CAGP Newsletter

Canadian Academy of Geriatric Psychiatry

Summer 1998
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From the Editor

I hope to find you all well after a long and energizing summer. This fall again begins with the Annual Scientific Meeting of the Academy of Geriatric Psychiatry, hopefully not too disrupted by the Air Canada strike. Unfortunately I will not be there due to commitments with the IPA in Munich, so I look forward to reading the summaries of the meeting in subsequent newsletters.

Many changes have occurred in the years since I have been editor of this newsletter. Our academy has grown considerably and our newspaper has evolved to a more structured newsletter with specific columns in each issue. Articles have been reproduced by other newsletters in the world and we have sent it to a number of our sister organizations.

Many of the other CAGP activities such as our fellowship program and our visiting professorship program have helped support Canadian geriatric psychiatrists and fellows from across the country. Our nursing home initiative right now is very active and is led by Dr. Ivan Silver. Long-term care is one of our key areas of development in geriatric psychiatry due to the increase in the elderly in society, so this area is felt by our executive to be an important area of resource allocation.

The biggest task the CAGP has had to this point is the production of the International Psychogeriatric Association Congress in Vancouver 1999. This congress is sponsored by the Canadian Academy of Geriatric Psychiatry with the University of British Columbia. Helping also is the Quebec Psychogeriatric Association, which has developed French language programming on two of the days. The IPA Congress presents a huge undertaking that will test us as an organization. Many of us are involved in the process from all areas of the country. Due to its demands on me as chair of the Organizing Committee, I am stepping down as editor, but will continue to support the new editor in whatever way I can.

Overall as I reflect on the years I have been involved in with the Academy, I have seen very active and vital growth, lots of initiative and ideas, and many positive working relationships between different professionals from across Canada. Our organization has also had growing pains, but it has managed to make its way through most of them, and has become stronger for it. Mostly though, I have appreciated the friendships I have been able to develop with all of you across the country, and I feel privileged to have been able to serve you as the editor of this newsletter. I hope you will join me in supporting our new editor in continuing and improving this publication..

My warmest regards,

Lilian Thorpe, M.D., F.R.C.P.
Chair, Publication and Communication Committee
Canadian Academy of Geriatric Psychiatry
http://www.psychiatry.ubc.ca/geriat/CAGP/cagp.htm

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President's Column

Dear Colleague:

In my last President's Column, I had signaled a change of leadership which will occur at our September 1998 Annual Meeting. Here we will officially elect a new President and Vice President to lead our organization into the next century. The work of many in our organization has provided a good beginning and a firm foundation for continued advocacy and development of geriatric psychiatry in Canada.

Our membership is now over 200. We have established an Annual Scientific Meeting, we continue to promote the field of subspeciality, and the journey to accreditation without certification is now proceeding again through the decision-making processes of The Royal College of Physicians and Surgeons of Canada.

Over the past four years as your President, I have been pleased to see the successful fruition of efforts by members to have the IPA Congress in Canada in 1999, and the continuation of the successful Visiting Professorship. I have been most pleased and encouraged by our Fellowship Program which has provided a mechanism for recruitment, and ensuring the future of Canadian geriatric psychiatry.

I would like to take this opportunity to thank the other office holders, the Board, and chairpersons of various committees as well as the membership for your support through the last four years.

I look forward to meeting with many of you in Halifax. Indeed, the Halifax experience will provide our membership with a day (prior to our Academy meeting) focusing entirely on nursing home psychiatry. This initiative is certainly in concert with a major thrust of the Academy at this point in time in terms of the Long Term Care Educational Initiative being implemented under the guidance of Dr. Ivan Silver. The Academy's day in Halifax looks as if it will provide us with an excellent opportunity to discuss issues of relevance to geriatric psychiatry and be exposed to new ideas and concepts through an array of excellent speakers. In addition, in conjunction with the CPA, a joint CE day in Halifax is being planned and we will have an opportunity to meet to further advance the long term care educational initiative.

Again, I would like to thank the organization for their support over the last four years and look forward to the continuing development of this important organization dedicated to improving the well-being, self-determination, and quality of life of older citizens in Canada with significant mental illness and their families.

Yours sincerely,

Yours sincerely,

J.K. Le Clair, MD, FRCP(C)

President
Canadian Academy of Geriatric Psychiatry

CPA Column

Due to the additional day dedicated to nursing home psychiatry on the day before the CAGP Annual Scientific Meeting , not enough members will be available to attend the CPA section meeting in Halifax. Any questions regarding the section may be directed before or after the CPA to myself.

