserve are Affirmative Action/Equal Opportunity Employers. Women and minorities are strongly encouraged to apply. The University is an equal-opportunity/affirmative action employer. Visit us on the web at www.case.edu/med/psychiatry.

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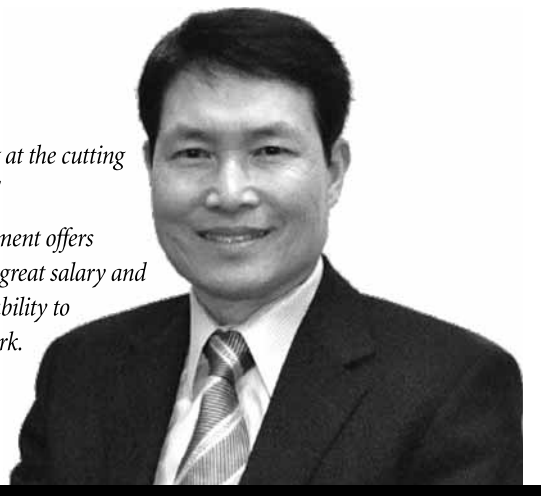
The Department of Psychiatry is located near the southern shore of Lake Erie where the University district includes the affordable and historic neighborhoods of Shaker Heights, University Heights, and Cleveland Heights, an outstanding public school system, a world class orchestra, and abundant recreational activities. University Hospitals of Cleveland and Case Western Reserve are Affirmative Action/Equal Opportunity Employers. Women and minorities are strongly encouraged to apply. The University is an equal-opportunity/affirmative action employer. Visit us on the web at www.case.edu/med/psychiatry.



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Please send a letter of interest with curriculum vitae and three letters of reference to:

Jonathan Kaplan, M.D., Interim Director
SUNY-Upstate Medical University
Department of Psychiatry
750 E. Adams Street
Syracuse, NY 13210
(315) 464-3104
OR email: cn00025@omh.state.ny.us

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For more information, contact:

Angie Farris, Director
St. John's Clinic
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Come to the beautiful and sunny southwest! Arizona State Hospital in Phoenix is recruiting for full-time board certified/qualified psychiatrists at our 338 bed JCAHO accredited hospital, including 160 beds-adult civil, 162 beds-forensic, and 16 beds-adolescent.

Phoenix offers a rich variety of cultural, sporting and recreational opportunities. The state of Arizona offers a diversity of climates and recreational opportunities all within a few hours of the sixth largest city in the U.S.

Salary is negotiable with an excellent fringe benefit package and additional compensation for Officer-of-the-Day duty. Bilingual Spanish applicants are encouraged to apply. Arizona state license required for process of application. Open until filled. Apply via e-mail to Jerry L. Dennis, MD @ dennisj@azdhs.gov.

Arizona State Hospital
2500 East Van Buren Street
Phoenix, Arizona 85008
www.azdhs.gov/azsh

The Arizona Department of Health Services is an Equal Opportunity Employer and Provides a Tobacco-Free Campus (hospital patients excepted).

CALIFORNIA

STANFORD/PALO ALTO: Established psychiatrist seeks additional child and/or adult psychiatrist to work PT/FT in outpatient office setting. BE/BC candidates should be comfortable managing patients with ADHD as well as general psychopathology. Candidates contact Angelica at 3303 Alma Street, Palo Alto, CA 94306 or call at (650) 856-0406.

COALINGA STATE HOSPITAL

Chief, Professional Education Exciting opportunity for Board Certified forensic psychiatrist!

Coalinga State Hospital is a new "state-of-the-art" 1,500 bed facility; located in the San Joaquin Valley. The hospital is an affiliate of University of California at Irvine Medical School. It is equidistant from Los Angeles and San Francisco and is 90 minutes from the California coast in the area of Monterey and San Luis Obispo. Housing prices are affordable in this part of California, and the position includes a full California Employee Benefits Program.

Duties will include supervision of psychiatric residents and medical students rotating through Coalinga State Hospital and the development of the continuing medical educational program at the hospital. One important activity will be the opportunity to develop a new forensic psychiatric fellowship program in partnership with UC Irvine. The successful applicant must be eligible for an academic appointment at University of California at Irvine Medical School, Department of Psychiatry and Human Behavior.

For further information, please contact: Stephen Wyman, M.D., at (559) 935-4079, or Erica Weinstein, M.D., at (559) 935-4343, or E-mail SWyman@csh.dmh.ca.gov or EWeinstein@csh.dmh.ca.gov. For more information, visit our website at www.dmh.ca.gov/Statehospitals/Coalinga. CSH is an equal opportunity employer.

Psychiatrist Opportunities

Are you tired of managing overhead expenses or are you finishing residency and looking for a stable opportunity to practice your clinical skills? We at the Riverside County Department of Mental Health are looking for qualified psychiatrists. The department operates an inpatient facility as well as out patient clinics in multiple locations. We serve people of all ages and are staffed by knowledgeable and supportive personnel.

Our salary is very competitive. Per-diem positions include liability insurance as well as a 401(a) pension plan. **Hours are flexible with no on-call**. Full-time employment may be offered on a case by case basis.

Riverside County is one of the fastest growing counties in coveted Southern California with numerous choices of both active and leisure lifestyles along with more affordable housing and an easy reverse commute from surrounding areas.

Interested? Please call Dr. Raja at (951) 358-4610 or send curriculum vitae by email to tahodge@co.riverside.ca.us or by mail to:

County of Riverside
Human Resources Department
Tammy Hodge, Human Resources Technician II
P.O. Box 7549
Riverside, CA 92513-7549

For additional information you may visit our website at www.hr.co.riverside.ca.us.

San Francisco Bay Area One Adult Psychiatrist One Child Psychiatrist

The Palo Alto Medical Foundation has been providing community based medicine since 1930, in the heart of Silicon Valley within minutes of San Francisco. As we expand to six campuses and more than three hundred physicians we maintain the collegial partnership environment that is the hallmark of our success. Join an established team of well trained psychiatrists and LCSWs. As an outpatient physician you will do medication management, evaluations, and some psychotherapy. A full benefits package is provided.

Palo Alto Medical Foundation, Martha Elle, Director of Physician Placement, 795 El Camino Real, Palo Alto, CA 94301 650 853-6070 ellem@pamf.org Be sure to visit our website at www.pamf.org

GREATER BAY AREA - Modesto, California

General & Child Psychiatrists needed, for unique, stable County Mental Health system in a welcoming community. Serve both public & private sector patients, in both inpatient/outpatient settings that have been benchmarked for their quality. Possibilities for Resident teaching & consultation with a full range of providers. When patients require hospitalization, inpatient & outpatient staff work **TOGETHER** to optimize care. Stanislaus County is located only 1 1/2 hours from both San Francisco and Yosemite, enjoying the best of both worlds.

Excellent salary scale, with steps from $159K to $194K; **PLUS** full benefits; **PLUS** 5% additional for each of following: Inpatient, General Boards, Child Boards; **PLUS** extra for limited On-Call; **PLUS** Union-negotiated increases already set for next few years. Negotiable hourly contract also an option. Fax CV to Marshall Lewis, MD, 209-558-8641 or call 209-558-4639.

SANTA BARBARA - THE AMERICAN RIVIERA

Santa Barbara County is an unrivaled natural paradise. Beautiful valleys, rugged mountains, and 50 miles of spectacular coastline make Santa Barbara County one of the most desirable locales in the world.

Live and work in Paradise! Culture, urban resources, and rural beauty - for quality of life Santa Barbara County is the place to be.

Santa Barbara County has **immediate openings** in adult outpatient psychiatry.

$136,207 - $166,723/yr including benefit allowance.

We offer a stable work schedule, competitive salary, and a **generous benefits package**, including paid holiday, vacation, and sick leave; medical, dental, and vision care coverage; and a retirement package that includes both a defined-benefit pension and an optional deferred compensation plan through your choice of several competitive investment options.

For more information, or to apply online, visit our Website at
www.sbcountyjobs.com
Or call 805-568-2800

Bay Psychiatric Associates, a well-established group in Berkeley, invites psychiatrist colleagues to work with us. Our congenial group, which is centered at Alta Bates Summit Medical Center, provides outstanding care to a mix of public and private patients. Excellent compensation and benefits. Three positions are available:
1. Full time or part time career track opportunity combining inpatient and outpatient practice.
2. Attending patients in the Partial Hospitalization Program one or two half days a week.
3. Weekend coverage - third and fourth year residents are also encouraged to apply.
Phone: (510) 204-4635. Fax (510) 548-5265. e-mail baypsychiatric@aol.com.

COLORADO

Colorado State Hospital needs two psychiatrists by July 1, 2006; one with forensic interest and one with civil interest. Forty-hour week and half time proposals considered. University of Colorado medical appointments with good benefits. Four-day workweek option. If interested, please call Jerra Harr, Recruitment Coordinator @ (719) 546-4637 or fax CV to (719) 546-4484.

CONNECTICUT

Associate Medical Director
New England Area

Nationally known as one of the MOST BEAUTIFUL residential communities in America! Located in the picturesque northwest corner of Connecticut. An **Associate Medical Director** is needed for a 12-Bed Geriatric inpatient psychiatric program. Behavioral health program is part of state-of-the-art 78-bed Medical Center serving CT, MA, and NY. The best that modern medicine has to offer with a 92 year history of community service. Lucrative private practice potential. Exceptional prep schools, parks, and recreation. Enjoy all the charms of New England! Contact Mark Blakeney, Horizon Health, 800-935-0099, email CV to mark.blakeney@horizonhealth.com, fax: 972-420-8233. EOE

PUTNAM, CT - ATTENDING PSYCHIATRIST/Faculty Position. UMass Memorial Medical Center, Department of Psychiatry, is seeking a full-time psychiatrist for an inpatient position with our affiliate, Day Kimball Hospital in Connecticut. Multiple career opportunities exist! Work in a collegial setting where clinical care, education and research are valued. A competitive salary, excellent benefits and progressive incentive plan. Academic rank commensurate with experience. Interested applicants send CV to Alan P. Brown, M.D., Vice Chairman for Clinical Services, Department of Psychiatry, UMass Memorial Medical Center, 55 Lake Avenue North, Worcester, MA 01655 or email BrownA01@ummhc.org AA/EOE

DISTRICT OF COLUMBIA

WASHINGTON DC-Bedroom Community! Mix of In & Outpatient work. Be employed by Hospital in newly renovated psych unit. See exclusively adult patients. *ECT a plus. Call is 1 in 6. Contact Sue Springer @ 800-575-2880 x 315. Call for a Free salary chart! sspringer@medsourceconsultants.com

FLORIDA

Gainesville - Position for Adult/Child psychiatrist available. Candidate must be BE/BC. Call is optional. Community Mental Health Facility looking for team player who is interested in working in a community mental health care setting. Our facility offers comprehensive treatment including crisis as well as outpatient management. Gainesville is an academic city that offers much of the culture of North Florida and is regarded as one of the best cities to live and raise a family. Competitive salary offered as well as benefit package. Please fax your CV to Human Resources (352) 374-5608 or contact us directly at (352) 374-5600 ex. 8252. I am looking forward to speaking with you.

Gulf Coast not-for-profit seeks medical director. Excellent benefits & competitive salary package. Gorgeous beaches, 100 golf courses, & great schools. Contact Jim Ault at St. John Associates, 1-800-737-2001 or **jault@stjohnjobs.com**. Visit **www.stjohnjobs.com**

On the Beautiful Nature Coast - Excellent opportunity for a Board Certified Psychiatrist in Crystal River. First year guarantee available for a solo practitioner. Background in ECT desirable.

Join the team at The Oaks at Seven Rivers Regional Medical Center, a 16-bed adult inpatient psychiatric center located within the 128 bed, general medical/surgical acute care facility. **Send CV to christine.lamaina@srrmc.hma-corp.com or fax to 352-795-8473**.

FT. MYERS/MERBOURNE/ORLANDO/DAYTONA/MIAMI/FORT LAUDERDALE/OCALA/GAINESVILLE - Psychiatrists needed for rapidly expanding Nursing Home Service. Great support. No call. Average Salary 210K + benefits. Part-time available. Some travel required. Must have FL Medicare & FL Medicaid provider #s. Call Mike at 866-936-5250.

Located along South Florida's east coast just minutes from the Atlantic Ocean, CARF accredited community mental health center is seeking a part-time/full-time inpatient and outpatient psychiatrists to provide comprehensive psychiatric care to children and adults. Must be Board Certified (or eligible). Excellent salary and benefits package, great staff and a lovely coastal community. Seeking applications directly from candidates. (No recruitment firms please!) Send/Fax CV: HR, New Horizons, 4500 W. Midway Rd., Ft. Pierce, FL 34981 FAX (772) 468-5606 EOE/ADA/DFWP www.nhtcinc.org

PSYCHIATRIST NEEDED to work side by side with other correctional health care professionals in North & Central **Florida** prisons. Great schedules and excellent State of Florida benefits. Must have Florida license prior to hire. For further information contact: Sharon McKinnie, R.N. @ 850-922-6645 or mckinnie.sharon@mail.dc.state.fl.us

OUTPATIENT GENERAL PSYCHIATRIST

Excellent opportunity - Physician-owned & run practice, 200 Physician in 38 specialties.
Office hours Mon-Fri 8am to 5pm. Inpatient care offered at 800 bed hospital located 2 blocks from clinic.
Nationally recognized by Money Magazine as the 10th "Best Place to Live in America" for medium sized cities!* Located between Tampa and Orlando -access to museums, theatres, colleges, shopping, festivals, sports events, Disney World, Sea World, and other attractions. 500+ lakes, numerous parks and access to beaches. Year-round outdoor activities such as tennis, golf, running, cycling, boating and fishing. Home of the **Sun 'n Fun Fly-in**, the **PGA Nike Classic** and the **Cadillac Open**. Growing population of 500,000+. Administrative support for coding, billing collections, transcription. Electronic Medical Record. **Salary guarantee + bonus the 1st year, Partnership after 2 years. NO STATE INCOME TAX! Watson Clinic LLP** 800-854-7786 FAX 863-680-7951 email: mmonroe@watsonclinic.com

PANAMA CITY - Adult board certified or board eligible psychiatrist to join staff of comprehensive community mental health center. Salary range is: $176,000 - $183,000. Beautiful area of the country. Apply through our website www.lifemanagementcenter.org or send CV to: **Peter Hampton, Ph.D., Executive Director, Life Management Center of Northwest Florida, 525 E. 15th St., Panama City FL 32405**, EOE/DFWP. Pre-hire drug screen required.

GEORGIA

Georgia Regional Hospital/Atlanta seeks a full-time BC/BE forensic psychiatrist for our long-term forensic unit. GRH/A is a 352-bed (90 forensic) JCAHO-accredited state psychiatric hospital serving Metro Atlanta. Large Medical Staff and opportunity to teach residents from Emory and Morehouse. Salary dependent on qualifications and experience (range $101-155,000). Excellent benefits with paid malpractice. Contact Dr. Mark Rowles: mrowles@dhr.state.ga.us Ph. 404-243-2114 or fax CV to 404-212-4628.

ATLANTA: PSYCHIATRY POSITIONS

SOUTHERN BEHAVIORAL HEALTHCARE is looking for two full-time psychiatrists, one child and one adult. We are located in the Atlanta area, 10 minutes from the airport.
Salary range: **Adult: $165,000-170,000, Child: $175,000-180,000. Plus an additional productivity bonus.** H-1 visa and foreign graduates are welcome. Generous benefit package. For more information, contact the medical director at 678 358 6065, e-mail to heal650@bellsouth.net or fax CV to 678 610 7111.

