

Cambridge University Press & Assessment

978-0-521-18208-9 — Case Studies: Stahl's Essential Psychopharmacology

Stephen M. Stahl, Edited by Debbi A. Morrisette, Illustrated by Nancy Muntner
Frontmatter

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Stahl's Essential Psychopharmacology

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Every effort has been made in preparing this book to provide accurate and up-to-date
information which is in accord with accepted standards and practice at the time of
publication. Although case histories are drawn from actual cases, every effort has been
made to disguise the identities of the individuals involved. Nevertheless, the authors,
editors and publishers can make no warranties that the information contained herein
is totally free from error, not least because clinical standards are constantly changing
through research and regulation. The authors, editors and publishers therefore
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material contained in this book. Readers are strongly advised to pay careful attention
to information provided by the manufacturer of any drugs or equipment that they plan
to use.

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 = designates a "Lighting Round," a short case without a tutorial

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Introduction

Joining the *Essential Psychopharmacology* series here is a new idea – namely, a case book. *Essential Psychopharmacology* started in 1996 as a textbook (currently in its third edition) on *how psychotropic drugs work*. It then expanded to a companion *Prescriber's Guide* in 2005 (currently in its fourth edition) on *how to prescribe psychotropic drugs*. In 2008, a website was added (stahlonline.org) with both of these books available online in combination with several more, including an *Illustrated* series of several books covering specialty topics in psychopharmacology. Now comes a *Case Book*, showing *how to apply the concepts* presented in these previous books to *real patients in a clinical practice setting*.

Why a case book? For practitioners, it is necessary to know the science of psychopharmacology – namely, both the mechanism of action of psychotropic drugs and the evidence-based data on how to prescribe them – but this is not sufficient to become a master clinician. Many patients are beyond the data and are excluded from randomized controlled trials. Thus, a true clinical expert also needs to develop the art of psychopharmacology: namely, how to listen, educate, destigmatize, mix psychotherapy with medications and use intuition to select and combine medications. The art of psychopharmacology is especially important when confronting the frequent situations where there is no evidence on which to base a clinical decision.

What do you do when there is no evidence? The short answer is to combine the science with the art of psychopharmacology. The best way to learn this is probably by seeing individual patients. Here I hope you will join me and peer over my shoulder to observe 40 complex cases from my own clinical practice. Each case is anonymized in identifying details, but incorporates real case outcomes that are not fictionalized. Sometimes more than one case is combined into a single case. Hopefully, you will recognize many of these patients as the same as those you have seen in your own practice (although they will not be the exact same patient, as the identifying historical details are changed here to comply with disclosure standards and many patients can look very much like many other patients you know, which is why you may find this teaching approach effective for your clinical practice).

I have presented cases from my clinical practice for many years online (e.g., in the master psychopharmacology program of the Neuroscience Education Institute (NEI) at neiglobal.com) and in live courses (especially at the annual NEI Psychopharmacology Congress). Over the years, I have been fortunate to have many young psychiatrists from my university and indeed from all over

Introduction

the world, sit in on my practice to observe these cases, and now I attempt to bring this information to you in the form of a case book.

The cases are presented in a novel written format in order to follow consultations over time, with different categories of information designated by different background colors and explanatory icons. For those of you familiar with *Essential Psychopharmacology: The Prescribers Guide*, this layout will look quite familiar. Included in the case book, however, are many unique sections as well; for example, presenting what was on the author's mind at various points during the management of the case, and also questions along the way for you to ask yourself in order to develop an action plan. Also, these cases incorporate ideas from the recent changes in maintenance of certification standards by the American Board of Psychiatry and Neurology for those of you interested in recertification in psychiatry. Thus, there is a section on Performance in Practice (called here "confessions of a psychopharmacologist"). This is a short section at the end of every case, looking back and seeing what could have been done better in retrospect. Another section of most cases is a short psychopharmacology lesson or tutorial, called the "Two Minute Tute," with background information, tables and figures from literature relevant to the case on hand. Shorter cases of only a few pages do not contain the Tutes, but get directly to the point, and are called "Lightning Rounds." Drugs are listed by their generic name, and often have a brand name mentioned the first time they appear in a case. A generic and brand name index is included at the back of the book for your convenience. Lists of icons and abbreviations are provided in the front of the book.

The case-based approach is how this book attempts to complement "evidence based prescribing" from other books in the *Essential Psychopharmacology* series, plus the literature, with "prescribing based evidence" derived from empiric experience. It is certainly important to know the data from randomized controlled trials, but after knowing all this information, case based clinical experience supplements that data. The old saying that applies here is that wisdom is what you learn AFTER you know it all. And so, too, for studying cases after seeing the data.

