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Clarification on melatonin

Although I was impressed by Drs. Scott R. Beach and Shamim H. Nejad's Pearl ("Using melatonin to reset the clock of hospitalized older patients" Current Psychiatry, April 2012, p. 38; http://bit.ly/JoVwYh), their recommended melatonin dosage (3 to 9 mg) seems high. Zhdanova et al recommended a much lower dose that can decrease time it takes to fall asleep, and said higher doses may cause daytime sleepiness and confusion.[1]

A patient of mine has been taking 1 mg of melatonin and developed night sweats, a side effect not mentioned in the Pearl. Is this common?

Kristina Jones, MD
Instructor in Psychiatry
New York University Medical School
New York, NY

Reference

1. Zhdanova IH, Friedman L. Therapeutic potential of melatonin in sleep and circadian disorders. In: Mischoulon D, Rosenbaum JF, eds. Natural medications for psychiatric disorders: considering the alternatives. 2nd ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:140-162.

The authors respond

We thank Dr. Jones for her interest in our article and for raising interesting points regarding melatonin. We are aware of the recommendation that lower doses of melatonin may be equally effective without causing oversedation. Unfortunately, use typically is limited by dosing preparations available, and most hospital formularies carry higher doses common among commercial preparations. That said, we have not encountered oversedation as a common problem in our patient population, and studies of melatonin for sleep and delirium in the hospital setting typically use high doses.

Disruption of the thyroid axis is not a common side effect. It is not listed as a side effect in the review of safety of complementary medicines cited in our Pearl, and a brief literature search reveals no other reported cases. We also are not aware of an association between melatonin and night sweats.

Scott R. Beach, MD
Attending Physician, Psychiatry Consultation and Acute Psychiatric Services
Instructor of Psychiatry

Shamim H. Nejad, MD
Director, Burns and Trauma Psychiatry
Attending Physician, Psychiatry Consultation Service
Instructor of Psychiatry
Massachusetts General Hospital
Harvard Medical School
Boston, MA

Depression in children

In response to Drs. Shailesh Jain, Rakesh Jain, and Jamal Islam's article, "How to lower suicide risk in depressed children and adolescents," (Current Psychiatry, May 2012, p. 21-31; http://bit.ly/LD77tK), the diagnosis of mood disorders is challenged by the need to discern the difference between fear and unhappiness and mood disorders such as anxiety and depression. Fear and unhappiness are part of life, whereas a mood disorder is an illness. Ambivalent outcomes from studies of antidepressants in children and adolescents come from the inability to know when a child's unhappiness stems from environmental factors rather than biological mood problems.

As a child and adolescent psychiatrist, I feel it is important to not "medicalize" a child's experience because doing so may discourage a thorough inventory of sources of stress and unhappiness. Sometimes it is difficult to know what is going on in a child's life. All self-reports are distorted, especially from children.

An important source of childhood stress may be medically undertreated. Failure in school often plays a part and predates the onset of "depression." School failure is not an incidental issue because school is the most important area of a child's life outside of family; failing is painful and demoralizing. A child who is failing often is very unhappy. I have known children who have committed suicide after failing "again." Often, a child fails his or her classes because of untreated attention-deficit/hyperactivity disorder (ADHD). Diagnosing and treating ADHD can make a real difference in a child's life. The best antidepressant is success.

In my experience, the risk of suicide can be lessened by the positive mood response to success. When we "medicalize" a child's unhappiness rather than address the causes, we might be worsening his or her sense of alienation, which may drive suicidality.

Rodney Vivian, MD
Private Practice
Cincinnati, OH

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Current Psychiatry
7 Century Drive, Suite 302
Parsippany, NJ 07054
letters@currentpsychiatry.com

Benzodiazapine risks

Although the title of April's cover story ("Benzodiazepines: A versatile clinical tool," Current Psychiatry, April 2012, p. 54-63; http://bit.ly/MrIAab) seems to encourage the use of benzodiazepines, the authors state benzodiazepines are second- or third-line treatments for most conditions, particularly for chronic problems.

As an addiction medicine physician, I see well-intentioned doctors prescribing benzodiazepines to patients with chronic ailments. I would like to emphasize the addictive nature of benzodiazepines. "When used appropriately" is contradictory if benzodiazepines are used daily. Tolerance manifests as an exacerbation of the original symptoms, usually leading to a dosage increase. Every day, I see patients in a state of chronic withdrawal manifested in unpleasant ways because they took benzodiazepines "exactly as prescribed, 3 times per day for 4 years."

Alprazolam is the bane of an addiction medicine practice because it crosses the blood-brain barrier immediately and is relatively short acting. This is a recipe for almost certain addiction, and there are better medications. I regularly transition patients from addictive substances, including benzodiazepines, and no matter what condition I am treating—panic attacks, obsessive-compulsive disorder, depression, generalized anxiety, social anxiety, posttraumatic stress disorder, or situational anxiety—I can almost always control the patient's symptoms using non-addictive medications.

If benzodiazepines are used for almost anything other than a short-lived condition, we are doing a tremendous disservice to our patients and exhibiting the "just give them a pill and get to the next patient" mentality we are accused of.

Terrance Reeves, MD, ABAM
Medical Director
South Walton Medical Center
Miramar Beach, FL

The authors respond

We thank Dr. Reeves for his comments and reminders of the downside to routine and long-term prescribing of benzodiazepines. As an addiction specialist, he is well positioned to see patients who are struggling with syndromes related to benzodiazepine abuse. We stand by our review of the evidence-based studies of the appropriateness of judicious benzodiazepine use in various psychiatric syndromes. The section of our article labeled "Risks of benzodiazepine use" addresses Dr. Reeves' concerns.

Jolene R. Bostwick, PharmD, BCPS, BCPP
Clinical Assistant Professor of Pharmacy
University of Michigan College of Pharmacy
Clinical Pharmacist

Michael I. Casher, MD
Clinical Assistant Professor
Department of Psychiatry
University of Michigan Medical School
Director of Inpatient Adult Psychiatry

Shinji Yasugi, MD
First-Year Psychiatry Resident
University of Michigan Health System
Ann Arbor, MI