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On Psychiatric Treatment

AN UNBIASED MONTHLY COVERING ALL THINGS PSYCHIATRIC

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Sleeping Pills: An Update

While sleeping pills have been around for a long time, the modern age of hypnotics began December 16, 1992, when the FDA approved **Ambien** (zolpidem). **Sonata** (zaleplon), a late bloomer, received approval in 1999.

Both Ambien and Sonata are officially classified as "non-benzodiazepines," although they do their pharmaco-slumbering magic on the same site as the benzodiazepines (BZs), namely by binding to the GABA-A/benzodiazepine/chloride channel receptor complex. However, the non-BZs bind more selectively to the Type 1 subtype of this complex, which is likely why these meds are more specifically helpful for insomnia, and not particularly helpful for either anxiety or muscle relaxation.

Let's look at how Ambien and Sonata differ from each other, and also take a peek at the soon-to-be new kid on the block, **Estorra** (eszopiclone).

Ambien, with a **half-life of 2.5 hours**, is effective both at putting patients to sleep and at increasing

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Focus of the Month:
To Sleep, To Awake

Provigil: It Has the Midas Touch

The FDA may not like it, but Provigil (modafinil) is hot, and getting hotter.

When it first gained FDA approval for narcolepsy in 1998, no one took much notice of Provigil. Sure, it helped narcoleptics stay awake, but when was the last time you diagnosed narcolepsy, which occurs at a rate of about 1 in 5000?

However, a funny thing happened to Provigil since 1998: most of it got prescribed off-label. Prescribers realized that here was a safe, relatively non-abusable medication that extinguished sleepiness in all of its forms, and so they started using it symptomatically, regardless of the underlying diagnosis. Currently, 90% of Provigil prescriptions are off-label.

With two new FDA-approved indications under its belt, Provigil may soon find its way into everyone's medicine cabinet.

A casual Medline search reveals an explosion of Provigil trials over the last 2 years, with efficacy demonstrated (mostly in uncontrolled trials) for the following conditions: major depression (more on this below), ADHD, schizophrenia, seasonal affective disorder, sedation due to brain injury, opioid-induced sedation, and recovery after general anesthesia, to name a few.

This doesn't even include the two new FDA-approved indications as of 2004: excessive sleepiness associated with sleep apnea and "shift work sleep disorder." Cephalon had requested a broader approval for excessive sleepiness due to any sleep disorder, but the FDA refused. Why? Probably not because of lack of efficacy, since by

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Learning objectives for this issue: 1. Describe the differences between the non-benzodiazepines. 2. Identify the presenting symptoms of common sleep disorders. 3. Cite the evidence concerning the use of Provigil in major depression.

This CME activity is intended for psychiatrists, psychiatric nurses, and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Sleeping Pills: An Update

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their total sleep time. **Sonata**, on the other hand, with a tiny **half-life of 1 hour**, gets patients to sleep but does not increase total sleep time. Ambien's superior versatility comes at a price: it causes more next-day impairment than Sonata (*J Clin Psychopharm* 2002; 22:576-583).

Over the years, Ambien (10 mg QHS).has been used most by patients who have both difficulty falling asleep and frequent awakenings throughout the night. Sonata (10 mg QHS) has carved out a niche for two situations: 1. Patients who can't fall asleep easily but who sleep well once they drop off, and 2. Patients who fall asleep easily but wake up in the middle of the night and need something that will allow them to wake up reasonably refreshed in the morning. Its lack of next day hangover apparently caught NASA's eye, as it has become the official sleeping pill used by the astronauts. Rock on, Sonata.

Estorra (eszopiclone) is zeroing in on FDA approval, which it should receive toward the end of 2004. It's another non-BZ, has a longer **half-life of 5 hours**, and probably works similarly to Ambien. Its claim to fame will be data showing efficacy and safety over a full year of treatment (see *Formulary* 2003; 38:583-593 for a review) allowing us to prescribe chronic insomniacs lots of refills without any twinges of guilt.

