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IN THIS ISSUE

Focus of the Month:
Bipolar Disorder

Learning Objectives
After reading these articles, you should be able to:
1. Implement effective interview and follow-up meeting goals with bipolar patients.
2. Identify the key factors in making antipsychotic polypharmacy decisions.
3. List the key changes related to the new ICD-10 codes.

Antipsychotic Polypharmacy: Helpful or Harmful?

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Daniel Carlat, MD, Publisher, The Carlat Psychiatry Report

Dr. Gable and Dr. Carlat have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

In Summary

- Although guidelines discourage polypharmacy, almost 50% of psychiatric inpatients receive antipsychotic polypharmacy.
- If using polypharmacy, consider the differing receptor-binding profiles of the antipsychotics available when deciding which combination(s) to use.
- Multiple antipsychotics with complicated dosing schedules can lead to challenges with treatment adherence.

Prescribing two antipsychotics to a single patient is a common practice in clinical settings. One study estimated that up to 50% of psychiatric

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Q&A With the Expert

Managing Bipolar Disorder: Practical Tips
Stephen M. Strakowski, MD

Senior Vice President and Chief Strategy Officer of UC Health; Professor of Psychiatry & Behavioral Neuroscience, Psychology & BME at the University of Cincinnati

Dr. Strakowski discloses that he has been a paid consultant to Sunovion and Procter & Gamble. Dr. Carlat has reviewed this article and has found no evidence of bias in this educational activity.

TCPR: Dr. Strakowski, it's often difficult to be certain of a bipolar disorder diagnosis based on an initial evaluation. As clinicians, we're always looking for better screening questions to quickly hone in on whether the patient has had genuine manic episodes. How do you start your interviews?

Dr. Strakowski: I generally start with two questions. First, "Has there been any period of time where you had a lot of energy to the point where you really didn't even need to sleep more than a few hours a night?" I think that one is characteristic enough of mania that it at least gets you started. Second, "Have you had periods of either euphoria or irritability that have lasted more than a few hours?" In addition, I usually inquire about family history: "Is there anyone in the family who has been treated for bipolar disorder or hospitalized for recurring odd behavior?" If those questions come back positive, then I go through a somewhat structured interview of mania, including the DSM-5 criteria.

TCPR: Sounds like a good start.

Dr. Strakowski: That's an important thing to realize—it is only a start. I often emphasize to clinicians that diagnosis isn't a thing you do at the first visit and then quit. Some psychiatrists feel the need to nail down a diagnosis after a single session, which is often unrealistic, especially with bipolar disorder.

TCPR: Can you give us some other examples of phrasing questions? We commonly ask about things such as euphoria or irritability, but our patients may

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Antipsychotic Polypharmacy: Helpful or Harmful?

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inpatients are receiving antipsychotic polypharmacy (Faries D et al, *BMC Psychiatry*;5:26). Increasingly, we are being scolded for this practice. A variety of guidelines discourage polypharmacy, and recent studies have documented that we are often not following such guidelines.

Clearly, psychiatrists aren't combining drugs in order to be obstinate, to cost the system more money, or to harm patients. We're doing it because we want to make our patients feel better, and in many cases a single drug is not doing the trick. Studies indicate that the patients who are more likely to be prescribed multiple antipsychotics are younger, single, unemployed, and male; they also present with more severe psychotic symptoms. Patients with frequent hospital admissions, involuntary admissions, and those prescribed long-acting injectables (LAI) are also more likely to eventually be on two antipsychotics at the same time (Fleischhacker WW and Uchida H, *Int J Neuropsychopharmacol* 2014;17(7):1083–1093).

If possible, stick with a single antipsychotic. But if the situation seems to call for polypharmacy, here are some factors to guide your decision-making. The published evidence base for any combination regimen is either slim or non-existent, so consider these to be commonsense guidelines drawn from clinical experience (when there are actual studies endorsing these practices, we cite them below).

