The Road to San Francisco: Developing DSM-5

The long and winding road that was the DSM-5 development process culminates this week at the APA Annual Meeting in San Francisco — approximately 2,800 miles and almost a decade and a half from where it began — with the official unveiling of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

The first step in the DSM-5 journey was taken in 1999, at the National Institute of Mental Health in Bethesda, when a discussion between Steven Hyman, MD, (then-director of the NIMH), Steven M. Mirin, MD (then-medical director of the APA), and David J. Kupfer, MD, (then-chair of the APA Committee on Psychiatric Diagnosis and Assessment) put the wheels in motion to begin the DSM-5 development process.

“The publication of DSM-5 is the culmination of a nearly 14-year process that began with the decision by APA to move forward with a DSM-5 revision that would reflect current advances and facilitate both clinical practice and research,” said David J. Kupfer, MD, Chair of the DSM-5 Task Force.

Darrel Regier, MD, MPH, Director of the APA Division of Research and Executive Director of the American Psychiatric Institute for Research and Education (APIRE) is Vice-Chair of the DSM-5 Task Force, serving jointly with Task Force Chair, the aforementioned Dr. Kupfer, who is the Thomas Detre Professor of Psychiatry and Professor of Neuroscience and Clinical and Translational Science at the University of Pittsburgh School of Medicine. Prior to the formation of the Task Force, preliminary work on DSM-5 began with three planning conferences held by the APA and NIMH in 1999 and 2000, which included psychiatrists, psychologists, other mental health professionals, and research experts. These meetings set the stage for the development process with the formation of several groups of national and international experts who worked to compile a series of white papers, published together as “A Research Agenda for DSM-5,” in 2002.

The next stage of development was supported by a $1.1 million cooperative agreement from the National Institutes of Health (U13 MH067855), including the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, to coordinate a series of additional conferences to identify research advances and major

Addiction Performance Project Returns for Encore Performance

National Institute on Drug Abuse Track

The APA Annual Meeting program once again includes a special educational track sponsored by the National Institute on Drug Abuse, featuring a wide range of symposia and lectures designed to update attendees on areas critical to psychiatric practice. Among the highlights of the NIDA Track, and returning for a repeat of last year’s popular performance, is the Addiction Performance Project — a unique educational event featuring a dramatic reading from the Eugene O’Neill play “Long Day’s Journey into Night” by Emmy Award-winning actress Mare Winningham and other actors. Although the play was published more than a half-century ago and is set in the early 1900s, the issues and themes it addresses make it powerful and relevant still today.

“At its core, it is a story of how addiction is both an individual and a family disease. It is the story of any family that has been torn apart by addiction,” said NIDA Director Nora D. Volkow, MD. “This play also speaks to how stigma and shame keep people that are addicted from getting the help they need from the medical establishment. As true today as it was over a hundred years ago.”

The Addiction Performance Project includes a panel and audience discussion after the reading. Joining Dr. Volkow on this year’s panel are Congressman Patrick Kennedy, Dr. Roger Weiss, Professor of Psychiatry at Harvard Medical School and Chief of the Division of Alcohol and Drug Abuse at McLean Hospital in Belmont, Massachusetts, and Dr. Steven Baskin, Professor in the UCSF Department of Psychiatry, Chief of the SFVAMC Substance Abuse Programs, and Director of the SFVAMC Addiction Research Program. The Addiction Performance Project takes place on Sunday, beginning at 2 p.m., in Room 130/131 of the Moscone Convention Center.

Frontiers of Science

Dr. Volkow will also deliver a Frontiers of Science Lecture on Monday at 11 a.m. in the Gateway Ballroom 102/103 of the Moscone Convention Center. In her lecture — “Substance Use Disorders: New Scientific Findings and Therapeutic Opportunities” — Dr. Volkow will discuss a range of findings in the area of addiction science, such as what researchers are learning about genetic vulnerability and resilience for drug abuse and effects of drug exposure on gene expression and on brain development.

“In the past few years our understanding of the biological, developmental, and environmental factors involved in drug abuse and addiction has grown enormously, and it is paving the way for exciting new treatment approaches,” Dr. Volkow said. “Translational research is also paving the way for the use of new imaging tools, as biomarkers, which will both help predict the effectiveness of prevention interventions and assess and monitor addiction treatment strategies.”

She will also talk about new addiction

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She will also talk about new addiction
Challenges and Opportunities in Schizophrenia Treatment

Sunday, May 19, 2013
1:00 PM - 2:00 PM
Lunch will be served

Please Join Sunovion Pharmaceuticals Inc. at Moscone Convention Center
Exhibit Halls A-C, Exhibit Level
for a Product Theater presentation given by

Stephen M. Stahl, MD, PhD
Adjunct Professor of Psychiatry
University of California, San Diego School of Medicine
Honorary Visiting Senior Fellow
University of Cambridge, UK
Editor-in-Chief, CNS Speçtrums
Director of Psychopharmacology Services
California Department of State Hospitals
Consultant of Sunovion Pharmaceuticals Inc.

This promotional non-CME program is only intended for those healthcare professional involved in the treatment of adult patients with schizophrenia.

The content and the views expressed therein are those of Sunovion Pharmaceuticals Inc. and not of the American Psychiatric Association (APA). Continuing Medical Education (CME) credit for this event is not offered by APA or Sunovion Pharmaceuticals Inc.

This program is not intended or eligible for continuing education credits and does not meet guidelines governing continuing education.

INDICATIONS AND USAGE for Latuda® (lurasidone HCl)
LATUDA is an atypical antipsychotic indicated for the treatment of adult patients with schizophrenia. Efficacy was established in five 6-week controlled studies of adult patients with schizophrenia. The effectiveness of LATUDA for longer-term use, that is, for more than 6 weeks, has not been established in controlled studies. Therefore, the physician who elects to use LATUDA for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

IMPORTANT SAFETY INFORMATION FOR LATUDA
WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS
See full prescribing information for complete boxed warning.
• Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death.
• LATUDA is not approved for the treatment of patients with dementia-related psychosis.

Please see additional Important Safety Information, including Boxed Warning, and full Prescribing Information available at Booth 1632 or www.LatudaHCP.com.
The mechanisms and clinical implications of smoking and ADHD comorbidity will be the topic of a Sunday symposium, co-chaired by Yu (Woody) Lin, MD, PhD, and Scott H. Kollins, PhD. “ADHD affects millions of Americans, young and old, and it is a significant independent risk factor for smoking and nicotine dependence,” Dr. Volkow said. “Yet we still know little about the specific factors involved in conferring these risks, how to reduce those risks, or how to treat individuals who have both ADHD and nicotine dependence.”

Dr. Volkow and other speakers in this symposium will address this critically important public health problem and present research findings from a range of perspectives.

On Monday morning, Wilson M. Compton, MD, MPE, will lead a symposium looking at comorbid psychiatric and substance use disorders, focusing on common and specific influences and implications for early identification and treatment. The speakers will present research findings on the patterns of interaction of co-occurring disorders, the potential for enhanced early identification, and possibilities for improved treatment.

“Comorbidities of psychiatric and substance use disorders are very common, and they are associated with greater difficulties and poorer outcomes of treatment,” Dr. Volkow said. “Research continues on the relationship of comorbid disorders and what predisposing and underlying influences determine their occurrence and course.”

Advances in pharmacotherapies for substance use disorders will be the topic of a Monday afternoon symposium, chaired by Ivan Montoya, MD, MPH. This session will provide an update of the results of recently completed clinical studies testing the safety and efficacy of new compounds for the treatment of opioid and cocaine dependence.

“Six million Americans seek treatment for substance use disorders every year, but there are few FDA-approved medications to treat these disorders, and their efficacy is far from optimal,” Dr. Volkow said. “In some cases, such as stimulant and cannabis dependence, no medications exist. But recent advances are providing an opportunity to discover and develop new treatments.”

Geetha Subramaniam, MD, will chair a symposium on Tuesday morning, during which attendees will hear updates on risk, assessment and treatment related to cannabis use and youths.

“Adolescent marijuana use is a particular concern for me and my colleagues at NIDA, given the erroneous perceptions of this drug’s safety, coupled with rising use over the past several years,” Dr. Volkow said. “Recent findings show starkly the drug’s negative impact on cognitive abilities during development. The speakers in this session will familiarize clinicians with recent findings on the effects of cannabis use on the adolescent brain, how to identify youth that have developed problem use, and how to provide brief or specialized treatments that could be integrated into psychiatric practices.”

The APA 2013 NIDA Track concludes on Wednesday morning with another symposium led by Dr. Compton, during which he, and presenters from Stanford and Yale universities, will provide updates on prescription opioid abuse and treatment options for psychiatrists.

“Abuse of prescription opioid pain drugs is epidemic in our society, and it puts clinicians who care for patients who have pain and also histories of substance abuse in a quandary — how to use these needed therapeutic tools and, at the same time, minimize the potential of addiction,” Dr. Volkow said. “This symposium will present recent research findings that may open new pathways of care that ensure effective pain treatment while reducing the risk of addiction in this population.”

NIDA and APA

The NIDA Track at the APA Annual Meeting provides APA members an unparalleled opportunity to hear the latest research and clinical advances related to drug abuse and addiction science by some of the top experts in the field — information psychiatrists can use to better treat and prevent addiction and related mental illnesses. The diverse activities, presentations, and interactive sessions included in the NIDA Track foster synergistic developments and opportunities for integrating science and practice in this important field.

“The prevalence of comorbidity of addictive and other mental health disorders is high, yet many psychiatrists are not adequately trained to recognize substance abuse in their patients or understand its impact on other mental illnesses and the need for treating both,” Dr. Volkow said. “By bringing the latest research findings and thinking about this subject to the broad psychiatric community, we hope to pique their interest in learning more and, in turn, become better able to help their patients.”