Are non-BZs really less "addictive" than BZs? Probably, but hard data on this issue is sparser than the drug-makers would like to admit. There was a recently published post-marketing study in which researchers surveyed graduates of three addiction centers in the UK and asked them about the street values and potential to make you high of a variety of sleep meds, including BZs, non-BZs, antidepressants, and antihistamines. The BZs had the highest abuse liability, followed by the ADs and non-BZs (which were judged as equally abusable). Benadryl was singularly unrecreational, according to these experts on getting high (*Addiction*, 2004; 99:165), though Dr. Mick's anecdote (below) suggests otherwise.

Of course, all these new hypnotics are expensive, and those of us inclined toward health care frugality find that meds like trazodone, Benadryl, and generic benzos work just fine for insomnia, thanks very much. Well, be prepared for an onslaught of "infotisements" from the hired guns and hired journals.

The most recent example comes from the *Journal of Clinical Psychiatry*, whose cover article in June 2004 was entitled "The Use of Trazodone as a Hypnotic: A Critical Review." The first author is a consultant to King Pharmaceuticals (Sonata), and the second author has consulted for Sanofi (Ambien). Given these credentials, you might predict that the article slams trazodone, a drug that has the pharmacokinetic property of competitively displacing the costly non-BZs from many psychiatrists' prescription pads. Your prediction would be accurate.

The gist of this review is that since there is little hard data on the efficacy or safety of trazodone as a hypnotic, we shouldn't be prescribing it so much. Particularly since it can cause priapism (they cite a reported 12% rate (!)--we suspect that "priapism" was confused by subjects in this study with nocturnal erections), orthostatic hypotension, and cardiac arrhythmias (three single cases reported 20 years ago in patients with significant pre-existing cardiac disease).

As with most well-written industry-serving articles, nothing said is frankly inaccurate, with the main intellectual sins being those of omission and inappropriate emphasis. For example, the authors conclude that "Although trazodone benefits some aspects of sleep in patients with major depressive disorder, there is little or no evidence from systematic studies that it aids sleep in insomnia patients." Left out is the important fact that the lack of systematic studies showing trazodone's efficacy is hardly the drug's fault, but rather a reflection of an economic reality. Since trazodone is generic, no company in its right mind will spend the millions of dollars required to conduct "systematic" studies for FDA approval, especially when it is already widely used for insomnia. In fact, dozens of small scale, non-industry supported studies have already shown trazodone to be an effective and safe medication for a variety of psychiatric conditions that present with insomnia, including depression, dysthymia, alcohol withdrawal, and SSRI-induced insomnia.

A final word to the wise (and surely, the weary): **Beware the Mallinckrodt reps peddling Restoril (temazepam) 7.5 mg, an "Effective Low-Dose Choice."** Temazepam has been a great low cost generic sleeping pill for years, and with no active metabolites, it's considered a good choice among the BZs for insomnia in the elderly. Here's the hitch: only the 15 mg and 30 mg forms are generic; the FDA granted patent exclusivity for the 7.5 mg capsule in 1991. The sales pitch is that 7.5 mg works as well as 15 mg, but with less "concern" for side effects. They chose that word carefully--they can hardly say "fewer" side effects when the major company-funded study (*Curr Med Res Opin* 2004; 20:441-449) showed no difference in side effects between the two doses!

So. Difference in effectiveness or side effects? None. Cost? Restoril 7.5 mg, about $100 per month, temazepam 15 mg, $10 per month. Lesson learned about the pharmaceutical industry? Priceless. ❖

TCR VERDICT: *Non-BZs: Good, but are they worth their price?*

The Carlat Report: Editorial Information

Editor: **Daniel J. Carlat, M.D.** is a psychiatrist in private practice in Newburyport, Massachusetts. He graduated from the psychiatric residency at Massachusetts General Hospital in 1995, has written a small textbook called *The Psychiatric Interview,* and currently is Series Editor for The Practical Guide Series in Psychiatry, published by Lippincott Williams & Wilkins.

Associate Editor: **Marcia L. Zuckerman, M.D**. is a psychiatrist and writer based in Charlestown, Massachusetts.

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Alan D. Lyman, M.D. Chief of Child and Adolescent Psychiatry, Beth Israel Medical Center, New York City.