Consider the differing receptor-binding profiles of the many antipsychotics available for use (see table below). First-generation antipsychotics, such as Haldol, bind tightly to dopamine receptors and occupy the sites longer. Some second-generation antipsychotics, especially quetiapine and clozapine, are known to have a quick "on-off" effect, meaning they dissociate from the dopamine receptor quickly (McIntosh DM et al, *The Canadian Journal of Diagnosis* 2011; (4):33–44). How does receptor affinity translate to clinical practice? Generally, longer and tighter binding to D2 will trigger more extrapyramidal side effects (EPS), whereas quick on-off binding translates to minimal or no risk of EPS development. Also take note of other receptor binding activity, such as histamine, alpha, and muscarinic, all of which are described in the table. Using this information, for example, you would predict that two highly histaminergic or muscarinic blocking antipsychotics, like clozapine and olanzapine, will likely lead to a very tired, cognitively impaired, and constipated patient.

Some common polypharmacy scenarios

Our clinical experience indicates that there are a few common scenarios leading to multiple antipsychotics. We'll describe each in turn, and comment on which ones are more or less reasonable.

1) Attempting to gain more rapid control of psychotic symptoms

Current treatment: quetiapine or other low-potency agent. Potential addition: haloperidol 1–2 mg every 6 hours PRN agitation, po or IM, depending on situation and setting.

This scenario is often appropriate. Haloperidol can be used to control acute agitation on top of an atypical antipsychotic, and it frequently works.

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Antipsychotic Receptor Binding Affinities

Antipsychotic	Dopamine (D2) blockade	Histamine (H1) blockade	Alpha1 blockade	Muscarinic (M1) blockade
Clinical effects of blockade	**EPS, akathisia**	**Sedation, weight gain**	**Orthostasis, dizziness**	**Constipation, dry mouth, and blurred vision**
Aripiprazole[1]	++++	++	++	-
Asenapine	+++	+++	+++	+
Brexpiprazole[1]	+++	++	+++	-
Cariprazine[1]	++++	++	++	-
Chlorpromazine	+++	++++	++++	+++
Clozapine	+	++++	++++	++++
Haloperidol	++++	-	+	-
Iloperidone	+++	++	+++	-
Lurasidone	+++	-	++	-
Olanzapine	++	+++	+	+++
Paliperidone	+++	+	+++	-
Quetiapine	+	+++	+++	+
Risperidone	+++	+	+++	-
Ziprasidone	+++	+	+	-

+weak binding affinity; ++++strong binding affinity; [1]partial D2 agonist activity

Adapted from: Correll CU, *Eur Psychiatry* 2010;25 Suppl 2:S12–21; Horacek J et al, *CNS Drugs* 2006;20(5):389–409; Kusumi I et al, *Psychiatry Clin Neurosci* 2015;69(5):243–258; Maeda K et al, *J Pharmacol Exp Ther* 2014;350(3):589–604; Kiss B et al, *J Pharmacol Exp Ther* 2010;333(1):328–340.

Antipsychotic Polypharmacy: Helpful or Harmful?

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One could also use other higher-potency antipsychotics, such as aripiprazole, risperidone, or paliperidone. Overall, we suggest limiting such combinations to short term use (1–4 weeks). Too many antipsychotics with complicated dosing schedules will only lead to difficulty with treatment adherence.

2) Refractory cases

Current treatment: clozapine. Potential addition: risperidone 1 mg daily due to poor symptom control: low-potency oral agent.

Clozapine is the clear favorite when it comes to the treatment of refractory schizophrenia. But what do we do when clozapine isn't enough? Adding risperidone to clozapine has become a favorite of clinicians, based on two placebo-controlled trials (Freudenreich O et al, *J Clin Psychiatry* 2009;70(12):1674–1680 and Josiassen RC et al, *Am J Psychiatry* 2005;162(1):130–136), though one larger trial showed no beneficial effect of adding risperidone (Honer et al, *N Engl J Med* 2006;354(5):472–482). We suggest trying this option only after a solid 12-week trial of clozapine monotherapy at therapeutic doses of 300–900 mg daily.

