When conducting a diagnostic workup for ADHD, Dr. Kaplan recommends a comprehensive psychiatric interview with expanded focus on:

- Present illness–academic and work status, areas of impairment, and the presence of significant symptoms of substance abuse, or affective or anxiety disorder
- Past History–the presence of ADHD childhood symptoms (corroborated with relatives when possible)
- Medical History–current medications, history of head trauma or other neurological conditions, presence of endocrinology problems

Appropriate rating scales include the Conners' Adult ADHD Rating Scale (CAARS), the Brown ADD Rating Scale (BAADS), and the Adult ADHD Self Report Scale v1.1 (ASRS-v1.1) for current symptoms and the Wender Utah Rating Scale (WURS) for retrospective childhood symptoms [Brown T ed. Comorbidities Handbook for ADHD Complications in Children and Adults. Washington DC, American Psychiatric Press. 2009]. It is expected that the criteria for ADHD will be revised to be more appropriate for the adult population in DSM-V.

The mainstay of treatment for ADHD is either long- or short-acting stimulants. There are currently 6 medications that are approved (5 stimulants; 1 nonstimulant). Adjunctive psychotherapy can also be associated with improved outcomes.

The Treatment of Alzheimer's Disease: Comparing Guidelines

IIt is projected that there will be 8.7 million patients with dementia who live in the United States by 2030 [Guttman R et al. *Arch Fam Med* 1999]. Cognitive decline that is associated with mild to moderate Alzheimer Disease (as measured by MMSE score) progresses an average of 2 to 4 points per year if left untreated [Becker JT et al. *Arch Neurol* 1988]. Alzheimer Disease (AD) is a complex, debilitating disease, and due to conflicting guidelines, there is confusion among practitioners regarding the best treatment practices for a patient who suffers from AD. Thus far, AD treatment is limited to symptomatic therapy, but prevention and disease-modifying therapy are the ultimate goals.

Methodologies for generating a consensus and evaluating evidence are evolving. Gary W. Small, MD, David Geffen School of Medicine, University of California, Los Angeles, CA, compared the American Association for Geriatric Psychiatry (AAGP) and American Psychiatric Association (APA) recommendations. Both models emphasize nonpharmacological and pharmacological therapies, but while the AAGP concentrates on AD, the APA has a wider focus that includes a recommendation coding system that is based on clinical evidence (I=substantial confidence, II=moderate confidence, and III=recommendation is based on individual circumstances with a lower level of confidence). The American Academy of Neurology (AAN) guidelines, presented by Martin R. Farlow, MD, Indiana University School of Medicine, Indianapolis, IN, use a coding system that is similar to the APA, but the recommendations are categorized by class (I=AAN Standard recommendation based on 1 or more randomized clinical trials with a high level of certainty, II=AAN Guideline recommendation based on well-designed observational trials with a moderate degree of certainty, and III=AAN Practice Option recommendation based on expert opinion and/or case reports, so clinical utility is uncertain).

William Maurice Redden, MD, St. Louis University School of Medicine, St. Louis, MO, discussed the clinical pharmacology of approved AD therapies that are related to the Alzheimer's Disease Management Council (ADMC) consensus and the National Institute for Health and Clinical Excellence (NICE). There are currently 4 cholinesterase inhibitors that are approved by the Food and Drug Administration (FDA) for the treatment of mild to moderate AD: tacrine, donepezil, galantamine, and rivastigmine. The APA guidelines state that 30% to 40% of patients with mild to moderate AD may have modest benefits with cholinesterase inhibitor therapy, and it should also be considered for patients with dementia that is associated with Parkinson Disease (APA Coding Level I). Additionally, memantine and donepezil have been FDA-approved for the treatment of moderate to severe AD. The AAN guidelines do not address the use of cholinesterase inhibitors or memantine in AD patients. Prof. Farlow attributes this discrepancy to the fact that the AAN guidelines are 8 years old and are in need of revision.