*Dr. Carlat, with editorial assistance from Dr. Zuckerman, is the author of all articles and interviews for *The Carlat Report*. All editorial content is reviewed by the Editorial Board. Dr. Carlat and Dr. Zuckerman have disclosed that they no significant relationships with or financial interests in any commercial companies pertaining to this educational activity. Dr. Agronin is the recipient of research grants from Bristol-Myers Squibb and Bohringer Ingelheim Pharmaceuticals, and is a member of the speakers bureau for Janssen Pharmaceutica and Forest Laboratories. Dr. Demopolus is a consultant and a member of the speakers bureau for Abbott Laboratories, Elan Pharmaceuticals, and Cephalon Inc., and is a consultant for GlaxoSmithKline, and Astra Zeneca Pharmaceuticals. Dr. Gardiner is a member of the speakers bureau for Forest Laboratories, Wyeth Pharmaceutical and GlaxoSmithKline. Dr. Lyman has disclosed that he has no significant relationships with or financial interests in any commercial companies pertaining to this educational activity.

Common Sleep Disorders: What Not to Miss

While there are plenty of excessively complicated classifications of sleep disorders in this world, *TCR*, in the midst of a sleep-deprived delirium, has decided that psychiatrists should become most familiar with the following four common problems:

1. Obstructive Sleep Apnea
2. Restless Leg Syndrome.
3. Circadian sleep disorders (mainly jet lag and shift work problems).
4. Chronic, primary insomnia

Obstructive sleep apnea (OSA). The typical patient with OSA is an overweight man in his 50s, although people of any age, gender, or body type may be afflicted. Ask patients if they snore (patients with OSA almost always snore, though not all snorers have OSA), and ask if they are sleepy during the day even when they think that they have slept through the night, a common paradoxical complaint in OSA. Refer patients who answer "yes" to both of these questions to a sleep specialist, since the only way to reliably diagnose OSA is by an overnight sleep study. Scare them into not procrastinating by pointing out that untreated sleep apnea can cause cardiac problems because of chronically low levels of oxygen during the night.

Restless Leg Syndrome (RLS). RLS is more common than you think (it affects 2-5% of the population), and is eminently diagnosable and treatable by psychiatrists. Learn about it, and you will soon have some very grateful patients in your practice. Ask, "Do your legs often feel restless, and do you get a creepy-crawly sensation in them that makes you want to get up and walk around to relieve it?" RLS symptoms are usually worse in the evenings, and most patients with RLS also have PLMS (periodic limb movements of sleep), which is what causes the presenting complaint of insomnia and daytime sleepiness. Oddly enough, you should order a serum ferritin in these patients, since iron deficiency can cause RLS. No medications are currently approved for RLS treatment, but based on positive controlled trials, dopamine agonists are used most frequently. . Many start with Mirapex (pramipexole) 0.25 mg - 0.5 mg QHS, which often does the trick (*Neurology* 1999; 52:938-43). Requip (ropinirole) is a newer option. Sinemet (carbidopa-levodopa) also works, but has more side effects. Klonopin (clonazepam) can be helpful if the above don't work.

Circadian Sleep Disorders. Both shift work insomnia and jet lag will often respond to a combination of a hypnotic and Provigil (modafinil, recently FDA approved shift work disorder); each medication must be timed appropriately, and may only need to be used temporarily, until the rhythm has been normalized. There continues to be a buzz about melatonin offering something specifically valuable for the insomnia of jet lag, but results of clinical trials have been inconsistent.

Chronic Insomnia. Sure, we've all read the perfunctory spiels on "sleep hygiene" and many of us are good doobies and go over the list with our patients, but if it helps one out of 10 patients we're happy. "Sleep hygiene," however, is actually a pale subcategory of a sophisticated batch of behavioral and cognitive therapy techniques that work very well for patients with the kind of insomnia that is so chronic that it has become a way of life. According to a recent meta-analysis of 21 clinical trials, behavior therapy and pharmacotherapy work equally well for chronic insomnia, though behavior therapy probably helps initial insomnia more (*Am J Psychiatry* 2002; 159:5-11). Pharmacological approaches are discussed elsewhere in this issue ("Sleeping Pills: An Update"). Helpful behavioral remedies include avoiding naps and waking up at the same early time each day, both of which increase the amount of wakefulness prior to bedtime, thus promoting sleepiness. Cognitive restructuring tips include educating your patient that it's no catastrophe to sleep only five or so hours, since this "core sleep" includes all of our deep sleep and allows us to function reasonably well. This often helps prevent the middle of the night clock-watching that plagues chronic insomniacs. An excellent book to recommend to patients is *Say Goodnight to Insomnia*, Gregg D. Jacobs, 1999, Owl Books (NY). ❖