National Institute on Drug Abuse Track

Saturday, May 18

9 a.m. – 10:30 a.m. Workshop (Session #W6): Substance Use Disorders in DSM-5/APA Taskforce on DSM-5

9 a.m. – 12 p.m. Symposium Session #S45: Smoking Cessation in Patients with Severe Mental Illness: New Research Findings and Clinical Implications

2 p.m. – 5 p.m. Symposium Session #S253: Substance Use Disorders in DSM-5: Evidence and Clinical Implications/APA Taskforce on DSM-5

Sunday, May 19

8 a.m. – 11 a.m. Symposium Session #S29: Smoking and ADHD Comorbidity—Mechanisms and Clinical Implications

2 p.m. – 4 p.m. Forum (Session #F3): Addiction Performance Project (APP), A NIDAMED Program

Monday, May 20

9 a.m. – 12 p.m. Symposium Session #S557: Comorbid Psychiatric and Substance Use Disorders: Common and Specific Influences and Implications for Early Identification and Treatment

Advances in Series (Session #A545): Advances in Addiction Psychopharmacology

11 a.m. – 12:30 p.m. Frontiers of Science Lecture (Session #L16): Substance Use Disorders: New Scientific Findings and Therapeutic Opportunities

2 p.m. – 5 p.m. Symposium Session #S748: Advances in Pharmacotherapies for Substance Use Disorders

Tuesday, May 21

9 a.m. – 12 p.m. Symposium Session #S594: Cannabis Use and Youth: Updates on Risk, Assessment and Treatment

1:30 p.m. – 3 p.m. Scientific and Clinical Reports (Session #S5CRC2): Substance Misuse: Opioids, Cannabis, Tobacco

3:30 p.m. – 5 p.m. Lecture (Session #L28): Evolutionary Explorations of the Human Genome

Wednesday, May 22

9 a.m. – 12 p.m. Symposium Session #S124: Update on Prescription Opioid Abuse and Treatment Options for the Psychiatrist
DAILY BULLETIN May 18/19, 2013

FACTS ABOUT THE ANNUAL MEETING

Each year many questions are asked about the Annual Meeting. This fact sheet has been prepared to answer the most commonly asked questions and to provide basic information about the APA meeting.

Did you know?

• The Annual Meeting is booked at least ten years in advance to obtain the necessary meeting space and sleeping rooms. Dates are held through 2027 now.
• APA strives for a geographical rotation based on adequate accommodations and availability.
• Approximately 7,000 hotel sleeping rooms are needed on peak night to house meeting attendees, exhibitors, and staff.
• The commercial/educational exhibits, APA Member Center, APP Bookstore, and the registration area require a minimum of 275,000 gross square feet of space. Over 200 10x10 booths are used for the exhibit program.
• Approximately 100-135 concurrent meeting rooms are used for scientific sessions, audience, allied and committee activities, and operational office space.
• Approximately 50 temporary personnel are employed to assist with registration, course monitoring, etc.
• During peak hours about 50 motor coaches are in use.

Facts About CME

• CME credit is earned on an hour-for-hour basis by attending scientific sessions. Signing into sessions is not necessary, nor is having your attendance verified by the APA. The APA does not keep records of registrants’ attendance at individual sessions; physicians are responsible for maintaining their own records. A Log Sheet for recording the individual sessions you attend is located in the Program Book. There are two ways for a physician to receive a CME Certificate:
  2. Or, complete the online General Evaluation at, www.psych.org/annualmeetingcme during or after the meeting until mid-August. This evaluation is identical to the evaluation available at the CME Certificate of Attendance booth.

ANSWERS TO COMMONLY ASKED QUESTIONS

Can my spouse/guest attend scientific sessions without a badge? No

Can my spouse/guest go through the exhibits without a badge? You can purchase a guest pass for $25 per day. This pass is only good to tour the exhibits for one day, and may be purchased in the registration area by a registered attendee.

Where can I leave messages? At one of the two message centers, located in the registration area and in the south lobby.

How can I get a copy of Dr. X’s paper? Copies of session abstracts can be obtained in the syllabus and proceedings book provided on a CD-ROM to each registered meeting attendee or post meeting on our website by visiting the APA Melvin Salshin library and archives.

I just got here how do I get a hotel room? How can I change my hotel? Go to the housing desk in the south lobby of the convention center.

Where can I change my currency into U.S. dollars? Check with your hotel for the nearest major bank. The airport and most hotels also offer foreign currency exchange.

Where can I get information on the 2014 Annual Meeting submission process, the 2013 APA Institute on Psychiatric Services, or Certificates of Attendance? At the APA Member Center in the exhibit hall at the convention center.

Where can I find information on exhibits? In the exhibits section of the Guide to the Annual Meeting, distributed at registration.

How can I find out where and when my committee is meeting, and where the reception is for residents and fellows? Refer to the APA Committee, Allied Organizations, and Sponsored Scientific Sessions Booklet, available in the registration area.

What is the difference between the books in my registration packet?

Days-at-a-Glance is a pocket-size booklet outlining the meeting by day and time, with formats listed alphabetically. Use for ease in finding sessions.

Annual Meeting Guide contains:

• A detailed listing of each session, including all presenters, listed by day, start time, then alphabetically by format, with locations.
• General information about the meeting, presenter disclosures, and a topic index, participant index, and floor plans.
• New Research Program listing all posters presented at the meeting
• Exhibits Section listing all exhibitors and exhibit floor plan

Syllabus & Proceedings Book is available as a PDF file on the CD-ROM in your registration materials and contains the title; educational objectives, presenter names, degrees and abstracts for scientific sessions. The CD also includes the Lecturer Brochure, Course Brochure, Research Track Highlights and other promotional materials related to the Annual Meeting program content.

APA TV returns for the 3rd year!

Welcome to San Francisco, host to the APA 166th Annual Meeting and APA TV - your conference television channel dedicated to news and views from the conference.

Whether it’s a workshop, debate or speech APA TV is here to cover all the important issues, raise the visibility of the APA and highlight the current emerging trends in psychiatry.

You will be able to watch exclusive reports, produced especially for the conference from medical centers, hospitals and universities.

Tune In!

We will be screening a new episode each day of the conference. Watch the program around the conference venue, in the rooms of selected hotels, and online at: www.webseedge.com/videos/health
www.youtube.com/WebsEdgeHealth
Twitter: @WebsEdge_Health and the conference #APAAM13

Be on TV - APA TV!

You will see our camera team touring throughout the Convention Center. Please say hello and share with us your comments on the speakers and sessions you attended.

The APA TV team welcomes all feedback and would like to hear what you think of your new conference TV show, as well as your views on the various issues raised at the conference.

We hope you enjoy the meeting and APA TV 2013!

APA TV is part of WebsEdge/Health - our group of products and services for health organizations, connecting issues and audiences through the power of television.

For up to date information and news, follow us on Twitter: @webseedge_health and the conference on #APAAM13
NewYork-Presbyterian
PSYCHIATRY

Visit us at booth 713 to learn more about our innovative research, educational and clinical programs.

Meet and share ideas with incoming APA President, Jeffrey Lieberman, M.D. at our booth on May 21st, 11 am – 12 pm.
Corporate Leaders Discuss Return To Work

Today’s workplace confronts people with increasingly high levels of uncertainty and stress. More workers are absent from work because of stress and anxiety than because of physical illness or injury. Effective psychiatric treatment requires understanding the impact of stress on the entire person, both physiologically and psychologically. Who is the champion for the employed psychiatric patient? Is it the psychiatrist? Is it the employer? Or can it be both?

APA leaders, along with employers DuPont and JPMorgan Chase, will present the symposium, “Return to Work: the Most Underutilized ‘Pill’ in the Psychiatrist’s Formulary” on Wednesday, May 22 from 2 p.m. – 5 p.m. in room 306 at the Moscone Center.

The symposium is being presented by the Partnership for Workplace Mental Health, a program of the American Psychiatric Foundation, dedicated to collaborating with employers to advance quality mental health care. Presentations will highlight real-world employer approaches to mental health.

Hear innovative employer mental health strategies and explore how psychiatry can be a partner in efforts to reduce employee stress and the amount of time away from work. “Employers increasingly recognize that untreated mental illness increases absenteeism, saps productivity, and drives up health care and disability costs. More than that, we see the impact of stress and emotional health on our employees every day,” said panelist Paul Heck, Med, LPC, Global Manager for Employee Assistance and WorkLife Services for DuPont and Advisor to the Partnership for Workplace Mental Health. “Let’s talk about how employers and psychiatry can partner in reaching our shared goals of people receiving quality treatment that avoids the need to miss work or that minimizes time away from work.”

Support a coordinated return-to-work strategy. The idea of “functional impairments” will be highlighted in conjunction with DSM-IV diagnoses to present a model of how psychiatry can better partner with workplaces to restore patient functioning. The session will present a pathway to understand disability and identify various roles mental health professionals can play to enhance return to work planning.

“A widespread culture of stigma continues to surround mental health, often preventing individuals from reaching out for help they need when they need it most,” said panelist Paul Pendler, PsyD, Vice President for Employee Assistance & WorkLife Program at JPMorgan Chase. “Employers are implementing strategies that enable help-seeking behavior and psychiatry needs to be at the table as part of an overall wellness and health promotion strategy.”

Partner with employer coalitions. The panel will explore how employers collaborate through business coalitions to make a positive impact on mental health care delivery and financing. “Beyond learning how employers are addressing stress and mental health with their employees, I believe that attendees of this symposium will discover firsthand how, in many ways, the goals of business and psychiatry are in fact aligned, and that employers can be a valuable ally to psychiatry,” said symposium chair Alan Axelson, MD and co-chair of the Partnership for Workplace Mental Health’s Advisory Council.
This year’s Annual Meeting features a full schedule of educational sessions, networking opportunities and social events for psychiatry residents and fellows, offering more choices than ever for members-in-training to meet and socialize with one another, ask questions, share information and learn more about their profession.

“The Resident’s Track that has been put together for the meeting here in San Francisco is going to be very exciting,” said Erik Vanderlip, MD, APA Member-in-Training Trustee. “One new thing I think everyone will appreciate is the MIT Center, which will serve as ‘home base’ for MITs throughout the meeting.”

The MIT Center, located in room 110 of the Moscone Convention Center, will house MIT-specific educational programming as well as live mentoring opportunities with leaders across all sub-specialties. The MIT Center will have all the real-time updated information on ongoing activities and events for residents and fellows.

Among the highlights of the 2013 Resident Track is a special workshop on Saturday, “DSM-5 for the Member-in-Training,” designed to introduce residents and fellows to the new manual, orient them to the DSM scientific process and familiarize them with significant updates across the disorders. The workshop begins at 9 a.m. in the MIT Center.

“The DSM-5 for the MIT presentation will include background information on the development process of the DSM-5 and some of the history of the document,” said Dr. Vanderlip, who will co-chair the workshop with Alik Widge, MD, APA Member-in-Training Trustee. “It will also explore challenges in criterion formation for DSM-5 diagnoses, and we will have a discussion on the tensions in developing a consensus for the current criterion set.”

Another “must-attend” workshop — “What Happens Now That You’ve Graduated? Pearls, Pitfalls, Strategies For Negotiating Your First Job, And Other Transitions After Residency” — will be held on Monday at 1:30 p.m. in the MIT Center. Chaired by Sarah Johnson, MD, MSc, this workshop will include tips and tricks from early career psychiatrists on how to “survive” the transition from residency into early careers.

