I’m mindful of the old adage “may you live in interesting times”. When I first heard this expression in my late teens I questioned if it was penned by a humourist, a cynic or a sage. Perhaps in a tangible manner the author was all three. We certainly can see its applicability in the dramatic events of 2009. We saw an intense drive to reform the mental health and addiction system with both a National Commission and a dramatic Provincial Initiative which began with a roar of media fanfare but appears to be going out with a diminutive whimper. It was followed by the monumental mismanagement that became the eHealth saga and the unfulfilled promise of more titillating disclosures to come. We ushered in a new Health Minister who echoed the party line of austerity. This, of course, was preceded by a massive bailout of multi-national corporations. Never has this year’s Presidential Theme of Dignity, Advocacy and Social Justice been more appropriate than now and never has a need for grassroots political activism been more desperately required. I’m not a political zealot but the events of the last few years have shaken me from my apathetic slumber. I think the collective wisdom and experience of many of our members is desperately required to balance the often well intended but brash policy initiatives. I am old enough to remember implementing ineffective health unit policies and receiving prompt and often colourful feedback on my naïveté from more seasoned clinicians. At present there are too many degrees of separation between an idea at a Ministry or LHIN level and the stark reality on the clinical front. I’d encourage all members to advise where you can, challenge where you must and serve where you are able. This invitation, of course, includes consideration of allowing your name to stand as a potential Council member of the OPA. Your wisdom is an asset that is highly valued, indeed.

I’m leaving my role as President just at the point I think I’m beginning to get good at it! This is certainly ironic. I could not be more delighted to introduce your incoming President, Dr. Doron Almagor, who has been a very active Council member at critical times in our recent history. He has a keen intellect and a thoughtful manner that will honour the trust we’ve placed in him. I hope you will attend our 90th Annual Conference on April 23 and 24, 2010, and speak with our Council members in attendance. Council members like our Treasurer, Dr. Deborah Elliott, who has served in this critical, but often thankless role, and Dr. Anne Hennessy, who is the very human face of the OPA in her duties as membership committee chair. Our communication committee is ably lead by Dr. Patricia Cavanagh. The delightfully distractible and incorrigibly inattentive Rick Green will entertain you. You will also enjoy our walk through the OPA timeline with Dr. John Deadman and historical scholar, Dr. Edward Shorter. Dr. Sonu Gaind has served you well as educational committee chair and Past President with an excellent selection of thought provoking topics. I’d like to thank him for his leadership during challenging times. Our venue, Le Méridien King Edward Hotel, was well received last year and promises to showcase another great CME event. I’d encourage you to join with your Council and OPA Manager, Halyna Troian, as we respectfully recognize our past, advocate to meet the challenges of the present and pursue social justice for our future to enhance and enrich the lives of the vulnerable patients we serve.
From the Editor

Coming together is a beginning.
Keeping together is progress.
Working together is success.
— Henry Ford

THIS YEAR the Ontario Psychiatric Association celebrates its 90th Anniversary. One of the oldest associations in Canada, it went through challenging times during its long history, dealing with issues of great importance to its members and the Canadian population in general. But at all times it remained a society of professionals that had two main objectives: to maintain the highest standards of the profession of psychiatry, and to advocate on behalf of the mentally ill and their families. Let us celebrate together this milestone anniversary at the Annual Conference in April! What could be a better opportunity to meet your colleagues and friends, to share your experience with your peers and to learn from your mentors.

In this issue of Dialogue Dr. J. Deadman continues to reflect on OPA history in his column. His article on educational programs at past OPA conferences is most informative.

Earlier this year we experienced first hand the nationwide response to the devastating earthquake in Haiti. We were all struck by the magnitude of the Haiti disaster, and the enormous need for help. In his article, Dr. A. Howlett explores the ways in which our members may offer support to relief efforts in Haiti.

This issue also features Dr. S. Jarmain’s article on the role of seclusion and restraint in an era of recovery; Dr. A. Howlett’s update on PAIRO and physician wellness; an update on tariffs by Dr. K. Sonu Gaind; and Dr. A. Hennessy’s thoughts on the meaning of being a member of the OPA.

We encourage you, our members, to share with us your memories of the OPA, stories about your mentors, people that influenced your career choice and served as role models for your professional development. As always, we welcome your articles, book reviews and clinical cases.

Look forward to seeing many of you at our not-to-be-missed history making 90th OPA Annual Conference!

Halyna Troian, CAE
Editor
We are eagerly looking forward to the upcoming Ontario Psychiatric Association Annual Conference, on April 23-24. This conference marks the OPA’s 90th Anniversary, and following the positive feedback from last year’s conference we are pleased to be returning to the elegant and historic Le Méridien King Edward Hotel in Toronto to celebrate turning 90!

The Education Committee has worked hard to bring you a strong and diverse program, which will start off with a keynote address, “My Award-Winning, Coast-to-Coast Mental Disorder”, by acclaimed producer, director and comedic performer Rick Green. Rick has been diagnosed with adult ADD. He produced the award-winning documentary *ADD & Loving It?!* and recently launched the website TotallyADD.com. We are thrilled that Rick will also be emceeing the Friday night gala dinner, where Sister Margaret Smith of North Bay will be receiving the *T.A. Sweet Award* for her longstanding work in the field of addictions. Other program highlights will include the Jane Chamberlin Memorial Lecture, delivered by Dr. Anthony Levitt on *The Art and Science of Dosing Strategies in the Treatment of Resistant Depression*, a keynote on *The History of Psychiatry and the OPA* by Dr. Edward Shorter and Dr. John Deadman, invited sessions on first episode psychosis by Dr. Suzanne Archie, child psychiatry by Dr. Umesh Jain, geriatric psychiatry by Dr. Marie-France Tourigny-Rivard, and others.