TCR VERDICT: *Insomnia: Rule out sleep disorders before pulling out the pad.*

Q&A With the Expert

This Month's Expert:

John W. Winkelman, M.D., Ph.D.
On Treating Sleep Disorders

Assistant Professor of Psychiatry, Harvard Medical School
Medical Director, Sleep Health Center,
Brigham &Women's Hospital

Financial Disclosure: Dr. Winkelman has disclosed that he has received research grants from Boehringer-Ingelheim, GlaxoSmithKline, Pfizer, UCB Pharma, and Xenoport, that he has served as a consultant for Boehringer-Ingelheim, Cephalon, GlaxoSmithKline, Pfizer, Sanofi, and Sepracor,, and is a member of the speakers bureau of Cephalon, Eli Lilly, GlaxoSmithKline, and Sanofi.

TCR: Dr. Winkelman, could you recommend a practical approach for psychiatrists diagnosing sleep disorders?

Dr. Winkelman: I usually base my diagnostic algorithm upon presenting symptoms. A patient will usually present with a chief complaint of insomnia (difficulty falling asleep or staying asleep, or nonrestorative sleep), excessive daytime sleepiness, or unusual behaviors during sleep, which are called "parasomnias." That is where I start, because, like DSM, I think it makes most sense to base your initial approach based on symptoms rather than putative causes. And the fact is that there is no clear one-to-one relationship of any particular sleep disorder or even psychiatric disorder with a particular type of insomnia. For example, the idea that anxiety causes problems falling asleep whereas depression causes early morning awakening is going to get you in trouble.

TCR: What are the most common causes of insomnia in a psychiatric practice?

Dr. Winkelman: The most common cause will be psychiatric illnesses producing insomnia. Most commonly, these would be depression and anxiety disorders, but certainly psychotic disorders can produce serious insomnia. You obviously want to treat the underlying psychiatric illness first. And that is really true for any sleep complaint. However, for many patients with psychiatric illness, the insomnia does not clear up even with adequate treatment of the underlying psychiatric illness; sometimes it even gets worse. And so you need to then go back to your differential diagnosis and see what else could be causing the problem.

TCR: Such as?

Dr. Winkelman: The second major cause of insomnia would be medications. Any of the activating serotonergic, adrenergic, or dopaminergic antidepressants can cause insomnia, or can prevent insomnia from improving even with successful treatment of an underlying psychiatric illness. It is not clear whether taking an SSRI in the morning instead of at night makes a difference, but it is worth a try. You want to try to keep the dose as low as is effective. And make sure that they are not taking their antidepressants inappropriately; for instance, you may have told them to take buproprion "twice a day" and they are taking it all at night. Other medications that can produce sleep disturbance include long-acting stimulants, of which there are many now, and short-acting stimulants like caffeine, which are frequently consumed, particularly by psychiatric patients. Alcohol is a bad actor for sleep, and even small amounts of alcohol--two glasses of wine--can produce nocturnal awakenings. I really challenge patients to stop their alcohol while we are trying to get a handle on their insomnia.

"I don't think that the non-benzos are any less abusable than the benzodiazepines. But both of these classes are rarely abused, except by people with substance abuse histories."
—John Winkelman, M.D.

TCR: Do you encourage good sleep hygiene in your patients?

Dr. Winkelman: Sleep hygiene issues are essential. Treating other problems without addressing habits and behaviors that promote good sleep will lead nowhere. You can give as much benzo as you want and, if people are napping all day long, they are not going to sleep at night. I always give my patient a handout of "10 Tips for a Good Night's Sleep," which readers can download for free at: http://www.mass.gov/Eeohhs2/docs/masshealth/pharmacy/10tips_goodnightsleep.pdf.