At the CPA this year will be a symposium on delirium, jointly held with the Section of Consultation -Liaison Psychiatry. Drs. Elie, Rousseau and Keller will be participating from our academy.

Lilian Thorpe, M.D., F.R.C.P.
Chair, Section on Geriatric Psychiatry, CPA

Membership

No new members have been approved since the last newsletter.

Isabel Martins, M.D., F.R.C.P.
Board member, CAGP (portfolio for membership)
St John's, Newfoundland

IPA Column

The IPA held this year's regional meeting in exotic Istanbul, Turkey, on the shores of the sea of Marmara. I had the great pleasure of attending this meeting along with other Canadians including Bernard Groulx, board member of the CAGP, who presented on clinical geriatric psychiatry issues as part of a panel discussion. The meeting was also marked by the public lecture that preceded the opening scientific program and that was attended by over a hundred members of the local community. The questions posed to the Israeli/American presenters were often very personal and poignant, reflecting the strong desire of both elders and their caregivers for guidance and reliable information. The session highlighted for me the responsibility we have to ensure that we remain open and responsive to the patients and communities we serve, creating appropriate forums for them to interact with us. The IPA has adopted a policy of including such public meetings in its programs and the congress in Vancouver will feature a WHO (World Health Organization) sponsored speaker for a lay audience lecture to open the meeting.

The great advantage of participating in IPA activities was especially evident to me at this meeting. Turkey, not unlike last year's congress venue, Israel, is a country rooted in antiquity and legend. It is one of the cradles of civilization where the ghosts of mythology walk- Paris and Aphrodite, Helen of Troy, the Multibreasted Artemus. In Istanbul we dodged persistent touts and hawkers to see the magnificent blue mosque, the Topkapi palace named after the famous movie with Peter Ustinov (or was it the other way round), the Dolmabahce palace on the shores of the legendary Bosphorous (where the congress dinner was held), the Ayasofya, the underground cistern and innumerable other smaller wonders. I also got a sense of some of the more difficult political and religious issues that affect medical and scientific life in a country that spans both Europe and Asia. For example, it is not always comfortable to speak out candidly on touchy political issues. At one of the medical schools there was a conflict between female student traditionalists and the administration. The school had barred these students from taking their exams because they insisted on wearing traditional head coverings.

I did not mean to turn this report into a travelog, but I have to admit that sometimes the environment of a meeting is more compelling than findings on the triggering effect of inflammation in Alzheimer's disease or the latest on international epidemiological findings on suicide in the elderly.

Joel Sadavoy, M.D. , F.R.C.P.
Chair, IPA Congress 1999

Researchers from around the world are invited to submit original, unpublished work for the 1999 IPA/Bayer research awards in psychogeriatrics. The awards, presented biannually, are given to encourage and reward important research around the world. They have been sponsored since their inception in 1989 by Bayer and the International Psychogeriatric Association. These prestigious awards carry cash prizes. The winners will be invited to present their papers at a special symposium at the IPA's International Congress in Vancouver in August of 1999. They will also receive a commemorative medallion and a travel and expense stipend to attend the Congress. The papers also will be published in the IPA quarterly journal, *International Psychogeriatrics*.

Entries must be written in English. The deadline for submission of papers is December 1, 1998. Awards will be announced on June 1, 1999. To obtain complete instructions for submitting a paper, interested researchers should contact the IPA, 550 Frontage Road, Suite 2820, Northfield air, Illinois.

I would like to also remind our colleagues of the IPA99 upcoming submission deadlines for symposia or workshops (Dec 1, 1998) and papers/posters (April 1, 1999). Dr. Nathan Herrmann is head of the scientific program, and all submissions will be channeled through him. We are encouraging collaboration between people from diverse backgrounds, reflecting our emphasis on cultural diversity. If you share an interest with a colleague from another country, why not consider phoning or emailing them, and suggesting a joint workshop or symposium? The most current list of already organized symposia and workshops is maintained by Nathan, and I can also forward this information.