ILLINOIS

PSYCHIATRIST NEEDED!

A well established and very busy private practice, located in the Chicago area is looking to hire a full time or part time psychiatrist. Work includes hospitals, outpatients and nursing homes. Compensation package is very attractive and negotiable. For more information please call Kathy at our office between 8am and 4pm 1-312-565-2251.

PSYCHIATRIST
90 MILES FROM CHICAGO

Horizon Health is seeking a Psychiatrist for a newly contracted 12-bed adult inpatient psychiatric program in **Rockford, IL. Salaried position with benefits**. Contact: Mark Blakeney, Horizon Health, 800-935-0099 x7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. Visit our web site: www.horizonhealth.com. EOE.

MEDICAL DIRECTOR

Horizon Health is seeking a **Medical Director** for a 10-bed geriatric inpatient psychiatric program in **Lawrenceville, IL**. Generous Administrative Stipend, thriving Private Practice, and available Health Department Contracts paying $140 - $150 per hour. Contact: Mark Blakeney, Horizon Health, 800-935-0099 x7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. Visit our web site: www.horizonhealth.com. EOE.

INDIANA

Easy Access to Indianapolis! CMHC offering a full continuum of care is seeking a **MEDICAL DIRECTOR** to work a combination of administrative & clinical duties. Exceptional benefits package! Generous salary up to **$200,000** DOE & boards. For more info, call Chris Maslyn @ 800.735.8261 ext. 221, fax your CV to 703.995.0647 or e-mail: cmaslyn@medsourceconsultants.com.

30 Minutes to Indianapolis! Local Med-Surge Hospital is seeking an Adult or Child and Adolescent Psychiatrist. 100% Outpatient work with No Call. Salaried Position, offering a full benefits package. Call Ken Pruchnicki 800-575-2880 x319.
kpruchnicki@medsourceconsultants.com

IOWA

Dynamic, highly regarded private non-profit multidisciplinary mental health clinic less than one hour from Des Moines seeks psychiatrist or ARNP with RX priveleges interested in working with clients of all ages. Position primarily involves outpatient medication management, but C/L work at local hospital possible as well as many other interesting opportunities. Would be affiliated with a variety of highly competent clinicians. Well supported by local medical community. Minimal on-call responsibilities (telephone back-up). Limited academic affiliation possible. Very flexible position that could be tailored to individual's needs. Very attractive benefit package. J-1 and loan repayment programs available. Send CV to Diane Baker at Center Associates, 9 North 4th Ave., Marshalltown, IA, 50158. Fax: 641-753-2171. dbaker@centerassoc.com

KENTUCKY

GENERAL ADULT PSYCHIATRIST

The HAZARD ARH REGIONAL MEDICAL CENTER, a 308 bed community medical center located in Hazard, Kentucky is seeking a compassionate, motivated BE/BC psychiatrist for its 100 bed psychiatric inpatient unit. The psychiatrist will lead a team of professionals in the evaluation and treatment of adults with mental, emotional, and behavioral problems. Center units include dual diagnosis, rehab, and general psychiatry. The salary range is excellent and fringe benefits are many. At full staff, the call is 1 in 7 with weekend rotation. Opportunities for teaching with nearby affiliated educational programs are available. Experience a rural lifestyle with abundant outdoor recreational opportunities. Also, other psychiatrist vacancies associated with our hospitals in Harlan and Whitesburg, Kentucky with similar excellent salary and fringe benefit packages. **Send C.V. and letter of introduction to: Gary Smock, ARH, Inc. P.O. Box 8086, Lexington, Kentucky 40533. Tel: 1-800-888-7045, X 528, 859-226-2528, fax: 859-226-2856, email: gsmock@arh.org and our web address is www.arh.org. EOE. J-1/H-1b applicants welcome.**

PSYCHIATRIST
EXCEPTIONAL INCOME

NEW opportunity in Western KY with exceptional income and stimulating practice environment. Nursing home consultations and outpatient clinics plus excellent referral base. This charming community offers a quiet pace, family friendly environment, and is a great place to live and work. Contact: Mark Blakeney, Horizon Health, 800-935-0099, fax CV: 972-420-8233 or email: markblakeney@horizonhealth.com. Visit our web site: www.horizonhealth.com. EOE

LOUISIANA

IMMEDIATE OPENING
FOR PSYCHIATRISTS -

J-1 Visa holders qualify - Attractive salary w/benefits. Other candidates - Guaranteed net income or attractive salary w/benefits. Board Certified or board eligible. Louisiana license required.

Please respond to Box P-469, Psychiatric News Classifieds, American Psychiatric Publishing, Inc., 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209

MAINE

Sweetser
YOUR PARTNER IN BEHAVIORAL HEALTH

Are you looking for a life of harmony? One that achieves a true balance?
At Sweetser it is a reality!

As a Child & Adolescent Psychiatrist for Maine's largest non-profit child welfare / mental health facility you can achieve true balance. This outpatient position will allow you to work with an amazing team developing, implementing, and overseeing a treatment plan for each of your clients that will encompass a wide range of services. All the while keeping you closely connected to each client. Sweetser's highly skilled staff of Crisis clinicians eliminates the need for inpatient work, providing you with more of that personal and/or family time we all yearn for.

The state of Maine also offers a great balance! Here you will find beautiful change of seasons, each presenting new and exciting recreational activities. Cultural activities are also abound from amazing art galleries to renowned theater groups. Maine has bustling cities full of shopping and nightlife, as well as an incredible countryside with farmers markets and talented craftsmen.

Sweetser is as dedicated to its employees and their families as they are to their clients. For the security of you and your family, Sweetser offers a competitive salary and a wide range of benefits, inclusive of generous retirement programs.

If you are a licensed Child & Adolescent Psychiatrist with the appropriate board certifications and want to achieve "True Balance", check out our website at www.sweetser.org or submit letter and C.V. to Sweetser Human Resources, 50 Moody St., Saco, ME 04072, Fax (207) 294-4420, or jobs@sweetser.org (text files only). Please state referral source.

Your resource for life.
MaineGeneral Health

Augusta & Waterville, ME

The MaineGeneral Medical Center is recruiting for **two adult psychiatrists** in Augusta. One psychiatrist will serve as Medical Director for the intensive outpatient service and provide outpatient services. The other will serve as a hospital-based psychiatrist working with two other psychiatrists to cover an 18 bed inpatient service and provide consultation to primary care and specialty clinicians. These two psychiatrists will join three other psychiatrists and a psychologist on the Augusta campus, and five psychiatrists and one psychologist on the Waterville campus. We emphasize team work to provide quality care to our patients and psychiatric support for a comprehensive behavioral health system.

We offer a competitive salary with a full benefits package, including paid leave, time off for CME and an educational allowance. On-call is approximately one in six at each campus.

Our mission in behavioral health: *"We help people build healthy relationships and satisfying lives."*

Contact:

David G. Folks, M.D.
Chief of Psychiatry and Medical Director
MaineGeneral Medical Center
6 East Chestnut Street
Augusta, ME 04330
Phone: 207-626-1278
Email: david.folks@mainegeneral.org

Maine's First Magnet Hospital and the World's First Free-Standing Psychiatric Magnet Hospital Seeking Adult and Child/Adolescent Psychiatrists

We are seeking BC/BE psychiatrists for both our adult and child/adolescent inpatient and outpatient programs. Acadia Hospital is a thriving, non-profit, private community-based hospital offering acute psychiatric care for adults and children, as well as chemical dependency programs. One of the only two private psychiatric hospitals in Maine. The Acadia Hospital offers physicians clinical practice in a highly collaborative, multi-disciplinary setting. Competitive salary and benefit package. Send resume to: Vice President of Medical Affairs, The Acadia Hospital, P.O. Box 422, Bangor ME 04402-0422. **www.acadiahospital.org**

Dartmouth Faculty Psychiatrists

Dartmouth Medical School, Department of Psychiatry, in collaboration with the State of Maine Department of Health and Human Services, seeks faculty psychiatrists for the Riverview Psychiatric Center in Augusta, Maine. The Center is the flagship inpatient hospital serving central and southern Maine's system of public mental health care. A 92-bed, state of the art, replacement hospital opened in the Spring of 2004. Preference will be given to candidates with forensic training and/or experience. Maine licensure required. These are full-time Dartmouth faculty appointments with salary and rank commensurate with experience and academic accomplishments. Protected time for scholarly activities. Central and southern Maine offers exceptional opportunities to enhance your quality of life. We have safe communities, with very low crime, good schools and unparalleled four season recreational activities. Augusta is less than one hour from the Maine coast and closer to numerous crystal clear lakes and mountains. It is no wonder Maine is called "vacationland." Please send CV and three letters of reference to: **Alan I. Green, MD, Professor and Chair of Psychiatry, Dartmouth Hitchcock Medical Center, One Medical Center Drive, Lebanon, NH 03756**. Dartmouth Medical School is an EOE/AA Employer and encourages applications from women and members of minority groups.

MARYLAND

Psychiatrist

Springfield Hospital Center - a 405 bed psychiatric in patient facility, operated by The Maryland State Mental Hygiene Administration seeks Maryland licensed Psychiatrists. Our rural 400 acre campus is located 22 miles west of Baltimore and convenient to Washington, DC. via routes 70 & 29. We offer full time and part time positions with comprehensive benefits, which include 27 days of paid leave, medical coverage and access to Maryland State Employees Pension at retirement. Additionally, Contractual day/night positions available. Both Board & Non-Board Certified physicians will be considered. Salary for these positions is negotiable. Please send CV to: Jonathan Book, M.D., Clinical Dir, SHC, 6655 Sykesville Rd. Sykesville, Maryland 21784. For questions call 410-970-7006 or email Jbook@dhmh.state.md.us. EOE

PSYCHIATRIST. Full-Time Medical Director Position for minority owned practice in Baltimore, MD. Excellent salary & benefits package. Ownership potential in fabulous psychiatric practice. Contact John Fisher at 410.779.3102 or fax 410.230.2687.

PSYCHIATRIST PT for fast-paced growing Geriatric Behavioral Health Practice to provide consultation services in LTC setting in Maryland. Background in medical/neurological basis for psychiatric symptoms desirable. Fax cover letter and resume to CGS, 410-832-5783, Attn.: Dr. Fitting.

MPB Group, Inc.-OMHC in Columbia, MD seeks **MD licensed Child/Adolescent Psychiatrists** for contractual day/evening to help meet our rising needs. Send CV to: Dr. Brewer, CEO, via fax to 301-829-7714 or email maggy@mpbhealth.com. Questions? 410-562-7677 www.mpbhealth.com

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The VA Maryland Health Care System (VAMHCS) is actively seeking a Director, Mental Health Clinical Center. The VAMHCS is a tertiary care facility and is classified as a Clinical Referral Level I Facility, and affiliated with the University Of Maryland School Of Medicine. The VAMHCS has a large research. The health care system consists of two Maryland VA Medical Centers located at Baltimore and Perry Point and a 120-bed Rehabilitation and Extended Care Center on the Loch Raven campus located in Baltimore City. The VAMHCS also has five Community Based Outpatient Clinics throughout the state of Maryland.

The Mental Health Clinical Center is the largest Clinical Center within the VAMHCS, which includes allied health and administrative positions in the areas of Acute Inpatient Mental Health; Sustained Inpatient Treatment; Residential Treatment; Community (Outpatient) Mental Health; and Special Programs: Addictions and Trauma. Mental health activities are conducted at both the Baltimore and Perry Point Divisions and 5 Community Based Outpatient Clinics across the state of Maryland. VAMHCS is also the home to the VISN 5 Mental Illness Research Education and Clinical Center (MIRECC), one of only 8 national MIRECCs funded across the VA system.

The incumbent is responsible for the management and operations of the Mental Health Clinical Center and its programs, residency supervision, and services. Duties include responsibility for meeting all applicable Mental Health regulatory and accrediting body requirements within the Department of Veterans Affairs, meeting and exceeding performance measure goals, improving and monitoring access to care while predicting and absorbing demand. The incumbent works as a member of the Medical Staff Management Team, which is responsible for overall leadership, policy, planning, budget, operations, and performance of the Mental Health Clinical Center. The Director, Mental Health Clinical Center fosters and maintains relations with the affiliate university, educational programs, and contracting services.

Qualified candidates must be citizen of the United States; must be proficient in spoken and written English as required by 38 U.S.C. 7402(d) and 7405(f); must be a mental health professional who meets VHA qualification standards for their respective discipline with relevant work experience (examples include: psychiatrists, psychologists, psychiatric social workers and psychiatric nurses); and preferred applicant should have an extensive history of significant leadership, mentoring, and management experience in a mental health environment; strong business acumen for managing health care operations; demonstrated expertise in the academic missions of education and research in an affiliated environment; and credentials warranting academic appointment in the School of Medicine at the University of Maryland School of Medicine.

Interested candidates should send C.V. and cover letter, by mail or electronically to Kathleen Barney, Executive Assistant to the Chief of Staff, VA Maryland Health Care System, 10 North Greene St., Baltimore, Maryland 21201; e-mails Kathy.Barney@med.va.gov; telephone (410) 605-7008. Contact for professional questions, Dorothy A. Snow, M.D., Acting Executive Chief of Staff 410-605-7019. The Department of Veterans Affairs is an equal opportunity employer.

Faculty Opportunity
Division of Child and Adolescent Psychiatry
University of Maryland, Baltimore

The University of Maryland, School of Medicine, Division of Child and Adolescent Psychiatry is seeking a full-time child and adolescent psychiatrist and psychologist. The positions carry faculty appointments at the University and offer exciting opportunities for clinical care, teaching and research. Academic rank and salary are commensurate with experience. Send a letter of introduction and CV to: David B. Pruitt, MD, Professor of Psychiatry and Pediatrics, Director, Division of Child and Adolescent Psychiatry, 701 W. Pratt Street, #429, Baltimore, Maryland 21201. *Affirmative Action/Equal Opportunity Employer.*

Psychiatrist

Pathways, Inc., the longest operating multi-service mental health agency in St. Mary's County, located on Maryland's western shore of the Chesapeake Bay, is seeking a licensed, board certified/board eligible Psychiatrist for the position of Medical Director.

St. Mary's County has been designated as an underserved area for mental health professionals so applicants with foreign visas are welcome. Assistance with moving expenses and student loan payments consistent with the underserved area designation for this county are possible. Additional benefits include a competitive wage, medical, dental, disability, and malpractice insurance, paid leave and no on-call requirement.

This position will require a minimum effort of twenty-eight (28) hours per week and a targeted start date of July 2006. Salary and other terms are negotiable. If interested please submit your C.V. and letter of interest to: Jack Dent, Administrative Officer, Pathways, Inc., P.O. Box 129, Hollywood, MD 20636, 301-373-3065 ext. 208, Fax 301-373-3265, e-mail: jdent@pathwaysinc.org

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Clifton T. Perkins Hospital Center, a JCAHO-accredited institution and Maryland's only maximum security forensic hospital, is seeking candidates for the position of staff psychiatrist. Candidates with forensic interest or experience would be especially well-suited. Responsibilities include the provision of high quality psychiatric care on an inpatient unit in a state-of-the-art forensic facility. Additional opportunities include evaluations of dangerousness, competency to stand trial, and criminal responsibility.

Join a vibrant medical staff with expertise in care of the seriously mentally ill within a forensic setting. Faculty appointments are available at University of Maryland and Johns Hopkins, if eligible. The hospital is centrally located 20 minutes from Baltimore, 35 minutes from DC, and 20 minutes from Annapolis. Competitive salary with excellent benefits, flexible working hours, and the opportunity for paid overnight call.