TCR: What are the most useful sleep hygiene methods in your experience?

Dr. Winkelman: The most effective techniques are sleep restriction and stimulus control. Restricting time in bed ("sleep restriction") is probably the most powerful treatment. I give my insomnia patients a bedtime and a wake time, which are six hours apart. This is a "no pain/no gain" kind of approach. You are using the body's own endogenous sleep drive rather than an exogenous chemical to help with sleep initiation and maintenance. "Stimulus control" is getting up and out of bed when you are awake for more than twenty minutes or so. The idea is to dissociate anxiety and the sleeping environment.

TCR: Can you say something about your approach to Restless Leg Syndrome (RLS)?

Dr. Winkelman: RLS is a common disorder, particularly in the elderly. While it's present in 1-5 % of people under the age of

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Q & A With the Expert

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60, it occurs in 10-20 % of people over the age of 65 or 70. It is a neurological disorder characterized by uncomfortable restless feelings in the legs that are relieved by movement and are most prominent at night.

TCR: How do you treat it?

Dr. Winkelman: First, you want to make sure that there is nothing driving it--in particular, iron deficiency. You want to check a ferritin or stored iron level in everybody with RLS. Anyone who has a ferritin below 40 should be treated with iron. If that is not the issue, then first-line treatments are dopaminergic drugs, primarily Requip (ropinirole) or Mirapex (pramipexole). Requip is started at 0.25 mg QHS for a few days, then increased to 0.5 mg for a few days, then to 1 mg for a few days, and if needed you can go up to 1.5 or 2 mg; the maximum dose is 4 mg. Mirapex is started at 0.25 mg QHS, and increased by 0.25 mg every few days up to a maximum of 1 mg. All doses should be taken about 2 hours before symptoms start.

TCR: They are both equally effective?

Dr. Winkelman: They appear to be. There are no head-to-head studies. The most common side effects with these agents are nausea, sedation, insomnia, and fatigue. You want to avoid these medications--or use them very cautiously--in patients with past or current psychosis. Second-line agents For RLS include opiates, such as low dose oxycodone or codeine, and Neurontin (gabapentin).

TCR: Are any of these treatments going to be FDA-approved?

Dr. Winkelman: Requip will be approved next year, and Mirapex maybe the year after.

TCR: What about sleep apnea as a cause of insomnia?

Dr. Winkelman: Sleep apnea can present as insomnia. Most of those people are not literally sleepless; they fall asleep and then have a series of abnormal or sleep-related breathing events that cause them to wake up briefly.

TCR: Do sleep apnea patients typically believe that they have slept most of the night?

Dr. Winkelman: They may believe that. They may say that they didn't feel refreshed when they wake up, but they do believe that they have slept. But you will also have people saying, "I can't fall asleep," whereas they may actually have fallen asleep, but they haven't recognized it because they haven't entered a deep stage of sleep.

TCR: There continues to be a lack of clarity about whether the non-benzos, such as Ambien (zolpidem) and Sonata (zaleplon), are less abusable than the benzodiazepines. What's your take?

Dr. Winkelman: Anything is abusable. I don't think that the non-benzos are any less abusable than the benzodiazepines. But both of these classes are rarely abused, except by people with substance abuse histories. As long as you use them for the appropriate patients, they are rarely a risk for nonmedical diversion. Rebound insomnia may be reduced in the non-benzos, although it's not clear. Estorra (eszopiclone) has got some great new data demonstrating that there is no tolerance over six months of continuous use.

TCR: Is that different from Ambien, Sonata, or the benzos?

Dr. Winkelman: We have no long-term data on any of these other medications, so we don't know. I am not sure that patients develop any more tolerance to these agents than they do to trazodone, Elavil, Seroquel, or Neurontin. I have seen tolerance to all of those agents; there are no long-term studies on any of them, either.

TCR: So why would we prescribe the more expensive newer alternatives if there is not a huge difference between them and the older agents?

