CAGP 2009 ANNUAL SCIENTIFIC MEETING: A SUMMARY

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This year the CAGP parted from the usual pairing with the Canadian Psychiatric Association Meeting in order to take full advantage of the International Psychogeriatric Association (IPA) Congress in Montreal, Quebec from September 1-5. The IPA Congress theme of "Path to Prevention" was supplemented by the CAGP Conference theme of "Treating the Untreatable: Refractory Mental Disorders in Late Life" on August 31.

A combination of keynote presentations, symposia and smaller-group workshops enhanced opportunities to learn strategies for treating older patients with difficult-to treat mental illness. Keynote presentations included: Treatment resistance in late life depression and anxiety (Dr. Charles Reynolds III), Treatment Refractory Behavioral disturbances in dementia (Dr. Clive Ballard), and Behavioral dysfunction in Parkinson's disease (Dr. Colin Powell). Workshops were presented twice concurrently on the topics of Motor aspects of Parkinson's Disease (Dr. Colin Powell), ECT (Dr. Charles Kellner) and in a submitted workshop, Psychosis (Dr. Zahinoor Ismail). 11 poster presentations were reviewed, and 9 were accepted.

This year, an arrangement was made with the CGS in which a speaker from CGS will come to present at our meeting annually and vice versa, with mutual financial support.

Dr. Charles Reynolds III is the UPMC Endowed Professor in Geriatric Psychiatry at the University Of Pittsburgh School Of Medicine. Dr. Reynolds began the day with a discussion of strategies for managing partial response in late-life depression. He outlined the morbidity of late-life depression including a reduced survival. He described the PROSPECT study in which more than 500 patients were randomized to either citalopram and "depression care management" or "usual care", and beyond 8 months, the intervention group had higher response rates. He demonstrated empirical evidence of examples of clinical factors associated with slower time to response, including comorbid anxiety, medical comorbidities, and higher rates of suicidality. He discussed a small open label trial of Aripiprazole, a newer antipsychotic for augmentation for older adults who did not respond to open-label antidepressant treatment, and indicated a faster time to remission. He also discussed a study of adjunctive interpersonal therapy or "depression care management" for those who showed an incomplete initial response to antidepressants – in that study, still under review, they found a remission rate of approximately 50%. Finally, on the basis of a study by Mulsant et al in 2006, he recommended that if there is no response to antidepressants at 4 weeks, it may not be helpful to increase the dose, but if there is a partial response, a dose increase may be helpful. Dr. Reynolds summarized that most 2nd line treatments are associated with a 50% response rate, and advised that if patients are not responding well to the first treatment, that consideration should be given to switch the antidepressant, add a specific psychotherapy, increase the dose of treatment, or augment with a second agent. Despite the difficulties with this population, he emphasized the importance of aiming for remission of symptoms to reduce suffering and caregiver burden.

Dr. Clive Ballard is the Director of Research for the Alzheimer's Society, and Professor of Age-Related Diseases at King's College London's Institute of Psychiatry. He began his session by explaining that 80% of patients in long-term care settings with dementia have at least one neuropsychiatric symptom. Throughout his talk, he emphasized the lack of literature on the treatment of BPSD in non-Alzheimer's

dementias. He emphasized the detriment of antipsychotics on cognition in dementia. He discussed the randomized discontinuation studies of antipsychotics in dementia showing no differences in the psychiatric symptoms, but a lessening in social withdrawal and an increased quality of life. He demonstrated evidence of non-pharmacological ways of improving BPSD, including a recent study of aromatherapy. He advised only using antipsychotics in the short term for this population, and highlighted some limited evidence for other pharmacological treatments including memantine, carbamazepine, citalopram, rivastigmine and donepezil. From a clinical perspective, he highlighted the importance of a "thick skin" – saying no to medication if would not be beneficial overall. He relegates antipsychotics as third line if behavioural or other measures are ineffective.