3) Management of acute symptom exacerbations during treatment with an LAI antipsychotic

Current treatment: paliperidone LAI IM q 4 weeks, or other LAI. Potential addition: low-potency oral agent.

Your patient has a worsening of psychosis, despite taking the maximum recommended dose of an LAI. There is no evidence-based guidance on to how to approach this problem. You will probably be reluctant to discontinue the shot if your patient has responded well to it in the past. You could consider shortening the interval of the injection first (eg, move from every 4 weeks to every 3 weeks). When you do add on a second antipsychotic, try one with a differing receptor-binding profile (see table). Be mindful of worsening EPS and hyperprolactinemia with these combinations. Ensure that you reevaluate the regimen routinely, and attempt to remove the additional oral antipsychotic periodically.

4) Treatment of co-occurring insomnia

Current treatment: risperidone. Potential addition: quetiapine 50 mg q HS.

It is quite common for psychiatrists to prescribe quetiapine for insomnia, agitation, and anxiety (Philip NS et al, *Ann Clin Psychiatry* 2008;20(1):15–20). A survey of Medicaid prescribing from 2004 indicated that quetiapine was the most likely antipsychotic to be co-prescribed long-term with other antipsychotics (Ganguly et al, *J Clin Psychiatry* 2004;65(10):1377–1388). Once you have maxed out your dopamine blocking threshold (for Haldol or Prolixin, this is between 10 and 20 mg a day), it does make sense to consider the addition of a low-potency, sedating antipsychotic—if the problem being targeted is psychosis. For a patient with insomnia, consider a sleep study referral, or a trial with one of the many dedicated hypnotics, such as benzodiazepines, non-benzos, melatonin, and others. Our suggestion would be to avoid antipsychotic polypharmacy here if you can. Quetiapine, while sedating and calming, is also likely to cause or exacerbate troublesome metabolic side effects such as weight gain and diabetes.

5) Treatment of antipsychotic-induced adverse effects

Current treatment: risperidone. Potential addition: aripiprazole to lower prolactin levels induced by risperidone.

There are varying opinions on the appropriateness of using an antipsychotic to treat antipsychotic-induced side effects. There are several studies highlighting the effectiveness of aripiprazole at reducing prolactin levels induced by other antipsychotics (Kane JM et al, *J Clin Psychiatry* 2009;70(10):1348–1355). This is due to its dopamine agonist properties. The biggest concern with this combination is the financial burden associated with its use, though aripiprazole will become much cheaper with time now that it is available as a generic. This combination should be considered for patients who have had a positive response to risperidone therapy but have significant hyperprolactinemia.

There are also limited data describing the benefit of adding aripiprazole to clozapine therapy to reduce metabolic-associated adverse effects. Adding aripiprazole to clozapine (Fan et al, 2013) or olanzapine (Henderson et al, *J Clin Psychopharmacol* 2009;29(2);165–169) has resulted in weight loss and LDL cholesterol lowering; however, you may not see a robust change in psychosis (Kane JM et al, *J Clin Psychiatry* 2009;70(10):1348–1355).

6) Caught in the cross-taper/titration

Current treatment: lurasidone (tapering due to poor response). Potential addition: olanzapine, with plan to titrate up while tapering lurasidone, but patient has a positive response to both treatments together.

Even great clinicians can be a victim of the taper/titration trap. All you really know here is that lurasidone didn't cut it by itself, and when you added olanzapine, the patient got better. So, was it the olanzapine or was it the combo? Sometimes it is just easier to leave well enough alone and not risk symptom relapse. Despite this, your patient deserves a try with olanzapine solo before keeping the combination going long-term. There are just no good data to support this kind of duo, and again, the risk of side effects continues to grow. An adequate taper/titration schedule should really be done within 8 weeks.

TCPR VERDICT: Combining antipsychotics can be helpful in some situations, but monitor closely for side effects and try to reduce back to monotherapy if possible.