Lilian Thorpe M.D., F.R.C.P.
Chair, Organizing Committee
IPA Congress 1999

Ethics Column

In the course of a recent discussion with a colleague regarding a clinical case, I was given pause for thought when I mentioned that the

patient, whom I had been seeing in psychotherapy for several years, had a recurrence of agoraphobia and, as such, had been unable to visit my office for over six months. My colleague's immediate and surprisingly firm advice was to refuse to treat the patient further until such time that she could resume her office visits. My colleague felt strongly that, by maintaining treatment through telephone contact for such an extended period, I was perpetuating the agoraphobia and, as well, placing myself on "thin ice" by continuing to prescribe medications without having seen the patient for some months.

I must say I was intrigued as it had actually not occurred to me to refuse or suspend treatment of the patient. Now, because the bulk of my clinical practice involves geriatric inpatients, such a scenario was not a common one. I have, however, subsequently wondered how clinicians who work with larger numbers of outpatients manage this type of situation, particularly when the disruption in therapy is a "permanent" one. This issue is undoubtedly highly relevant to geriatric psychiatrists as we are more likely to have patients under our care who may, at some point in therapy, become incapable of continuing their outpatient visits due either to their "psychiatric" or physical limitations. While the obvious option of transfer of care to a community resource may be appropriate in some cases, there will be others, wherein such a management plan proves either unavailable or far too simplistic, unsatisfactory or potentially disruptive. Hence, the ethical dilemma: for patients with whom the therapeutic relationship has been established and serves as an important sustaining feature of therapy, is it ethically responsible to transfer or, indeed, discontinue their care solely on the basis of their ability to attend at outpatient clinics or our offices? If not, what options do we have?

To illustrate, the following is an overview of the case that precipitated my thinking on this issue: M.R. is a 68 year old divorced mother of two, referred to my geriatric outpatient practice several years ago for ongoing treatment of depression and anxiety disorder. Our initial treatment plan involved maximization of her antidepressant and weekly psychotherapy sessions focused on issues of abandonment, poor self-esteem with a need for perfectionism, as well as affect and anxiety regulation.

The only daughter of a socially and politically prominent couple, M.R. was a bright, attractive "show-piece" for her physically and emotionally frail mother and distant father. The patient's mother, frequently admitted to hospital for medical treatment, also had a history of repeated "suicide" attempts which she openly blamed on her daughter's "misbehavior." The patient's father, preoccupied with his political career, seemingly ignored his wife's verbal and physical mistreatment of his daughter, instructing M.R. only to "maintain appearances."

M.R. was married, at an early age, to a very successful executive and brought up a son and daughter in a highly privileged style. Despite an outwardly "perfect life," she struggled throughout much of her adult life with recurrent depression and anxiety. Shortly after their children married, M.R.'s husband left her for a younger woman, filed for bankruptcy and, as such, she was forced to find a job for the first time in her life. Shortly thereafter, M.R.'s daughter and family joined a religious cult and moved across the country, thereby creating a tremendous rift in their relationship.

In the course of her two year struggle to manage her intense anxiety at work, and despite ongoing pharmacological treatment in combination with psychotherapy, M.R. suffered a relapse of depressive and agoraphobic symptoms. Reports of frequent falls and the emergence of rather notable memory lapses led to an additional diagnosis of alcohol abuse.

M.R.'s reluctant acceptance of a visiting nurse allowed for monitoring of her medical status while a community occupational therapist encouraged the patient's involvement in a systematic desensitization programme. An addiction counselor with a local Drug and Alcohol Rehabilitation Programme provided telephone support with regard to her excessive drinking. I maintained my involvement through frequent psychotherapy sessions by telephone and did make one home visit before switching antidepressants.

In this case, the patient's agoraphobia disrupted her outpatient care, however, we are all familiar with the myriad of factors that can limit the elderly patient's ability to attend outpatient visits. In some cases, as in acute medical or psychiatric illness, the disruption may be transient, however, in others, the patient may never be capable of resuming their office visits. Certainly, transfer of M.R.'s care to a community outreach team would have been a "reasonable" approach to the situation. With time, she would undoubtedly have developed a relationship with the person or persons involved and benefited from more direct contact. The management decisions made, however, were based more on the "dynamics" of the case and my own interpretation of three of the basic principles of ethical decision-making; beneficence, non-maleficence and justice as they related to the patient.