Finally, you will note we have moved the conference into the spring, a wonderful time to visit Toronto. Please join us for the conference and the Friday night gala dinner and meet up with your colleagues from around the province, it promises to be a great program.

K. Sonu Gaind, MD, FRCP(C)
Past President, Ontario Psychiatric Association
OPA Education Committee Chair
I PROXY ELIGIBILITY

Full Members, Life Members and Members-in-Training who are in good standing are entitled to vote at the OPA’s Annual General Meeting. If you are unable to attend the meeting, you may request another person to represent you and your vote.

II VOTING CARD

Voting card(s) will be issued to each voting member on April 23, 2010, just prior to the meeting.

III SUBMISSION OF PROXIES

All those who will be exercising a proxy for a member must hand in a completed proxy form. One voting card per proxy will be issued at the OPA Annual General Meeting registration desk.

IV CONSULTATION WITH THE PERSON EXERCISING YOUR PROXY

Voting members should inform their proxy of their preferred stand on each topic under consideration.

ONTARIO PSYCHIATRIC ASSOCIATION
Annual General Meeting

PROXY

I, ____________________________
(Please print your name)
will be unable to attend the April 23, 2010, Annual General Meeting of the Ontario Psychiatric Association, and hereby designate,

______________________________
(Name of proxy)

OR

☐ OPA Secretary
to act at this meeting with the same power as if I personally attended.

Signature ____________________________

Date ____________________________

Please submit the completed proxy form to the OPA office by Monday, April 19, 2010, by mail (2233 Argentia Road, Suite 100, Mississauga, ON L5N 2X7), fax (905-826-4873) or e-mail opa@eopa.ca.
Reaching Out to Haiti

Following the disastrous earthquake in Haiti, a number of medical organizations, including the Royal College of Physicians and Surgeons of Canada, the Canadian Medical Association, the Ontario Medical Association, and the American Psychiatric Association, wrote to their members offering their condolences and response plans. The OPA would also like to offer its condolences to all those who have been affected by this tragedy. As physicians we are concerned about the well-being and mental health of our patients, neighbours, and communities and we know that this will greatly affect all of us. We hope to do our best to react swiftly to an anticipated increase in demands for psychiatric services.

New information with regards to needs and support options come forward every day and we recommend that you follow these updates online. All organizations indicate that financial donations remain the most effective way to contribute at this time. Our Canadian Government has removed its $50-million dollar cap and will match dollar-for-dollar every donation made by individual Canadians. The OPA would like to thank our members who have already found a way to support relief for Haiti.

If you wish to provide a charitable donation, there are many organizations involved in providing aid to Haiti. Proceeds from the nation-wide program Canada For Haiti (www.canadaforhaiti.com) go toward a coalition of Canadian NGOs, including Canadian Red Cross Society, Care Canada, Free the Children, Oxfam Canada, Oxfam Quebec, Plan Canada, Save the Children Canada, UNICEF Canada and World Vision Canada. Additional information on other charities and how to evaluate charities before making a donation can be found at www.cbc.ca/haitirelief.

Physicians have also asked how they can assist with on-site relief efforts. Physicians have been recruited through organizations such as Médecins Sans Frontières/Doctors Without Borders. The role of psychiatry on the ground has yet to be determined. The APA, for instance, is not yet recruiting volunteers. Those interested in volunteering should refer to these organizations above; however, the APA Guidelines on Mental Health and Psychosocial Support in Emergency Settings (Action Sheet 4.1 Point 7, pages 73-74) state the following: Well-intending foreign mental health professionals (who are not affiliated to any organization) should be discouraged from traveling to disaster affected regions unless they meet the following criteria:

- Previous work in emergency settings;
- Previous work outside own socio-cultural setting;
- Basic competence in interventions covered in guidelines understanding of either community psychology or public health principles;
- Written invitation from a national or established international organization to work in the country;
- Invited to work as part of an organization that is likely to maintain a sustained community presence in the emergency area;
- Not focus work on implementing interventions themselves (e.g. clinical work), but rather providing support to programs on a general level, including the transfer of skills to local staff, so that interventions and supports are implemented by local staff.

To assist in the mental health response, the APA has many resources on disaster psychiatry and disaster mental health care and services posted on their web site, including: Disaster Resources for First Responders, and Providing Assistance to Victims.

Here at home, the Ottawa Sun reported that Haitian-born Psychiatrist, Dr. Pierre Monpremier, and colleagues are offering free psychiatric treatment and counseling over the next six months for those with family and friends in Haiti.

The OPA would be pleased to hear from you about your stories, ideas and efforts to bring relief to those affected. Please write to us at opa@eopa.ca.

Andrew L. Howlett, MD
PGY-3 / University of Toronto
OPA Council Member

Tariff Update

As reported in the last issue of Dialogue, the proposed new relativity model, the Comparison of Average Net Daily Income (CANDI) model, had finally been modified to include a “Skills Acquisition Modifier”, or SAM, which placed a value on additional years of minimum required post-graduate specialty training. This revised CANDI model with SAM modifier was approved in November by OMA General Council, and thus will form the basis for the OMA’s proposals for determining 2010 and 2011 relativity allocations. The Ministry of Health and Long Term Care has also identified several priority areas it wishes to discuss with Sections and address for 2010 and 2011 allocations. While the Section will of course engage in discussions to improve patient care in areas of need, we are also very aware of the need to ensure sectional allocations negotiated on behalf of members are directed in ways to also address our members’ needs. Once more information is available we are planning to survey members for their opinions regarding possible options for future allocations.