Interested candidates should contact C. Dennis Barton, Jr., MD, MBA, at 410-724-3078 or P.O. Box 1000, 8450 Dorsey Run Road, Jessup, MD 20794 (BartonD@dhmh.state.md.us.)

MASSACHUSETTS

CONSULTATION-LIAISON PSYCHIATRIST

Mount Auburn Hospital, affiliated with Harvard Medical School, is seeking a full-time consultation-liaison psychiatrist. This clinical position involves working closely with our medical and surgical services, including residents in our internal medicine residency program. Academic appointment, salary package. Please send CV to: Joseph D'Afflitti, M.D., Chair, Department of Psychiatry, 330 Mount Auburn Street, Cambridge, MA 02138; tel: 617 499-5008; email: jdafflit@mah.harvard.edu.

Psychiatrist Medical Director
Southeastern MA

Cape and Islands Community Mental Health Center seeks a dynamic, board-certified psychiatrist for a leadership position. Our JCAHO accredited DMH facility is located in Cape Cod, Massachusetts with easy access to Boston and Providence. We offer a 16-bed inpatient unit, day treatment, crisis services and multiple community programs.

HIGHLY COMPETITIVE salary and excellent benefits.

Send letter of interest and CV to:
Nancy Langman MS, MPH
Vice President Psychiatric and Professional Services
May Institute Comprehensive Psychiatric Services
60 Hodges Avenue Extension
Taunton, MA 02780
Phone: 508-977-3738
E-mail: nlangman@mayinstitute.org

CORRECTIONAL & FORENSIC PSYCHIATRY

The University of Massachusetts Medical School seeks psychiatrists for its innovative and multidisciplinary correctional mental health program, which provides services at several locations throughout the state. We offer generous, newly enhanced salaries, excellent benefits, regular hours without call responsibilities, and a faculty appointment with the University of Massachusetts Medical School. Send letter of interest and curriculum vitae to: Kenneth Appelbaum, MD, University of Massachusetts Medical School, Health & Criminal Justice Programs, 1 Research Drive, Suite 120C, Westborough, MA 01581; Kenneth.Appelbaum@umassmed.edu; Phone: 508-475-3236; Fax: 508-475-3258. UMMS is an equal opportunity employer.

CENTRAL MASSACHUSETTS - UMass Memorial Medical Center, Department of Psychiatry is seeking a psychiatrist for our affiliated hospital Health Alliance, in Fitchburg, Massachusetts. The position involves primarily inpatient and partial hospital responsibilities. Academic opportunities and faculty rank commensurate with experience and interests. Candidates must be BE/BC in Psychiatry. Applicants should send letter of interest and CV to Alan Brown, MD, Vice Chairman for Clinical Services, Department of Psychiatry, UMass Memorial, 55 Lake Avenue North, Worcester, MA 01655 or e-mail BrownA01@ummhc.org AA/EOE

WORCESTER - Director of Outpatient Psychiatry Service
Excellent opportunity for outstanding clinical psychiatrist at large multidisciplinary university hospital clinic. Position involves supervisory, teaching and direct care responsibilities, with opportunities for research. Faculty rank commensurate with experience. Applicants should send letter of interest and CV to Alan Brown, MD, Vice Chairman for Clinical Services, Department of Psychiatry, UMass Memorial, 55 Lake Avenue North, Worcester, MA 01655 or e-mail BrownA01@ummhc.org AA/EOE

CENTRAL MASSACHUSETTS - UMass Memorial Medical Center, Department of Psychiatry seeks a Psychiatrist for our Geriatric Psychiatry Inpatient Unit at Clinton Hospital. Clinical care on a 20-bed unit that serves as an important referral site for the region. Psychiatry and Family Practice resident, medical student teaching occurs on-site. Opportunities for collaboration and teaching at Worcester Campus. Competitive compensation with complete benefit package. Faculty rank commensurate with experience. Candidates should be BC/BE in general psychiatry. Added qualifications in Geriatric Psychiatry and/or previous experience working with geriatric patients is preferred. Applicants should send letter of interest and CV to Tatyana Shteinlukht, MD, Medical Director, Geri/Psych Unit, Clinton Hospital, 201 Highland Street, Clinton, MA 01510 or e-mail Shteinlt@ummhc.org AA/EOE

Cooley Dickinson Hospital is seeking a Medical Director of Inpatient Services. Applicant must be Board Certified in Psychiatry, have at least 2 years of inpatient experience.

Maximum call 1 week in 7, with less call possible. An extremely competitive compensation complimented by a full benefits package, is offered with the position.

Cooley Dickinson Hospital is at the heart of a vibrant, five-college community that offers residents extraordinary educational opportunities and unlimited cultural amenities. Northampton, MA, an exciting arts and college community was voted the #1 small arts town in the country by the Boston Globe and also ranked in the top 100 places to live in the U.S., according to *Money* magazine.

For more information, contact Erin Wertheim, Physician Recruiter at 413-582-2720 or erin_wertheim@cooley-dickinson.org.

Child and/or Adult Psychiatrist to join busy, large, established private psychiatric group practice. Work consists of outpatient psychiatric treatment, both psychotherapy and psychopharmacology, and some hospital consultations. A lot of flexibility in terms of job and schedule. Please send C.V. to Paul Menitoff, M.D., Greater Lowell Psychiatric Associates, LLC 9 Acton Road Suite 25 Chelmsford, MA 01824.

Medical Director
Methuen, MA

Horizon Health managed inpatient psychiatric program seeks Medical Director for a 22-bed general adult and a 25-bed geriatric inpatient unit in Methuen, MA. Contact: Mark Blakeney, Horizon Health, 800-935-0099 x7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. Visit our web site: www.horizonhealth.com. EOE.

MINNESOTA

PRAIRIE ST. JOHN'S

Offering Hope and Healing to Those Suffering from Psychiatric Conditions and Addictions

General Psychiatrist
Child and Adolescent Psychiatrist

Prairie St. John's, a Catholic Healthcare Organization, is looking for enthusiastic and dynamic psychiatrists dedicated to helping others improve the quality of their lives. We are expanding services in the Mpls-St. Paul area and need Psychiatrists to provide care at Child_Adolescent and Adult PHP's and Clinic. No night or weekend call.

The Prairie St. John's organization started in Fargo, ND and provides services in a continuum of care that includes inpatient, partial hospital, intensive outpatient and clinic services to adults, adolescents and children. Starting salary up to $210,000 dependent on qualifications, including productivity compensation. Excellent benefits. View us on-line at www.prairie-stjohns.com.

Send CV and letter of interest to: Karen Frigen, Development Specialist, Prairie St. John's, 510 4th St. S., Fargo, ND 58103 or e-mail to kfrigen@prairie-stjohns.com.

MISSOURI

Provide psychiatric services to long-term inpatients. No acute unit, no ER. Modern facility with electronic medical record, dictated progress notes. Salary range up to $165,000 depending on experience. Moving expenses, student loan repayment available. Benefits and malpractice coverage provided by employer. Small city community, one hour from Kansas City, half hour from major airport. Medical school affiliation. Pharmacy residency program on site. Training site for Certified Forensic Examiners.

James B. Reynolds, M.D.
Medical Director
(816)387-2501

PSYCHIATRISTS
Salary plus Benefits!

Two Opportunities south of St. Louis to work with the nation's largest psychiatric contract management company as either Medical Director or Associate Medical Director. **Well-established** inpatient programs and excellent potential for outpatient **Private Practice. Excellent salaries and benefits offered**. Contact: Mark Blakeney, Horizon Health, 800-935-0099, x7473, fax CV: 972-420-8233 or email: mark.blakeney@horizonhealth.com. Visit our web site: www.horizonhealth.com. EOE

MONTANA

Enjoy an extraordinary outdoor lifestyle in a beautiful western Montana university town. Several opportunities currently available for motivated psychiatrists. *Outpatient practice* opportunities with an established, well-managed neurobehavioral group for a psychiatrist with an interest in general adult psychiatry; subspecialty interest(s) a plus. Group includes four psychiatrists, two clinical psychologists, two neuropsychologists and two neurologists. Busy practice, with both inpatient and outpatient opportunities is very quickly anticipated from both internal and regional referrals. Remuneration is production-based with start-up financing assistance available. *Psychiatric hospitalist* opportunity in association with a 213 bed, acute care, JCAHO, regional referral center. Patient population includes inpatient mental health and addiction treatment. Missoula, Montana offers an extraordinary lifestyle and is the home of the University of Montana and the Montana Neuroscience Institute Foundation. Research opportunities exist in collaboration with the Neuroscience Institute, including PET and fMRI capabilities. View the Northern Rockies from your office window, fly fish the Clark's Fork River 6 blocks away during lunch, or ski 20 minutes from the office during winter. For more information direct CV and inquiries to: Psychiatry, PO Box 8169, Missoula MT 59807, e-mail to AmyS@mtneuro.com or call Amy Shoales, Practice Mgr at (406) 327-3371. Visit our web site at montanaminds.com.

ST. PATRICK HOSPITAL & HEALTH SCIENCES CENTER

PSYCHIATRIC HOSPITALIST

MISSOULA, MONTANA

St. Patrick Hospital, located in Missoula, Montana, is home to the International Heart Institute of Montana and the Montana Neuroscience Institute Foundation. We are a 213-bed, acute care, JCAHO accredited, Sister's of Providence, regional referral center for W. Montana and N. Idaho. Missoula is home to the University of Montana and offers an abundance of beauty & recreational opportunities. Close to Glacier and Yellowstone National Parks, you can live and recreate in beautiful country and work for a stable and well-respected hospital. We currently have a full-time Psychiatric Hospitalist opportunity for our co-occurring 26-bed inpatient unit. The co-occurring unit consists of 60-70% psychiatric patients and 30-40% addiction patients including acute detoxification. Position will also include call.

****We offer a competitive wage & benefit package.**

For a Big Sky Welcome!!
Contact: Jan Van Fossen
Vanfoss@saintpatrick.org
Human Resources Department
St. Patrick Hospital
P.O. Box 4587
Missoula, MT 59806
1-800-325-7271 ext#5627
Job line: 406-329-5885
Fax: 406-329-5856
www.saintpatrick.org

NEVADA

Northern Nevada Adult Mental Health Services; JCAHO accredited State Facility; Hiring BE/BC psychiatrists FY 2006; hospital and outpatient positions. Active Resident training; Possible University Medical School Affiliation; Relocation assistance; Salary up to $166,000; Excellent Benefit and Retirement packages. No State income tax

Contact:
Dr. Harold Cook PhD, Agency Administrator
775-688-2015
Dr. Ira Pauly MD
775-688-2015
NNAMHS
480 Galletti Way
Sparks, Nevada 89431-5578
775-688-2011
775-688-2052 (fax)

Southern Nevada Adult Mental Health Services (SNAMHS); Las Vegas, NV JCAHO accredited; Active Resident training; System expanding; Hiring BE/BC psychiatrists October 2005; hospital and outpatient. New Acute Hospital opens May 2006. Limited call responsibilities; Relocation assistance; Salary up to $163,000; Good Benefit and Retirement packages. No State income tax.
Contact David A. Rosin, MD; 6161, W. Charleston Blvd, Las Vegas, NV, 89146 mddirect@snamhs.nv.gov or psmith@snamhs.nv.gov; Phone 702-486-6050

The University of Nevada School of Medicine, Department of Family Medicine, is seeking candidates for a full-time, administrative faculty position as a clinical physician at the Mojave Adult, Child and Family Services (MACFS) clinics in Las Vegas. Duties include: Clinical service in outpatient community psychiatry; evaluation and treatment of patients at MACFS outpatient clinics in collaboration with Medical Director in utilization review/quality assurance. For complete position description and requirements, contact: Search Chair/Coordinator, (Jim Parcells, C.O.O./Pam Soucy, HR Director 702-968-5071) or view at http://jobs.unr.edu/professional. For full consideration, please apply by April 15, 2006.

The University of Nevada School of Medicine, Department of Family Medicine, is seeking candidates for a full-time, administrative faculty position as a clinical physician at the Mojave Adult, Child and Family Services (MACFS) clinics in Reno. Duties include: Clinical service in outpatient community psychiatry; evaluation and treatment of patients at MACFS outpatient clinics in collaboration with Medical Director in utilization review/quality assurance. For complete position description and requirements, contact: Search Chair/Coordinator, (Jim Parcells, C.O.O./Pam Soucy, HR Director, 702-968-5071) or view at http://jobs.unr.edu/professional. For full consideration, please apply by April 15, 2006.

NEW HAMPSHIRE

ADULT PSYCHIATRIST

Riverbend Community Mental Health, Inc. a large community mental health center with a staff of over 200, including six full-time psychiatrists, seeks a BE/BC psychiatrist with expertise (fellowship training) or experience in **geropsychiatry** to provide elder outpatient and nursing home care several days a week. This position also includes practice in a general psychiatric outpatient office and an opportunity to provide consultation and supervision to family practice residents in a family practice clinic. Experience or a willingness to learn ECT is required. Shared on-call responsibilities in a 15 bed psychiatric unit located in a general hospital are part of this position.

We are part of the N.H. mental health system that is currently rated #2 among community mental health systems nationally. Concord is a family-oriented small city located one hour from Boston, the White Mountains, and the Seacoast. This position is full-time, salaried with excellent benefits including medical, dental, life, disability, retirement plan, paid malpractice insurance, continuing medical education, and reimbursement for professional expenses. Interested applicants should send a CV to Riverbend CMHC, Attn: Human Resources, P.O. Box 2032, Concord, NH 03302-2032. For more information about this opportunity, contact Elvira Downs, MD, at (603) 228-1551. EOE
www.riverbendcmhc.org

NEW JERSEY

Psychiatrist - well established, for profit outpatient mental health practice has immediate opening for experienced adult, adolescent and/or child psychiatrist. Fee for service cliental, private practice model within comprehensive multi-disciplinary group of highly qualified clinicians. Fax CV to (856) 985-8148 or call (856) 983-3866 ext. 3018.

GREAT OPPORTUNITY
CHILD & ADOLESCENT PSYCHIATRIST

Exciting opportunity for a BC/BE child & adolescent psychiatrist to join a thriving private outpatient Child Therapy Center in an upscale suburban area of Northwestern New Jersey, just one hour from NYC. Position is part time, with opportunity for growth, if desired. Position involves providing clinical evaluations and treatment in a supportive, colleaguial atmosphere. Exciting growth. Excellent compensation. Fax CV to (973)898-9305 or e-mail to gllach@optonline.net.

New Jersey Psychiatrists - Rapidly expanding behavioral health organization has immediate positions available in Newark and Cranford locations. Seeking adult and child Psychiatrists for partial hospitalization and outpatient services. Spanish speaking a plus. Full and part-time positions available. Excellent employment package including competitive salary, benefits and malpractice insurance. Fax CV to (732) 212-0061 or e-mail hr@ppenet.com.

Child/Adol. Psychiatrist

Child/Adol. Psychiatrist- needed for growing multi-disciplinary group in affluent community in North/Central N.J. Expertise in psychopharmacology requried. No Managed Care! Please fax CV to (908) 598-2408

STAFF PSYCHIATRIST-MED SRVCS

P/T Position (20 HRS per week / Negotiable). Responsible for providing direct Psychiatric Services to clients assigned. These services include: Comprehensive psychiatric evaluations, medication follow up, order laboratory and other diagnostic tests; Must possess a current New Jersey medical license; current DEA registration; current CDS registration.