Other highlights of the 2013 Resident Track include the “Meet the Experts Breakfast,” beginning at 7 a.m. Monday in Nob Hill Room A-D at the Marriott Marquis; the MIT Caucus Meeting Sunday evening at 7:30 p.m., California Pizza Kitchen (53rd Street, 2 blocks from Moscone, across from the Westin); and the always popular Mind Games competition, which will be held on Tuesday at 5:30 p.m. Moscone, room 135.

“All in all, our goal is to make the MIT program at the Annual Meeting current and comprehensive for the residents and fellows attending the meeting, and make it flexible and adaptable to their interests and availability,” Dr. Vanderlip said.
More than 500,000 U.S. participants in the Middle East conflicts may suffer from Post-Traumatic Stress Disorder.

Meet one of them.

Retired Lieutenant Colonel John O'Brien served four tours as a Special Operations officer in the Middle East. He received a Purple Heart and a Bronze Star for service to his country. The nightmares of war can leave the body and the mind ravaged. But there’s a real stigma associated with PTSD. John says that some of his fellow soldiers believe that the need to go to psychotherapy means you’re “weak,” and that it’s something only “crazy” people do.

John participated in a PTSD clinical trial at NewYork-Presbyterian, where both medical and virtual therapy treatments are being pioneered. He says, “My treatment at NewYork-Presbyterian has brought me to a point in my life where I can really start to move on and do the things I want to do.”

Visit NewYork-Presbyterian’s Booth #713, and at nyp.org/psychiatry.
Minority, Underrepresented Groups Share Concerns Through Caucuses

Psychiatrists who identify with any of APA’s recognized minority and underrepresented (M/UR) groups are urged to join that group’s caucus and attend its meeting during the APA 2013 Annual Meeting in San Francisco. The minority and underrepresented group caucuses were established to provide a networking opportunity and foster communication among members who share a special interest.

There are caucuses for the following groups: American Indian/Alaska Native/Native Hawaiians; Asian Americans; Blacks; Hispanics; Lesbians, Gays, and Bisexuals; International Medical Graduates; American Indian/Alaska Native/Native Hawaiians; Asians; Blacks; Hispanics; Lesbians, Gays, and Bisexuals; International Medical Graduates; and Women.

Participation in a caucus is a pathway to the following:

- Exploring concerns about professional growth and advancement
- Identifying, supporting, and electing top-notch M/UIs for leadership posts
- Networking with members with shared backgrounds
- Advocating for minority patient populations
- Talking about key issues facing APA
- Initiating mentoring relationships
- Bringing concerns to APA leadership
- Assuming leadership roles in APA.

To join a caucus, at www.psychiatry.org, click on:
- “Join & Participate” then
- “My Account” then
- Log into your account then
- “Member Profile” section 3fa and select the appropriate caucus(es).

College Mental Health Caucus to Meet

APA members with a special interest in college mental health issues are invited to participate in a meeting of APA’s College Mental Health Caucus at this year’s Annual Meeting in San Francisco. Participants will have an opportunity to discuss issues, raise concerns, and share information. The meeting will be held Tuesday, May 21, from 9:30 a.m. – 11:30 a.m. at the San Francisco Marriott Marquis, Sierra Suite C, Fifth Floor.

Sunday, May 19

2 p.m. – 3:30 p.m.
Caucus of Hispanic Psychiatrists
Sierra Conference Suite F, 5th Floor, San Francisco Marriott Marquis

3 p.m. – 4:30 p.m.
Caucus of Gay, Lesbian, and Bisexual Psychiatrists and Association of Gay and Lesbian Psychiatrists (Joint Meeting)
Howard Room, 5th floor, Intercontinental San Francisco

Monday, May 20

4 p.m. – 5 p.m.
Caucus of International Medical Graduate Psychiatrists
Laurel Room Upper B2 Level, San Francisco Marriott Marquis

6:45 p.m. – 7:45 p.m.
Caucus of Black Psychiatrists
Golden Gate Hall, Salon C3, Level B2, San Francisco Marriott Marquis

6:45 p.m. – 8 p.m.
Caucus of Asian-American Psychiatrists
Pacific Suite E, 4th Floor, San Francisco Marriott Marquis

6:45 p.m. – 8:30 p.m.
Caucus of American Indian, Alaska Native, and Native Hawaiian Psychiatrists
Laurel Room Upper B2 Level, San Francisco Marriott Marquis

Tuesday, May 21

5:30 p.m. – 7:30 p.m.
Caucus of Women Psychiatrists and the Association of Women Psychiatrists (Joint Meeting)
Pacific Suite 1, 4th Floor, San Francisco Marriott Marquis

Psychiatric Care During Pregnancy To Be Focus of AJP Forum

by Leslie Sinclair

Clinical treatment decisions during pregnancy require careful balancing of risk and benefit. Authors of studies recently published in AJP will give clinical guidance for such decisions.

“The American Journal of Psychiatry (AJP) will host a forum titled “Treatment of the Pregnant Woman and Her Child,” chaired by Robert Freedman, MD, editor in chief of AJP, on Monday, May 20, at 11 a.m. We strive to make the journal’s cutting-edge research germane to today’s practicing clinicians," Freedman told Psychiatric News, “and we particularly target clinical situations in which even the most experienced psychiatrists are the most careful in their approach. The care of the psychiatrically ill pregnant woman and her fetus is an area in which all clinicians want to be informed about the latest research that investigates the risk and benefit of treatment.” He added that the forum “will bring together authors of four recently published articles to discuss their research, all of which informs current care and will affect future treatment development.”

But first, Harita Raja, MD, a psychiatry resident at Medstar Georgetown University Hospital in Washington, D.C., will begin the symposium with a case presentation. She is the author of a recent review article on treatment of maternal depression in the Residents’ Journal, an online publication of the American Journal of Psychiatry. The first speaker will be Katherine Wisner, MD, a professor of psychiatry; obstetrics; gynecology; and reproductive sciences and epidemiology at the University of Pittsburgh School of Medicine. Wisner has meticulously characterized the effects of depression and medication treatment for it on the growth and development of the fetus and found independent effects of each, but little evidence that antidepressants cause additional harm to the fetus.

Malay-Occhigrossi, MD, an assistant professor of psychiatry at Weill Cornell Medical College, and her colleagues made similar findings about newborn pulmonary hypertension, once thought to be an adverse effect of SSRIs treatment during pregnancy (Psychiatric News, May 4, 2012). Their extensive epidemiologic investigations revealed that the effect is small and as likely to be caused by depression itself as by the medications.

Veerle Bergink, MD, a psychiatrist at the Erasmus Medical Center in Rotterdam, the Netherlands, will present a study of the approach preferred by her clinic for pregnant women with a history of bipolar disorder or postpartum psychosis (Psychiatric News, May 4, 2012). Her clinic’s prophylactic treatment diminishes some but not all risk for subsequent illness during or after pregnancy.

The final speaker, Randal Ross, MD, a professor in the Department of Psychiatry at the University of Colorado School of Medicine, has developed a physiological indicator of the newborn’s brain development. With this technique, he finds that antidepressant treatment frequently prevents the otherwise deleterious effect of a maternal anxiety disorder and that the nutrient choline may prevent the development of pathological brain dysfunction associated with later mental disorders in the child.
Addressing the Major Unmet Needs in Schizophrenia:

Physician, Patient and Caregiver Perspectives

Saturday, May 18, 2013
San Francisco Marriott Marquis
Yerba Buena Ballroom 9 • Lower Level B2

6:30 PM – 7:00 PM  Registration & Dinner
7:00 PM – 9:00 PM  Educational Program

Overview Statement
Schizophrenia has a substantial impact on everyday functioning, being one of the top five causes of disability in individuals under the age of 25. In most cases, individuals who develop schizophrenia manifest behavioral and cognitive changes prior to the formal diagnosis of the condition. Clinicians face challenges in diagnosing this disorder, as well as designing treatment plans that will reduce negative symptoms, maximize adherence and reduce side effects. This program will feature a patient and caretaker interview, while world renowned experts will discuss pathobiology, as well as current and future therapies designed to improve cognitive function in addition to alleviating symptoms, improving the quality of life for patients and their caregivers.

Learning Objectives
Upon successful completion of the live non-certified activity, participants will be able to:
• Review the recent neuroscience advances that shed light on the neurobiology of schizophrenia.
• Discuss the clinical features of the “prodrome” in schizophrenia and how specific symptoms and deficits emerge before the conversion to psychosis.
• Recognize the various measurement tools used to assess the severity of clinical symptoms and cognitive dysfunction in schizophrenia.
• Evaluate therapeutic strategies utilized to treat specific symptoms and deficits in schizophrenia to address the major unmet needs associated with this disabling neuropsychiatric syndrome.

Target Audience
This activity is designed for psychiatrists and other healthcare professionals involved in the treatment of patients with schizophrenia.

Course Chair
Henry A. Nasrallah, MD
Professor and Vice Chair,
Department of Psychiatry
Director, Schizophrenia Program
University of Cincinnati
College of Medicine
Cincinnati, OH

Faculty
Leslie Citrome, MD, MPH
Clinical Professor of Psychiatry & Behavioral Sciences
New York Medical College
Valhalla, NY

Diana O. Perkins, MD, MPH
Professor, Department of Psychiatry
University of North Carolina at Chapel Hill
Chapel Hill, NC

This live activity is not approved for AMA PRA Category 1 Credit™

Pre-registration is encouraged but not required. Seating to be based on arrival order; early arrival is recommended.
For your patients with schizophrenia who need improvement in symptom control—
FANAPT MAY HELP

INDICATION
FANAPT is an atypical antipsychotic agent indicated for the treatment of schizophrenia in adults. In choosing among treatments, prescribers should consider the ability of FANAPT to prolong the QT interval and the use of other drugs first. Prescribers should also consider the need to titrate FANAPT slowly to avoid orthostatic hypotension, which may lead to delayed effectiveness compared to some other drugs that do not require similar titration.

IMPORTANT SAFETY INFORMATION

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analysis of seventeen placebo-controlled trials (modal duration 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times the risk of death 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. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. FANAPT is not approved for the treatment of patients with dementia-related psychosis.

Please see additional Important Safety Information and brief summary of Prescribing Information, including Boxed WARNING, on adjacent pages.
**FANAPT FACTS**

**Efficacy**
- FANAPT significantly improved overall symptoms in 2 clinical trials, as measured by the Positive and Negative Syndrome Scale (PANSS; 4-week trial) and the Brief Psychiatric Rating Scale (BPRS; 6-week trial)\(^1\)

**Akathisia/EPS\(^*\)**
- Incidence of akathisia and EPS was similar to placebo\(^3\)

**Metabolics**
- Mean change in weight from baseline at end point for FANAPT patients was 2.1 kg across all short-term and long-term trials\(^1\)
- The majority of patients taking FANAPT 24 mg/day did not experience a shift from normal to high in fasting lipid measurements in a 4-week study\(^5\)
  Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics.
  Weight gain has been observed with atypical antipsychotic use. Clinical monitoring of weight is recommended.