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Expert Interview

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not really know what we mean by these descriptions in a clinical sense.

Dr. Strakowski: For the euphoria, what I say—and this is usually in the context of someone who has come in for recurrent depression—"Has there been a time where you've had the opposite of this kind of down period where you've felt really up and high or too good in such a way that people commented on it or said they thought you were acting very differently?" For a patient you may not know very well, the tricky part is determining whether it's someone who's depressed all the time and finally got healthy vs. someone who became manic. So again, I put the question in context of what other people have noticed such as, "When you felt better, did people say, 'You look like you're feeling pretty well' vs. 'Wow, you're acting sort of different or strange'?" For irritability I'll say, "Do you find that you've had periods where you were snapping at friends and strangers, not just your family?" Everybody argues or gets irritable with their family, so that is not very helpful for a diagnosis. Often in these first appointments, there's a spouse or a parent who will start nodding their head, and then you can jump in and say, "Well, it looks like your wife thinks you do," and you can go on from there.

TCPR: Aside from core diagnostic information, what other pieces of information do you like to get during the initial interview that might end up helping to manage the illness over the long term?

Dr. Strakowski: I always ask about drug and alcohol use because that's the number one confound. Not only is that going to mimic symptoms, but it's the one that's going to worsen outcome. Family history for me is very important, particularly in bipolar disorder since it is highly inheritable (Strakowski S. *Bipolar Disorder*. New York, NY: Oxford University Press; 2014). If there is no evidence of psychiatric illness in the family, then that really questions the diagnosis in my mind.

"Probably the most common mistake I see psychiatrists make when treating bipolar disorder is they're constantly reactive. There is a tendency to pathologize even normal day-to-day variability in people's mood, but you don't want to be making constant medication changes and additions in response to what is probably a 2-day blip."

Stephen Strakowski, MD

TCPR: If you ascertain that somebody has an alcohol or drug abuse history, what do you do with that information? How does it affect your treatment?

Dr. Strakowski: I often try to determine the timing of the two disorders—did the substance use come before the mood disorder or vice versa? I will almost never wait to try to get someone sober before I treat the mood disorder; I always try to treat them concurrently. But it's an important part of that initial conversation: "As long as you're smoking marijuana daily, you are immediately impairing the ability of our treatment to be effective."

TCPR: We've heard about the importance of a regularized daily rhythm for patients with bipolar disorder. When do you ask about that?

Dr. Strakowski: That discussion often comes during the second visit, and becomes part of the treatment response discussion. I tell people that there is reasonable evidence that maintaining a regular sleep, exercise, and activity pattern is important. There's some evidence that patients with bipolar disorder don't manage these things naturally without help, and so it's part of the recovery process. I usually introduce it fairly early as part of the treatment approach rather than as a diagnostic element per se. When I talk with patients about treatment, I really position them to think about it like managing any kind of chronic major medical illness. It's not going to be as simple as just taking a pill. They have to understand that it's really a programmatic treatment to manage a condition that can be complicated, and rhythmicity management is part of that.

TCPR: Let's talk about mood charting, which is something we've been taught to do but for some reason many of us don't do it. We provide a table of online mood charting tools for our readers in this issue. Maybe you can help us to figure out a system that works well.

Dr. Strakowski: I think mood charting is perceived as being a lot more time-consuming and difficult than it is, but in my experience it is exactly the opposite. Mood charting is the best way to facilitate an effective follow-up meeting. First, you have to find one, and I recommend the chart created by the Depression and Bipolar Support Alliance—it's on their website, and it's very inexpensive (http://www.dbsalliance.org). The way I sell mood charting to patients is I talk about how human beings are designed, that we tend to assume that how we feel right now is how we've felt for the last 30 days or more. I say, "And so if we don't have a way of capturing this information between visits, we end up making bad treatment decisions because we're basing it on today rather than what's happened since I saw you last." So we work out a simple plan that the patient is going to check a box on the chart where their mood was when it was at its worst for that day. It can be the last thing they do at bedtime. There are lots of other things they can note, such as sleep and medication. Different patients will use it to varying degrees, but the only thing I really care about is that once a day they are checking where their mood was, and that's fairly straightforward and easy.