A note of caution. I am not so naive as to think that there are not potential pitfalls to the centuries-old tradition of case-based teaching. Thus, I think it is a good idea to point some of them out here in order to try to avoid these traps.

Do not ignore the "law of small numbers" by basing broad predictions on narrow samples or even a single case.

Do not ignore the fact that if something is easy to recall, particularly when associated with a significant emotional event, we tend to think it happens more often than it does.

Do not forget the recency effect, namely, the tendency to think that something that has just been observed happens more often than it does.

According to editorialists (1), when moving away from evidence-based medicine to case-based medicine it is also important to avoid:

- Eloquence- or elegance-based medicine
- Vehemence-based medicine
- Providence-based medicine
- Diffidence-based medicine
- Nervousness-based medicine
- Confidence-based medicine

I have been counseled by colleagues and trainees that perhaps the most important pitfall for me to try to avoid in this book is “eminence-based medicine,” and to remember specifically that:

- Radiance of gray hair is not proportional to an understanding of the facts
- Eloquence, smoothness of the tongue and sartorial elegance cannot change reality
- Qualifications and past accomplishments do not signify a privileged access to the truth
- Experts almost always have conflicts of interest
- Clinical acumen is not measured in frequent flier miles

So, it is with all humility as a practicing psychiatrist that I invite you to walk a mile in my shoes, experience the fascination, the disappointments, the thrills and the learnings that result from observing cases in the real world.

Stephen M. Stahl, M.D, Ph.D.

(1) Isacacs D and Fitzgerald D, Seven alternatives to evidence based medicine, British Medical Journal 1999, 319:7225

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In memory of Daniel X. Freedman, mentor, colleague, and scientific father.

*To all the courageous patients and their families that have been part of my
practice of psychiatry over the years*






To Cindy, my wife, best friend, and tireless supporter.

*To Jennifer and Victoria, my daughters, for their patience and understanding of
the demands of authorship.*

List of Icons

	Pre and Posttest Assessment Question
	Lightning Round
	Patient Intake
	Psychiatric History
	Social and Personal History
	Medical History
	Family History
	Medication History
	Current Medications

List of Icons

	Psychotherapy History
	Mechanism of Action Moment
	Attending Physician's Mental Notes
	Further Investigation
	Case Outcome
	Case Debrief
	Take-Home Points
	Performance in Practice: Confessions of a Psychopharmacologist
	Tips and Pearls
	Two-Minute Tute

Abbreviations used in this book

ACE	angiotensin converting enzyme	MSLT	multiple sleep latency test
ADHD	attention deficit hyperactivity disorder	MTHFR	methylene tetrahydrofolate reductase
BMI	body mass index	NE	norepinephrine
BP	blood pressure	NIMH	National Institute of Mental Health
BUN	blood urea nitrogen	NMDA	N-methyl-d-aspartate
CBT	cognitive behavioral therapy	NOS	not otherwise specified
CD	conduct disorder	NRI	norepinephrine reuptake inhibition
COMT	catechol O methyl transferase	OCD	obsessive compulsive disorder
CSF	cerebrospinal fluid	ODD	oppositional defiant disorder
CT	computerized tomography	PFC	prefrontal cortex
DA	dopamine	PET	positron emission tomography
DBS	deep brain stimulation	prn	as needed (Latin)
DKA	diabetic ketoacidosis	PSG	polysomnogram
DLPFC	dorsolateral prefrontal cortex	PTSD	post traumatic stress disorder
ECT	electroconvulsive therapy	qhs	at bedtime (Latin)
EEG	electroencephalogram	REM	rapid eye movements
EMDR	eye movement desensitization and reprocessing	RLS	restless legs syndrome
EPS	extrapyramidal symptoms	SAMe	S-adenosyl-methionine
ESS	Epworth sleepiness scale	SERT	serotonin transporter
fMRI	functional magnetic resonance imaging	SNRI	serotonin norepinephrine reuptake inhibitor
GAD	generalized anxiety disorder	SOREMP	sleep onset rapid eye movement periods
HHS	hyperglycemic hyperosmolar syndrome	SSRI	serotonin selective reuptake inhibitor
HMO	health maintenance organization	TBI	traumatic brain injury
ICU	intensive care unit	TCA	tricyclic antidepressant
IM	intramuscular	TMS	transcranial magnetic stimulation
MAOI	monoamine oxidase inhibitor	VNS	vagal nerve stimulation
MDD	major depression disorder		
MDE	major depressive episode		
MRI	magnetic resonance imaging		