Please email, fax or mail resumes w/ salary requirements to:
mirceac@careplusnj.org
FAX: 201-265-6908
Care Plus NJ, Inc.
ATTN: Recruiter
610 Valley Health Plaza
Paramus, NJ 07652
EOE

Northern New Jersey!
Psychiatrist

A **Psychiatrist** is needed for a 23-bed adult inpatient unit with a geropsychiatric track located in **Englewood, NJ**. Positioned north of Newark and adjacent to New York City, the location offers easy access to one of the greatest cultural centers in the world. Please contact Mark Blakeney, Horizon Health, for more details. Office 800-935-0099, e-mail mark.blakeney@horizonhealth.com, fax 972-420-8233. EOE

NEW MEXICO

Presbyterian Medical Services is a non-profit integrated healthcare network with JCHO accreditation providing medical, dental, behavioral health, children's services and supportive living services to the multi-cultural people of New Mexico. We are seeking a **Psychiatrist** who will see clients of all ages to work in our Farmington clinic. Excellent benefits. Sign-on bonus offered. For more information contact Diane Kramer at (800) 477-7633; fax (505) 954-4414; diane_kramer@pmsnet.org; P.O. Box 2267, Santa Fe, NM 87504. EOE.

NEW YORK CITY & AREA

Enjoy the hustle and bustle of the "Big Apple"!!!!
Several exceptional opportunities available in New York City! All opportunities come with **NO CALL**. 1) Forensic Psychiatrist 2) Unit Chief 2) Staff Inpatient. Enjoy the security of an employed position with excellent compensation and full benefits! For more info, call Carrley Ward @ 800-735-8261 x 219, fax your CV to 703-995-0647 or e-mail: cward@medsourceconsultants.com.

Columbia University
College of Physicians and Surgeons
Department of Psychiatry

F/T Attending position available in the Intensive Outpatient Program, for Assistant Professor or Instructor level for MD candidates. Instructor level requires graduation from psychiatric residency program. Will be providing direct patient care in both the Individual and Group setting and be involved in the supervision of residents and medical students. Ability to speak Spanish not required, but preferred. Equal Opportunity, Affirmative Action Employer.

Please forward resumes to:
New York Presbyterian Hospital
622 West 168th Street
HP2-254/Diane Looney
New York, NY 10032
Fax #212-305-4724

Psychiatrist
Child/Adolescent & Adult

YAI/Premier Healthcare is a nationally recognized, well-established NYC diagnostic & treatment center for people with disabilities and their families. We are currently seeking full and part time psychiatrists for our outpatient facilities in the Bronx.
This is an opportunity to work with a professional team of doctors and nurses in a multi-cultural, team environment. Send CV to: Karen Meyers, Clinical Recruiter, Premier HealthCare, 460 West 34 Street, N.Y., N.Y. 10001 Fax 212-563-4836
Email: kmeyers@yai.org

Part time in NYC borough! Be a part of a well-organized, well-run mobile team for a residential program. Loosely based on ACT/mobile crisis team work. Transportation reimbursed or provided. **NO CALL!** Contact **Karen Brennan at 800-575-2880 x307. E-mail CV to kbrennan@medsourceconsultants.com.**

Psychiatrists

Full time positions available at Kirby Forensic Psychiatric Center, a New York State Office of Mental Health facility specializing in the treatment of a wide range of patients with forensic concerns. The psychiatrist leads a multi disciplinary team, with opportunities to utilize clinical, administrative, and teaching skills. Prior forensic training is not expected, but opportunities exist to develop forensic skills. Kirby is affiliated with the NYU residency and forensic fellowship programs. We are conveniently located near the Triboro Bridge.

Please fax or mail resume to:
Kirby Forensic Psychiatric Center
Wards Island Complex
Wards Island, NY 10035
James Hicks, M.D.,
Associate Clinical Director
Fax 646-672-6893
Kirby Forensic Psychiatric Center is an equal opportunity employer

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Enhance your Public Sector Career

Applicants to the one-year Columbia University Public Psychiatry Fellowship, now in its TWENTY-FIFTH year, are helped to find top quality public sector positions which serve as fellowship placements. Alternatively, psychiatrists who already have 3-5 day per week clinical and/or management positions can use the fellowship training program to become more productive in their current roles. The agency or hospital salary is supplemented by a stipend of approximately $25,000 for the 1½ day per week academic curriculum and faculty supervision at New York State Psychiatric Institute. The rich curriculum includes evidenced-based clinical practices in social psychiatry, strategic organizational management, program evaluation and public policy. A few positions are still available for the class of ten fellows commencing July 1. Please direct inquiries to **Jules Ranz, M.D., Director, Fellowship in Public Psychiatry, Box 111, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032; (212) 543-5655, e-mail: jmr1@columbia.edu. Website: ppf.hs.columbia.edu. Columbia University is an AA/EOE.**

Med Director position, west of NYC. The fantastic hours, autonomy & compensation package will enable you to enjoy life! Job is for 25-30 hrs per week. Duties include a mix of inpatient & outpatient. NO CALL. Call Dave Featherston @ 800-575-2880 x314
dfeatherston@medsourceconsultants.com

PSYCHIATRIST
Downtown Bronx Medical Associates, the Faculty Practice of Lincoln Medical and Mental Health Center, a major teaching facility in NYC and part of the Health and Hospital Corporation is seeking FT/PT BC/BE Psychiatrists - the Adult Outpatient UnitPsychiatrists - Inpatient Unit and Director of Psychiatry - ER Services Responsible for teaching and supervising residents, and direct patient care. Spanish speaking pref. Academic Appt. with Weill-Cornell Med. College.
Send CV to A. John Pellowe, MD: Fax: 718-579-6060 or Email: somwarub@dbmapc.org.
AA/EOE M/F.

Westchester Suburb- 1 Child/Adol MD
PT or FT Child & Adol IP. Easy 35 minute Manhattan drive. Strong child grp, little mang'd care. No call, no evenings, no weekends! Why do OP? PT job has flex hrs for kids or priv practice. 917-710-2456 or toacp@aol.com. Also, **1 ADULT MD for OP** -daily PT flex daytime hrs!

Psychiatrists

Full Time/Part Time/Inpatient Positions for NYS licensed, board eligible/board certified psychiatrists are available at Manhattan Psychiatric Center, an OMH facility specializing in the treatment of the refractory patient with innovative pharmacological and manualized cognitive behavioral interventions. The psychiatrist leads a multidisciplinary team, with opportunities to utilize clinical, administrative, and teaching skills on specialty units. MPC is a residency training affiliate of NYU with rotations in the STAIR program, research and outpatient clinic as well as opportunities for teaching medical students. We are conveniently located near the Triboro Bridge.

Please fax resume to:
Manhattan Psychiatric Center
Ward's Island Complex
Ward's Island, NY 10035
Samuel J. Langer, M.D., Chief of Psychiatry
646 672 6386
MPC is an equal opportunity employer
A Bridge to Recovery

NEW YORK STATE

Psychiatrist/Child Psychiatrist: St. Lawrence Psychiatric Center, a fully accredited, Equal Opportunity- Affirmative Action Employer, seeks Board Certified or Board Eligible Psychiatrists licensed to practice medicine in New York State (or eligible to obtain NYS licensure). We are designated by Federal Government as M.H. P.S.A. In addition to salary ($145,167 to $154,528 - based on qualifications) and guaranteed additional compensation by voluntary participation in the Physicians Extra Service Program (paid on-call hospital coverage at an hourly rate), we offer an excellent benefit package including: housing, malpractice insurance, health insurance, paid vacation, holiday and sick time, an excellent retirement plan and educational and professional leaves.

St. Lawrence Psychiatric Center is located in Ogdensburg, NY, an idyllic rural community on the St. Lawrence River in northern New York State. The area boasts strong public schools, a low crime rate, nearby universities, and affordable housing (including riverfront property) making it a wonderful place to live and raise a family. Despite the rural location, a number of large cities are within reasonable driving distance: Ottawa (1 hour), Montreal (2 hours), Syracuse (2 hours). In addition, given our location on the St. Lawrence River and close proximity to the Adirondack Mountains and Canada, there is easy access to a variety of unspoiled natural areas for numerous outdoor activities.

Submit letter of interest to: Geri Kentner, Director Institutional Human Resources Management 1, St. Lawrence Psychiatric Center, 1 Chimney Point Drive, Ogdensburg, NY 13669 or call (315) 541-2182

NORTHERN WESTCHESTER, NEW YORK - Therapy practice, well established in the community, managed care friendly, seeking both child/adolescent and adult psychiatrists. Salaried position. Part time hours to begin. Growing practice with many opportunities for creative involvement. Please fax resume to L. Innes, MD @ (914) 242-5152

CHILD AND ADOLESCENT PSYCHIATRIST
Section on Child and Adolescent Psychiatry
Westchester Medical Center
New York Medical College

Clinical academic position available as chief of inpatient adolescent unit. The Section on Child and Adolescent Psychiatry is a growing program at a major regional medical center with a new children's hospital, and has the only accredited child psychiatry fellowship program between NYC and Albany. The adolescent unit is undergoing reconstruction as a short term, acute unit, integrating therapeutic interventions and programming, collaboration with community mental health programs, and new clinical and support staff positions. Responsibilities include supervision of social work, psychology, medical student, and physician trainees, involvement in didactics of the medical college, administrative and clinical oversight of the unit, implementation of staff training, and direct clinical care. Salary and benefits are competitive, and academic rank is commensurate with qualifications. WMC and NYMC are Affirmative Action/Equal Opportunity Employers. Women and minorities are encouraged to apply.

Please send inquiries to:

Flemming Graae, MD
Chief, Child and Adolescent Psychiatry
95 Grasslands Road
Valhalla, NY 10595-1646
Fax: 914 493-1076
E-mail Graaef@wcmc.com

Excellent opportunity for BC/BE Psychiatrist in Central New York. Fast paced environment. Dedicated Psychiatry ER at St. Joseph's Hospital Health Center in Syracuse, NY. Full or Part-Time, 8-hour shifts. No beeper call. Excellent salary/benefits incl. malpractice, CME, health, 401(k). Contact: Joseph Gross - phone: (315) 448-2783; fax: (315) 703-2198; e-mail: Joseph.Gross@sjhsyr.org.

Psychiatrists Needed

Comprehensive Neuroscience, Inc., a national clinical research organization specializing in CNS research is seeking part-time, board certified psychiatrists to assist in conducting clinical trials for our sites in Northern New Jersey, Washington, DC, Northern Virginia, Chicago, IL and Southern California (LA area). Position responsible for acting as sub-investigator for outpatient studies with various CNS investigational compounds.

E-mail resume to hr@cnsmail.com or fax to 914-997-4024. EOE

The Department of Psychiatry of the State University of Buffalo School of Medicine and Biomedical Sciences has openings for two newly ACGME-accredited PGY 5 Geriatric Psychiatry fellows to begin July 2006. The Geriatric Psychiatry fellow will have clinical experiences in geriatric dedicated home-health care, outpatient, day hospital, acute inpatient, consultation-liaison, long-term care, ECT and hospice. The fellows will participate in a clinical milieu emphasizing understanding the psychiatric aspects of medical conditions along with the medical aspects of psychiatric conditions. Fellows will have the unusual opportunity through collaborative consultation-liaison work to develop clinical expertise and professional relationship skills working closely with trainees and faculty in geriatric medicine and neurology. They will participate in a comprehensive didactic program in preparation for the ABPN geriatric psychiatry certification.Contact the Geriatric Psychiatry Division for additional information or submit an application including your CV, your letter of interest, three letters of reference including one from your residency training program director to: **Marion Zucker Goldstein M.D. ECMC Dept of Psychiatry, Division of Geriatric Psychiatry, 462 Grider Street, Buffalo, New York 14215**
The Geriatric Psychiatry Program Coordinator Sandra Gilliam can be reached at: Tel. 716-961 6955 email gilliam3@buffalo.edu

GREATER BINGHAMTON HEALTH CENTER
ADULT PSYCHIATRISTS
And
CHILD/ADOLESCENT PSYCHIATRISTS

GBHC, (JCAHO-Accredited New York State Office of Mental Health facility) is seeking full time, board certified/board eligible **ADULT PSYCHIATRISTS** for its 140 bed adult inpatient facility and **CHILD/ADOLESCENT PSYCHIATRISTS** for its Child/Adolescent Behavioral Health Center (outpatient only, no inpatient, no call). Abundant on-site CME. Salaried, permanent positions with excellent New York State benefits.

Submit CV to: Personnel Office
Greater Binghamton Health Center
425 Robinson St., Binghamton, NY 13904
Fax: (607) 773-4117. EOE/AAE

Board Certified Child Psychiatrist looking for a full time (40 hr) **Out Patient Child** position in the NY Westchester area. Location should be no more than 35mins from White Plains NY. Will not relocate. E-mail position description and contact information to drpret@yahoo.com.

P/T CHILD/ADOLESCENT PSYCHIATRIST WANTED. Outpatient position with leading LI Children and Family Mental Health Agency. Fax Resume: HR-(516)626-8403.

Northern New York!
Psychiatrist

A **Psychiatrist** is needed for a 28-bed adult inpatient unit located in a 159-bed community hospital and regional referral center. Positioned on the US/Canadian border, the city offers the opportunity to explore the cultures of neighboring Canada. Charming city located along the southern shore of the beautiful **St. Lawrence River**. Salaried position. **J-1 Waiver Available**. Please contact Mark Blakeney, Horizon Health, for more details. Office 800-935-0099, e-mail mark.blakeney@horizonhealth.com, fax 972-420-8233. EOE

NORTH CAROLINA

Practice ALL OUTPATIENT psychiatry with four colleagues in coastal North Carolina. Enjoy a strong salary with benefits. Contact Jim Ault at St. John Associates, 1-800-737-2001 or **jault@stjohnjobs.com. www.stjohnjobs.com**

Child Psychiatrist (Assistant or Associate Professor)
Department of Psychiatric Medicine
The Brody School of Medicine at East Carolina University

The Department of Psychiatric Medicine at Brody School of Medicine at ECU is now accepting applications for a full-time faculty position (Assistant or Associate Professor). The position offers an excellent opportunity to work in an outpatient community-based mental health setting, working with multidisciplinary staff. There are opportunities for teaching medical students and residents and participating in collaborative research. Requirements include MD or equivalent degree, completion of accredited child and adolescent psychiatry residency training, preferably board certification, eligible for NC medical licensure. This is not a HPSA site. Salary and academic rank commensurate with experience and academic background. Applications accepted until position is filled. East Carolina University is the 3rd largest public university in the state, located near many recreational areas, including the Atlantic Ocean coastal resorts. **Please send a letter of interest and CV to: John Diamond, M.D., Chair Search Committee, Department of Psychiatric Medicine, the Brody School of Medicine, 4E-94B Brody Building, 600 Moye Blvd., Greenville, NC 27834, telephone 252-744-2673, e-mail: diamondj@mail.ecu.edu. East Carolina University is an AA/EO Employer.**

Suburb of Charlotte! Adult & Child Psychiatrists needed. **Outpatient** opportunity is open due to program expansion. Enjoy the security of an employed position with a **competitive salary, full benefits, and incentive program!** For more info, contact Ariana Sanjabi @ 800.735.8261 x214, fax your CV to 703.995.0647 or email to asanjabi@medsourceconsultants.com

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PSYCHIATRISTS ($124,620 - $179,068)

John Umstead Hospital, a state psychiatric hospital located in Butner, NC seeks psychiatrist for the Adult Admissions and Alcohol & Drug Abuse Treatment units. Convenient to Raleigh/Durham/Chapel Hill and has close ties with Duke University and UNC-Chapel Hill. Competitive salary and benefits package. Requires graduation from an accredited medical school, completion of an accredited psychiatric residency, and board certification or eligibility. Selected employees may qualify for the education loan repayment program authorized by Section 332 of the Public Health Service Act. Send state application (PD-107) and/or vitae to JUH, Human Resources Office, 1003 12th St., Butner, NC 27509 or contact Dr. Lou Ann Crume, Clinical Director at 919-575-7233. FAX 919-575-7550. EEO/AA Employer

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Coastal North Carolina Residential Treatment Center seeks BC/BE child or general psychiatrist with child experience for Clinical Director of a 46 bed RTC. This employed position offers generous base salary, great benefits and a lucrative performance bonus. For info call S. Wiltgen, CEO at (910) 577-1400 or email sarah.wiltgen@psysolutions.com

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SENIOR FACULTY POSITION

The University of North Carolina School of Medicine is seeking a senior psychiatrist at the Associate or Full Professor level (fixed-term) for the position of Clinical Director for a new, modern public psychiatric facility which is under construction in nearby Butner, North Carolina. This 432 bed hospital will provide psychiatric services for the central region of the state, and will include vibrant academic, teaching, and research programs in partnership with both the UNC School of Medicine and Duke University Medical Center. The Clinical Director will be responsible for medical leadership and the planning and organization of clinical, research and teaching functions. Candidates must have an M.D. from an accredited university, be Board Certified/Eligible, and able to obtain medical licensure in North Carolina. A strong track record of administrative leadership in a public academic setting is highly desirable.