TCPR: Does it take a while to teach patients this?

Dr. Strakowski: No, it takes 5 to 7 minutes, and it isn't as though we have one shot and we're done. When they bring it back next time, if it's not filled out correctly, we can talk about it. And over 3, 4, or 5 months, it gets easier. Then what happens is when they get good at it, they flop it on my desk and say, "Here's my mood chart," instead of me having to ask, "How were you the last month?" "What happened a week ago?" So that facilitates a much more efficient follow-up appointment. We can look at the graph together and say, "Well, it looks like you've had some ups and downs, but the overall trend is up or the overall trend is down," and then we can move on to making decisions.

TCPR: How do patients take to mood charting?

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Expert Interview

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Dr. Strakowski: In my experience, they pick it up easily; it's not complicated. Do all patients religiously complete their mood charts? Of course not; I'm completely aware that some will be filling it in on the car ride over or in the waiting room. But at least they are paying attention and thinking about it. And over time they realize, "Hey, this helps my doctor make decisions, and I don't have to spend all my time recounting day-to-day events. I can actually talk about what's important to me." So that's how I've approached it, and I've had very good success across all ages. Patients find that it is just easier to do them than talk about why they weren't done. So I really can't over-recommend mood charting; it will make your follow-ups that much more efficient.

TCPR: Yes, the time constraints in our follow-up appointments are definitely challenging. What do you recommend we accomplish during these shorter visits?

Dr. Strakowski: Probably the most common mistake I see psychiatrists make when treating bipolar disorder is they're constantly reactive. There is a tendency to pathologize even normal day-to-day variability in people's mood, but you don't want to be making constant medication changes and additions in response to what is probably a 2-day blip. But if you had a 30-day charting, you'd be able to say, "Well, this has happened twice and I don't need to do anything because the trend is still towards recovery." Of course, with patients who are acutely ill, we are going to ask about suicidality most visits. Then usually I'm building a program over time, and so I try to introduce elements of that, whether it's focusing on sleep schedule or appetite or diet. I don't try to do everything at every appointment. I try to think about how we can space out different pieces of what I need to know so that we're covering them, say, over a span of 6 months.

TCPR: It's challenging when issues arise that are more suited to be handled therapeutically, in terms of time. You want to help your patient, but you also have a lot to cover from a clinical perspective.

Dr. Strakowski: With a 15-minute med check, you have to be very clear on your responsibilities. You're not the therapist, so you will want to make sure that someone is working with that person whenever possible because it's a programmatic treatment. I usually have some functional metric that we're following—work, school, etc.—and we talk about whatever treatment changes that we need to make. I tend to see 2–3 patients an hour. Once someone is stabilized, it takes me about 3 minutes with a mood

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Mood Charting Online Tools[1]