**Tolerability**
- Discontinuation rates due to adverse events were similar for FANAPT (5%) and placebo (5%)\(^1\)
  The most common adverse reactions were dizziness, dry mouth, fatigue, nasal congestion, somnolence, tachycardia, orthostatic hypotension, and weight increase.\(^1\)

**TRIAL SAVINGS OFFER**
Receive savings on up to 34 days (68 tablets) of FANAPT.
Visit www.FANAPT.com to learn more.

*Extrapyramidal symptoms.
†Based on pooled data from 4 placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies.
‡Pooled data from 4 placebo-controlled, fixed- or flexible-dose studies show a change from baseline in body weight of 2.0 kg with FANAPT 10-16 mg/day (n=481), 2.7 kg with FANAPT 20-24 mg/day (n=391), and -0.1 kg with placebo (n=576).
§13.6% of patients taking FANAPT 24 mg/day experienced a shift from normal (<200 mg/dL) to high (≥240 mg/dL) in fasting total cholesterol versus 1.4% of patients taking placebo. 10.1% of patients taking FANAPT 24 mg/day experienced a shift from normal (<150 mg/dL) to high (≥200 mg/dL) in fasting triglycerides versus 8.3% of patients taking placebo.

**IMPORTANT SAFETY INFORMATION**
Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain. While all atypical antipsychotic drugs have been shown to produce some metabolic changes, each drug in the class has its own specific risk profile.

FANAPT\(^\text{®}\) is a registered trademark of Vanda Pharmaceuticals Inc. and is used by Novartis Pharmaceuticals Corporation under license.
FANAPT\(^\text{®}\) is licensed by Novartis Pharmaceuticals Corporation from Titan Pharmaceuticals, Inc.
Receive a Rebate by Becoming a Member at the Annual Meeting

Psychiatrists who are eligible for APA General Membership may qualify for a $755 rebate equal to the difference between the nonmember and member Annual Meeting registration fees if they join at the meeting. The rebate will be applied toward annual membership dues, and any balance will be applied toward future years’ dues. To qualify, you must be a psychiatrist residing in the United States or Canada and be eligible for APA General Membership status and have paid the full nonmember registration rate to attend the meeting. To apply, submit your General Membership application at one of the Membership Desks located in the meeting registration area or in the Member Center, both located in the Exhibit Hall. You will also need to submit proof of ACGME-AOA or ACP(S) - approved psychiatry residency training and valid medical license to APA no later than June 30.

Join Us at the APA International Discussion Groups

The International Discussion Groups at the APA Annual Meeting afford psychiatrists the opportunity to meet and discuss relevant medical and mental health issues pertinent to the world. These groups are open to all Annual Meeting attendees and chaired by APA members.

- **Sunday, May 19**
  - **7:30 a.m. – 9 a.m.**
    - Europe Discussion Group
    - Marriott Marquis, Laurel Room, Upper B2
  - **2:30 p.m. – 4:30 p.m.**
    - Africa Discussion Group
    - Marriott Marquis, Willow Room, Upper B2

- **Monday, May 20**
  - **2 p.m. – 4 p.m.**
    - South Asia Discussion Group
    - Marriott Marquis, Willow Room, Upper B2

Dyslipidemia: Undesirable alterations in lipids have been observed in patients treated with atypical antipsychotics.

**Weight Gain:** Weight gain has been observed with atypical antipsychotics alone. Clinical monitoring of weight is recommended.

**Seizures:** As with other antipsychotics, FANAPT should be used cautiously in patients with a history of seizures or conditions with or with conditions that potentially lower seizure threshold, such as, e.g., Alzheimer’s dementia.

**Orthostatic Hypotension and Syncope:** FANAPT must be titrated from a low starting dose to avoid orthostatic hypotension. FANAPT is contraindicated in individuals with orthostatic hypotension associated with dizziness, tachycardia, and syncope. Therefore, FANAPT must be titrated as described above to reach the target range of 6-12 mg twice daily (12-24 mg/day) may be made with daily dosage adjustments not to exceed 2 mg twice daily (4 mg/day). The maximum recommended dose is 12 mg twice daily (24 mg/day). Control of symptoms may be delayed during the first 1 to 2 weeks of treatment. FANAPT should be used with caution in patients with known cardiovascular disease, cerebrovascular disease, or conditions that predispose the patient to hypotension. Monitoring of orthostatic vital signs should be considered in patients who are vulnerable to hypotension.

**Leukopenia, Neutropenia, and Agranulocytosis:** In clinical trial and postmarketing experience with antipsychotic agents, events of leukopenia/neutropenia have been reported temporally. Agranulocytosis (including death) has also been reported. Patients with a preexisting low white blood cell count or a history of drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and should discontinue FANAPT at the first sign of decline in WBC in the absence of other causative factors.

**Hyperprolactinemia:** As with other drugs that antagonize dopamine D2 receptors, FANAPT elevates prolactin levels. Galactorrhea, amenorrhea, gynecomastia, and impotence have been reported with prolactin-elevating compounds.

**Body Temperature Regulation:** Appropriate care is advised when prescribing FANAPT for patients who may be experiencing conditions which may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

**Aspiration Pneumonia:** Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with Alzheimer’s dementia. FANAPT and other antipsychotics should be used cautiously in patients at risk for aspiration pneumonia.

**Suicide:** The possibility of a suicide attempt is inherent in psychiatric illness, and close supervision of high-risk patients should accompany drug therapy. Prescriptions for FANAPT should be written for the smallest possible number of tablets in order to reduce the risk of overdose.

**Phenytoin:** Three cases of phenytoin have been reported in the premarketing FANAPT program. Severe phenytoin may require surgical intervention.

**Cognitive and Motor Impairment:** FANAPT, like other antipsychotics, has the potential to impair judgment, thinking, or motor skills. Patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that therapy with FANAPT does not affect them adversely.

**Commonly observed adverse events:** Commonly observed adverse reactions (occurrence % and twofold greater than placebo) were: dizziness, dry mouth, fatigue, nausea, constipation, orthostatic hypotension, somnolence, tachycardia, and weight increase.

**Specific Populations:**

**Pregnancy:** FANAPT is Pregnancy Category C.

**Hepatic Impairment:** FANAPT is not recommended for patients with hepatic impairment.

**Drug Interactions:** Given the primary CNS effects of FANAPT, caution should be used when it is taken in combination with other centrally acting drugs and alcohol. FANAPT has the potential to enhance the effect of certain antipsychotropic agents. Coadministration of FANAPT with potential CYP2D6 inhibitors (e.g., fluoxetine, paroxetine) and potential CYP3A4 inhibitors (e.g., ketoconazole) should be done with caution. FANAPT dose should be reduced based on these interactions. Caution is recommended in coadministration of drugs mainly eliminated via CYP3A4 with FANAPT.

Please see brief summary of Prescribing Information, including **Bold WARNING**, on adjacent pages.
WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOsis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death compared to placebo. A meta-analysis of 17 randomized, double-blind trials (totaling 2,580 patients) of antipsychotic drugs showed a 2.6-fold increase in mortality in elderly dementia patients. Most of the studies were short-term, with a median duration of 10 months. The causes of death were primarily cardiovascular and cerebrovascular adverse events.

Dosage adjustment for patients taking FANAPT who are poor metabolizers of CYP2D6: FANAPT dose should be reduced by one-half for poor metabolizers of CYP2D6 (see Pharmacokinetics (12.3) in the full prescribing information).

1 INDICATIONS AND USAGE

FANAPT tablets are indicated for the treatment of adults with schizophrenia.

1.1 Clinical Studies

FANAPT was administered alone or in combination with lamotrigine, olanzapine, quetiapine, risperidone, or ziprasidone in several randomized, double-blind, multiple-dose trials in patients with schizophrenia. These studies demonstrated that FANAPT, as monotherapy and in combination with lamotrigine, olanzapine, quetiapine, risperidone, or ziprasidone, were effective and generally safe in the treatment of schizophrenia.

2 DOSAGE AND ADMINISTRATION

2.1 Usual Dose

FANAPT must be initiated slowly from a low starting dose to avoid orthostatic hypotension due to its alpha-adrenergic blocking properties. The recommended starting dose for FANAPT tablets is 1 mg twice daily. Dose increases to reach the target dose of 6 to 12 mg twice daily (12-24 mg/day) may be made with daily dosage adjustments not to exceed 2 mg twice daily (4 mg/day). The maximum recommended dose is 12 mg twice daily (24 mg/day). FANAPT dosages above 24 mg/day have not been systematically evaluated in the clinical trials and have not been demonstrated with FANAPT in a dose range of 6 to 12 mg twice daily. Prescriptions should be mindful of the fact that patients need to be titrated to an effective dose of FANAPT. Thus care of controls may be delayed by the first 1 to 2 weeks of treatment compared to some other antipsychotic drugs that do not require similar titration. Prescriptions should be mindful of this delay when selecting an antipsychotic drug for the treatment of schizophrenia (see Dosage and Administration (2.1) and Clinical Studies (14) in the full prescribing information).

The effectiveness of FANAPT in long-term use, that is, for more than 6 weeks, has not been systematically evaluated in controlled trials. Therefore, the physician and the patient should use FANAPT for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient [see Dosage and Administration (2.3)].

2.2 Dosage in Special Populations

Dosage recommendations are not indicated on the basis of age, gender, race, or renal impairment status [see Use in Specific Populations (8.6, 8.7)].

Dosage adjustment for patients taking FANAPT concomitantly with potent CYP3A4 inhibitors: FANAPT dose should be reduced by one-half when administered concomitantly with strong CYP3A4 inhibitors such as ketoconazole or clarithromycin. When the CYP3A4 inhibitor is withdrawn from the combination therapy, FANAPT dose should then be increased to where it was before [see Drug Interactions (7.1)].

Dosage adjustment for patients taking FANAPT concomitantly with potential CYP3A4A inhibitors: FANAPT dose should be reduced by one-half when administered concurrently with strong CYP3A4 inhibitors such as ketoconazole or clarithromycin. When the CYP3A4 inhibitor is withdrawn from the combination therapy, FANAPT dose should be increased to where it was before [see Drug Interactions (7.1)].
Apply to Become an APA Fellow

Are you ready to take the next step in your professional career? Being a Fellow of the APA is an honorary designation to recognize early-career members who have demonstrated allegiance to their profession and commitment to the ongoing work of the APA. Members who pursue Fellow status perceive it as one of the first steps to enhancement of their professional credentials. Members who apply and are approved this year for Fellow status will be invited to participate in the Convocation of Fellows and Distinguished Fellows during the 2014 APA Annual Meeting.