Candidates should submit a letter of application, current CV, and the names and contact information of three professional references to: David Rubinow, M.D., Meymandi Professor and Chair of Psychiatry, Campus Box #7160, University of North Carolina School of Medicine, Chapel Hill, NC 27599-7160. UNC is an Equal Opportunity/ADA Employer.

NORTH DAKOTA

MeritCare Health System of Fargo, ND is seeking an Adult Psychiatrist to join its 32-member multi-disciplinary Psychiatry Department. Faculty appointment and teaching of psychiatry residents is available through University of North Dakota School of Medicine. MeritCare is an integrated 384-physician multi-specialty group practice, 583-bed Level II tertiary/trauma hospital with 26 primary care clinic sites in two states. Sister cities, Fargo, ND and Moorhead, MN are a tri-college community of 200,000 located near the heart of Minnesota's lake country. Fargo-Moorhead offers excellent educational systems, recreation and sporting activities as well as a variety of entertainment and cultural events. This is an excellent opportunity with a competitive compensation and benefits package being offered. Drug-free workplace. AA/EOE. This is not a designated HPSA site.

To apply send CV to:

Jill Gilleshammer, Physician Recruiter
MeritCare Health System
P O Box MC
Fargo, North Dakota 58122
Phone: (800) 437-4010, ext. 280-4851
Email: Jill.Gilleshammer@meritcare.com

OHIO

COME HOME TO THE MIDWEST

Opportunities are available in Ohio's Department of Mental Health for psychiatrists seeking personal growth, and professional challenge, in staff or administrative positions. Our Behavioral Healthcare facilities offer doctors an opportunity to work in a progressive JCAHO accredited system that is a nationally recognized leader in mental health reform. We offer attractive salaries and benefits, as well as academic affiliations for a 40 hour work week with fully paid malpractice at all nine BHO locations across Ohio in **Cincinnati, Dayton, Columbus, Athens, Cambridge, Massillon, Cleveland and Toledo**. If you are interested in making a positive change to a beautiful rural or urban Midwest area, please contact:

Dale Svendsen, M.D. Medical Director
Demetra Mutchler, Recruitment Manager
(614) 466-9916
mutchlerda@mh.state.oh.us

TENURE TRACK: The MetroHealth System, an affiliated teaching hospital of Case Western Reserve University, is currently seeking an outpatient consult liaison psychiatrist at the instructor or assistant professor level. This psychiatrist will provide clinical care and teaching of residents and students at MetroHealth Medical Center. Benefits include a competitive salary, incentive potential, health insurance, paid time off, liability insurance, an academic appointment and CME opportunities. Please submit a letter of interest and curriculum vitae to R. T. Segraves, M.D., Ph.D., Chairperson, Department of Psychiatry, MetroHealth Medical Center, 2500 MetroHealth Drive, Cleveland, OH 44109-1998 or rsegraves@metrohealth.org. In employment, as in education, The MetroHealth System and Case Western Reserve University are committed to Equal Opportunity and World Class Diversity. The Psychiatry Department at MetroHealth has HPSA designation.

PSYCHIATRIST
Greater Cleveland Area

Horizon Health managed inpatient psychiatric program seeks psychiatrist to work with our current Medical Director in greater **Cleveland** area. **Salaried position with benefits. J-1 waiver applicants welcome**. Contact: Mark Blakeney, Horizon Health, 800-935-0099 x7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. Visit our web site: www.horizonhealth.com. EOE.

OREGON

Physician Specialist needed: Must have M.D. & completion of residency in Psychiatry, Internal Medicine, or General Medicine. Must be BE/BC in Psychiatry, Internal Medicine or General Medicine and eligible for OR Medical License. Location: Pendleton, OR. If interested, mail resume to: Charles E. Wood, Manager Human Resource at the State of Oregon, Eastern Oregon Training Centers, 2575 Westgate, Pendleton, OR 97801.

PENNSYLVANIA

Outstanding Private Practice - Seeking BC/BE psychiatrist for successful, established private group practice in southeastern Pennsylvania's Lehigh Valley. Great earning potential, option to teach and do clinical research. In and outpatient responsibilities, weekend call is 1 in 6. Beautiful suburban area 1 hour from Philadelphia, 1.5 hours from NYC. Email CV to Dr. Paul Gross at pkgmd@yahoo.com, Fax to (610) 820-3835.

PSYCHIATRISTS... BE/BC exellent salary, benefits, no billing, upscale working environment, Inpatient or Outpatient. Full time and Part time available. Pennsylvania locations send CV bp@pennhurstmedical.com or fax to 610-524-0952 **Pennhurst Medical Group, P.C.** Some LT also!

Medical Director
Salary Plus Benefits

Horizon Health managed inpatient psychiatric program seeks psychiatrist in Western Central PA. **Salaried position with benefits. Relo assistance, sign-on bonus, CME**, and more. Contact: Mark Blakeney, Horizon Health, 800-935-0099 x7473, fax CV: 972-420-8233, or email mark.blakeney@horizonhealth.com. Visit our web site: www.horizonhealth.com. EOE.

SOUTH CENTRAL PENNSYLVANIA — BE/BC Psychiatrist needed to join thriving psychiatry department at Chambersburg Hospital. Position flexible based upon physician preference. Excellent salary with bonus program and outstanding benefits package. Local colleges and universities. Family-oriented lifestyle with very affordable housing and abundant outdoor and cultural activities yet an easy drive to Harrisburg, Baltimore or DC. Email CV to mroyce@summithealth.org Mail CV to Marie Royce, Director of Physician Relations, Summit Health, 112 N. 7th Street, Chambersburg, PA 17201. Call 1-800-758-8835. Fax 717-267-7769. Visit us at www.summithealth.org

RHODE ISLAND

Rhode Island Hospital
Director of Substance Abuse

The Department of Psychiatry, Rhode Island Hospital, Providence, RI, is seeking a full-time Psychiatrist for Director of Substance Abuse of the Division of Adult Psychiatry, Department of Psychiatry, at Rhode Island Hospital. Must be an M.D. and Board certified in General and Addiction Psychiatry. Must have successfully completed training in Adult Psychiatry in an accredited program, with residency served in Adult Psychiatry. Also responsible for education and research, as agreed upon. Candidates should have a record of clinical research or scholarly activity in the area of Substance Abuse. The candidate should also have a record of teaching and supervision of psychiatry residents. Five years post-training in staff capacity in a teaching-training environment experience preferred. Candidate must be eligible for academic appointment at Brown University at the Assistant, Associate, or Full Professor level, Teaching or Research Scholar Track. Demonstrated clinical research productivity is necessary for appointment at the Assistant Professor level. If hired at the Associate Professor level in the Teaching Research Scholar Track, or the Associate Professor level of the Research Scholar Track, the candidate will have to demonstrate a national reputation in his or her field. If hired at the Full Professor level in the Research Scholar Track, candidate must demonstrate international reputation in his or her field. Rhode Island Hospital is a EO/AA employer, and encourages applications from minorities, women, and protected persons. Review of applicants will begin immediately and will continue until the position is filled or the search is closed. Send letter and CV to: Martin B. Keller, M.D., Chairman, Department of Psychiatry and Human Behavior, Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906.

Rhode Island Hospital

Psychiatrist Adult, Inpatient and Outpatient (Mood Disorders)

The Department of Psychiatry, Rhode Island Hospital, a Lifespan partner and Brown University affiliated program, is seeking a psychiatrist to share inpatient and outpatient responsibilities with an established fulltime hospital-based group. The inpatient component involves treating patients with a wide range of acute conditions. The outpatient component involves assessing and treating patients with mood disorders as a member of a specialized multidisciplinary clinical research team. The candidate must be Board Certified or eligible, and may be eligible for a clinical appointment at Brown University School of Medicine. Salary and benefits commensurate with level of training. Please send CV's along with a letter of interest to Richard J. Goldberg, M.D., Psychiatrist-in-Chief, APC-9, Rhode Island Hospital, 593 Eddy St, Providence, RI 02903 and/or e-mail to rjgoldberg@lifespan.org

SOUTH CAROLINA

PRIVATE PRACTICE AVAILABLE

Solo private practice available in downtown Charleston, S.C. Outpatient, private pay. Available July 06. BC only. Fax 843-723-4144.

The Center for Drug and Alcohol Programs and Department of Psychiatry & Behavioral Sciences at the Medical University of South Carolina in Charleston, South Carolina, announce the availability of an Assistant Professor faculty position. Applicants must be an M.D., have completed a Psychiatry residency, be Board certified or eligible, have research experience or a fellowship alcohol or substance abuse, and be suitable for licensure in South Carolina. The Center for Drug and Alcohol Programs includes an NIAAA-funded Alcohol Research Center (ARC) and has over 20 faculty scientists, access to alcohol and other substance abuse patients, and basic and clinical science facilities. Emphasis in the ARC is on translational research dealing with biomedical etiology and pharmacological treatment of alcoholism. It is anticipated collaborative research endeavors will occur in these areas. Review of applications begins immediately. Applications will be considered until position is filled. Send letter of application, vita, and supporting materials to Dr. Raymond Anton, Director, Center for Drug and Alcohol Programs, Medical University of South Carolina, P.O. Box 250861, Charleston, SC 29425. MUSC is an Equal Employment Opportunity/Affirmative Action Employer.

Coastal South Carolina-Great location! CMHC located a short drive from Myrtle Beach; SC is looking for a locum tenens Psychiatrist to provide four weeks or more of outpatient coverage. The assignment starts February 6, 2006 until March 3, 2006 with no call. APA endorsed Occurrence Malpractice, travel; lodging, rental car and excellent pay are provided. Contact Gene Itoh at 800.735.8261 ext.223, fax your CV to 703.995.0647 or e-mail: gitoh@medsourceconsultants.com for this or any of our other Nationwide Locum Tenens assignments.

TENNESSEE

The University of Tennessee Health Science Center at Memphis, has two full-time, faculty positions open in the Department of Psychiatry. The first position is for a Board Certified Psychiatrist who would meet the academic tenure and rank requirements at the Professor level. Consideration will be given to qualified individuals who possess geriatric psychiatry experience, have functioned in an academic administrative position, and possess excellent clinical skills. Willingness to travel throughout the local service area desirable. The second position is for a non-tenure track Board Certified/Eligible Child Psychiatrist who has completed a fellowship in Child and Adolescent Psychiatry. Administrative and academic experience preferred. Ability to work in other disciplines desirable. Interested candidates should send a letter of interest and Curriculum Vitae to Dr. James Greene, MD, Interim Chair, University of Tennessee Department of Psychiatry, and 135 N. Pauline Street, Memphis, Tennessee 38103. **The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA institution in the provision of its education and employment programs and services.**

EAST TENNESSEE STATE UNIVERSITY JAMES H. QUILLEN COLLEGE OF MEDICINE DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES

CHILD PSYCHIATRIST

Full-time position available for Child Psychiatrist. Responsibilities include training of psychiatric residents and medical students and research activities. Salary is competitive with funding available through the Medical School, faculty private practice and extramural contracts. ETSU is located in the Tri-Cities area, rated #1 place in North America in cost-of-living, crime rate, climate and health care. Applicants should submit a CV and two letters of reference to Merry N. Miller, M.D., Chair, Department of Psychiatry and Behavioral Sciences, ETSU, Box 70567, Johnson City TN 37614. Telephone inquiries should be made at (423)439-2235 or e-mail at lovedayc@etsu.edu. AA/EOE.

TEXAS

Geriatric Psychiatrist for busy private practice. Outpatient, research, drive to nursing homes and assisted livings. Competitive salary and benefits. Send CV to SASH at JWinston@austin.rr.com or fax to 512-476-0195.

The Department of Psychiatry at The University of Texas Health Science Center at San Antonio seeks an academic psychiatrist to head the Forensic Psychiatry Division. The position is fulltime on either the tenure or non-tenure track. Successful candidates must be ABMS certified in forensic psychiatry and have strong academic and teaching credentials, significant administrative experience, and the energy and vision to lead and further develop this program. Salary and academic rank are commensurate with qualifications. The Department has strong educational, research and clinical programs in an attractive, culturally rich city situated on the edge of the Texas Hill Country, with a pleasant climate, an excellent public school system and abundant recreational activities. Interested individuals should forward their curriculum vitae to Pedro L. Delgado, M.D., Dielmann Professor and Chairman, Department of Psychiatry, Mail Code 7792, The University of Texas Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio TX 78229-3900, phone 210-567-5391, FAX 210-567-6941. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity/Affirmative Action Employer. All faculty appointments are designated as security sensitive positions.

Weekend Drive To Dallas! Expanding CMHC is looking for a psychiatrist to work **100% OUTPATIENT!** Enjoy the security of an employed position with a competitive salary and full benefits package! 40 hour work week with **NO CALL!** For more info, call Sarah McGlinnen @ 800-735-8261 ext 216, fax your CV to 703-995-0647, or e-mail: smcglinnen@medsourceconsultants.com.

Assistant Professor

The Department of Psychiatry and Behavioral Sciences at the University of Texas Medical Branch in Galveston is seeking an Assistant Professor.

Responsibilities include inpatient care, outpatient clinics, resident supervision and teaching. Research opportunities are available. Successful candidates must be board certified/board eligible in Psychiatry.

Candidates with interest and skills in this area should send a curriculum vitae and cover letter to: **Robert M.A. Hirschfeld, M.D., The University of Texas Medical Branch, Department of Psychiatry and Behavioral Sciences, 301 University Boulevard, Galveston, TX 77555-0188**.

The University of Texas Medical Branch is an equal opportunity, affirmative action institution which proudly values diversity. Candidates of all backgrounds are encouraged to apply.

Nacogdoches and Livingston - The Burke Center, a multi-site, JCAHO accredited community mental health center, currently has a full time Adult Psychiatrist position available in Nacogdoches, and a full time Child Psychiatrist (or General Psychiatrist with child experience) position available in Livingston to see a mix of child and adult patients. Physician Assistants and Advanced Nurse Practitioners will be considered as well. Both positions are outpatient only, 40 hour weeks, with no on call. Enjoy a comfortable lifestyle in the beautiful, piney-woods/lakes area of East Texas. Recreational opportunities abound in national forests nearby. Houston less than 2 hours away; Dallas 3 hours; major state university nearby. Excellent benefits and competitive salary. Please send CV to Mark Janes, M.D., Medical Director, Burke Center, 4101 S. Medford Drive, Lufkin, TX 75901. Fax: (936) 634-8601. Email: markj@burke-center.org. Check out the details on our website: www.burke-center.org.