Online Tool	Cost and Availability	Features
eMoods Bipolar Mood Tracker (emoodtracker.com)	Free, Android only	• Record mood and treatment effects (irritability, anxiety, sleep, therapy, and medication) • Option to email monthly summary report to health care provider
iMoodJournal (www.inexika.com/imood)	$1.99, iOS $1.00, Android	• Record mood, sleep, medications • Color-coded summary reports • Option to share on Facebook
Moodlytics Smart Mood Tracker (www.moodlytics.com)	Free, iOS Free, Android	• Record mood with emojis • Set reminders to add entries • Make behavior goals • Option to share on Facebook
Moodtrack Diary (www.moodtrack.com)	Free, iOS Free, Android Private profiles available with upgrade	• Record moods, medication, therapy • Daily reminder to record mood • View on phone or computer • All profiles are public, but username can be anonymous • Option to share profile with health care provider
Mood Tracker (www.moodtracker.com)	Browser-based tool	• Track moods and medication • Medication reminder alerts • Audio relaxation and stress relief meditations • Share profile with health care provider
MyMoodTracker (aspyreapps.com/project/my-mood-tracker)	$4.99, iOS only	• Track moods with emojis and notes • Create daily, weekly, monthly, or yearly charts • Export history to email for health care provider • PIN code access to app for extra security
Optimism (www.findingoptimism.com)	Browser-based tool Free, iOS Free, Windows PC	• Record mood, sleep, and many other variables • Pay feature allowing clinicians access to track patient status
T2 Mood Tracker (t2health.dcoe.mil/apps/t2-mood-tracker)	Free, iOS Free, Android	• Monitors anxiety, stress, depression, brain injury, post-traumatic stress, general well-being • Reminders to update moods • Generates PDF or spreadsheet reports that can be emailed to health care providers
Wellness Tracker[2] (www.dbsalliance.org/wellness_tracker)	Free, iOS Free, Android	• Developed by Depression and Bipolar Support Alliance • Record mood, sleep, medication, symptoms, exercise, medication, overall health and more • At-a-glance summary of trends • Download PDF reports over custom period of time

[1]Some of these apps are also accessible on the web, with the option to print for clients who prefer using paper scales. [2]See Dr. Strawkoski's expert Q&A interview.

ICD-10: What You Need to Know

Daniel Carlat, MD, Publisher, The Carlat Psychiatry Report

On October 1, 2015, you had to start using ICD-10 codes for reporting diagnoses in order to get paid by insurance companies. But what does ICD-10 mean? And how does it relate to DSM-5?

ICD-10 stands for "International Classification of Diseases, 10th edition." First published in 1900, ICD is a list of diseases in all medical specialties. It has been maintained by the World Health Organization (WHO) for decades, and its purpose is to help all countries agree on how to classify the many ailments that strike our human frames. This system allows nations to speak the same medical language in keeping track of disease prevalence in different parts of the world—knowledge that can be very helpful in puzzling out the causes of diseases.

How are ICD and DSM related? ICD is primarily a list of diseases, and it is not limited to mental health. ICD-10 contains 22 chapters and 68,000 disease codes. One of those chapters, Chapter 5, focuses on mental health. DSM, on the other hand, is a creation of the American Psychiatric Association. It focuses exclusively on mental health and is more than a list of codes—it is also a textbook describing the criteria used to diagnose psychiatric disorders.

Until October 1, we were using DSM codes on our claims to insurance companies. Or so we thought. One surprising piece of news is that those DSM codes were, in actuality, identical to ICD-9 codes. We have been using ICD-9 codes since the publication of DSM-III in 1980.

Just as DSM undergoes periodic updates, so does ICD. ICD-9 was the world's medical bible from 1978 to 1994, which was when WHO updated ICD-9 to ICD-10. Most European countries adopted the new standard by 2000, but the U.S. health care system was very late to this party. Why? Primarily because ICD-10 is much more complex than its predecessors. ICD-9 included 13,000 disease codes, whereas ICD-10 mushroomed to 68,000 codes. The good news about having all these extra codes is that it allows you to diagnose a condition with greater precision and specificity. The bad news is that the amount of detail can be excruciating. For example, ICD-10 has numerous codes to diagnose injuries sustained by contact with animals, such as getting bitten by pigs or being struck by macaws. That in itself sounds reasonable, as different animals can cause different types of injuries. It's the drilling down from there that seems excessive. There are 9 different codes for injuries sustained through human-turkey contact: "struck by turkey, initial encounter," "struck by turkey, subsequent encounter," "struck by turkey, sequela;" then there's "pecked by turkey, initial encounter…." You get the idea.

After many years of resistance, in 2009, the U.S. Department of Health and Human Services ordered that we had to switch to ICD-10 by 2013. However, the code set's adoption was delayed to 2014, then delayed once more to October 1, 2015.

How does ICD-10 affect you?