Eligibility Criteria:
• Certification by the ABPN, RCPsych, or AOA

The deadline for submitting a Fellowship application is September 1. Stop by the APA Membership Booth in the Member Center at the Convention Center to pick up an application.

UPDATE
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Online Member Profile

Stop by the Membership Booth in the Member Center at the Exhibit Hall to update your contact, biographical and practice information. It only takes a moment! Periodically checking and updating your membership record will make it easier for other members to get in touch with you — and you with them.

5.3 Neuroleptic Malignant Syndrome (NMS)
A potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with administration of antipsychotic drugs, including FANAPT. Clinical manifestations include hyperpyrexia, muscle rigidity, altered mental status (including cataleptic signs) and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure.

The diagnosis of patients with this syndrome is complicated. In arriving at a diagnosis, it is important to identify cases in which the clinical presentation includes both extrapyramidal illness (e.g., pneumonia, systemic infection, etc.) and untreated or inadequately treated extrapyramidal signs and symptoms (EPS). Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever, and primary central nervous system (CNS) pathology.

The management of this syndrome should include: (1) immediate discontinuation of the antipsychotic drugs and other drugs not essential to concurrent therapy, (2) intensive symptomatic treatment and medical monitoring, and (3) treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacological treatment regimes for NMS.

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.

5.4 Tardive Dyskinesia
Tardive dyskinesia is a syndrome consisting of potentially irreversible, involuntary, dyskinetic movements, which may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely on prevalence estimates to predict, at the inception of antipsychotic treatment, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown.

The risk of developing tardive dyskinesia and the likelihood that it will become irreversible are believed to increase as the duration of treatment and the total cumulative dose of antipsychotic administered increases. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby possibly mask the underlying process. The effect that symptomatic suppression has upon the long-term course of the syndrome is unknown.

Given these considerations, FANAPT should be prescribed in a manner that will most likely minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who suffer from a chronic illness (that is known to respond to antipsychotic drugs), and (2) for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically.

If signs and symptoms of tardive dyskinesia appear in a patient on FANAPT, drug discontinuation should be considered. However, some patients may require treatment with FANAPT despite the presence of the syndrome.

5.5 Metabolic Changes
Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and body weight gain (see Patient Counseling Information (17.2) in the full prescribing information).

While all atypical antipsychic drugs have been shown to produce some metabolic changes, each drug in the class has its own specific risk profile.

Hyperglycemia and Diabetes Mellitus
Hyperglycemia, in some cases extreme and associated with ketoadiposis or hyperosmolar coma or death, has been reported in patients treated with atypical antipsychotics including FANAPT. 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. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia/hyperglycemia-related adverse events in patients treated with atypical antipsychotics included in these studies. Because FANAPT was not evaluated at the time these studies were performed, it is not known if FANAPT is associated with this increased risk.

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 (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weight gain. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of antidiabetic treatment despite discontinuation of the suspect drug.

Data from a 4-week, fixed-dose study in adult subjects with schizophrenia, in which FANAPT was dosed once daily, are presented in Table 1.

Table 1: Change in Fasting Glucose

<table>
<thead>
<tr>
<th>FANAPT® 20-24 mg/day</th>
<th>Change from Baseline (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Change from Baseline</td>
<td>Proportion of Patients with Shifts</td>
</tr>
<tr>
<td>n=114</td>
<td>n=228</td>
</tr>
<tr>
<td>Placebo</td>
<td>FANAPT®</td>
</tr>
<tr>
<td>3-6 months</td>
<td>6-12 months</td>
</tr>
<tr>
<td>3.6 (N=34)</td>
<td>-9.0 (N=31)</td>
</tr>
<tr>
<td>5.4 (N=23)</td>
<td>5.4 (N=425)</td>
</tr>
</tbody>
</table>

Pooled analyses of glucose data from clinical studies including longer term trials are shown in Table 2.

Table 2: Change in Glucose

<table>
<thead>
<tr>
<th>Mean Change from Baseline (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=114</td>
</tr>
<tr>
<td>Change from baseline</td>
</tr>
<tr>
<td>3-6 months</td>
</tr>
<tr>
<td>Placebo</td>
</tr>
<tr>
<td>FANAPT 10-16 mg/day</td>
</tr>
<tr>
<td>FANAPT 20-24 mg/day</td>
</tr>
</tbody>
</table>

Pooled analyses of glucose data from clinical studies including longer term trials are shown in Tables 3 and 4.

Table 3: Change in Fasting Lipids

<table>
<thead>
<tr>
<th>Mean Change from Baseline (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=114</td>
</tr>
<tr>
<td>Change from baseline</td>
</tr>
<tr>
<td>3-6 months</td>
</tr>
<tr>
<td>Placebo</td>
</tr>
<tr>
<td>Cholesterol Normal to High (&lt;200 mg/dL, ≥160 mg/dL)</td>
</tr>
<tr>
<td>LDL Normal to High (&lt;100 mg/dL, ≥160 mg/dL)</td>
</tr>
<tr>
<td>HDL Normal to Low (&lt;40 mg/dL, ≥40 mg/dL)</td>
</tr>
</tbody>
</table>

Pooled analyses of cholesterol and triglyceride data from clinical studies including longer term trials are shown in Tables 4 and 5.

Table 4: Change in Triglycerides

<table>
<thead>
<tr>
<th>Mean Change from Baseline (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=114</td>
</tr>
<tr>
<td>Change from baseline</td>
</tr>
<tr>
<td>3-6 months</td>
</tr>
<tr>
<td>Placebo</td>
</tr>
<tr>
<td>FANAPT 10-16 mg/day</td>
</tr>
<tr>
<td>FANAPT 20-24 mg/day</td>
</tr>
</tbody>
</table>
Events Explore the Intersection Between Work, Mental Health and Cultural Diversity

The APA Office of Minority and National Affairs (OMNA) and the American Psychiatric Foundation’s Partnership for Workplace Mental Health are teaming up during the APA Annual Meeting to focus on the intersection between work, mental health, and race and culture. The symposium, “Work, Mental Health and Cultural Diversity: A Dynamic Triad,” takes place on Sunday, May 19, 8 a.m. – 11 a.m. at the Moscone Center in room 3022.

The symposium will look at how discrimination in the workplace — be it racial, ethnic, cultural, or sexual orientation — affects one’s mental health, and how it can be addressed in clinical practice. This symposium will discuss the important role of employment in recovery and will examine the reality of discrimination and its impact in the workplace. While many companies articulate a commitment to diversity, successfully putting it into practice is a much more difficult reality. A corporate policy alone cannot prevent employees from experiencing the effects of discrimination that exists in society at large. This symposium will address the effects of such discrimination and the disconnect between corporate policies related to diversity and the reality of everyday life at work. Attendees will learn how to help patients succeed at work in the face of overt discrimination or subtle micro-aggressions.

Expert speakers for the symposium include Price Cobb, MD, Keris Myrick, MBA, MS, PhD, Donald Williams, MD, and Amani Nuru-Jeter, PhD, MPH.

The symposium is part of the OMNA on Tour program, which is a series of community meetings around the nation addressing the significance and impact of mental health disparities and serves as a catalyst for collaboration to improve societal health and well-being.

Tissue culture experiments indicate that approximately one-third of human leukocytes/neutrophils secrete IFN-α, IL-6, and TNF-α, which are factors of potential importance in the pathogenesis of severe neutropenia. In patients treated with IFN-α, neutrophils were reported to be slightly lower at the time of the first few months of therapy and should be monitored frequently during the first few months of treatment to ensure the continuation of a dose of IFN-α in the absence of other causative factors. Patients with neutropenia should be carefully monitored for fever or other symptoms of infection and treated promptly if such symptoms or signs occur. Patients with severe neutropenia (absolute neutrophil count <500/mm^3) should discontinue FANAPT and have their WBC followed until recovery.

Weight Gain
Weight gain has been observed with typical antipsychotic use. Clinical management of weight gain is recommended.

Across all short- and long-term studies, the overall mean change from baseline to endpoint was 2.1 kg.

Changes in body weight (kg) and the proportion of subjects with ≥2% change in body weight from four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies in adults subjects are presented in Table 6.

Table 6: Change in Body Weight

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>FANAPT 10-16 mg/day</th>
<th>FANAPT 20-24 mg/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Weight</td>
<td>n=576</td>
<td>n=481</td>
<td>n=391</td>
</tr>
<tr>
<td>Change from Baseline</td>
<td>-0.1</td>
<td>2.0</td>
<td>2.7</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>≥2%</td>
<td>12%</td>
<td>18%</td>
</tr>
</tbody>
</table>

5.6 Seizures
In short-term placebo-controlled trials (4- to 6-weeks), seizures occurred in 0.1% (17/15,344) of patients treated with FANAPT compared to 0.3% (25/7,587) on placebo and with other antipsychotics. FANAPT should be used cautiously in patients with a history of seizures or with conditions that potentially increase the seizure threshold, e.g., glomerulonephritis and chronic renal failure, or in combination with other antiepileptic agents. Certain agents that lower the seizure threshold, e.g., phenothiazines, may contribute to an elevation in core body temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity, or being subject to dehydration.

5.11 Drowsiness
Excessive drowsiness and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer’s dementia. FANAPT and other antipsychotic drugs should be used cautiously in patients at risk for aspiration pneumonia (see boxed Warning).

5.12 Suicide
The possibility of a suicide attempt is inherent in psychotic illness, and close supervision of high-risk patients should accompany drug therapy. Prescriptions for FANAPT should be written for the smallest quantity of tablets consistent with good patient management in order to reduce the risk of overdose.

5.13 Priapism
Three cases of priapism were reported in the pre-marketing FANAPT program. Drugs with alpha-adrenergic blocking effects have been reported to induce priapism. FANAPT shares this pharmacologic activity. Severe priapism may require surgical intervention.

5.14 Potential for Cognitive and Motor Impairment
FANAPT, like other antipsychotics, has the potential to impair judgment, thinking or motor skills. In short-term, placebo-controlled trials, somnolence (including sedation) was reported in 11.5% (1043/9147) of patients treated with FANAPT at doses of 10 mg/day or greater versus 5.3% (317/6076) with placebo. Patients with somnolence should be monitored about operating hazardous machinery, including automobiles, until they are reasonably certain that therapy with FANAPT does not affect them adversely.