Despite some discomfort with treatment over the telephone, I felt strongly that a refusal to continue psychotherapeutic work would be damaging to this patient who had been struggling, in therapy, with issues of abandonment for many years. At the same time, I did not feel that regularly scheduled home visits would be appropriate nor feasible. Despite the limiting features of such and the considerable time commitment involved, continued therapeutic contact via telephone seemed the most ethically-sound plan. It is to be expected that management decisions made under similar circumstances would be as diverse as the clinicians, patients and settings involved. Certainly, my ability to provide ongoing "telephone therapy" would have been limited had I more patients with similar needs. Management options would have been constrained further had I been treating the patient in a city or town with limited community resources. Thus, as I believe this case illustrates, the complexity of many such clinical scenarios may leave us questioning both our clinical and ethical responsibility as we attempt to balance our beliefs with the very real constraints of everyday practice.

I am left now with even more questions than when I began. Some of these questions are presented for your review with an invitation to submit your comments at: (pturcaj@front.net).

1. How clinically sound was it to continue treating this patient to
2.
3.

utcome have been had I refused to treat

4. her further or referred

5. What is going outpatients when they can no longer visit our offices?

6. What options will we have to appropriate community resources?

7. gly over burdened? If we do choose to maintain our involvement b

8. We are not currently compensated for telephone contact

9. Benefits in this regard? Are home visits as necessary as they used to be?

Education Column

UNDERGRADUATE EDUCATION:

Last year I was invited to participate in a project co-sponsored by the WHO (World Health Organization) and the Geriatric Section of the World Psychiatric Association. Our mission was to write a monograph on education issues in geriatric psychiatry that would outline the goals, teaching strategies and content of a curriculum for health professionals and the public. A small group wrote the monograph online and then we met in Lausanne, Switzerland, for three days in May 1998 for the final editing. Tom Airie from London, England chaired this group most effectively. The document will be translated into a number of languages. Its primary audience will be faculties of medicine in developing countries who have not yet addressed the educational needs of health professionals in geriatric psychiatry.

The group that gathered in Lausanne was an interesting one composed of died in the wool clinicians, educational pedagogists and representatives from a number of disciplines. Jean Wertheimer was the most gracious host. The experience taught me about the difference between what a group can accomplish online versus what a group can do in person. The quality of the document vastly improved when we were together face-to-face.

Dr. Jeff Lyness (University of Rochester) from the "AAGP" has formed an undergraduate education interest group that will report to the executive of the AAGP. The group will develop two initiatives:

1. The creation of specific learning objectives in geriatric psychiatry for the medical undergraduate school curriculum.
2. Develop specific recommendations to entice medical students into geriatric psychiatry training including traveling fellowships for electives and research projects.

For those of you who are interested in joining this group, please contact me.

CAGP FELLOWSHIP:
I am pleased to announce the winners of the 1998-1999 Fellowship in Geriatric Psychiatry:
Dr. Melissa Andrew, University of Toronto
Dr. Lisa McMurray, McGill University

We had four very able applicants this year and the decision of the adjudicators was very difficult. Honourable mentions to the other two applicants:
Dr. Zahinoor Ismail, University of Alberta
Dr. Pat Krawetz, University of Manitoba

Thanks also to the adjudicators Dr. Marie-France Rivard (University of Ottawa); Dr. Kiran Rabheru (University of Western Ontario); and Dr. Howard Strong (Memorial University).

RESEARCH IN EDUCATION AWARD:
The First Annual Research in Education Award will be announced at the CAGP meeting in Halifax on September 14.

CONTINUING EDUCATION:
Project Millennium
As discussed in previous newsletters, this project is intended to enhance the performance of health professionals in nursing homes to provide high quality geriatric psychiatry assessment in treatment in these facilities.

There will be a meeting on Saturday, September 12 , from 6:30 - 9:00 p.m. of the organizing committee and the regional captains of this project. The goal of this meeting will be to outline regional and national implementation strategies.

There will also be a special session on Sunday, September 13, at the Janssen sponsored Nursing Home Psychiatry Day that will engage CAGP members in further discussion of this project.

Looking forward to seeing everyone at the CAGP meeting.

Educationally yours,

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Informatics

Managing Information, managing time

You can never save time, only spend it. Those of us who forget this truism are apt to become disillusioned with the computer and with the information age. The promise of computers freeing up valuable time and doing our work for us has clearly never materialized. Most serious computer users I have spoken with find that they have less unoccupied time now than before computers entered their lives. Perhaps it is this that has contributed to the slow penetration of computer technology into medical practice.