The ICD-10 switch is, frankly, a non-issue for most psychiatrists. True, we have to say farewell to those trusty old friends engraved in our memory like 296.32 (major depression, recurrent, moderate) and 300.02 (generalized anxiety disorder)—which have been replaced with, respectively, F32.1 and F41.1.

But the DSM-5 makes life easy by listing both the old ICD-9 codes for each disorder, as well as the new ICD-10 codes. If you don't want to open up your DSM-5 every time you need to look up a code, you can take advantage of many free online resources.

An online converter allows you to type in the ICD-9 code, press enter, and obtain the corresponding ICD-10 code (http://www.icd10data.com/convert). A more interesting option is found on Dr. Bob's Virtual En-psych- lopedia (http://www.dr-bob.org/tips/dsm5n10.html), whose tables allow you to search alphabetically for disorders and find out how to convert them from ICD-9 to ICD-10. In that same vein, we've included a brief table below, "ICD-9 to ICD-10 Conversions for Common Diagnoses," that lists some of the more common psychiatric disorders. If you're using an electronic health record, chances are that the computer software is doing all this automatically for you via drop-down menus.

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ICD-9 to ICD-10 Conversions for Common Diagnoses

Diagnosis	ICD-9	ICD-10
Alcohol use disorder (moderate)	305.90	F10.20
Anorexia nervosa (restricting type)	307.1	F50.01
Anxiety disorder (unspecified)	300.00	F41.9
Attention-deficit hyperactivity disorder, combined type	314.01	F90.2
Bipolar I disorder, depressed episode	296.52	F31.32
Bipolar I disorder, manic episode	296.42	F31.12
Borderline personality disorder	301.83	F60.3
Bulimia nervosa	307.51	F50.2
Delirium (due to general medical condition)	293.0	F05
Major neurocognitive disorder due to Alzheimer's disease	294.10	F02.80
Persistent depressive disorder (dysthymia)	300.4	F341
Generalized anxiety disorder	300.02	F41.1
Major depression, single episode, moderate	296.22	F32.1
Major depression, recurrent, moderate	296.32	F33.1
Obsessive-compulsive disorder	300.3	F42
Panic disorder	300.01	F41.0
Personality disorder, unspecified	301.9	F60.9
Posttraumatic stress disorder	309.81	F43.10
Schizoaffective disorder, bipolar	295.70	F25.0
Schizoaffective disorder, depressive	295.70	F25.1
Schizophrenia	295.90	F60.1
Social anxiety disorder	300.23	F40.10

CME Post-Test

This CME post-test is intended for participants seeking AMA PRA Category 1 Credit™. For those seeking ABPN self-assessment (MOC) credit, a 13 question pre- and post-test must be taken online. For all others, to earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by January 31, 2017. As a subscriber to *TCPR,* you already have a username and password to log on www.TheCarlatReport.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning objectives are listed on page 1.

1. Which antipsychotic medication is most commonly co-prescribed with other antipsychotics to treat insomnia, agitation, and anxiety? (Learning Objective #2)
   [ ] a. Risperidone [ ] b. Quetiapine [ ] c. Haloperidol [ ] d. Lurasidone

2. The Depression and Bipolar Support Alliance developed which of the following mood charting online tools? (LO #1)
   [ ] a. Wellness Tracker [ ] b. MyMoodTracker [ ] c. Optimism [ ] d. Moodtrack Diary

3. ICD-10 offers how many codes to classify the different varieties of bipolar 1 disorder? (LO #3)
   [ ] a. 13 [ ] b. 19 [ ] c. 22 [ ] d. 27

4. Which antipsychotic medication is most commonly co-prescribed with clozapine for treatment of refractory schizophrenia? (LO #2)
   [ ] a. Aripiprazole [ ] b. Ziprasidone [ ] c. Olanzapine [ ] d. Risperidone

5. Which of the following self-management strategies used by patients has not been proven effective to help manage their bipolar condition? (LO #1)
   [ ] a. Maintaining a regular sleep pattern [ ] b. Keeping an alcohol intake diary
   [ ] c. Starting a regular exercise program [ ] d. Maintaining a regular activity schedule

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Expert Interview

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chart if that patient is generally doing well. Then I'll have time to do a little bit of cognitive therapy. If we're focused on cognitive behavioral interventions, I can bill for both the E/M code and the therapy code.