K. Sonu Gaind, MD, FRCP(C)
Tariff Chair, OMA Section on Psychiatry
On October 10, 2008, The Globe and Mail reported: “Mental health workers should avoid using physical restraint to control combative patients and adhere to far stricter standards when there is no other option but to use them.” This was a recommendation that came out of the Jeffrey James Coroner’s Inquest, which looked into the death of a 34 year old man with a long and complex history of schizophrenia. Jeffrey James was transferred from Penatanguishine to CAMH, and died of a pulmonary embolism after 5 days of restraint use. The inquest identified a number of concerns including inadequate physician assessment for both mental and physical status of the patient while in restraint. They issued 65 recommendations with far reaching implications for the standards of practice around restraint use. Specific organizations named in the report included Accreditation Canada, CAMH, Psychiatric and Schedule 1 facilities, LHIN’s, RNAO and the Psychiatric Patient Advocate Office (PPAO). As a result of these recommendations, psychiatric facilities have had to reexamine their restraint policies, and often make significant changes in the level of observation and frequency of reassessment of patients by physicians.

The Jeffrey James inquest comes at a time when there has been increasing focus on restraint use in psychiatric facilities across North America, and a concern about the morbidity and mortality related to prolonged use of restraint. In 1998, a team of Hartford Courant reporters and researchers compiled a national database (US) to shed light on deaths that occurred during or shortly after psychiatric or developmentally disabled patients were restrained or secluded. The database documented 142 deaths from 1988 to the 1998, as identified by public agencies, advocacy offices and news accounts. This triggered a report to the US Congress, and subsequently a commissioned report outlining the need for transformation within the mental health system.

A Cochrane Review in 2000 supported the concerns about restraint use when it stated:

“No controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness. There are reports of serious adverse effects for these techniques in qualitative reviews. Alternative ways of dealing with unwanted or harmful behaviours need to be developed.”

(Sailas EES, Fenton M. Seclusion and restraint for people with serious mental illnesses. Cochrane Database of Systematic Reviews 2000, Issue 1.)

In 2003 the Substance Abuse and Mental Health Services Administration (SAMHSA) launched “A National Call to Action: Eliminating the Use of Seclusion and Restraint”. Their National Action Plan has included state incentive grants to identify alternatives to restraint use. They have adopted the “The Six Core Reduction Strategies” – Huckshorn, K. (NTAC, 2006) as an evidence-based approach to work towards elimination of seclusion and restraint:

1. Leadership toward Organization Change
2. Use of Data to Inform Practice
3. Workforce Development
4. Use of Seclusion and Restraint Prevention Tools
5. Full Inclusion of Consumers and Families
6. Rigorous Debriefing [incident review].

One of the most successful examples of significant reduction of seclusion and restraint is the Pennsylvania State Hospital System’s Seclusion and Restraint Reduction Program (Psychiatric Services, September 2005), in which they dramatically reduced the use of seclusion and restraint from 1990 to 2000 — over 90% in some cases.

Canada has lagged behind the US in its lack of a national strategy to reduce the use of seclusion and restraint, but within Ontario there have been a number of significant task forces examining the issues. In 2000, the PPAO completed a Review of Seclusion and Restraint Practices in Ontario Provincial Psychiatric Hospitals in which they identified significant concerns in the use of seclusion and restraint within Ontario. CAMH issued a Restraint Minimization Taskforce Report in 2008 which outlines key components of restraint use minimization that can be used by mental health institutions. The Canadian Patient Safety Institute and the OHA sponsored a paper “Patient Safety in Mental Health” which is the first compendium of information in the area of patient safety and mental health within Canada, and includes a review of the relevant literature. In September 2009 the Ontario Hospital Association (OHA) and Ontario Shores cosponsored a Mental Health Thought Leadership Forum to look at “transforming current practices in the use of restraint and seclusion.” Discussion identified that in order for there to be elimination or even significant reduction in seclusion and restraint use, there needs to be a cultural transformation — where leaders, staff, physicians, clients and families work together to prevent conflict from occurring in the first place, use a trauma-informed approach, and attend to concepts of resiliency and recovery. For physicians in Ontario, it is important to be aware of the changing standards of practice in this area and to actively engage in transforming the system so that our clients receive the highest quality of care possible, while maintaining safety for all involved.

Sarah Jarmain, MD, FRCP(C)
OPA Council Member
New and Relevant from PAIRO

The Provincial Association of Interns and Residents of Ontario (PAIRO) remains active in ensuring that residents across the province continue to receive high standard education, opportunities and value for their efforts in serving the people of Ontario. Here are a few highlights from PAIRO’s activities that I thought might be of importance and interest to our OPA members.

1. RESTRICTED REGISTRATION
Informally known as “moon-lighting”, restricted registration is a program being piloted for residents who wish to work during off-hours. While some provinces enable residents to work as primary care givers, cover in-patient units or community call-shifts over weekends, Ontario removed this privilege for their residents years ago. Given an increase in demand for physician services and a request from members of PAIRO to provide this option, the restricted registration program is bridging this gap. There is a fairly formal process in place for residents to receive restricted registration. For those OPA members who are interested in finding out more about this program, or to post job opportunities for residents, please visit www.restrictedregistrationontario.ca or contact me through the OPA office for more details.

2. DEBT DEFERRAL
Still somewhat buried behind red-tape, residents will soon be able to hold off paying interest or any principal payment on their federal and provincial student loans during residency through the Resident Loan Interest Relief Program. The Ministry of Health and Long Term Care has agreed to temporarily pay the bill. The catch — residents participating in this program will be required to practice in Ontario for five full years after completing their residency, while at the same time paying off their loans.

3. H1N1 PANDEMIC RESPONSE
PAIRO has agreed that their residents would respond in any fashion necessary to help prevent or manage a H1N1 pandemic outbreak. This may include working outside the general expectations and responsibilities of one’s training program such as psychiatry residents operating primary care or vaccine clinics. However, it has not come to this, and in fact, preparation for a H1N1 pandemic response seems almost trivial now given the recent disaster in Haiti. PAIRO has not made a statement with regards to the Haiti disaster, although you may refer to my comments on page 5 of this issue of Dialogue.