Dr. Winkelman: The main difference is the half-life properties of these agents. Sonata has an ultra-short half-life, Ambien's is short, and Estorra's is going to be medium. Some of the older agents don't have as favorable a half-life profile, so many people will wake up feeling knocked out excessively from drugs like Restoril, Ativan, Klonopin or Dalmane. Halcion, on the other hand, has a short half-life, about equivalent to Ambien, and has an undeserved bad reputation.

TCR: So, for you, the reason to choose the non-benzos would be more based on shorter half-lives?

Dr. Winkelman: More favorable half-life, and when Estorra comes out, more assurance about long-term tolerance issues.

TCR: Do you think this tolerance data is going to allow the insurance companies to start to pay for more than a 14-day supply?

Dr. Winkelman: Yes. I think that there will be no short-term restriction for Estorra, so there will be no basis for them to limit the supply. They will make it a high co-pay, I'm sure, but there will be no basis for restricting it the way they have for the other agents.

Provigil: It Has the Midas Touch

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now it is clear that Provigil will wake up any human being on the planet who is sleepy, regardless of the cause. More likely, the FDA is concerned that Provigil is *too* effective, and that it will become an over-prescribed "lifestyle" drug that will be used by the excessively driven as a sleep-substitute.

Nobody knows how Provigil works, although we know it doesn't work via dopamine release--which is how both Ritalin (methylphenidate) and Dexedrine (dextroamphetamine) keep you up. It's available in 100 mg and 200 mg tablets, both of which are scored and easily breakable. Starting patients too high can cause terrible initial jitteriness. **Start most patients with a prescription for 200 mg tablets and have them take half a tablet initially.** If they don't notice an improvement after 3 days, increase to a full tablet. With a **15-hour half-life**, a morning dose will usually last into the afternoon, and the amount left in the body at bedtime generally doesn't cause insomnia. The **most common side effects** are jitteriness, nervousness, diarrhea, headache, and nausea. The most clinically significant drug-drug interaction is the **induction of clearance of steroidal contraceptives**, necessitating increased OCP dosing in some patients.

As psychiatrists, we are unlikely to be prescribing Provigil for its FDA-approved indications, since such bonafide sleep disorders are generally treated by primary care physicians or in sleep clinics. Psychiatrists use Provigil mainly for depression, ADHD, and medication-induced sedation. Here's some of the evidence on Provigil and depression.

There are four published studies on adjunctive Provigil for major depression. Three of these studies involved adding Provigil to pre-existing antidepressants in patients with partially-treated depression. Of these three, two were small uncontrolled trials and yielded predictably positive results (*J Clin Psychopharmacol* 2003; 23:1-3, and *J Clin Psychopharmacol* 2004; 24:87-90). The larger double-blind placebo-controlled study enrolled 136 patients who had been on antidepressants (ADs) for at least 6 weeks and exhibited only partial responses (*J Clin Psychiatry* 2003; 64:1057-1064). They were randomized to receive either adjunctive Provigil or placebo for 6 weeks. Those on Provigil took 100 mg QAM on days 1 through 3, then 200 mg QAM, after which the dose could be raised or lowered as necessary. All patients continued on their ADs (mostly SSRIs) throughout the study.

How did the two groups fare? Those on Provigil rapidly became less fatigued and sleepy--separating from placebo by week one or two, depending on the scale used. However, this difference disappeared by week 6. What about measures of depression? Unfortunately, there was no significant difference between adjunctive Provigil and placebo in HAM-D scores, at any time point. The bottom line appears to be that prescribing adjunctive Provigil to patients already on ADs may wake them up a bit, especially over the first 2 weeks, but it probably won't improve their overall depression.

What about starting patients on a combination of an AD and Provigil? Since Provigil has been shown to jump-start wakefulness, perhaps its ideal use would be to speed up the initial response to an AD. One recent study has looked at this, though without the crucial ingredient of a control group (*J Clin Psychiatry* 2004;65:414-420). In order to be included in this study, patients had to have both major depression and significant fatigue. A total of 29 patients were enrolled in this Cephalon-funded study; at study entry, they were all started on either Prozac 20 mg QD or Paxil 20 mg QD, in addition to Provigil 100 mg QAM for 3 days, increasing to 200 mg QD on day 4. **Depression in these patients improved robustly and quickly, with 42% responding by week 2, 65% by week 4, and 79% by week 6**.