6 ADVERSE REACTIONS

6.1 Clinical Studies Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trial of a drug cannot be directly compared to rates in the clinical trials of another drug or to the rates observed in clinical practice. The information below is derived from a clinical trial database for FANAPT consisting of 2070 patients exposed to FANAPT at doses of 10 mg/day or greater, for the treatment of schizophrenia. Of these, 808 received FANAPT for at least 6 months, with 463 exposed to FANAPT for at least 12 months. All of these patients who received FANAPT were participating in multiple-dose clinical trials. The conditions and duration of treatment with FANAPT varied greatly and included (in overlapping categories), open-label and double-blind phases of trials, inpatients and outpatients, fixed-dose and flexible-dose studies, and short-term and longer-term exposure.

Adverse reactions during exposure were obtained by general inquiry and recorded by clinical investigators using their own terminology. Occasionally, to provide a meaningful estimate of the proportion of individuals experiencing adverse reactions, reactions were grouped in standard categories using MedDRA terminology.

The stated frequencies of adverse reactions represent the proportions of individuals who experienced a treatment-emergent adverse reaction of the type listed. A reaction was considered treatment emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation.

The information presented in these sections was derived from pooled data from four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies in patients who received FANAPT at daily doses within a range of 10 to 24 mg (n=874).

Adverse Reaction Occurring at an Incidence of 2% or More Among FANAPT-Treated Patients and More Frequent than Placebo

Table 7 enumerates the pooled incidences of treatment-emergent adverse reactions that were spontaneously reported in four placebo-controlled, 4- or 6-week, fixed- or flexible-dose studies in patients treated with FANAPT for which these reactions occurred in 2% or more of patients treated with FANAPT in any of the dose groups, and for which the incidence in FANAPT-treated patients in any one dose group was greater than the incidence in patients treated with placebo.
New APA Programs Exclusively for International Psychiatrists

The APA has created a new International Fellow membership category for international psychiatrists. International Fellow status is an honor that reflects dedication to the work of the APA and signifies allegiance to the psychiatric profession. International Fellows are recognized by their colleagues in the APA as members of a very select group and are particularly recognized at the Convocation of Fellows and Distinguished Fellows during APA’s Annual Meeting. Membership dues for APA International Members and Fellows are the same.

International Members Save on APA Membership Dues: All international psychiatrists who join the APA as a new International Member are eligible to receive a one-time discount of 25 percent off their membership dues. The discount will be calculated on their membership dues invoice prior to payment. Interested applicants can join APA onsite at the Annual Meeting by stopping by the Membership Booth in the Annual Meeting Registration Center area and completing the International Membership application and pay their dues onsite. They will be issued their APA membership card that day and can use it to obtain a 20 percent member discount during the Annual Meeting at the American Psychiatric Publishing Bookstore. The discount applies to all APP titles, including the new DSM-5!

Eligibility requirements:
- Eligibility for International Membership (i.e., licensed physicians who have completed an acceptable program of training in psychiatry)
- Three (3) years of either APA membership or membership in the applicant’s national or local psychiatric organization, if one exists
- Letter of verification that the applicant is a member in good standing of the national or local psychiatric organization (letter must be written on organizations letterhead)
- Board certification or equivalent, if certification exists in applicant’s country
- Approval by the Membership Committee
- Approval by the Board of Trustees

The deadline for submitting an application is August 1. Stop by an APAMembership Booth in the Exhibit Hall for an application or go online at www.psychiatry.org and select the link for Join & Participate / International Psychiatrists.

### Table 7: Treatment-Emergent Adverse Reactions in Short-Term, Fixed- or Flexible-Dose, Placebo-Controlled Trials in Adult Patients

<table>
<thead>
<tr>
<th>Body System or Organ Class</th>
<th>Placebo (N=587)</th>
<th>FANAPT 10-16 mg/day (N=483)</th>
<th>FANAPT 19-24 mg/day (N=391)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypotension</td>
<td>&lt;1</td>
<td>&lt;1</td>
<td>3</td>
</tr>
<tr>
<td>Orthostatic Hypotension</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Extrapyramidal Disorder</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Dizziness</td>
<td>7</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Upper Respiratory Tract Infection</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Vision Blurred</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>1</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Weight Increased</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Musculoskeletal Stiffness</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
| Laboratory Test Abnormalities in Clinical Trials

There were no differences between FANAPT and placebo in the incidence of discontinuation due to changes in hematology, urinalysis, or serum chemistry. In short-term placebo-controlled trials (4- to 6-week), there were 1.0% (13/1342) iloperidone-treated patients with hematocrit at least one time below the extended normal range during post-randomization treatment, compared to 0.3% (5/865) on placebo. The extended normal range for low hematocrit was defined as in each of these trials as the value 75% below the normal range for the centralized laboratory that was used in the trial.

Other Reactions During the Pre-marketing Evaluation of FANAPT

The following is a list of MedDRA terms that reflect treatment-emergent adverse events in patients treated with FANAPT at multiple doses or 4 mg/day during any phase of the database of the trial of 2010 FANAPT-treated 787 patients. All reported reactions are included except those already listed in Table 7 or other parts of the Adverse Reactions (6) section, those considered to be manifestations of the conditions already listed, and those that occurred with a lesser incidence in the patients treated with FANAPT and at least twice the placebo incidence in the patients treated with FANAPT and which occurred at greater incidence than in the placebo group. Figures rounded to the nearest integer.

<table>
<thead>
<tr>
<th>Body System or Organ Class</th>
<th>Placebo (%)</th>
<th>FANAPT 10-16 mg/day (%)</th>
<th>FANAPT 19-24 mg/day (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypotension</td>
<td>&lt;1</td>
<td>1</td>
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<td>Orthostatic Hypotension</td>
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<td>Extrapyramidal Disorder</td>
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<td>4</td>
</tr>
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<td>Dizziness</td>
<td>7</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Upper Respiratory Tract Infection</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Vision Blurred</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>1</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Weight Increased</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Musculoskeletal Stiffness</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

### Table 8: Percentage of EEs Compared to Placebo

<table>
<thead>
<tr>
<th>Placebo (%)</th>
<th>FANAPT 10-16 mg/day (%)</th>
<th>FANAPT 19-24 mg/day (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All EEs</td>
<td>11.6</td>
<td>13.5</td>
</tr>
</tbody>
</table>

Adverse Reactions Associated with Discontinuation of Treatment in Clinical Trials

Based on the pooled data from four placebo-controlled, 4- to 6-week, fixed- or flexible-dose studies, there was no difference in the incidence of discontinuation due to adverse events between FANAPT-treated (5%) and placebo-treated (5%) patients. The types of adverse events that led to discontinuation were similar for the FANAPT- and placebo-treated patients.

Demographic Differences in Adverse Reactions in Clinical Trials

An examination of population subgroups in the four placebo-controlled, 4- to 6-week, fixed- or flexible-dose studies did not reveal any evidence of differences in safety on the basis of age, gender or race [see Warnings and Precautions (5.1)].
7 DRUG INTERACTIONS

Given the primary CNS effects of FANAPT, caution should be used when it is taken in combination with other medications that have CNS depression. Due to its α1-adrenergic receptor antagonism, FANAPT has the potential to enhance the effect of certain concomitant monoamine oxidase inhibitors and other antihypertensive agents.

7.1 Potential for Other Drugs to Affect FANAPT

FANAPT is not a substrate for CYP1A2, CYP2C9, CYP2D6, CYP2C19, CYP3A4, or CYP3A5. It is a competitive inhibitor of CYP2D6, CYP2C9, and CYP3A4, and an uncompetitive inhibitor of CYP2C19.

Fluoxetine: A single 3 mg dose of iloperidone had no effect on the pharmacokinetics of fluoxetine.

Dextromethorphan: A study in mild and moderate liver impairment has not been conducted. In an embryo-fetal development study, pregnant rabbits were given 4, 10, or 20 mg/kg/day (3, 8, and 20 times the MRHD on a mg/m² basis) of iloperidone during the period of organogenesis. The highest dose caused increased early post-partum pup survival. There were no drug effects on the neurobehavioral or reproductive development of the surviving pups. Non-effect doses ranged from 4 to 12 mg/kg except for the increase in stillbirth rates which occurred at the lowest dose tested of 4 mg/kg, which is 1.6 times the MRHD on a mg/m² basis. Maternal toxicity was seen at the higher doses in these studies.

The iloperidone metabolite P88, which is a major circulating metabolite of iloperidone in humans but is not present in significant amounts in rats, was given to pregnant rats during the period of organogenesis at oral doses of 20, 80, or 200 mg/kg/day. No teratogenic effects were seen. Delayed skeletal ossification occurred at all doses. No evidence of maternal toxicity was produced. Plasma levels of P85 (AUC) at the highest dose tested were twice those in humans receiving the MRHD of iloperidone.

There are no adequate and well-controlled studies in pregnant women. Non-Teratogenic Effects

Neonates exposed to antipsychotic drugs, during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hyperpyrexia, hypertonia, tremor, seizures, respiratory distress, hypotension, and respiratory depression in neonates. These complications have varied in severity; in some cases symptoms have been self-limited, but in others neonates have required intensive care unit support and prolonged hospitalization.

FANAPT should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

8.7 Labor and Delivery

The effect of FANAPT on labor and delivery in humans is unknown.

8.3 Nursing Mothers

FANAPT was excreted in milk of rats during lactation. It is not known whether FANAPT or its metabolites are excreted in human milk. It is recommended that women receiving FANAPT should not breast feed.

8.4 Pediatric Use

Safety and effectiveness in pediatric and adolescent patients have not been established.

8.5 Geriatric Use

Clinical Studies of FANAPT in the treatment of schizophrenia did not include sufficient numbers of patients aged 65 years and over to determine whether or not they respond differently than younger adult patients. Of the 3210 patients treated with FANAPT in pre-marketing trials, 23 (0.7%) were ≥ 75 years old and there were no patients ≥85 years old. Studies of elderly patients with psychosis associated with Alzheimer’s disease have suggested that there may be a different tolerability profile (i.e., increased risk in mortality and cerebrovascular events including stroke) in this population compared to younger patients with schizophrenia (see Warnings and Precautions (8.1)). The safety and efficacy of FANAPT in the treatment of patients with psychosis associated with Alzheimer’s disease has not been established. If the prescriber elects to treat such patients with FANAPT, vigilance should be exercised.

8.6 Renal Impairment

Because FANAPT is highly metabolized, with less than 1% of the drug excreted unchanged, renal impairment alone is unlikely to have a significant impact on the pharmacokinetics of FANAPT. Renal impairment (creatinine clearance <30 mL/min) had minimal effect on maximum plasma concentrations (Cmax) of iloperidone (given as a single dose of 3 mg) and its metabolites P88 and P95 in any of the three analytes measured. AUCinf was increased by 24%, decreased by 6%, and increased by 52% for iloperidone, P88, and P95, respectively, in subjects with renal impairment.