4. PHYSICIAN HEALTH & WELLNESS RESOURCE
This resource (www.ePhysicianHealth.com) is available to all physicians and I strongly encourage you to visit this site and review its services. More details about www.ePhysicianHealth.com can be found in the article below.

5. OTHER PAIRO PROJECTS
Please visit www.pairo.org for the latest details on PAIRO activities. Funding for residents is available for enhancing resident programs as well as new patient care initiatives that provide non-clinical benefits for patients served by residents.

Andrew L. Howlett, MD
PGY-3 / University of Toronto
OPA Council Member

The Latest in Physician Wellness

Physicians may be the most difficult patient population to treat. Although they share many illnesses with other patient populations, doctors’ professional demands and pride may interfere with timely recognition and management of conditions. These may ultimately become quite costly to their health and their ability to practice. Mental health conditions are one of the most serious and under-recognized ailments of physicians. To improve physician wellness a number of experts in the area, including members of the OPA, have spear-headed an e-based wellness program for all physicians. ePhysicianHealth.com is now free and accessible on the Internet. I encourage you to peruse the site and review the variety of modules: from managing appropriate life style behaviours, to more serious conditions such as disruptive behaviour of physicians and substance abuse problems.

This will be of value to physicians who are well, and also when you find yourself under stress. When I read through this site I was surprised to discover many familiar faces including my OPA colleagues as well as Dr. Yoni Freedhoff from the Bariatric Medical Institute in Ottawa. These prompted me to remember just how important it is to remain connected to those invested in healthy living and in particular, physician wellness. As a psychiatrist in training, it is critical to mold one’s practice into a healthy and sustainable one.

Andrew L. Howlett, MD
PGY-3 / University of Toronto
OPA Council Member
The Ontario Psychiatric Association and its predecessor, the Ontario Neuro-Psychiatric Association will be officially 90 years old at the time of our Annual Meeting in April. The meeting will be held at Le Méridien King Edward Hotel on the 23rd and 24th of April which is only a few days before the anniversary of the first meeting on the 28th of April, 1920. Throughout those 90 years, the ONPA and the OPA have always included scientific papers and presentations in their general meetings. For a time in the 1920s, the ONPA published a journal consisting of papers presented at recent meetings. There was an attempt to restart the journal after the Second World War. A mimeographed document did come out a few times but the costs and long delays in commercial printing in those years meant that this journal was short-lived.

The Evolution of the Annual General Meeting

The Annual General Meeting was the focus of the presentations, but from the early years, a Fall Meeting was also held. These were held in the various Ontario Hospitals in the system with occasional meetings at the Toronto Psychiatric Hospital or the Homewood Sanatorium. Several meetings after the war were held at Sunnybrook or Westminster because the mental health of returning veterans was a big concern as it is now. These were afternoon or one day meetings depending on the length of the program. The fall clinical meeting on 28th of September, 1956, was held at the Park Plaza Hotel and for several years after that, annual meetings were held at the King Edward Hotel. By this time, there was a growing program that meant that the presentations were sometimes spread out over two days.

I attended my first OPA annual meeting at the Park Plaza Hotel in January 1966. I remember that there were paper sessions and symposia by different sections and usually a keynote speaker on a topic of the day. It was a Friday and Saturday meeting, but that year the Community Psychiatry Section held a panel discussion on the Thursday evening before. I have only missed two OPA annual meetings since then.

The January meeting was gradually extended to three days. Dr. Stanley Greben was Program Chair at that time and he can be credited with creating an annual meeting that was the equal of any in Canada. As the program got busier, the Park Plaza could no longer accommodate us and the meeting was moved to the Sheraton Centre. We had a couple of years at the Royal York. One of those years was the big blizzard which closed down the downtown of Toronto for almost a day. This led people to comment that there always seemed to be a big snowstorm at the time of the OPA meeting. It was then at the King Edward, the Delta Chelsea and the Eaton Centre Marriott until last year when we returned to the King Edward Hotel.
SOME TOPICS OF DISCUSSION OVER THE YEARS

In the early years there was a heavy emphasis on medical and neurological topics. The 1925 meetings had presentations on the diagnosis of frontal lobe tumours, and acute haemorrhagic encephalitis. The one psychiatric paper, presented by Professor Humphries of Queens University, was entitled: “Some Criticisms of the Freudian Concept of the Preconscious.”

In 1926 there was much discussion on Dementia Praecox and the new term, Schizophrenia that was then beginning to appear in the literature. Dr. W.E. Blatz, for many years chair of the Department of Psychology at the University of Toronto, gave a paper on Mental Hygiene. Dr. C.B. Farrar, Chair of the Department of Psychiatry described the community services available at the Toronto Psychiatric Hospital.

In 1927, the spring meeting was at the Ontario Hospital for Epileptics in Woodstock, and the fall meeting was at the Ontario Hospital for the Feeble Minded in Orillia with topics related to those facilities.

A paper in 1928 was: “The Intensive Use of Bromides in the Treatment of the Functional Neuroses.” Another topic was: “Post-encephalitic Paralysis Agitans.” Does anyone know what that condition is?

The eugenic sterilization of the feeble-minded was discussed at the meeting of 27th of May, 1930. The outcome of the discussion is not recorded. In 1932, the psychiatric examination for deportation was discussed. The ONPA seemed to get into loaded socio-political topics at that time. There were also discussions on neuro-syphilis and general paresis of the insane (GPI) which were filling the back wards of all the hospitals in those days. This was in the days before penicillin. How quickly we forget.

A sample program from 1934 has much about it that is familiar although the terminology has changed:

“Encephalography”
— Dr. D.R. Gunn, Ontario Hospital, Toronto.

“Analysis of Death Resulting from Acute Mental Excitement”
— Dr. G.H. Hutton, Ontario Hospital, Hamilton.

“Psychoneurosis and Conjugal Psychopathy”
— Dr. H.C. Moorehouse, Ontario Hospital, Brockville.