Of course, we can critique this study for its open-label design and lack of a control group. A comparison group given ADs plus placebo might have responded just as well. However, these response rates are pretty high when compared to other open label antidepressant trials published. So while this study doesn't prove anything, it does suggest that starting fatigued depressed patients on Provigil along with an AD is a potential psychopharmacologic pearl. ❖

TCR VERDICT: *Provigil: It'll jump start just about anyone.*

Anecdotes from the Field: Beware Benadryl!

Dr. Robert L. Mick is a psychiatrist and Clinical Director of Park Ridge Chemical Dependency, a service of Unity Health System, in Rochester, N.Y.

Dr. Mick has disclosed that he has no significant relationships with or financial interests in any commercial companies pertaining to this educational activity.

"In practicing addiction medicine and psychiatry, I have found that the judicious use of Ambien or Sonata has a place in the management of early abstinence, especially since insomnia is an oft-cited cause of relapse. However, the use of Benadryl and Vistaril are problematic in the treatment of insomnia and anxiety in the substance dependent population. Patients prescribed these meds are often too somnolent to participate meaningfully in the group process, the foundation of addiction treatment. They often forget didactic material presented to them just hours before. Also, certain patients who receive *prn* doses for anxiety never miss a dose and often appear giddy. I've surmised that this was a subjective "high" and this has been confirmed on direct questioning of several patients. Indeed, the abuse of antihistamines is not uncommon--I believe these agents should be reserved for poison ivy!"

CME Post-Test

To earn CME credit, you must read the articles and complete the quiz below, answering at least four of the questions correctly. Mail a photocopy or fax the completed page to Wolters Kluwer Health, Office of Continuing Education, 530 Walnut Street, 8th Floor East, Philadelphia, PA 19106; fax: (215) 521-8637. Only the first entry will be considered for credit and must be received by WKH by September 30, 2005. Acknowledgment will be sent to you within 6 to 8 weeks of participation.

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Please identify your answer by placing a check or "X" mark in the box accompanying the appropriate letter.

1. The major difference between Sonata and Ambien is:
- [ ] a. Ambien is abusable but Sonata is not.
- [ ] b. Ambien, but not Sonata, is approved for maintenance treatment.
- [ ] c. Ambien, but not Sonata, increases total sleep time at the expense of next day impairment.
- [ ] d. The "street value" of Sonata is higher.

2. Provigil is now FDA-approved for:
- [ ] a. Narcolepsy, and sleepiness due to sleep apnea and shift work disorder.
- [ ] b. Excessive sleepiness due to any recognized sleep disorder.
- [ ] c. Narcolepsy and Attention Deficit Disorder.
- [ ] d. Narcolepsy and adjunctive use in Major Depression and ADD.

3. Mirapex is an FDA-approved treatment for Restless Leg Syndrome.
- [ ] a. True [ ] b. False

4. Restless Leg Syndrome typically presents as:
- [ ] a. Shaking of the legs that is not noticed by the patient unless pointed out.
- [ ] b. An inner feeling of agitation that is identical to akathisia.
- [ ] c. An uncomforatble feeling in the legs that is relieved by moving.
- [ ] d. Sudden jerking of the legs, primarily in the early morning.

5. According to Dr. Winkelman, non-benzos are less abusable than benzodiazepines.
- [ ] a. True [ ] b. False

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2. On a scale of 1 to 5, with 5 being the highest, how do you rank the overall quality of this educational activity?
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3. As a result of meeting the learning objectives of this educational activity, will you be changing your practice behavior in a manner that improves your patient care? If yes, please explain.
   [ ] Yes _____
   [ ] No _____
4. Did you perceive any evidence of bias for or against any commercial products? If yes, please explain.
   [ ] Yes _____
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5. How long did it take you to complete this CME activity? ___ hour(s) ___ minutes
6. Please state one or two topics that you would like to see addressed in future issues. _____

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This Month's Focus:
To Sleep, To Awake

Next Month in *The Carlat Report*: Preventing. suicide, including the latest on the risks of antidepressants in children, tips for evaluating suicidality, and a primer on medicolegal aspects of chart documentation for your suicidal patients.