I certainly spend plenty of time using (and occasionally fixing) my computer systems. Although I spend my time on the computers, they allow me to spend less time writing out and copying information that I would otherwise do by hand, or pay somebody else to do. Here's how:

I keep my daily schedule and my task list in an electronic form. My daytimer is now gone, for good.

Office workers have used electronic scheduling for some years now, but it was really only suited to those who spent most of their productive time at a fixed workstation. Physicians, because the greatest part of our work is "at the bedside," have generally been too mobile to benefit from this kind of schedule management. Multiple examination rooms, practice in hospital, clinic, office and elsewhere all meant that to be effective, the electronic schedule would need to be able to move with the doctor. Even the lightest notebook computers still weigh over 3 pounds—far too heavy to carry as a constant companion.

The first product to break through the barrier of information portability was the PalmPilot, now marketed by 3Com (http://www.3com.com/). This device can load a clone copy of the schedule information in your desktop system. The information is

readily accessible, and can be edited and then updated back into the desktop system. All in a package that is about the size of a wallet. The Palm III is the latest version of this device. There is no keyboard, because all data is input with a stylus. A simple handwriting system allows text entry. The unit has built-in calendar, contact and task lists. Other applications are available commercially.

There are now a number of other devices available, competing head-to-head with the Pilot. These new "Palmsize PCs" (PPCs) feature a trimmed-down version of Microsoft Windows: WindowsCE. They boast improved interoperability with Microsoft Office applications, such as Schedule+, Exchange and Outlook. Devices are available from Everex, Casio, and Philips at present, and more are expected. Like the Pilot, these devices use a stylus for entry. They also have built-in microphones for recording voice notes.

Any of these small devices would work for the scheme I'm going to outline below. For my practice, that involves a greater than average information processing load, I chose to use a slightly higher power mobile computing device, the Handheld PC (H/PC). These are roughly twice the size and weight of a PalmPilot. In exchange for the increased weight, you get a QWERTY-layout keyboard as well as a stylus, and a screen display that is equivalent to the top ½ of a desktop computer's VGA display. The H/PCs also run WindowsCE, but the H/PC version supports additional features not available on the PPC. Compact "pocket" versions of Microsoft Word and Microsoft Excel both exchange files with their full-featured desktop versions. There is also a pocket PowerPoint, which can be installed if you need to use the unit to give presentations. The H/PCs have a PC card slot to allow the use of additional storage memory, fax/modems, or network interfaces. Both the H/PCs and the PPCs have web-browsing capability with pocket Internet Explorer. Without a modem, though, material has to be downloaded to the unit from the main desktop system and stored for later browsing.
My information management system consists of 3 components: my H/PC, my desktop PC, and the rest of the network. The network includes computer systems of the secretaries, social workers, research nurses and residents, all of whom can place or request appointments in my schedule directly from their systems.
I begin my day by connecting my H/PC to its docking cradle, and synchronizing data between it and the desktop system. I have been entering mileage information into an Excel spreadsheet on the H/PC, which gets uploaded. Any new appointments or tasks get downloaded. I check my E-mail. Non-urgent items can be pushed into an Inbox on my H/PC for later perusal during an idle moment. Then, I'm off to the wards.

New consults and follow-ups have billing information placed right into the schedule item. There is no duplication of records, so later searching and retrieval of information is extremely quick and simple. Putting my fee-for-service items in the schedule this way also clearly separates my clinical time into sessional and fee-for-service segments, in case of later audit. Requests for service, say from a colleague passing in the nursing station, can be given a definite schedule slot, or simple placed in the pending task list, at the time the request is made. In this way, no consults "slip through the cracks."

The same procedure follows for my nursing home visits, and for my time at the geriatric day hospital. When I return to my office to see private patients, then I use the desktop to schedule follow-ups with the patient and caregiver before they leave my consulting room. I am constantly aware of my waiting list and available follow-up times this way.

At the end of the week, fee for service items are collated for transmission to the service bureau that submits to the provincial health plan on my behalf. I copy and paste items from the schedule directly into my billing submission form, with no retyping or hand copying. Most of my colleagues use an excel spreadsheet for this form. I prefer to use a database that I wrote myself in MS Access. It serves the same function as a basic spreadsheet, but implements drop-down scroll boxes that allow me to rapidly choose the diagnosis- and fee-codes that are required for each line item in the submission. It also will automatically complete insurance number and date of birth field for me when the patient is one for which a previous service item exists. Finally, the data are sent out to the bureau via fax, directly from my computer. The cover sheet information is pre-formatted and saved for re-use each week. Later, paid items can be reconciled within the database.