“Psychiatry and the Criminal Code”
— Dr. K.G. Gray, Ontario Hospital, Mimico.

“Current Trends in Mental Hygiene”
— Dr. C.M. Hincks (Guest Speaker), General Director National Committee for Mental Hygiene.

Some names from the past. I don’t remember Dr. Hutton, but all of the others were still active when I was a student.

The topics continued in this vein throughout the 1930s and 1940s. At the June 1938 meeting, Dr. Norm Easton, who just retired from the Ontario Hospital, New Toronto in the early 1960s, gave a paper: “The Insulin Shock Treatment of Schizophrenia.” This is the first mention of Insulin Coma in the minutes.

No meetings were held in 1940, 1941 or 1942 because of the extreme shortages of psychiatrists and physicians during the Second World War. At the meeting of 15th January, 1943, members were given the opportunity of witnessing a leucotomy operation at the Toronto General Hospital and a long discussion followed. It was performed by neurosurgeon Dr. K.G. McKenzie who worked in many hospitals in the system over the next 20 years. A quote in those minutes. The final sentence is a harbinger of things to come: The afternoon session was held at the Psychiatric Hospital and Dr. L.D. Proctor of the Research Unit presented post-operative cases, all of whom have received Metrazole, Insulin or Electro-Shock without definite improvement.

After the Second World War, the topics begin to take on a more familiar tone although there is an increasing awareness of the happenings in psychiatry by the general public. The Canadian Psychiatric Association was founded in 1951 and discussions as to whether the ONPA should amalgamate with it resulted in a decision to affiliate but not amalgamate. A joint meeting between CPA and ONPA in 1955 at the Royal York Hotel was chaired by Dr. Ewen Cameron of McGill University, and Sir Aubrey Lewis from the Maudsley Hospital in London England was the discussant.

On September 29th, 1956, the name was changed to the Ontario Psychiatric Association and a new constitution was adopted. Although it could be thought of as the end of an era, the transition was so seamless that many people did not notice the change.

John C. Deadman, MD, DPsych, FRCP(C) Archivist
Membership of OPA: What does membership mean?

In these times of Internet connectivity, when it is easy to reach halfway across the world with a couple of keyboard clicks many groups are having a tough time getting people together to connect, discuss issues and support each other.

Membership means being part of a group but I like the derivation where a member is a supporting strut holding up an edifice. Without you, the members, the whole house will fall down for the Ontario Psychiatric Association.

This organization has been around for 90 years arising from the Ontario Neuro-Psychiatric Association.

The council represents all university faculties of Ontario and community based psychiatrists and liaises with the OMA through the Coalition of Ontario Psychiatrists. We also have a healthy relationship with the CPA.

The OPA has the mandate to enhance scientific discourse between members, and through its Annual Meeting and the meeting of the psychotherapy section it endeavours to meet this mandate.

Membership is under pressure because of many factors:
• The greying of the psychiatric profession.
• Difficulty recruiting younger psychiatrists.
• A plethora of meetings and associations competing for a shrinking market (pun intended).

As a member of the OPA Council I am aware of the constant need to be relevant, responsive to members and recruitment focused.

The OPA has been a constant part of my professional life; the meetings are friendly, collegial and allow residents and younger members to meet and connect with friends and colleagues and to learn at the same time.

We welcome your input, your voice and thank you for your ongoing MEMBERSHIP!

Anne Hennessy, MD, FRCP(C)
OPA Member Services Committee Chair

AGHPS – Connecting through Technology

The Association of General Hospital Psychiatric Services (AGHPS) is pleased to have this opportunity to provide a brief summary of our activity in 2009 and some of the planning for 2010.

With the People at Risk of Suicide Project completed, the AGHPS focused attention in 2009 to complete extensive work on our web site in order to be increasingly helpful to Ontario’s Schedule I hospitals.

The AGHPS has always been a pragmatic Association interested in making a difference to the front line mental health professionals in Ontario. Throughout our work with the Prevention of Suicide Project and in various surveys over the last few years we have asked our members how we can be more helpful to them. Repeatedly we were asked to play a lead role in bringing the hospitals together — to act as a “hub” that would allow the collecting and sharing of good ideas and best practices across Ontario. As we worked through the Project we were struck with the number of excellent initiatives and practices at individual hospitals and the inability to share our collective work in a simple and effective manner.

The AGHPS took this vision forward and has now developed an interactive web site that will allow General Hospitals to easily ask questions, post comments, attach policies, guidelines and other documents — to interact with their peers.

In practical terms, we are now in a position to be able to send an e-mail blast to Chiefs of Psychiatry and/or Directors of Mental Health in all Schedule I facilities in Ontario. We can ask them directly to advise us on their priorities (needs assessments), survey the province on specific questions ranging from administrative issues (e.g. office rents) to practice guidelines. We can ask those professional leaders to post comments and share their policies and documents with others.

To assist with the launch of the web site, the AGHPS had USB flash drives with www.aghps.com made and a tutorial about how to use the web site. These are being mailed to Chiefs of Psychiatry and Directors of Mental Health throughout the province. We will also hold online educational sessions through March 2010. We encourage everyone to take advantage of this new interactive site and we welcome your comments.

June Hylands
Executive Director, AGHPS
Prescribing Summary

Patient Selection Criteria

INDICATIONS AND CLINICAL USE

Adults: SEROQUEL XR (quetiapine fumarate extended-release) is indicated for the symptomatic relief of major depressive disorder (MDD) when currently available approved antidepressant drugs have failed either due to lack of efficacy or/and lack of tolerability. While there is no evidence that the efficacy of SEROQUEL XR is superior to other antidepressants, it provides a treatment option for patients who have failed on previous antidepressant treatments. Treatment must take into account the safety concerns associated with antipsychotic drugs, a class of drugs to which SEROQUEL XR belongs.