VIRGINIA

No CALL! Join hospital staff in beautiful southwestern Virginia. Enjoy a practice that has a strong salary and benefits. Contact Jim Ault at St. John Associates, 1-800-737-2001 or **jault@stjohnjobs.com. www.stjohnjobs.com**

WASHINGTON

BC/BE PSYCHIATRIST
Seeking a BC/BE Psychiatrist with an interest in geriatrics (*fellowship training a plus*), to join a *colloborative* practice **affiliated with a comprehensive medical center. Mostly outpatient with some inpatient. Competitive base salary guarantee, good benefits plus potential additional compensation for productivity**. Located just 20 minutes from downtown Seattle and the shores of Puget Sound. This area is consistently rated as one of the best places to live. For more information send CV to Gail Mumma, gmumma@HighlineMedical.org or Fax to 206-242-4625 or Call: (206)431-0785

Live in the beautiful Wine Country Of Southeast Washington State.

Opportunity for Board Eligible Psychiatrist with WA State License. Up to full time Contractor position with staff placement possible at later date if desired. Inpatient and Outpatient care at Washington State Penitentiary

Contact: Michael Wall 509.526.6436
mbwall@DOC1.WA.GOV

WISCONSIN

Madison, WI - noted as "U.S. Best City", two years, seeks a BC/BE child psychiatrist. *Capitol Associates*, well-recognized for more than 20 years, is Madison's largest, independent, licensed mental health clinic and is dedicated to comprehensive inpatient/outpatient care. CA boasts 14 mental health professionals, including 2 psychiatrists. A university town surrounded by many lakes, Madison has abundant recreational activities, high educational standards and support for the arts. Please consider joining our caring, energetic team. Capitol Associates, LLC, Attention: Johna Gerasch, PhD (Managing Partner), 440 Science Dr., Suite 200, Madison, WI 53711. (608) 238-5176, ext. 314.

SPECTACULAR OPPORTUNITY FOR INPATIENT MEDICAL DIRECTOR

Gundersen Lutheran, a multidisciplinary 400 member group practice in La Crosse, WI, is seeking an experienced BC/BE Psychiatrist to perform the functions of the Medical Director of an existing Inpatient Unit and to develop a day hospital program.

This candidate will join 9 general and 4 child psychiatrists, 7 psychologists and more than 40 therapists in providing outpatient/inpatient care for a broad range of clinical disorders.

Psychiatric outpatient care is offered on our main campus and at several sites in the Gundersen Lutheran healthcare system. Inpatient care is provided in a 27-bed unit, which is adjacent to the medical center. Call will be 1:12.

Located in a city of 52,000 with a metropolitan area of 120,000 and a service delivery area of more than 500,000, Gundersen Lutheran provides the opportunity to practice metropolitan-scale medicine in a context of small town character and comforts. Nationally recognized schools, three universities, safe neighborhoods, affordable housing and extensive recreational and cultural activities make La Crosse, on the Mississippi River, an outstanding place to live and work. Our compensation package, pension plan and continuing education opportunities are exceptional.

Interested candidates are invited to call Gale Kreibich, Medical Staff Development, Gundersen Lutheran, at 1-800-362-9567, ext. 56863, 1900 South Ave., La Crosse, WI, 54601, or e-mail grkreibi@gundluth.org

We support a safe, healthy and drug-free work environment through background checks and controlled substance screening.
EOE/AA

Outpatient Adult and Child/Adolescent Psychiatry Openings

Are you looking for:

- an experienced multidisciplinary team?
- a comfortable call schedule?
- an efficient network of Electronic Medical Records accessed with personal tablets?
- the advantage of practicing where genetic research and educational opportunities are easily accessible?
- a community offering affordable housing, excellent schools, plus proximity to numerous indoor and outdoor recreational activities?
- a benefit package including a fully funded retirement plan, matching 401K plan, four weeks paid vacation, two weeks CME with up to $5,500 allowance, generous relocation, and more?

To learn about these excellent opportunities, please contact: Mary Treichel, Physician Recruiter, Marshfield Clinic, 1000 North Oak Avenue, Marshfield WI 54449; Ph: 800-782-8581 ext 19774; Fax: 715-221-9779; E-mail: treichel.mary@marshfieldclinic.org; Website: www.marshfieldclinic.org/recruit

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CHILD-ADOLESCENT/ADULT PSYCHIATRIST - LA CROSSE, WI

Board certified/eligible child-adolescent psychiatrist needed to join the Psychiatry Department/Behavioral Health Program at Franciscan Skemp Healthcare-Mayo Health System in La Crosse, WI. At least 50% of the position will be devoted to outpatient child-adolescent psychiatry patients. Remainder of the practice will be a mix of inpatient and outpatient adult psychiatry. Position will include sharing in the general Psychiatry call schedule with five adult psychiatrists. Competitive salary & comprehensive benefits. Franciscan Skemp Healthcare, part of Mayo Health System, is a multispecialty group/healthcare network with 200+ providers, serving a primary care population of 240,000 in WI, MN & IA. La Crosse, city of 52,000 with metro area of 120,000, located on the scenic Upper Mississippi River, offers an ideal family environment with unlimited, four-season recreational & cultural activities. Excellent schools, including two universities and technical college.

Contact Bonnie Guenther or Mike Hesch,
Physician Services
Franciscan Skemp Healthcare-
Mayo Health System
700 West Avenue South, La Crosse, WI 54601
800-269-1986 / fax 608-791-9898
guenther.bonnie@mayo.edu /
hesch.michael@mayo.edu
www.franciscanskemp.org

WYOMING

Ideal practice setting
Outstanding compensation & quality of life

Practice in a setting free of managed care restrictions & formulary constraints. Based on your qualifications you can expect no less than $170k and up to $200k per year. Enjoy incredibly low taxes & cost of living, and an unbelievable quality of life. Great skiing and shopping are nearby in Park City, home of the annual Sundance Film Festival. As a member of our team at the Wyoming State Hospital you will have the ability to provide inpatient, residential or outpatient services to adolescent, adult, forensic or geriatric patients. This beautiful state-of-the-art hospital is located in Evanston, WY and accessible online at http://mentalhealth.state.wy.us/hospital. We would like to tell you more about what we have to offer you, and learn about your clinical interests and expertise - please call Ian Castronuovo at Liberty Healthcare: (800) 331-7122, ext. 161. You are welcome to email your CV to ianc@libertyhealth.com for immediate consideration. EOE.

Fellowships

PSYCHODYNAMIC PSYCHOTHERAPY PROGRAMS. Two year training includes coursework, case conferences, and supervision with experienced analysts. NEW CHILD-ADOLESCENT PROGRAM. The New York Psychoanalytic Institute, 247 East 82nd Street, NY NY 10028, (212) 879-6900
www.psychoanalysis.org

Research Fellowships for Young Psychiatrists and Advanced Residents: The Yale University Department of Psychiatry and the Connecticut Mental Health Center are pleased to offer NIMH funded fellowships that provide two years of research support and training for psychiatrists who have recently completed residency or are in their PGY-4 training year. Fellows will choose a mentor from among over 20 Yale faculty researchers, and develop and carry out their own research project. A formal didactic program provides seminars on research design, statistics and review of the current evidence base regarding key clinical questions. Program focus is on adding to the evidence base to guide treatment of people with chronic and recurrent psychiatric illnesses, especially during the 95% of their lives when they are not in periods of acute symptom exacerbation. Fellowships are designed for psychiatrists interested in academic careers in clinical, psychosocial, epidemiological or translational neuroscience research. To apply send CV, statement of research interests and two letters of recommendation to: Bruce E. Wexler, MD, Professor of Psychiatry, Yale University School of Medicine, Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519, or bruce.wexler@yale.edu.

Clinical Psychopharmacology Research Fellowship

The Bipolar Disorder Research Program at Emory University is seeking a PGY-5 clinical research fellow. Fellowship provides clinical and research experience, specializing in bipolar disorder, with extensive individual supervision by Dr. Nassir Ghaemi. Fellows will gain expertise in diagnosing and treating bipolar disorder, and in functioning as investigators in clinical trials. Fellows will learn statistical method methods, and write research papers. Ideal for those who want more clinical expertise and for those interested in an academic psychiatry career. Competitive salary with full benefits package. Send CV and letters of reference to: Dr. Nassir Ghaemi, 1365 Clifton Rd NE., Bldg B, Suite 6100, Atlanta, GA 30322, nghaemi@emory.edu

Geriatric Psychiatry Fellowship with Emphasis on Integrated Consultation-Liaison Psychiatry

The Department of Psychiatry and Behavioral Science at Stony Brook University announces the availability of an innovative ACGME-accredited geriatric psychiatry fellowship position starting July 2006 with the option for special emphasis on consultation-liaison psychiatry. With eight board-certified geriatric psychiatrists on the faculty, the geriatric psychiatry fellow will have dedicated experiences in geriatric inpatient, long-term care, outpatient, ECT, and consultation-liaison psychiatry at both the University Hospital as well as several community settings. Located within the new Stony Brook Division of Medical and Geriatric Psychiatry, fellows in geriatric psychiatry will participate in a clinical milieu emphasizing understanding the psychiatric aspects of medical conditions along with the medical aspects of psychiatric conditions. Fellows have the unusual opportunity through collaborative consultation-liaison work to develop added clinical expertise and professional relationship skills working closely with trainees and faculty in geriatric medicine, neurology, and family medicine. To apply for the position, send by U.S. mail, fax (631) 444-7534, or e-mail *steven.cole@stonybrook.edu*, your letter of interest, your CV, and three letters of reference to Steven Cole, M.D., Head, Division of Medical and Geriatric Psychiatry, Health Sciences Center, 10th Floor, Room 042, Stony Brook NY 11794-8101. AA/EOE.

PSYCHOSOMATIC MEDICINE FELLOWSHIP - VIRGINIA COMMONWEALTH UNIVERSITY

One year exciting, well established, fellowship program, one of the first approved by the ACGME, in a 750-bed university hospital, accepting applications for July 1, 2006.
Advanced training offered to psychiatrists who have completed residency. Please write or call: James L. Levenson, M.D., Chairman, C-L Division, VCU Health System, Department of Psychiatry, Box 980268, Richmond, VA. 23298-0268; jlevens@vcu.edu (804) 828-0762 or Yaacov R. Pushkin, M.D.; ypushkin@vcu.edu

PSYCHIATRY RESEARCH FELLOWSHIP

at the Zucker Hillside Hospital/North Shore Long Island Jewish Medical Center, Glen Oaks, NY, starting July 1, 2006. This 2-year fellowship, under the direction of John Kane, MD is designed for Board Certified/ Board Eligible Psychiatrists who seek advanced training in biomedical, neuroscience, and behavioral neuroscience research. Fellows work closely with senior faculty on existing studies in schizophrenia, bipolar and unipolar mood disorders, and dementia. Projects may encompass psychiatric genetics/pharmacogenetics, neuroimaging (fMRI, DTI, PET), psychopharmacology (e.g., clinical trials, challenge assays), neuroendocrinology, neurochemistry, neurocognition, prodromal/first episode studies, electrophysiology (ERPs), phenomenology and assessment, and outcome (e.g., functional disability, suicide). Fellows develop independent lines of investigation and are encouraged to publish and pursue funding in preparation for careers in academic medicine. Applicants should send a CV and letter outlining their interests to: Serge Sevy, MD., The Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004; ssevy@lij.edu. Minority applicants are encouraged to apply.

ANXIETY & FUNCTIONAL NEUROIMAGING. The University of California San Diego (UCSD) in La Jolla, CA, is seeking applicants for a PGY-5 Anxiety & Functional Neuroimaging Fellowship starting July 1, 2006. Fellows have an opportunity to develop expertise in anxiety disorders outcomes research and functional magnetic resonance imaging (fMRI) task design and analysis. Dual mentorship by Martin Paulus MD and Murray B. Stein MD, MPH. Competitive salary. Two-year commitment preferred. Applicants must be board-eligible in psychiatry and eligible for California medical licensure. Interested candidates should send a CV and statement of interest by e-mail to Dr. Stein (mstein@ucsd.edu) and/or Dr. Paulus (mpaulus @ucsd.edu).

PUBLIC PSYCHIATRY FELLOWSHIP CMHC - YALE

The Connecticut Mental Health Center - Yale University School of Medicine is offering a one-year Fellowship in Public Psychiatry beginning July 2006. CMHC is a major site for training, research and clinical service within the Yale and State systems. As a state-funded, academic, urban mental health center it provides a unique setting for psychiatrists to obtain advanced training as they pursue careers as leaders in the field. Fellows will spend 50% time in seminars, supervision, and administrative/policy meetings of CMHC and the CT Dept. of Mental Health and Addiction Services; and 50% effort providing direct clinical service and/or consultation within public mental health settings in New Haven. Candidates must be eligible for board certification and CT licensure. Minority applicants are encouraged to apply. For further information contact Jeanne Steiner, D.O. Medical Director, CMHC - Yale Univ., 34 Park St New Haven, CT 06519 or Jeanne.Steiner @yale.edu.

Practice for Sale

Retiring in July 2006 from established practice in Vail, Colorado. The practice is for sale - Income potential $200,000-300,000 per year - Office furniture and introduction to referral sources included. If interested please contact Robert Truitt, MD at 970-476-1551.

Prime location in South Florida, near major medical center, solo practice, 100% private pay, no insurance, very lucrative with great expansion potential. Outstanding reputation. Turnkey operation. Please fax inquiries to Davis Co. 561-482-9582.

Adult psychiatric private practice for sale located in Scottsdale, Arizona. If interested contact Arizona Guidance and Counseling Center at 480-949-5700. Office space and staff are shared by two other psychiatrists.

We've taken the psychiatric resources you use every day and put them online @ PsychiatryOnline.com

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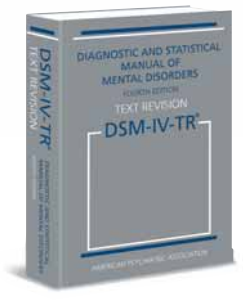

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> —Scott Monteith, M.D., Traverse City, Michigan

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CYMBALTA®
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Brief Summary: Consult the package insert for complete prescribing information.

WARNING

Suicidality in Children and Adolescents—Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Cymbalta or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Cymbalta is not approved for use in pediatric patients. (*See* WARNINGS *and* PRECAUTIONS, Pediatric Use.)

Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

INDICATIONS AND USAGE: Cymbalta is indicated for the treatment of major depressive disorder (MDD). Cymbalta is indicated for the management of neuropathic pain associated with diabetic peripheral neuropathy (DPN).

CONTRAINDICATIONS: ***Hypersensitivity***—Known hypersensitivity to duloxetine or any of the inactive ingredients. ***Monoamine Oxidase Inhibitors (MAOIs)***—Concomitant use with Cymbalta is contraindicated (*see* WARNINGS). ***Uncontrolled Narrow-Angle Glaucoma***—In clinical trials, Cymbalta use was associated with an increased risk of mydriasis; therefore, its use is not recommended in patients with uncontrolled narrow-angle glaucoma.

WARNINGS: Clinical Worsening and Suicide Risk—Patients with MDD, both adult and pediatric, may experience worsening of their depression and/or the emergence of suicidal ideation and behavior (suicidality) or unusual changes in behavior, whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. There has been a long-standing concern that antidepressants may have a role in inducing worsening of depression and the emergence of suicidality in certain patients. Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with MDD and other psychiatric disorders.