It's a far cry from a paperless office or an electronic patient chart. But, I now spend about 20 minutes per week doing my billing submissions, rather than 20 minutes or more per day with my old all-paper system. I haven't saved any time, but I spend less on a task that is a tedious necessity.

Lonn Myronuk, BSc, M.D. , F.R.C.P.
Email: myronuk@mail.bc.rogers.wave.ca

Fellows' Column

Drs. Schovanek and Li will be presenting at the CAGP Annual Scientific Meeting this year in Halifax. Dr Schovanek will be presenting on Naltrexone for verbal agitation in dementia, and Dr. Li will be presenting on the Neuroprotective effect of atypical antipsychotics. We look forward to their presentations.

Pharmacologia

Anticonvulsants for Behavioral Disturbances: Should we *Seize* the Opportunity?

With all the excitement about new therapies for the cognitive disturbances of dementia, we sometimes forget the strides we have made in the past few years treating the behavioral disturbances (BD). Behavioral disturbances which include agitation, aggression, depression, hallucinations and delusions are common serious problems that impair quality of life for both patient and caregiver and are often primarily responsible for the decision to institutionalize. There are numerous effective interventions for these disturbances that span the spectrum from non-pharmacological treatments (environmental, behavioral) to drug therapies. Detailed reviews of the literature on the pharmacotherapy of BD have concluded that until recently the only class of drugs that have demonstrated efficacy based on double-blind placebo controlled trials are the neuroleptics (1). Based upon these studies, the neuroleptics appear only modestly effective and have significant potential side-effects. While we await the recently completed trials of risperidone (keep an eye on your journals over the next year) and other atypicals to be published, investigators have long been searching for non-neuroleptic therapies that may be more effective and better tolerated. These efforts have mostly focused upon serotonergic agents (eg. trazodone, SSRI's, buspirone, etc.)(2) and the anticonvulsants.

The use of carbamazepine for the treatment of BD has been documented in numerous case series and uncontrolled trials. While a preliminary double-blind randomized controlled study published in 1982 had negative results (3) the study suffered from numerous methodological flaws which could have accounted for this outcome. In contrast, three recent studies (4,5,6) with a total of 82 patients were all positive. Pierre Tariot from Rochester published an initial case report on the use of carbamazepine in 1988 (7) and has spent the past decade backing up his claims with controlled trials. The most recent study was a double-blind randomized parallel group study of 51 nursing home residents with agitation and aggression (6). Modal doses of carbamazepine were 300 mg with mean serum levels of 5.3 ⏭g/mL (that's 22.4 ⏭mol/L for us SI types). Carbamazepine patients were improved significantly based upon scores on the Brief Psychiatric Rating Scale, with 77 percent of patients being judged as improved, compared with 21 percent of placebo-treated patients. Significantly more side effects were noted in the carbamazepine group, though only two cases were rated as clinically significant. While not statistically significant, there was more ataxia and disorientation noted in the carbamazepine group.

Clinical recommendations for the use of carbamazepine include doses of 200 to 600 mg divided per day aiming for serum levels between 17 to 38 ⏭mol/L. Concentrations above 38 ⏭mol/L appear to be associated with more adverse events in the elderly. Response should be noted in 2 to 4 weeks and patients should be monitored for excess sedation and ataxia. Baseline and periodic evaluations of liver function and CBC should be monitored for hepatic dysfunction and leukopenia. Potential for drug interactions is significant as carbamazepine induces CYP3A isoenzymes.

Because of concerns regarding the safety and tolerability of carbamazepine, valproic acid has been studied for the treatment of BD. There have been 12 case series reported in the literature with a total of 133 patients (8-19). Extracting global improvement scores on 120 of these patients revealed improvement (very much improved, much improved or minimally improved) in 64 percent, with 36 percent demonstrating no improvement or worsening. Valproic acid was prematurely discontinued in only 6 percent. In the largest prospective series to date, Herrmann (19) (hey, it's my column and I'll cite myself if I want to!) treated 16 patients with total daily doses of divalproex sodium between 750 and 2500 mg per day, divided and serum levels of 184 to 742 ⏭mol/L. Average scores on the Cohen-Mansfield Agitation Inventory and Behave AD declined significantly. One patient was rated as very much improved, 3 as much improved, 4 as minimally improved and 8 as unchanged. The drug was well tolerated with only one premature discontinuation for diarrhea. Other side effects were mild and included excess sedation and ataxia.