Charles A. Cefalu, MD, MS, Professor and Chief, Section of Geriatric Medicine, Louisiana State University Health Sciences Center and School of Medicine at New Orleans, New Orleans, LA, presented the American College of Physicians (ACP)/American Academy of Family Physicians (AAFP) 2007 guidelines for the pharmacological management of patients with AD. The guidelines suggest that the initiation of cholinesterase inhibitor or memantine therapy should be based on individualized assessment after careful consideration of tolerability, adverse effect profiles, ease of use, and cost. The level of confidence that is associated with this ACP/AAFP recommendation is weak, based on insufficient evidence that compares the effectiveness

of these agents for the treatment of AD. Prof. Cefalu expressed that the high level of cholinesterase inhibitor discontinuation among AD patients remains a problem and that withdrawal may be associated with acceleration of cognitive and physical decline. Therefore, it is important to educate family members, caregivers, and patients (when appropriate) regarding the risks and benefits of these pharmacological treatments prior to initiating therapy.

There are a few topics that correspond across all of these guidelines. The use of atypical antipsychotics has been associated with an increased risk of death that is related to vascular disease in elderly patients with dementia. Also, the CATIE study suggested that the adverse effects that are associated with these agents may offset the advantages in the efficacy of atypical antipsychotic drugs in AD patients [Schneider LS et al. *N Engl J Med* 2006]. Therefore, they should only be used after careful assessment of the risks and benefits. These guidelines all agree that the use of NSAIDS, statins, and estrogen are no longer recommended due to their lack of efficacy and safety. The presenters all stressed the importance of early detection and the need for disease-modifying therapies.

Suicide Risk Factors and Prevention

In 2006, the suicide rate was 11.2 people/100,000 (n=33,000), averaging 1 person every 16 minutes and exceeding the rate of homicide (6.2/100,000) in the United States [Centers for Disease Control and Prevention. www.cdc.gov/ncipc/wisquars/default.htm.]. Paula Clayton, MD, American Foundation for Suicide Prevention, New York, NY, discussed possible risk factors and suicide prevention strategies at the APA Annual Meeting. Mental disorders, past suicide attempts, symptomatic precursors, genetic factors, sociodemographics, and environmental factors have been shown to play a role in suicide. Mental illness is the number 1 risk factor for suicide, and psychological autopsies and interviews with family members and caregivers after a suicide have shown that 90% of victims of suicide have 1 or more mental disorders at the time of death [Harris & Barraclough. *Br J Psychiatry* 1997]. Schizophrenia, unipolar depression, and bipolar disorder are associated with the highest short-term risk [Tidermalm et al. *BMJ*, 2008]. Acute anxiety, psychic pain, and panic attacks during an acute depressive episode are also linked to higher rates of suicide [Lewis LM et al. *Suicide & Life Threat Beh* 2007].

In a study by Lewis and colleagues, the use of no-harm contracts as a prevention method was shown to have little efficacy [Fawcett et al. *AJP* 1990]. Therefore, other prevention tools are needed. Prof. Clayton pointed out that method restriction is the best strategy for patients who are at risk. Bridge barriers and netting, as well as increased firearm restriction, have been the best methods of prevention, according to Prof. Clayton, because bridgeside phones and signs have not impacted suicide rates thus far. Time delays that are associated with these prevention methods allow the suicidal patient to change his mind, resolve the preceding conflict or stressor, detoxify if there are contributing substances that lead to an attempt, and seek professional help.

Medications, such as antidepressants and lithium therapy, are also helpful tools in the prevention of suicide. Although only 20% of medicated depressed patients are adequately treated with antidepressants, Prof. Clayton stressed that lithium therapy is underutilized and that the use of this treatment in combination with psychotherapy should be encouraged for at-risk patients. Prof. Clayton concluded that early detection and treatment for mental disorders, method restriction, and responsible reporting on the part of the media to avoid sensationalizing suicide are currently the best practices for prevention.