Safety Concerns of this Class Include: weight gain, hyperglycemia, hyperlipidemia, tardive dyskinesia, and neuroleptic malignant syndrome (see WARNINGS AND PRECAUTIONS). SEROQUEL XR should only be prescribed in patients with MDD by clinicians who are aware of the importance and are experienced in the early detection and management of the aforementioned safety issues associated with this class. Long-term safety of SEROQUEL XR in MDD has not been systematically evaluated. Thus, the physician who elects to use SEROQUEL XR in the treatment of MDD should use SEROQUEL XR for the shortest time that is clinically indicated. When long-term treatment is indicated, the physician must periodically reevaluate the long-term usefulness of the drug for the individual patient keeping in mind the long-term risks (see SUPPLEMENTAL PRODUCT INFORMATION). Quetiapine (≥65 years of age): SEROQUEL XR is not indicated in elderly patients with dementia (see Serious Warnings and Precautions box and Special Populations). Pediatrics (≤18 years of age): The safety and efficacy of SEROQUEL XR in children under the age of 18 years have not been established.

SEROQUEL XR is also indicated for the management of the manifestations of schizophrenia, as monotherapy for the acute treatment of manic episodes associated with bipolar disorder and as monotherapy for the acute management of depressive episodes associated with bipolar II disorder. Please consult the Product Monograph for complete prescribing information.

CONTRAINDICATIONS

SEROQUEL XR (quetiapine fumarate extended-release) is contraindicated in patients with a known hypersensitivity to this medication or any of its ingredients.

Special Populations

Pregnant Women: Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with SEROQUEL XR. The safety and efficacy of SEROQUEL XR during human pregnancy have not been established. Therefore, SEROQUEL XR should only be used during pregnancy if the expected benefits justify the potential risks. Nursing Women: The degree to which quetiapine is excreted into human milk is unknown. Women who are breast-feeding should therefore be advised to avoid breast-feeding while taking SEROQUEL XR. Pediatrics (≤18 years of age): The safety and efficacy of SEROQUEL XR in children under the age of 18 years have not been established. Quetiapine (≥65 years of age): The number of patients 65 years of age or over exposed to SEROQUEL XR during clinical trials was limited (n=68). When compared to younger patients the mean plasma clearance of quetiapine was reduced by 30% to 50% in elderly subjects. In addition, as this population has more frequent hypotension, erect, central nervous system, and cardiovascular dysfunctions, more frequent use of concomitant medication, caution should be exercised with the use of SEROQUEL XR in the elderly patient (see ADMINISTRATION). In a clinical trial that evaluated nonmanic elderly patients (aged 66 to 89 years) with MDD, the tolerability of SEROQUEL XR was once daily compared to that seen in adults (aged 18-65 years) other than the incidence of extrapyramidal symptoms (see WARNINGS AND PRECAUTIONS, Neurologic, Sympathetic Dystonia (TD) and Extrapyramidal Symptoms (EPS)). Use in Geriatric Patients with Dementia: Overall Mortality: Elderly patients with dementia treated with atypical antipsychotic drugs showed increased mortality compared to placebo in a meta-analysis of 13 controlled trials of various atypical antipsychotic drugs. In two placebo-controlled trials with seroquel in this population, the incidence of mortality was 3.5% for seroquel-treated patients compared to 3.2% for placebo-treated patients. SEROQUEL XR is not indicated in elderly patients with dementia. Dystypia: Dystypia (dyskinesia and dystonia) have been associated with antipsychotic drug use. Dystypia (dyskinesia and dystonia) have been associated with antipsychotic drugs. Hyperglycemia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. SEROQUEL XR and other antipsychotic drugs should be used cautiously in patients at risk for hyperglycemia.