Clinical recommendations for the use of valproic acid include the use of divalproex sodium, initiating at doses of 125 mg p.o. B.I.D. with slow titration as tolerated. Response is usually noted within 2 to 4 weeks. Side effects include sedation, ataxia and gastrointestinal disturbances. It is unclear if serum levels correlate with improvement.

What should be striking from the previous discussion is the relative strength of the evidence supporting carbamazepine (3 Randomized Controlled Trials [RCTs]) versus valproic acid (0 RCT's). And yet, in the recently published Expert Consensus Guidelines for the Treatment of Agitation in Older Persons with Dementia (20) divalproex was rated the treatment of first choice for the long term management of anger with or without aggression, while carbamazepine received only "modest" support for use with these indications. Have clinicians said "don't confuse me with the facts!" or have they anticipated the results of the RCT's to come? Only time will tell, because as you read this article, double-blind placebo control trials are already under way. But while we wait, you might also want to think about the possibilities for a whole series of even newer anticonvulsants: gabapentin, lamotrigine, clobazam and vigabatrin to name a few. Stay tuned as the story continues to unfold.....

Nathan Herrmann, M.D., F.R.C.P.
Head, Division of Geriatric Psychiatry
University of Toronto

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(For the remaining references, please contact Dr Herrmann directly)

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Dementia. The Expert Consensus Guidelines Series. Post-graduate

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Research

(Reprinted form a news release, August 18, 1998)

ALZHEIMER SOCIETY OF CANADA FUNDS $1.2 MILLION IN RESEARCH

The Alzheimer Society announced on August 18th today a commitment of over $1.2 million to further the cause of Alzheimer research in Canada. Since 1989, the Society has funded both biomedical and psychosocial research in an effort to find a cause and cure for the disease and find improved methods of caregiving and delivering services to people affected by Alzheimer Disease.

Dr. Marilyn Miller of McGill University in Montreal is one of the 20 researchers across Canada receiving funding. Dr. Miller is investigating the role that estrogen plays in Alzheimer Disease. Alzheimer Disease affects more women than men and affected women score lower than men in performance scores. Previous research has indicated that women given estrogen replacement therapy showed improved cognitive function. Dr. Miller seeks to determine why this occurs and whether estrogen could be used as a treatment for the disease.

In an effort to enhance care for those with Alzheimer Disease, Dr. Marian Campbell of the University of Manitoba in Winnipeg will use her grant to research eating and feeding issues of people with Alzheimer Disease. Those with the disease are at risk of malnutrition and weight loss because of under consumption of food and liquids. Eating-related difficulties contribute to these problems and can make meals difficult and emotionally taxing for both the caregiver and the person with the disease. Dr. Campbell's research will examine the challenges encountered and strategies used by caregivers in thehome to determine how food preparation, environmental adaptations and the promotion of independence in eating can enhance the eating experience of people with Alzheimer Disease.

Other projects the Society is funding include research on the role of anti-inflammatory drugs, amyloid-beta protein, managing challenging behaviours and reducing vehicle crash injuries.

While the Society's $1 million commitment to research is significant, Alzheimer research in general remains severely underfunded. ``There is such potential for Alzheimer research in this country; Canadians are leaders in Alzheimer research'', says Dr. Peter Scholefield, Chair of the Research Policy Committee of the Alzheimer Society of Canada. ``Unfortunately, funding is not keeping up with the need. Especially with the aging baby boom population, there is an urgent and immediate need for more Alzheimer research funding."

Funding for the Joint Alzheimer Society Research Program includes contributions from provincial and local Alzheimer Societies across Canada, individuals, and corporations including key leadership gifts from Bayer Healthcare, Extendicare Health Services and the Royal Bank of Canada Charitable Foundation.

The Alzheimer Society's nationwide Coffee Break(TM) fundraiser is on Thursday, September 24, 1998. Check your community for coffee breaks in your area.