TCPR: Can you share any types of cognitive behavioral interventions that you find particularly effective?

Dr. Strakowski: Sure. I create these 3- to 4-column charts where we look at specific upsetting events: the mood, the feeling response, the thought response. And then we do thought restructuring. With my really anxious patients, I do a lot of threat assessing. I teach them that when they're anxious, it means their brain thinks they are in danger, and so we try to get them to acknowledge this overreaction to a perceived threat. We try to diminish how important a specific threat is and how to evaluate this to work through anxious moments.

TCPR: We have a lot of tools in our medication arsenal to treat different symptoms, and so I think there is a tendency to treat symptoms as they pop up. We can end up piling one medication on top of another, and then we have a patient subsequently on multiple meds. Any suggestions for preventing this?

Dr. Strakowski: Well, I often say that if you look at the psychiatric medication evidence base, there are a few studies with combinations of two medicines, and few if any studies with three. This isn't like cancer care where there have been carefully developed regimens that have been tested in large groups over time. We don't have that data, and so the instant you go from two or three multidrug medications, you're off the evidence base. My general rule is no more than three medications. To your point earlier, when I was training, one of my supervisors used to say, "You identify the symptoms, then you treat each one." I disagree with that; you identify the diagnosis because trials are usually based on diagnoses, not symptoms. You use what we know is effective in a diagnostic group, realizing that if your treatment is failing, your diagnosis may be wrong. And if you do that, then there's less of a tendency to chase symptoms with lots of drugs.

TCPR: In my own practice, I think back to the last few patients where I've had a lot of meds, and usually one is an antidepressant. There is always that fear: "Well, if I do discontinue the antidepressant—you know, they seem to be stable now—what's going to happen?"

Dr. Strakowski: Right. So you work collaboratively with that in your mood charting. You say, "Look we're going to keep an eye on this. I take it seriously." And if it turns out that going off that med does cause symptoms to recur, you hit it right away. And it's not likely that suddenly they'll lose treatment response. I do this all the time with my patients. I say, "Okay, we've just learned you need this. Let's look at something else."

TCPR: Thank you for your time, Dr. Strakowski.

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This Month's Focus:
Bipolar Disorder

Next month in *The Carlat Psychiatry Report:* Private Practice

ICD-10: What You Need to Know

Continued from page 6

ICD-10's time saving secret

At first blush, converting ICD-9 codes to ICD-10 disorders appears to require more precision than we're used to. For example, ICD-9 allowed you to use a single code for anorexia nervosa (307.51), whereas ICD-10 forces you to specify whether the anorexia is the restricting type (F50.01) or the binge-eating purging type (F50.02). Luckily, those in the know have discovered a hidden section of the codebook allowing you to use "unspecified" for all manner of diagnoses, such as anorexia nervosa, unspecified (F50.00). In fact, there are "unspecified" codes for all the major disorders, such as bipolar disorder, major depression, substance use disorders, and so on. This makes our jobs easier—for example, ICD-10 offers a mind-numbing menu of 22 separate codes for different varieties of bipolar I disorder, depending on whether the most recent episode was depressed, manic, or hypomanic; whether it was mild, moderate, or severe; and with or without psychotic features. You can spend a good chunk of your day choosing the "right" one, or you can go with F31.9: "Bipolar I disorder, unspecified."

Meanwhile—sorry to alarm you—ICD-11 will be published in 2018. Not to worry, since if history is any indication, the U.S. will take a decade or two to adopt it, giving you plenty of time to get cozy with ICD-10.

(I'd like to gratefully acknowledge Dr. Bruce Black for helping me understand the basics of ICD.)

(For a good primer on ICD-10, go to the APA website at: http://www.psychiatry.org/psychiatrists/practice/dsm/icd-10)