General: Body Temperature Regulation: Disruption of the body's ability to induce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SEROQUEL XR (quetiapine fumarate extended-release) for patients who will be experiencing conditions which may contribute to an intolerance of core temperature, e.g., exercising strenuously, exposure to extreme heat, maintaining concurrent medication with an anti-cholinergic activity or being subject to hypothermia. Acute Withdrewal (Discontinuation) Symptoms: Acute discontinuation symptoms such as insomnia, sweating, hypotension, tachycardia, and irritability have been described after abrupt cessation of antipsychotic drugs including SEROQUEL XR. Symptoms usually resolved within two weeks post discontinuation. Cardiovascular: Hypotension and Syncope: As with other drugs that have high α1 adrenergic receptor blocking activity, SEROQUEL XR may induce orthostatic hypotension, dizziness and somnolence syncope, especially during the initial titration phase. These events may lead to falls. In placebo-controlled SEROQUEL XR trials, there was little difference in the adverse reaction reporting rates of syncope in patients treated with SEROQUEL XR (0.5%, 11/2388) compared to patients on placebo (0.3%, 4/1267). Syncope was reported in 1.9% (35/1803) of patients treated with SEROQUEL XR (quetiapine, immediat华人版 formulation), compared with 0.3% (9/3170) on placebo and 0.4% (2/527) on active control drugs. SEROQUEL XR should be used with caution in patients with known cardiovascular disease (e.g., history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cardiovascular disease or other conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications) (see OVERDOSAGE). Cholesterol and Triglyceride Elevations: Very common (>10%) cases of elevations in serum high-density lipoprotein (HDL) cholesterol (0.25 mmol/L or at least one occasion) and elevations in total cholesterol (predominantly LDL cholesterol) and increased triglyceride levels have been observed during treatment with quetiapine in clinical trials (see ADVERSE REACTIONS). Lipid increases should be managed as clinically appropriate. In a 6-week MDD monotherapy clinical trials, SEROQUEL XR-treated patients had increases from baseline in mean triglycerides of 8%, compared to a mean decrease of 1% for placebo-treated patients. In the same trials, both SEROQUEL XR and placebo-treated patients had decreases from baseline in mean cholesterol of 1% and 3%, respectively. In a long-term randomized expanded MDD trials, patients who completed at least 158 days of SEROQUEL XR treatment (n=196) showed mean increases from baseline in triglycerides of approximately 5% and mean decreases from baseline in cholesterol of approximately 4%. Edema and Metabolism: Hypoglycemia: As with other atypical antipsychotics, hypoglycemia and diabetics medications (including association of pre-existing diabetes, diabetic ketoacidosis and diabetic coma including some fatal cases) in the aggregate have been reported rarely (0.01% - 0.1%) during the use of quetiapine in post-marketing experience, sometimes in patients with an unreported history of hypoglycemia (see ADVERSE REACTIONS, Post-Marketing Adverse Drug Reactions). Blood glucose increases to hypoglycemia levels (fasting glucose ≥7.0 mmol/L, or a non-fasting blood glucose ≥11.1 mmol/L or at least one occasion) have been observed commonly (≥1% - <10%) with quetiapine in clinical trials. Occasional reports of diabetes have also been observed in clinical trials with quetiapine (see ADVERSE REACTIONS, Abnormal Hematologic and Clinical Chemistry Findings). Assessment of the relationship between atypical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes mellitus in patients with schizophrenia and the increasing incidence of diabetes mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemia-related adverse events is not completely understood. However, epidemiologic studies suggest an increased risk of treatment-emergent hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemia-related adverse events in patients treated with atypical antipsychotics are not available. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia and weight gain. Patients who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued, however, some patients required continuation of anti-hyperglycemic treatment despite discontinuation of the suspected drug. Patients with risk factors for diabetes mellitus (e.g., obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Patients with an established diagnosis of diabetes mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Hyperprolactinemia: During Clinical
trials with quetiapine, elevation in proctid levels occurred in 5.6% (156/4416) of patients treated with quetiapine compared to 2.6% (51/1960) on placebo (see ADVERSE REACTIONS). Increased proctid levels with quetiapine were observed in ret studies. As is common with compounds which stimulate proctid release, the administration of quetiapine resulted in an increase in the incidence of mammary neoplasms in rats. The physiological differences between rats and humans with regard to proctid make the clinical significance of these findings unclear. In date, neither clinical nor epidemiological studies have shown an association between chronic administration of drugs that stimulate proctid release, and mammary tumorigenesis. Tissue culture experiments, however, indicate that approximately one third of human breast cancers are proctid dependent in vitro, a point of potential importance if proctid is used in a patient with previously detected breast cancer. Possible mechanisms associated with elevated proctid levels are aromatization, galactorrhoea and mammosomatostatin. Hypertension/myocardial infarction in SERQUEL XR clinical trials, 0.2% (6/3359) of patients on SERQUEL XR compared to 0.1% (19/7646) on placebo experienced decreased free thyroxine and 2.7% (60/3359) on SERQUEL XR compared to 0% (0/7646) on placebo experienced increased free thyroxine levels in clinical trials. However, because of proctid-dependent increase in proctid levels and total cumulative dose of any proctid drugs administered to the patient increase, the symptoms of thyroid dysfunction may occur more frequently during long-term treatment with SERQUEL XR. These reductions were not associated with serious consequences or progression during long-term treatment. Decreases in TSH were not associated with systemic changes in I SH or clinical signs or symptoms of hypothyroidism. Approximately 0.1% (2/2429) of patients treated with SERQUEL XR experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. Weight Change: In 6-week placebo-controlled MAD acute monotherapy clinical trials, for patients treated with SERQUEL XR mean weight gain was 0.69 kg (0.2-3.6 kg) compared to 0.37 kg (0.1-3.6 kg) in patients treated with placebo. In a longer term randomized, placebo controlled clinical trial, patients who completed at least 156 days of SERQUEL XR treatment (n=107), mean weight gain for patients in SERQUEL XR 50, 150 and 300 mg/day groups was 1.0 kg, 2.5 kg and 2.0 kg, respectively. In those same patients the generation of patients experiencing a weight increase of 5% by 156 days in SERQUEL XR 50, 50 and 300 mg/day groups was 15%, 34% and 35%, respectively. Based on the cumulative acute and chronic controlled clinical trial database, weight gain (based on a 28% increase in body weight from baseline) was reported in 9.6% in quetiapine-treated patients and 3.8% in placebo-treated patients, which occurs predominantly during the early weeks of treatment in adults. Gastrointestinal: Affective/Anxiety: Consistent with its dopamine antagonist effects, SERQUEL XR may have an anticholinergic effect. Such an effect may cause an increased dryness of mouth due to overdose of other drugs, as no major symptoms of disease such as brain humour or interstitial haemorrhage. Haematologic: Neutropenia: Severe neutropenia (<0.5 x 10^9/L) has been uncommonly reported in quetiapine clinical trials. There was no apparent dose relationship. Possible