8.7 Hepatic Impairment

A study in mild and moderate liver impairment has not been conducted. FANAPT is not recommended for patients with hepatic impairment.

8.8 Smoking Status

Based on in vitro studies utilizing human liver enzymes, FANAPT is not a substrate for CYP1A2; smoking should therefore not have an effect on the pharmacokinetics of FANAPT.
APA Product Theater Sessions

Product Theaters will again be held this year during the Annual Meeting. These promotional programs are being held as an extension of the exhibit hall. Seating is limited to 250, and is on a first-come, first-served basis. They feature promotional programs supported by our exhibitors. CME credit is not provided for these sessions. The 60-minute sessions will be held in APA Exhibit Hall C in the Moscone Convention Center. Sessions will be from Sunday to Tuesday with two sessions each day at 11 a.m. and 1 p.m. Boxed lunch and beverages are provided by the APA for the programs. Topics may include treatment management, disease updates, and issues of interest to the supporting company.


Look for signs announcing the presenters and topics in the exhibit hall.

Sunday, May 19

11 a.m. – 12 p.m.
Sponsored by Takeda Pharmaceuticals America, Inc. and Lundbeck, Inc.
Depression: Deeper Evaluation of Symptoms and Neurobiology
Presenter: Pierre Blier, MD, PhD, Director of the Mood Disorders Research Unit, University of Ottawa Institute of Mental Health Research
1 p.m. – 2 p.m.
Sponsored by Sunovion Pharmaceuticals, Inc.
Effective Dosing Strategies for a New Generation Antipsychotic Frontiers in Neuroscience – Understanding the Complexities of Schizophrenia
Presenter: Stephen M. Stahl, MD, PhD, Adjunct Professor of Psychiatry, University of California San Diego School of Medicine, Honorary

DAILY BULLETIN
May 18/19, 2013

9 DRUG ABUSE AND DEPENDENCE
9.2 Abuse
FANAPT has not been systematically studied in animals or humans for its potential for abuse, tolerance, or physical dependence. While the clinical trials did not reveal any tendency for drug-seeking behavior, these observations were not systematic and it is not possible to predict on this basis of experience the extent to which a CNS active drug, FANAPT, will be misused, diverted, and/or abused once marketed. Consequently, patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of FANAPT misuse or abuse (e.g., development of tolerance, increases in dose, drug-seeking behavior).

10 OVERDOSAGE
10.1 Human Experience
In pre-marketing trials involving over 3210 patients, accidental or intentional overdose of FANAPT was documented in eight patients ranging from 48 mg to 576 mg taken at once and 292 mg taken over a three-day period. No fatalities were reported from these cases. The largest confirmed single ingestion of FANAPT was 576 mg; no adverse physical effects were noted for this patient. The next largest confirmed ingestion of FANAPT was 438 mg; no adverse physical effects were reported for this patient. Similarly, it is reasonable to expect that the alpha-blocking properties of bretylium might be additive to those of FANAPT, resulting in problematic hypotension. Hypotension and circulatory collapse should be treated with appropriate measures such as intravenous fluids or sympathomimetic agents; epinephrine and dopamine should not be used, since beta stimulation may worsen hypotension in the setting of FANAPT-induced alpha blockade. In cases of severe extrapyramidal symptoms, anticholinergic medication should be administered. Close medical supervision should continue until the patient recovers.

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Novartis Pharmaceuticals Corporation
East Hanover, NJ 07936
T2013-07
January 2013

11.2 Management of Overdose
There is no specific antidote for FANAPT. Therefore appropriate supportive measures should be instituted. In case of acute overdose, the physician should establish and maintain an airway and ensure adequate oxygenation and ventilation. Gastric lavage (after intubation, if patient is unconscious) and administration of activated charcoal together with a laxative should be considered. The possibility of dilution, oximes or antidotes (e.g., the head and neck following overdose may create a risk of aspiration with induced emesis. Cardiovascular monitoring should commence immediately and should include continuous ECG monitoring to detect possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide and quinidine should not be used, as they have the potential for QT-prolonging effects that might be additive to those of FANAPT. Similarly, it is reasonable to expect that the alpha-blocking properties of bretylium might be additive to those of FANAPT, resulting in problematic hypotension. Hypotension and circulatory collapse should be treated with appropriate measures such as intravenous fluids or sympathomimetic agents; epinephrine and dopamine should not be used, since beta stimulation may worsen hypotension in the setting of FANAPT-induced alpha blockade. In cases of severe extrapyramidal symptoms, anticholinergic medication should be administered. Close medical supervision should continue until the patient recovers.

Help Protect Your Patients From Relapse: A New Treatment Option for Schizophrenia
Presenter: Andrew J. Cutler, MD, founder Florida Clinical Research Center, Assistant Professor of Psychiatry at the University of Florida

Product Theaters
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• All product theaters are 30 or 60 minutes in length and are supported promotional presentations. Attendance is limited and on a first-come, first-serve basis. Only registered APA Annual Meeting participants may attend the presentations.

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American Psychiatric Association
1000 Wilson Boulevard, Ste 1825
Arlington, VA 22209
phone: 703-907-7300
email: press@psych.org

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The evolution of the Internet and the explosion of user-generated content have undeniably altered our society’s basic notions of privacy, connectivity and communication. As more and more people are interacting and sharing more information in the Internet, one notable consequence has been the blurring of boundaries between social and professional spheres—and psychiatrists have not been immune from these trends.

“With more psychiatrists blogging, posting on social media websites, and uploading personal videos onto the Internet, distinctions between personal and professional realms have become blurred,” said Paul Appelbaum, MD, Director of the Division of Law, Ethics, and Psychiatry at Columbia University.

Dr. Appelbaum will address the challenges to traditional notions of psychiatrist-patient boundaries that result from the exponential growth of social media in the workshop, “Social Media & the Internet: New Challenges to Boundaries in Psychiatry,” beginning at 1:30 p.m. on Monday in Room 122 of the Moscone Convention Center. The workshop is part of the APA Annual Meeting Ethics Track.

Whether as users of data posted by others or creators of information that others are interacting and sharing more and more, psychiatrists are full participants in the social media revolution, Dr. Appelbaum notes, which creates a complex set of practical and ethical challenges for psychiatric practice. He points to several inherent conflicts that speak directly to the nature of the practice of psychiatry versus the nature of social media use.

“Whereas psychiatry emphasizes the privacy of the therapeutic relationship, for example, social media encourages open sharing of personal and private information, often leading to what is known as the disinhibition effect,” Dr. Appelbaum said. “In a professional setting, there are defined boundaries within which psychiatrists and their patients interact. Social media, on the other hand, erases boundaries by blurring the distinction between personal and public information.”

During the workshop, Dr. Appelbaum will share case examples of psychiatrists’ involvement in social media, and outline approaches that psychiatrists can use to avoid compromising their professional roles.

“The bottom line is physicians don’t have to shun social media, so long as they use it prudently, which includes using appropriate privacy settings, avoiding unprofessional content and learning to manage their digital footprint,” Dr. Applebaum said. “Above all, keep in mind that behaving badly online can have severe consequences in the real world.”

Saturday, May 18
9 a.m. – 12 p.m.
Update on the Status of Psychiatry in the Arab World
11 a.m. – 12:30 p.m.
Disruptive Behavior in the Workplace: Dealing With the Distressed and Disruptive Physician
1:30 p.m. – 3 p.m.
The Risks and Responsible Roles for Psychiatrists Who Interact With the Media
3:30 p.m. – 5 p.m.
United Kingdom Critical Psychiatry Network: Implications for APA and Global Psychiatry

Sunday, May 19
9 a.m. – 4 p.m.
Sex, Drugs, and Social Media: Professionalism and Ethics Put to the Test
10 a.m. – 11:30 a.m.
Overview of Conscientious Objection With Special Attention to Quaker Conscientious Objectors in World War II: Unlike Heroes of Psychiatric Reform
12:30 p.m. – 2 p.m.
Brain Imaging and Psychiatric Diagnosis: Scientific and Societal Issues
Rejuvenating Empathy Through Reflective Writing: A Workshop for Clinicians
1 p.m. – 4 p.m.
Attention Deficit Hyperactivity Disorder and Driving Safety
2:30 p.m. – 4 p.m.
The Internet and Electronic Communication

Monday, May 20
9 a.m. – 10:30 a.m.
When Patients Can’t Decide: A Case Discussion of Good Clinical Practice, Ethics, Law and the Boundaries of Self-Determination
9 a.m. – 12:2 p.m.
Ethical Waves of the Silver Tsunami: Focus on Capacity, Decision Making, and End-of-Life Issues
11 a.m. – 12:30 p.m.
Deciding Who Decides: Surrogate Decision-Making Policies Across the United States
1:30 p.m. – 3 p.m.
Mental Health, Involuntary Treatment, and Due Process Of Law
Social Media And The Internet: New Challenges To Boundaries In Psychiatry
3:30 p.m. – 5 p.m.
You Can’t Call My Mom: Balancing Privacy Versus Potential Negligence In Emergency Psychiatric Assessment
Professionalism In Social Networking: What Shouldn’t Be Tweeted, Blogged Or Posted
gaps in knowledge for the full range of mental disorder diagnostic areas. These conferences, co-sponsored by the World Health Organization, took place between 2003 and 2008.

“...the development of the research questions and weaknesses in the current DSM-IV, which led to...” Dr. Regier said. “We held a total of 13 conferences around the world, involving nearly 400 clinicians and scientists. A series of monographs was published, based on the findings and recommendations that came out of those conferences.”

In 2006, then-APA President Dr. Steven Sharfstein announced the formation of the DSM-5 Task Force and the appointments of Drs. Kuper and Regier as chair and vice-chair. They, along with other leaders at the APA, nominated additional members to the Task Force to serve as chairs of 13 Work Groups to focus on different diagnostic categories.

Over the next two years, additional Task Force and Work Group members were recruited based on their expertise and leadership in their respective fields. In all, more than 160 researchers and clinicians with expertise in mental disorders, neuroscience, biology, genetics, statistics, epidemiology, and public health would serve on the DSM-5 Task Force and Work Groups — and included psychiatrists, psychologists, social workers, psychiatric nurses, pediatritians, and neurologists. In addition, Study Groups were created and assigned to review important aspects of diagnosis relevant to all of the diagnostic categories, such as gender, age and cross-cultural issues; assessment of impairment and disability; and development of dimensional scales and ratings to better characterize patients’ symptoms, inform treatment planning, and track treatment response.

“The volunteer Task Force and Work Group members reviewed the findings and recommendations developed from the conferences with an eye towards drafting proposals for DSM-5 criteria and revisions that might be supported by the earlier work,” said Dilip Jeste, MD, President of APA and a former member of the DSM-5 Task Force. “They began by analyzing the strengths and the weaknesses in the current DSM-5, which led to the development of the research questions and the hypotheses that would set the agenda for the revision process.”