Pooled analyses of short-term placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with MDD, OCD, or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal behavior or thinking (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. There was considerable variation in risk among drugs, but a tendency toward an increase for almost all drugs studied. The risk of suicidality was most consistently observed in the MDD trials, but there were signals of risk arising from some trials in other psychiatric indications (obsessive compulsive disorder and social anxiety disorder) as well. **No suicides occurred in any of these trials.** It is unknown whether the suicidality risk in pediatric patients extends to longer-term use, ie, beyond several months. It is also unknown whether the suicidality risk extends to adults.

All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. Such observation would generally include at least weekly face-to-face contact with patients or their family members or caregivers during the first 4 weeks of treatment, then every other week visits for the next 4 weeks, then at 12 weeks, and as clinically indicated beyond 12 weeks. Additional contact by telephone may be appropriate between face-to-face visits.

Adults with MDD or co-morbid depression in the setting of other psychiatric illness being treated with antidepressants should be observed similarly for clinical worsening and suicidality, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for MDD as well as for other indications, both psychiatric and nonpsychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, there is concern that such symptoms may represent precursors to emerging suicidality.

Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse, or who are experiencing emergent suicidality or symptoms that might be precursors to worsening depression or suicidality, especially if these symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

If the decision has been made to discontinue treatment, medication should be tapered, as rapidly as is feasible, but with recognition that abrupt discontinuation can be associated with certain symptoms (*see* PRECAUTIONS, Discontinuation of Treatment with Cymbalta).

Families and caregivers of pediatric patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and nonpsychiatric, should be alerted about the need to monitor patients for the emergence of agitation, irritability, unusual changes in behavior, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers. Such monitoring should include daily observation by families and caregivers. Prescriptions for Cymbalta should be written for the smallest quantity of capsules consistent with good patient management, in order to reduce the risk of overdose. Families and caregivers of adults being treated for depression should be similarly advised.

Screening Patients for Bipolar Disorder—A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder. Whether any of the symptoms described above represent such a conversion is unknown. However, prior to initiating treatment with an antidepressant, patients with depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression. It should be noted that Cymbalta is not approved for use in treating bipolar depression.

MAOIs—In patients receiving a serotonin reuptake inhibitor (SSRI) in combination with an MAOI, there have been reports of serious, sometimes fatal, reactions including hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. These reactions have also been reported in patients who have recently discontinued SSRIs and are then started on an MAOI. Some cases presented with features resembling neuroleptic malignant syndrome. The effects of combined use of Cymbalta and MAOIs have not been evaluated in humans or animals. Therefore, because Cymbalta is an inhibitor of both serotonin and norepinephrine reuptake, it is recommended that Cymbalta not be used in combination with an MAOI, or within at least 14 days of discontinuing treatment with an MAOI. Based on the half-life of Cymbalta, at least 5 days should be allowed after stopping Cymbalta before starting an MAOI.

PRECAUTIONS: ***General***—Hepatotoxicity—Cymbalta increases the risk of elevation of serum transaminase levels. Liver transaminase elevations resulted in the discontinuation of 0.4% (31/8454) of Cymbalta-treated patients. In these patients, the median time to detection of the transaminase elevation was about two months. In controlled trials in MDD, elevations of alanine transaminase (ALT) to >3 times the upper limit of normal occurred in 0.9% (8/930) of Cymbalta-treated patients and in 0.3% (2/652) of placebo-treated patients. In controlled trials in DPN, elevations of ALT to >3 times the upper limit of normal occurred in 1.68% (8/477) of Cymbalta-treated patients and in 0% (0/187) of placebo-treated patients. In the full cohort of placebo-controlled trials in any indication, 1% (39/3732) of Cymbalta-treated patients had a >3 times the upper limit of normal elevation of ALT compared to 0.2% (6/2568) of placebo-treated patients. In placebo-controlled studies using a fixed-dose design, there was evidence of a dose-response relationship for ALT and AST elevation of >3 times the upper limit of normal and >5 times the upper limit of normal, respectively Postmarketing reports have described cases of hepatitis with abdominal pain, hepatomegaly and elevation of transaminase levels to more than twenty times the upper limit of normal with or without jaundice, reflecting a mixed or hepatocellular pattern of liver injury. Cases of cholestatic jaundice with minimal elevation of transaminase levels have also been reported.

The combination of transaminase elevations and elevated bilirubin, without evidence of obstruction, is generally recognized as an important predictor of severe liver injury. In clinical trials, three Cymbalta patients had elevations of transaminases and bilirubin, but also had elevation of alkaline phosphatase, suggesting an obstructive process; in these patients, there was evidence of heavy alcohol use and this may have contributed to the abnormalities seen. Two placebo-treated patients also had transaminase elevations with elevated bilirubin. Postmarketing reports indicate that elevated transaminases, bilirubin and alkaline phosphatase have occurred in patients with chronic liver disease or cirrhosis. Because it is possible that duloxetine and alcohol may interact to cause liver injury or that duloxetine may aggravate pre-existing liver disease, Cymbalta should ordinarily not be prescribed to patients with substantial alcohol use or evidence of chronic liver disease. Effect on Blood Pressure—In MDD clinical trials, Cymbalta treatment was associated with mean increases in blood pressure, averaging 2 mm Hg systolic and 0.5 mm Hg diastolic and an increase in the incidence of at least one measurement of systolic blood pressure over 140 mm Hg compared to placebo. Blood pressure should be measured prior to initiating treatment and periodically measured throughout treatment (*see* ADVERSE REACTIONS, Vital Sign Changes). Activation of Mania/Hypomania—In placebo-controlled trials in patients with MDD, activation of mania or hypomania was reported in 0.1% (1/1139) of Cymbalta-treated patients and 0.1% (1/777) of placebo-treated patients. Activation of mania/hypomania has been reported in a small proportion of patients with mood disorders who were treated with other marketed drugs effective in the treatment of MDD. As with these other agents, Cymbalta should be used cautiously in patients with a history of mania. Seizures—Cymbalta has not been systematically evaluated in patients with a seizure disorder, and such patients were excluded from clinical studies. In placebo-controlled clinical trials in patients with MDD, seizures occurred in 0.1% (1/1139) of Cymbalta-treated patients and 0% (0/777) of placebo treated patients. In placebo-controlled clinical trials in patients with diabetic peripheral neuropathy, seizures did not occur in any patients treated with either Cymbalta or placebo. Cymbalta should be prescribed with care in patients with a history of a seizure disorder. Controlled Narrow-Angle Glaucoma—In clinical trials, Cymbalta was associated with an increased risk of mydriasis; therefore, it should be used cautiously in patients with controlled narrow-angle glaucoma (*see* CONTRAINDICATIONS, Uncontrolled Narrow-Angle Glaucoma). Discontinuation of Treatment with Cymbalta—Discontinuation symptoms have been systematically evaluated in patients taking Cymbalta. Following abrupt discontinuation in MDD placebo-controlled clinical trials of up to 9 weeks duration, the following symptoms occurred at a rate greater than or equal to 2% and at a significantly higher rate in Cymbalta-treated patients compared to those discontinuing from placebo: dizziness; nausea; headache; paresthesia; vomiting; irritability; and nightmare.

During marketing of other SSRIs and SNRIs (serotonin and norepinephrine reuptake inhibitors), there have been spontaneous reports of adverse events occurring upon discontinuation of these drugs, particularly when abrupt, including the following: dysphoric mood, irritability, agitation, dizziness, sensory disturbances (eg, paresthesias such as electric shock sensations), anxiety, confusion, headache, lethargy, emotional lability, insomnia, hypomania, tinnitus, and seizures. Although these events are generally self-limiting, some have been reported to be severe.

Patients should be monitored for these symptoms when discontinuing treatment with Cymbalta. A gradual reduction in the dose rather than abrupt cessation is recommended whenever possible. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, the physician may continue decreasing the dose but at a more gradual rate.

Use in Patients with Concomitant Illness—Clinical experience with Cymbalta in patients with concomitant systemic illnesses is limited. There is no information on the effect that alterations in gastric motility may have on the stability of Cymbalta's enteric coating. As duloxetine is rapidly hydrolyzed in acidic media to naphthol, caution is advised in using Cymbalta in patients with conditions that may slow gastric emptying (eg, some diabetics). Cymbalta has not been systematically evaluated in patients with a recent history of myocardial infarction or unstable coronary artery disease. Patients with these diagnoses were generally excluded from clinical studies during the product's premarketing testing. However, the electrocardiograms of 321 patients who received Cymbalta in MDD placebo-controlled clinical trials and had qualitatively normal ECGs at baseline were evaluated; Cymbalta was not associated with the development of clinically significant ECG abnormalities (*see* ADVERSE REACTIONS, Electrocardiogram Changes). In DPN placebo-controlled clinical trials, Cymbalta-treated patients did not develop abnormal ECGs at a rate different from that in placebo-treated patients (*see* ADVERSE REACTIONS, Electrocardiogram Changes). In clinical trials of Cymbalta for the management of neuropathic pain associated with diabetic peripheral neuropathy, the mean duration of diabetes was approximately 11 years, the mean baseline fasting blood glucose was 163 mg/dL, and the mean baseline hemoglobin A_{1c} (HbA_{1c}) was 7.8%. In these studies, small increases in fasting blood glucose were observed in Cymbalta-treated patients compared to placebo at 12 weeks and routine care at 52 weeks. The increase was similar at both time points. Overall diabetic control did not worsen as evidenced by stable HbA_{1c} values and by no differences in incidence of serious and non-serious diabetes-related adverse events relative to placebo or routine care. Increased plasma concentrations of duloxetine, and especially of its metabolites, occur in patients with end-stage renal disease (requiring dialysis). For this reason, Cymbalta is not recommended for patients with end-stage renal disease or severe renal impairment (creatinine clearance <30 mL/min) Markedly increased exposure to duloxetine occurs in patients with hepatic insufficiency and Cymbalta should not be administered to these patients.

Laboratory Tests—No specific laboratory tests are recommended.

Drug Interactions—*Potential for Other Drugs to Affect Cymbalta*—Both CYP1A2 and CYP2D6 are responsible for duloxetine metabolism. Inhibitors of CYP1A2—Concomitant use of duloxetine with fluvoxamine, an inhibitor of CYP1A2, results in approximately a 6-fold increase in AUC and about a 2.5-fold increase in C_{max} of duloxetine. Some quinolone antibiotics would be expected to have similar effects and these combinations should be avoided. Inhibitors of CYP2D6—Because CYP2D6 is involved in duloxetine metabolism, concomitant use of duloxetine with potent inhibitors of CYP2D6 may result in higher concentrations of duloxetine. Paroxetine (20 mg QD) increased the concentration of duloxetine (40 mg QD) by about 60%, and greater degrees of inhibition are expected with higher doses of paroxetine. Similar effects would be expected with other potent CYP2D6 inhibitors (eg, fluoxetine, quinidine). *Potential for Duloxetine to Affect Other Drugs*—Drugs Metabolized by CYP1A2—*In vitro* drug interaction studies demonstrate that duloxetine does not induce CYP1A2 activity, and it is unlikely to have a clinically significant effect on the metabolism of CYP1A2 substrates. Drugs Metabolized by CYP2D6—Cymbalta is a moderate inhibitor of CYP2D6. When duloxetine was administered (at a dose of 60 mg BID) in conjunction with a single 50-mg dose of desipramine, a CYP2D6 substrate, the AUC of desipramine increased 3-fold. Therefore, co-administration of Cymbalta with other drugs that are extensively metabolized by this isozyme and which have a narrow therapeutic index, including certain antidepressants (tricyclic antidepressants [TCAs], such as nortriptyline, amitriptyline, and imipramine), phenothiazines and Type 1C antiarrhythmics (eg, propafenone, flecainide), should be approached with caution. Plasma TCA concentrations may need to be monitored and the dose of the TCA may need to be reduced if a TCA is co-administered with Cymbalta. Because of the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, Cymbalta and thioridazine should not be co-administered.

Drugs Metabolized by CYP3A—Results of *in vitro* studies demonstrate that duloxetine does not inhibit or induce CYP3A activity. *Cymbalta May Have a Clinically Important Interaction with the Following Other Drugs*—Alcohol—When Cymbalta and ethanol were administered several hours apart so that peak concentrations of each would coincide, Cymbalta did not increase the impairment of mental and motor skills caused by alcohol. In the Cymbalta clinical trials database, three Cymbalta-treated patients had liver injury as manifested by ALT and total bilirubin elevations, with evidence of obstruction. Substantial intercurrent ethanol use was present in each of these cases, and this may have contributed to the abnormalities seen (*see* PRECAUTIONS, Hepatotoxicity). CNS-Acting Drugs—Given the primary CNS effects of Cymbalta, it should be used with caution when it is taken in combination with or substituted for other centrally acting drugs, including those with a similar mechanism of action. Potential for Interaction with Drugs that Affect Gastric Acidity—Cymbalta has an enteric coating that resists dissolution until reaching a segment of the gastrointestinal tract where the pH exceeds 5.5. In extremely acidic conditions, Cymbalta, unprotected by the enteric coating, may undergo hydrolysis to form naphthol. Caution is advised in using Cymbalta in patients with conditions that may slow gastric emptying (eg, some diabetics). Drugs that raise the gastrointestinal pH may lead to an earlier release of duloxetine. However, co-administration of Cymbalta with aluminum- and magnesium-containing antacids (51 mEq) or Cymbalta with famotidine, had no significant effect on the rate or extent of duloxetine absorption after administration of a 40-mg oral dose. It is unknown whether the concomitant administration of proton pump inhibitors affects duloxetine absorption.

Monoamine Oxidase Inhibitors—*See* CONTRAINDICATIONS *and* WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility Carcinogenesis—Duloxetine was administered in the diet to mice and rats for 2 years. In female mice receiving duloxetine at 140 mg/kg/day (11 times the maximum recommended human dose [MRHD, 60 mg/day] and 6 times the human dose of 120 mg/day on a mg/m^2 basis), there was an increased incidence of hepatocellular adenomas and carcinomas. The no-effect dose was 50 mg/kg/day (4 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis). Tumor incidence was not increased in male mice receiving duloxetine at doses up to 100 mg/kg/day (8 times the MRHD and 4 times the human dose of 120 mg/day on a mg/m^2 basis). In rats, dietary doses of duloxetine up to 27 mg/kg/day in females (4 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis) and up to 36 mg/kg/day in males (6 times the MRHD and 3 times the human dose of 120 mg/day on a mg/m^2 basis) did not increase the incidence of tumors. Mutagenesis—Duloxetine was not mutagenic in the *in vitro* bacterial reverse mutation assay (Ames test) and was not clastogenic in an *in vivo* chromosomal aberration test in mouse bone marrow cells. Additionally, duloxetine was not genotoxic in an *in vitro* mammalian forward gene mutation assay in mouse lymphoma cells or in an *in vitro* unscheduled DNA synthesis (UDS) assay in primary rat hepatocytes, and did not induce sister chromatid exchange in Chinese hamster bone marrow *in vivo*. Impairment of Fertility—Duloxetine administered orally to either male or female rats prior to and throughout mating at daily doses up to 45 mg/kg/day (7 times the maximum recommended human dose of 60 mg/day and 4 times the human dose of 120 mg/day on a mg/m^2 basis) did not alter mating or fertility.