For a complete listing of the 1998-1999 research grants and awards, look under ``Research'', then ``Research Program'' on our Web site: www.alzheimer.ca

For further information: NATIONAL CONTACT: Debbie Krulicki, (416) 488-8772, ext. 232

Council of Academies

For the past two years, the Canadian Academy of Geriatric Psychiatry, as a member of the Council of Academies of the Canadian Psychiatric Association, has been actively participating in promoting the approval of psychiatric subspecialities in Canada. The CPA, in conjunction with its member Academies (Canadian Academy of Geriatric Psychiatry, Canadian Academy of Child Psychiatry, Canadian Academy of Psychiatry and the Law) submitted an application for the sub-speciality recognition in geriatrics, child psychiatry and forensic psychiatry. The applications were put on hold while the Royal College concluded its deliberations about whether and how subspecialities would be recognized in Canada. Recently, the College concluded that subspeciality recognition would move ahead but that new subspecialities would be recognized on the basis of accreditation without certification. Essentially, this means that graduates of University subspeciality programs that have been accredited by the Royal College will receive recognition as subspecialists. There will be no additional Royal College examination other than that already in place for the approved parent specialty (i.e. psychiatry).

The College has also indicated that, based on its current rules, there will be no retrospective approval (grandfather clause) for those already practicing and leading subspecialities. The Council of Academies together with the CPA will review this issue and see whether negotiations with the College are possible or useful.

I will be stepping down as Chair of the Council of Academies in September of 1998. The members of the council will elect a new Chair who would take office at the end of the annual meeting of the CPA in Halifax. Serving as the founding Chair of the Council has been a gratifying and rewarding experience, because it has offered the opportunity to participate in helping to unify the various subspeciality components within psychiatry, enhancing the relationship of subspecialities within the Canadian Psychiatric Association, and promoting and facilitating the formal recognition of the subspecialities in Canada. The Council is now a strong an influential component of the CPA. The member Academies are all strengthened by their capacity to work together in the interests of the subspeciality populations which they serve and have strengthened their national voice by working in close collaboration and partnership with the Canadian Psychiatric Association. By taking this approach, the CPA and the member Academies have avoided the dangers of fragmentation that have been evident in other jurisdictions.

Yours sincerely,

Joel Sadavoy, M. D., F. R.C. P.

Chair, Council of Academies
Canadian Psychiatric Association

Upcoming Events

Date	Name of Meeting	Location	Contact
Sept 24-25 1998	1998 Institute of Psychiatry Short Course in Old Age Psychiatry	London, UK	Lee Wilding, Conference Office, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London, UK, SE58AF. Tel: 0171 919 3170 Fax 0101 740 5172
Oct 15-18 1998	Canadian Association on Gerontology Annual Meeting	Halifax, NS Canada	Canadian Association on Gerontology 500-1306 Wellington St. Ottawa K1Y 3B2 Tel:(613)728-9347 Fax: -8913
Oct 23-24 1998	AAGP Longterm Care Conference	Baltimore, MD USA	AAGP, 7910 Woodmont Ave, Suite 1350, Bethesda, MD, 20814
Nov 20-24 1998	Gerontological Society of America (GSA) Meeting	Philadelphia, PA USA	GSA: Tel- (202) 842-1275 Fax -(202)842-1150
Feb 21-25, 1999	Pan-American Congress on Gerontology	San Antonio, Texas, USA	Dr. Roger McCarter, Dept. of Physiology, U Texas Health Science Center, San Antonio, Texas. Tel: (210)567-4329
Spring 1999	IPA Regional Meeting	Beijing, China	IPA
March 14-17 1999	AAGP Annual Scientific Meeting	New Orleans, LA USA	AAGP
Aug 6-9 1999	XIth World Congress of Psychiatry	Hamburg, Germany	DGPPN Secretariat, Düsseldorf, Bergische Landstrasse 2, D-40629 Düsseldorf, Germany
Aug 15-20, 1999	IXth IPA Congress	Vancouver, B.C. Canada	Venue West Conference Services Ltd., 645 The Landing, 375 Water Street, Vancouver, BC, V6B 5C6 Tel: (604)681-5226 Fax:-2503 Congress@venuewest.com
Spring 2001	IPA Regional Meeting	Australia	IPA
July 1-6 2001	International Association on Gerontology, 17th World Congress	Vancouver, B.C. Canada	Dr. Gloria Gutman, Director, Gerontology Research Center, 515 Hastings St., Vancouver, B.C.
Summer 2001	IPA Meeting	Nice, France	IPA

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