Based on comprehensive reviews of scientific advancements, targeted research analyses, and clinical expertise, the Work Groups developed the first draft of the DSM-5 diagnostic criteria, which was posted online for public comment in February 2010.

“...Also in 2010, APA launched a series of field trials of approximately 30 disorders that were either new disorders or ones that had significant changes. We also included some that had very few changes so we’d have a basis of comparison,” Dr. Regier said. “To conduct the trials, we selected four child-oriented centers and seven adult-oriented centers. We then launched a very sophisticated field trial protocol in these 11 centers to look at selected disorders in both child and adolescent populations and in adult populations.”

After reviewing and deliberating the public feedback and preliminary data from the field trials, the Work Groups and Task Force further revised the DSM-5 criteria and posted them for a second open-comment period in 2011. Following a similar review and deliberation process, proposed criteria were posted for a third and final public comment period in May 2012.

The final Work Group proposals were then evaluated by the Task Force, and two panels convened specifically to evaluate the proposals — a Scientific Review Committee and a Clinical and Public Health Committee. Additionally, there was a forensic review by members of the APA Council on Psychiatry and Law. After final Task Force approval, recommendations were reviewed by the DSM-5 Summit Group. The criteria were then put before the APA Assembly for review and approval. The APA Board of Trustees’ review was the last step in the process.

“The Board of Trustees review was completed in the first week of December 2012, finally and officially bringing DSM-5 to the APA,” said Dr. Jeste. “As part of the DSM-5 launch here in San Francisco, we’ll be offering a number of courses, events, and workshops to introduce members to the new manual. It’s going to be a very comprehensive and exciting roll-out for DSM-5.”

The 2013 American Psychiatric Publishing Bookstore has over 400 titles that can help you grow professionally and increase your knowledge of psychiatric issues.

2013 APA Annual Meeting: DSM-5

Track Schedule of Sessions

Saturday, May 18
9 a.m. – 10:30 a.m. Substance Use Disorders in DSM-5 (workshop)
9 a.m. – 12 p.m. Symptoms and Disability Measures in DSM-5
DSM-5 Psychosis Chapter
9 a.m. – 4 p.m. DSM-5: What You Need to Know (master course)
2 p.m. – 5 p.m. Substance Use Disorders in DSM-5

Sunday, May 19
1 p.m. – 4 p.m. The DSM-5 Cultural Formulation Interview: A Standardized Cultural Assessment
DSM-5 and Major Depression

Monday, May 20
9 a.m. – 12 p.m. DSM-5 Intellectual Disability (Intellectual Developmental Disorder); New Criteria, Co-Occurring Psychiatric Conditions, and Forensic Implications
Sleep-Wake Disorders in Psychiatric Practice: Guidance From DSM-5
Trauma and Stress-Related and Dissociative Disorders in DSM-5

11 a.m. – 12:30 p.m. Feeding and Eating Disorders: New Issues for DSM-5 (workshop)
1:30 p.m. – 3 p.m. Understanding and Operationalizing the Somatic Symptom Disorders (workshop)
2 p.m. – 5 p.m. Obsessive-Compulsive and Related Disorders in DSM-5
DSM-5 Bipolar Disorders: Update on Revised Criteria and Their Clinical Implications
Eating Disorders Update
Looking Towards DSM-5:1. The Utility of Assessing Personality Functioning and Traits in Personality Disorder Diagnosis

Tuesday, May 21
9 a.m. – 12 p.m. Sexual Disorders and Sexual Health in the ICD-11: Parallels and Contrasts with DSM-5
2 p.m. – 5 p.m. Autism and Social Communication in DSM-5
Culture and DSM-5: Changes to Disorder Criteria and Text

Wednesday, May 22
9 a.m. – 12 p.m. Report from the DSM-5 Sexual and Gender Identity Disorders Work Group
Cancellations/Withdrawals
NR9-55 has been withdrawn.
NR19-28 has been withdrawn.
NR2-74 WITHDRAWN
Monday, May 20
Cancellations/Withdrawals
Small Interactive Session 17 - WITHDRAWN
Poster NR9-45 has been WITHDRAWN
Poster NR9-48 has been WITHDRAWN
Poster NR9-50 has been withdrawn.
Poster NR9-51 has been WITHDRAWN
Carola Koopman, MD will be an additional speaker on presentation title Suicide Prevention with Frederick Langheim, MD.
Symposium 53 – Thomas Spencer, MD will not present.
Symposium 118 – Carol Koplan, MD will be an additional speaker on this course.
NR2-29 Adam Hunzeker will not be presenting.
NR3-99 has been withdrawn.
NR3-21 Anusha Manjegowda, MBBS, will not be presenting.
NR4-27 has moved to NR6-45 Medical Comorbidities in an Acute Inpatient Setting presented by Jessy Warner-Cohen, MD.
NR5-08 presented by David Bickford – has moved to poster session.
NR4-33 has been moved to NR6-45 Medical Comorbidities in an Acute Inpatient Setting presented by Jessy Warner-Cohen, MD.
NR6-25 For the sake of clarity, David Bickford will not be presenting.
NR6-45 Medical Comorbidities in an Acute Inpatient Setting presented by Jessy Warner-Cohen, MD.
NR6-45: The dose of desipramine should be markedly reduced. If NUEDEXTA and desipramine are prescribed concomitantly, the initial dose of desipramine should be markedly reduced. The dose of desipramine should not be increased above a moderate dose of several hundred milligrams. Other adverse reactions occasionally reported include cardiac arrhythmias (e.g., syncope or palpitations), NUEDEXTA should be discontinued and the patient further evaluated by a healthcare provider experienced in cardiac arrhythmia management.QT Prolongation can cause torsades de pointes-type cardiac events, generally during the first few weeks of therapy.
Cardiac Effects: NUEDEXTA causes dose-dependent QT prolongation (i.e., Clinical Pharmacology (1.2 in full PI)). QT prolongation can cause torsades de pointes-like ventricular tachycardia, with the risk increasing as prolongation increases. When initiating NUEDEXTA, stable QTc intervals at baseline of 450 ms or less should be at baseline and at 3 hours after the first dose. This includes patients concomitantly taking drugs that prolong the QT interval or that are moderate CYP2D6 inhibitors (e.g., thioridazine or pimozide)

ADVERSE REACTIONS
A total of 38 patients participated in Phase I and II trials and 30 patients participated in Phase III trials. The number of patients in each dose group is not provided. Most adverse events are self-limiting and do not require discontinuation of treatment. NUEDEXTA is a combination of dextromethorphan and quinidine sulfate. NUEDEXTA is a combination of dextromethorphan and quinidine sulfate. NUEDEXTA is a combination of dextromethorphan and quinidine sulfate. NUEDEXTA is a combination of dextromethorphan and quinidine sulfate.

Cancellations/Withdrawals
NR6-25: Dr. Bickford will not be presenting.
NR9-55: Poster will be presented by Barbara Barrows, MD, PhD.
NR12-04 Dr. Bickford will not be presenting. Poster will be presented by Brian Frazier, MD.
NR17-03 Symposium 118 – Carol Koplan, MD will be an additional speaker on this course.
NR19-52 Richard Breaux, MD, MS, will not be presenting.
NR2-29 Adam Hunzeker, MD, will not be presenting.
NR3-99 has been withdrawn.
NR3-21 Anusha Manjegowda, MBBS, will not be presenting.
NR4-27 has moved to NR6-45 Medical Comorbidities in an Acute Inpatient Setting presented by Jessy Warner-Cohen, MD.
NR4-29 Dr. Bickford will not be presenting. Poster will be presented by William Rumbaugh, MD.
NR4-33 has been moved to NR6-45 Medical Comorbidities in an Acute Inpatient Setting presented by Jessy Warner-Cohen, MD.
NR8-09 has moved to NR-060
Saturday, May 18
Courses Sold Out
• Master Conference 09 – Presenters have been added: Laura Dunn, MD, and Stefana Borovits.
• Workshop 131 – Charles Nemeth, MD, will be replaced by Paul Summara, MD.
• Symposium 199 – Phoenix Schneider, MSW will be replaced by Attena Bitter.

Wednesday, May 22
Participant Changes
• Carol Koplan, MD will present – will be replaced by Niels Jønburg, MD.

Courses Sold Out
• Course 38 Course 40

Tuesday, May 21
Cancellations/Withdrawals
Workshop 106 – WITHDRAWN (title: The DSM-5: Do Values Realistically Undermine Objectivity in Disease Classification?)
Poster 10-12 WITHDRAWN

Participants
NR5-02 and NR5-03 canceled.
NR-50 and NR5-51 changed to NR5-57 and NR5-58 and will both be presented by Leslie Citrome, MD.
Symposium 53 – Thomas Spencer, MD will not present.
Symposium 118 – Carol Koplan, MD will be an additional speaker on this presentation title Suicide Prevention with Frederick Langheim, MD.
Symposium 130 – Dan G. Blaze, MD, PhD will not be in attendance and will be replaced by Andrew Nevegaw, MD.
NR-50 Mike Dunne is not presenting – poster will be presented by Byron Trahan, MD.
NR-54 – Jennifer Kim Slawik, PhD, is not presenting poster will be presented by Cyndi Boshe, PhD.
NR-58 – Mark Nubel is not presenting poster will be presented by L. Danielle Chakravurti, MD.
NR-59 – Linda Becker is not presenting poster will be presented by Donna Zubik.
NR-11 – Suzanne Silverman, MD, is not presenting poster will be presented by Arnd Pandya, MD.
NR-10 – Kuni Endo is no longer presenting – poster will be presented by Nils Jønburg, MD.

Courses Sold Out
Course 17, Course 22

Cancellations/Withdrawals
• Workshop 38 – Francis Lu, MD will not be in attendance and will be replaced by Neil Argawal, MD.
• Forum 3: Addiction Performance Program Mace Winningham will be in attendance.

Courses Sold Out
• Course 11, Course 17
NUEDEXTA Important Safety Information

NUEDEXTA® is indicated for treatment of pseudobulbar affect (PBA).

NUEDEXTA® may offer rapid relief from pseudobulbar affect (PBA) episodes within the first week of treatment.

Efficacy was sustained over the course of 12 weeks.

Reduction in PBA episodes for placebo was 45% at 12 weeks.

NUEDEXTA® is the only FDA-approved treatment for PBA

Visit NUEDEXTA.com or call 1-855-4NUEDEX (468-3339).

Encourage neurologic patients to open up about PBA by asking, “Do you ever cry or laugh for no reason?”

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