Pregnancy—Pregnancy Category C—In animal reproduction studies, duloxetine has been shown to have adverse effects on embryo/fetal and postnatal development. When duloxetine was administered orally to pregnant rats and rabbits during the period of organogenesis, there was no evidence of teratogenicity at doses up to 45 mg/kg/day (7 times the maximum recommended human dose [MRHD, 60 mg/day] and 4 times the human dose of 120 mg/day on a mg/m^2 basis, in rats; 15 times the MRHD and 7 times the human dose of 120 mg/day on a mg/m^2 basis in rabbits). However, fetal weights were decreased at this dose, with a no-effect dose of 10 mg/kg/day (2 times the MRHD and =1 times the human dose of 120 mg/day on a mg/m^2 basis in rats; 3 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis in rabbits). When duloxetine was administered orally to pregnant rats throughout gestation and lactation, the survival of pups to 1 day postpartum and pup body weights at birth and during the lactation period were decreased at a dose of 30 mg/kg/day (5 times the MRHD and 2 times the human dose of 120 mg/day on a mg/m^2 basis) ; the no-effect dose was 10 mg/kg/day. Furthermore, behaviors consistent with increased reactivity, such as increased startle response to noise and decreased habituation of locomotor activity, were observed in pups following maternal exposure to 30 mg/kg/day. Post-weaning growth and reproductive performance of the progeny were not affected adversely by maternal duloxetine treatment.

There are no adequate and well-controlled studies in pregnant women; therefore, duloxetine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects—Neonates exposed to SSRIs or serotonin and norepinephrine reuptake inhibitors (SNRIs), late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome (*see* WARNINGS, Monoamine Oxidase Inhibitors). When treating a pregnant woman with Cymbalta during the third trimester, the physician should carefully consider the potential risks and benefits of treatment.

Labor and Delivery—The effect of duloxetine on labor and delivery in humans is unknown. Duloxetine should be used during labor and delivery only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Duloxetine and/or its metabolites are excreted into the milk of lactating rats. It is unknown whether or not duloxetine and/or its metabolites are excreted into human milk, but nursing while on Cymbalta is not recommended.

Pediatric Use—Safety and effectiveness in the pediatric population have not been established (*see* BOX WARNING *and* WARNINGS, Clinical Worsening and Suicide Risk). Anyone considering the use of Cymbalta in a child or adolescent must balance the potential risks with the clinical need.

Geriatric Use—Of the 2418 patients in clinical studies of Cymbalta for MDD, 5.9% (143) were 65 years of age or over. Of the 1074 patients in the DPN studies, 33% (357) were 65 years of age or over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS: Cymbalta has been evaluated for safety in 2418 patients diagnosed with MDD who participated in multiple-dose premarketing trials, representing 1099 patient-years of exposure. Among these 2418 Cymbalta-treated patients, 1139 patients participated in eight 8 or 9 week, placebo-controlled trials at doses ranging from 40 to 120 mg/day, while the remaining 1279 patients were followed for up to 1 year in an open-label safety study using flexible doses from 80 to 120 mg/day. Two placebo-controlled studies with doses of 80 and 120 mg/day had 6-month maintenance extensions. Of these 2418 patients, 993 Cymbalta-treated patients were exposed for at least 180 days and 445 Cymbalta-treated patients were exposed for at least 1 year. Cymbalta has also been evaluated for safety in 1074 patients with diabetic peripheral neuropathy representing 472 patient-years of exposure. Among these 1074 Cymbalta-treated patients, 568 patients participated in two 12 to 13 week, placebo-controlled trials at doses ranging from 20 to 120 mg/day. An additional 449 patients were enrolled in an open-label safety study using 120 mg/day for a duration of 6 months. Another 57 patients, originally treated with placebo, were exposed to Cymbalta for up to 12 months at 60 mg twice daily in an extension phase. Among these 1074 patients, 484 had 6 months of exposure to Cymbalta, and 220 had 12 months of exposure. For both MDD and DPN clinical trials, adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Clinical investigators recorded adverse events using descriptive terminology of their own choosing. To provide a meaningful estimate of the proportion of individuals experiencing adverse events, grouping similar types of events into a smaller number of standardized event categories is necessary. MedDRA terminology was used to classify reported adverse events.

The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. Events reported during the studies were not necessarily caused by the therapy, and the frequencies do not reflect investigator impression (assessment) of causality.

Adverse Events Reported as Reasons for Discontinuation of Treatment in Placebo-Controlled Trials—Major Depressive Disorder—Approximately 10% of the 1139 patients who received Cymbalta in the MDD placebo-controlled trials discontinued treatment due to an adverse event, compared with 4% of the 777 patients receiving placebo. Nausea (Cymbalta 1.4%, placebo 0.1%) was the only common adverse event reported as reason for discontinuation and considered to be drug-related (ie, discontinuation occurring in at least 1% of the Cymbalta-treated patients and at a rate of at least twice that of placebo). Diabetic Peripheral Neuropathic Pain—Approximately 14% of the 568 patients who received Cymbalta in the DPN placebo-controlled trials discontinued treatment due to an adverse event, compared with 7% of the 223 patients receiving placebo. Nausea (Cymbalta 3.5%, placebo 0.4%), dizziness (Cymbalta 1.6%, placebo 0.4%), somnolence (Cymbalta 1.6%, placebo 0%) and fatigue (Cymbalta 1.1%, placebo 0%) were the common adverse events reported as reasons for discontinuation and considered to be drug-related (ie, discontinuation occurring in at least 1% of the Cymbalta-treated patients and at a rate of at least twice that of placebo).

Adverse Events Occurring at an Incidence of 2% or More Among Cymbalta-Treated Patients in Placebo-Controlled Trials—Major Depressive Disorder—Treatment-emergent adverse events that occurred in 2% or more of patients treated with Cymbalta in the premarketing acute phase of MDD placebo-controlled trials (N=1139 Cymbalta; N=777 placebo) with an incidence greater than placebo were: Gastrointestinal Disorders—nausea, dry mouth, constipation, diarrhea, vomiting; Metabolism and Nutrition Disorders—appetite decreased (includes anorexia); Investigations—weight decreased; General Disorders and Administration Site Conditions—fatigue; Nervous System Disorders—dizziness, somnolence, tremors; Skin and Subcutaneous Tissue Disorders—sweating increased; Vascular Disorders—hot flushes; Eye Disorders—vision blurred; Psychiatric Disorders—insomnia (includes middle insomnia), anxiety, libido decreased, orgasm abnormal (includes anorgasmia); Reproductive System and Breast Disorders—males only: erectile dysfunction, ejaculation delayed, ejaculatory dysfunction (includes ejaculation disorder and ejaculation failure).

The following events were reported by at least 2% of patients treated with Cymbalta for MDD and had an incidence ≤ placebo: upper abdominal pain, palpitations, dyspepsia, back pain, arthralgia, headache, pharyngitis, cough, nasopharyngitis, and upper respiratory tract infection.

The most commonly observed adverse events in Cymbalta-treated MDD patients (incidence ≥5% and at least twice the incidence in placebo patients) were: nausea; dry mouth; constipation; decreased appetite; fatigue; somnolence; and increased sweating.

Diabetic Peripheral Neuropathic Pain—Treatment emergent adverse events that occurred in 2% or more of patients treated with Cymbalta in the premarketing acute phase of DPN placebo-controlled trials (N=225 Cymbalta 60 mg BID; N=228 Cymbalta 60 mg QD; N=115 Cymbalta 20 mg QD; N=223 placebo) with an incidence greater than placebo were: Gastrointestinal Disorders—nausea, constipation, diarrhea, dry mouth, vomiting, dyspepsia, loose stools; General Disorders and Administration Site Conditions—fatigue, asthenia, pyrexia; Infections and Infestations—nasopharyngitis; Metabolism and Nutrition Disorders—decreased appetite, anorexia; Musculoskeletal and Connective Tissue Disorders—muscle cramp, myalgia; Nervous System Disorders—somnolence, headache, dizziness, tremor; Psychiatric Disorders—insomnia; Renal and Urinary Disorders—pollakiuria; Reproductive System and Breast Disorders—erectile dysfunction; Respiratory, Thoracic and Mediastinal Disorders—cough, pharyngolaryngeal pain; Skin and Subcutaneous Tissue Disorders—hyperhidrosis.

The following events were reported by at least 2% of patients treated with Cymbalta for DPN and had an incidence ≤ placebo: edema peripheral, influenza, upper respiratory tract infection, back pain, arthralgia, pain in extremity, and pruritus.

The most commonly observed adverse events in Cymbalta-treated DPN patients (incidence ≥5% and at least twice the incidence in placebo patients) were: nausea; somnolence; dizziness; constipation; dry mouth; hyperhidrosis; decreased appetite; and asthenia.

Adverse events seen in men and women were generally similar except for effects on sexual function (described below). Clinical studies of Cymbalta did not suggest a difference in adverse event rates in people over or under 65 years of age. There were too few non-Caucasian patients studied to determine if these patients responded differently from Caucasian patients.

Effects on Male and Female Sexual Function—Although changes in sexual desire, sexual performance and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. Sexual side effects spontaneously reported by at least 2% of either male or female patients taking Cymbalta in MDD placebo-controlled trials were: Males (N=378 Cymbalta; N=247 placebo): orgasm abnormal (includes anorgasmia), ejaculatory dysfunction (includes ejaculation disorder and ejaculation failure), libido decreased, erectile dysfunction, ejaculation delayed. Females (N=761 Cymbalta; N=530 placebo): orgasm abnormal, libido decreased.

Because adverse sexual events are presumed to be voluntarily underreported, the Arizona Sexual Experience Scale (ASEX), a validated measure designed to identify sexual side effects, was used prospectively in 4 MDD placebo-controlled trials. In these trials, patients treated with Cymbalta experienced significantly more sexual dysfunction, as measured by the total score on the ASEX, than did patients treated with placebo. Gender analysis showed that this difference occurred only in males. Males treated with Cymbalta experienced more difficulty with ability to reach orgasm (ASEX Item 4) than males treated with placebo. Females did not experience more sexual dysfunction on Cymbalta than on placebo as measured by ASEX total score. These studies did not, however, include an active control drug with known effects on female sexual dysfunction, so that there is no evidence that its effects differ from other antidepressants. Physicians should routinely inquire about possible sexual side effects. See Table 4 in full PI for specific ASEX results.

Urinary Hesitation—Cymbalta is in a class of drugs known to affect urethral resistance. If symptoms of urinary hesitation develop during treatment with Cymbalta, consideration should be given to the possibility that they might be drug-related. ***Laboratory Changes***—Cymbalta treatment, for up to 9 weeks in MDD or 13 weeks in DPN placebo-controlled clinical trials, was associated with small mean increases from baseline to endpoint in ALT, AST, CPK, and alkaline phosphatase; infrequent, modest, transient, abnormal values were observed for these analytes in Cymbalta-treated patients when compared with placebo-treated patients (*see* PRECAUTIONS). ***Vital Sign Changes***—Cymbalta treatment, for up to 9 weeks in MDD placebo-controlled clinical trials of 40 to 120 mg daily doses caused increases in blood pressure, averaging 2 mm Hg systolic and 0.5 mm Hg diastolic compared to placebo and an increase in the incidence of at least one measurement of systolic blood pressure over 140 mm Hg (*see* PRECAUTIONS). Cymbalta treatment, for up to 9 weeks in MDD placebo-controlled clinical trials and for up to 13 weeks in DPN placebo-controlled trials caused a small increase in heart rate compared to placebo of about 2 beats per minute. ***Weight Changes***—In MDD placebo-controlled clinical trials, patients treated with Cymbalta for up to 9 weeks experienced a mean weight loss of approximately 0.5 kg, compared with a mean weight gain of approximately 0.2 kg in placebo-treated patients. In DPN placebo-controlled clinical trials, patients treated with Cymbalta for up to 13 weeks experienced a mean weight loss of approximately 1.1 kg, compared with a mean weight gain of approximately 0.2 kg in placebo-treated patients. ***Electrocardiogram Changes***—Electrocardiograms were obtained from 321 Cymbalta-treated patients with MDD and 169 placebo-treated patients in clinical trials lasting up to 8 weeks. The rate-corrected QT (QTc) interval in Cymbalta-treated patients did not differ from that seen in placebo-treated patients. No clinically significant differences were observed for QT, PR, and QRS intervals between Cymbalta-treated and placebo-treated patients. Electrocardiograms were obtained from 528 Cymbalta-treated patients with DPN and 205 placebo-treated patients in clinical trials lasting up to 13 weeks. The rate-corrected QT (QTc) interval in Cymbalta-treated patients did not differ from that seen in placebo-treated patients. No clinically significant differences were observed for QT, PR, QRS, or QTc measurements between Cymbalta-treated and placebo-treated patients.

Postmarketing Spontaneous Reports—Adverse events reported since market introduction that were temporally related to Cymbalta therapy include rash reported rarely and the following adverse events reported very rarely: alanine aminotransferase increased, alkaline phosphatase increased, anaphylactic reaction, angioneurotic edema, aspartate aminotransferase increased, bilirubin increased, glaucoma, hepatitis hyponatremia, jaundice, orthostatic hypotension (especially at the initiation of treatment), Stevens-Johnson Syndrome, syncope (especially at initiation of treatment), and urticaria.

DRUG ABUSE AND DEPENDENCE: ***Controlled Substance Class***—Duloxetine is not a controlled substance. ***Physical and Psychological Dependence***—In animal studies, duloxetine did not demonstrate barbiturate-like (depressant) abuse potential. In drug dependence studies, duloxetine did not demonstrate dependence-producing potential in rats.

While Cymbalta has not been systematically studied in humans for its potential for abuse, there was no indication of drug-seeking behavior in the clinical trials. However, it is not possible to predict on the basis of premarketing experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of misuse or abuse of Cymbalta (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

OVERDOSAGE: There is limited clinical experience with Cymbalta overdose in humans. In premarketing clinical trials, as of October 2003, no cases of fatal acute overdose of Cymbalta have been reported. Four non-fatal acute ingestions of Cymbalta (300 to 1400 mg), alone or in combination with other drugs, have been reported. ***Management of Overdose***—There is no specific antidote to Cymbalta. In case of acute overdose, treatment should consist of those general measures employed in the management of overdose with any drug.

Literature revised September 22, 2005

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Cymbalta® (duloxetine hydrochloride) Delayed-release Capsules

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DEPRESSED PATIENTS NEED EMOTIONAL SYMPTOM RELIEF BUT IS THERE SOMETHING MISSING?

Help relieve both the ***emotional*** and ***painful*** symptoms of depression. Depression hurts. Cymbalta helps.

Cymbalta is the first and only agent approved for both the treatment of major depressive disorder and the management of diabetic peripheral neuropathic pain.

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Important Safety Information:

- **Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders.**
- **Patients started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.**
- **Cymbalta is not approved for use in pediatric patients.**

Cymbalta should not be used concomitantly with monoamine oxidase inhibitors (MAOIs) or thioridazine and not in patients with a known hypersensitivity or with uncontrolled narrow-angle glaucoma.

Clinical worsening and suicide risk: All adult and pediatric patients being treated with an antidepressant for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially when initiating drug therapy and when increasing or decreasing the dose. A health professional should be immediately notified if the depression is persistently worse or there are symptoms that are severe, sudden, or were not part of the patient's presentation. If discontinuing treatment, taper the medication.

Cymbalta should not be administered to patients with any hepatic insufficiency or patients with end-stage renal disease (requiring dialysis) or severe renal impairment (CrCl <30 mL/min).

Postmarketing, severe elevations of liver enzymes or liver injury with a cholestatic or mixed pattern have been reported.

Cymbalta should generally not be prescribed to patients with substantial alcohol use or evidence of chronic liver disease.

Most common adverse events (≥5% and at least twice placebo) in MDD premarketing clinical trials were: nausea, dry mouth, constipation, fatigue, decreased appetite, somnolence, and increased sweating. Most common adverse events in diabetic peripheral neuropathic pain (DPNP) premarketing clinical trials were: nausea, somnolence, dizziness, constipation, dry mouth, increased sweating, decreased appetite, and asthenia.

See Brief Summary of full Prescribing Information, including Boxed Warning, on adjacent page.

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