Dr. Colin Powell is Professor of Medicine at University of Calgary. He gave two sessions –a workshop on managing refractory motor disturbances in Parkinson's disease (PD), and a plenary session on managing refractory behavioural disturbances in PD. He reviewed the etiology and differential diagnosis of PD, as well as associated clinical features. He emphasized the lack of recognition of depression among patients in PD, and advised thinking of depression in patients complaining of deterioration when objective evidence for deterioration is lacking, as well as keeping an eye open for depression among the caregivers. He discussed an approach to differentiating the causes of cognitive impairment among patients with Parkinsonism, and emphasized the importance of executive dysfunction. He discussed the psychological themes of "trapped in the body" and "just a little more time", along with the therapeutic challenges that the disease itself is treatable but not curable, and the iatrogenic problems associated with the treatment. He highlighted the different clinical trajectory that PD has compared with other chronic diseases, and the impact of the uncertainties on patients: Uncertain prognosis, exacerbation, precipitants, and ending.

Dr. Charles Kellner is Professor of Psychiatry at the Mt Sinai School of Medicine. He gave a practical workshop on Electroconvulsive therapy (ECT). He first reviewed the indications for ECT, and discussed the evolution of literature on ECT response rates, with more recent rates being in the range of 64-74%. He showed data from 2 research groups indicating higher responses among older adults. He reviewed the workup for this procedure, and discussed the use of ECT among medically frail older adults, with the relative contraindications of acute MI, unstable angina, recent hemorrhagic stroke, and aneurysm, as well as strategies for managing other chornic diseases like pulmonary disease and diabetes. Finally, he reviewed the cognitive effects of ECT, including the variability of retrograde amnesia, with advice to consider spacing out treatments, change placement or stimulus dosing, re-evaluate cognition, and ultimately stop ECT if cognitive effects are severe. He concluded by discussing the dynamic assessment of capacity to consent to the treatment.

François Rousseau, M.D., M.S.c., FRCPC is Head of the Department of Geriatric Psychiatry at the Quebec City Mental Health University Institute. As well he holds an appointment as Associate Clinical Professor at Laval University's Department of Psychiatry.

Jean-François Côté, M.D., is a Fellow in Geriatric Psychiatry working at the Quebec City Mental Health University Institute. He completed his training in psychiatry at Laval University in 2009.

François Rousseau and Jean-François Côté gave a practical workshop on Detection and treatment of depression and psychosis in Dementia. Depression and psychosis are highly prevalent during the course of dementia, but they are often overseen or wrongly considered as irreversible manifestations of this disorder. Their detection and diagnosis are complicated by their atypical clinical presentation compared to conventional psychiatric syndromes. Depression may present with less typical symptoms, irritability or anxiety instead of sadness, somatic complaints and decreased reactivity to social cues. The various clinical presentations and differential diagnoses for depression in dementia were reviewed in order to enhance recognition of this markedly under diagnosed and disabling disorder. Appropriate assessment tools such as the Cornell Scale for Depression in Dementia and proposed modified depression diagnostic criteria for subjects with Alzheimer's disease (NIMH) were discussed. Preliminary results from a Quebec City Nursing Home study were presented. We observed in a sample of 116 demented nursing home patients a prevalence of depression of 14,7% (CI: 8,7-20,7%) and the detection rate of this condition by

the clinical team was 41,2% (CI: 17,8-64,6%). A summary of the literature on the clinical presentation and course of psychosis of dementia was also presented. The atypical clinical picture of this type of psychosis and the confounding impact of associated cognitive impairment increase the challenge of detection and diagnosis of this condition. It is also sometimes difficult, especially in severe dementia, to clarify if the psychotic symptoms are related to delirium. Many epidemiological studies have identified risk factors for psychosis of dementia, severe cognitive impairment and older age being the most important. Some risk factors can be targeted to enhance detection of this condition. Proposed diagnostic criteria for psychosis of Alzheimer's disease were presented (Jeste and Finkel, 2000). Assessments scales such as the BEHAVE-AD and the NPI were discussed as potential tools to improve recognition of this disorder. A summary of the evidence-based non-pharmacological and pharmacological treatments of depression and psychosis of dementia were reviewed. New generation antidepressants and atypical antipsychotics are first choice agents. Limited therapeutic effects of antipsychotic medication for psychosis and associated potential serious adverse events were debated. Potential efficacy of cholinesterase inhibitors and memantine were discussed.