risk factors for leukopenia and/or neutropenia include pre-existing low white cell count (WBC) and history of drug-induced leukopenia and/or neutropenia. SERQUEL XR should be discontinued in patients with a neutrophil count <1.0 x 10^9/L. These patients should be observed for signs and symptoms of infection and neutrophil counts followed (until they exceed 1.5 x 10^9/L) (see ADVERSE REACTIONS: Abnormal Hematologic and Clinical Chemistry Findings and Food/Market Advisor Drug Interactions). Hepatic: Hepatic Impairment: Decreased clearance of SERQUEL XR was observed in patients with mild hepatic impairment (see ACTION AND CLINICAL PHARMACOLOGY). Special Considerations: Contraindicated in patients with decompensated liver disease, and those with chronic liver disease. SERQUEL XR should be avoided in patients with moderate or severe hepatic impairment. However, should clinical judgement deem treatment with SERQUEL XR necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see ADMINISTRATION). Transaminases: Asymptomatic, transient and reversible elevations in serum transaminases (primarily ALT) associated with SERQUEL XR have been reported. The proportion of patients with transaminase elevations of >3 times the upper limits of the normal reference range in a pool of placebo-controlled trials were approximately 1% for both SERQUEL XR and placebo. During double-blind clinical trials, therapy with SERQUEL XR was associated with an elevation of hepatic transaminases, primarily ALT. Precipitation should be associated when using SERQUEL XR in patients with pre-existing hepatic disorders, in patients who are being treated with potentially hepatotoxic drugs, or if treatment-emergent signs or symptoms of hepatic impairment appear. For patients who have been known or suspected abnormal hepatic function prior to starting SERQUEL XR, standard clinical assessment, including measurement of transaminase levels, is recommended. Periodic clinical assessment with transaminase levels is recommended for such patients, as well as for patients who develop any signs and symptoms suggestive of a new onset liver disorder during SERQUEL XR therapy. Neurologic: Neuroleptic Malignant Syndrome (NMS): Neuroleptic malignant syndrome is a potentially fatal symptom complex that has been reported in association with antipsychotic drugs, including SERQUEL XR. The clinical manifestations of NMS are hyperthermia, muscle rigidity, altered mental status and evidence of autonomic instability (tachycardia, labile blood pressure, hyperthermia, diaphoresis and hyperpyrexia). Additional signs may include dilated pretndent chlorophantophobia, myalgia/arthralgia and acute mental failure. In a review of the literature, it is important to identify cases when the clinical presentation includes both severe medical illness (e.g., pneumonia, systemic infection, etc.) and eunuchoid or inadequately treated antipsychotic signs and symptoms. Other important considerations in the differential diagnosis include central anticholinergic toxicity, heat stroke, drug fever and primary central nervous system pathology. The management of NMS should include immediate discontinuation of antipsychotic drugs, including SERQUEL XR, and other drugs not essential to control therapy; intensive symptomatic treatment and medical monitoring, and treatment of any concomitant serious medical problems for which specific treatments are available. There is no general agreement about specific pharmacologic treatment regimens for uncomplicated NMS. If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored since reoccurrence of NMS have been reported. Tardive Dyskinesia (TD) and Extrapyramidal Symptoms (EPS): Tardive dyskinesia is a syndrome of persistently irreversible, involuntary, dyskinetic movements that may develop in patients treated with antipsychotic drugs. Although the prevalence of the syndrome appears to be highest among the elderly, especially elderly women, it is impossible to rely upon estimates to predict which patients are likely to develop the syndrome. In short-term, placebo-controlled monotherapy clinical trials in MAD, the aggregated incidence of EPS was 5.4% for SERQUEL XR and 3.2% for placebo. In a short-term, placebo-controlled monotherapy trial in elderly patients with MAD, the aggregated incidence of EPS was 9.0% for SERQUEL XR and 2.3% for placebo. In long-term studies of schizophrenic, bipolar disorder and MAD, the aggregated incidence of tardive dyskinesia of treatment-emergent EPS was similar between quetiapine and placebo. The risk of developing TD was much higher (4.8%) in elderly patients who were anticholinergic treated and received the combined dosage of anticholinergic treatment and the total cumulative dose of antipsychotic drugs administered to the patient increases. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of TD, although the syndrome may remit, partially or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect that antipsychotic suppression has on the long-term course of the syndrome is unknown. Given these considerations, SERQUEL XR should be prescribed in a manner that is most likely to minimize the occurrence of TD. Chronic antipsychotic treatment should generally be reserved for patients who appear to suffer from a chronic illness that is known to respond to antipsychotic drugs, and who, for the treatment of unusual interests, efficacy, but potentially less harmful treatments are not available or inappropriate. In patients who do require chronic treatment, the smallest dose and the shortest duration of treatment producing a satisfactory clinical response should be sought. The need for continued treatment should be reassessed periodically. If signs and symptoms of TD appear in a patient on SERQUEL XR, drug discontinuation should be considered. However, some patients may require treatment with SERQUEL XR despite the presence of the syndrome. Consideration should be given to clinical trials with SERQUEL XR, there was no difference in the incidence of seizures in patients treated with SERQUEL XR (0.04%, 1/2938) or placebo (0.2%, 5/256). Nevertheless, as with all antipsychotics, caution is recommended when treating patients with a history of seizures or with conditions associated with a lowered seizure threshold (see ADVERSE REACTIONS). Potential Effect on Cognitive and Motor Performance: Sermonix was a very commonly reported adverse event in patients treated with SERQUEL XR, especially during the initial dose titration period. Since SERQUEL XR may cause sedation and impair motor skills, patients should be cautioned about performing activities requiring mental alertness, such as operating a motor vehicle or hazardous machinery, until they can reasonably ensure that therapy with SERQUEL XR does not affect them adversely. Sermonix may lead to fall. Cholinergic System: Anticholinergic: The development of anticholinergic symptoms was evaluated in association with quetiapine treatment in chronic drug studies at 4 times the recommended human dose. Lapse changes have also been observed in patients during long-term SERQUEL treatment that are consistent with the cholinergic effects observed with SERQUEL XR. There were no changes in pupil size or ptosis. None of these effects were detected after 6 months treatment with SERQUEL XR and 6 months intervals thereafter, are recommended. If clinically significant loss changes associated with SERQUEL XR use are observed, discontinuation of SERQUEL XR should be considered. Psychologic: Sedation/Sedative Thoughts or Clinical Worsening: Depression and cognitive adverse events are associated with increased risk of suicidal thoughts, self-harm and suicide (includes self-harm events). This risk persists until significant remission of depression occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery. Patients with a history of suicide-related events are also known to be at a greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment. In MAD acute monotherapy clinical trials, the incidence of treatment-emergent suicidal ideation or suicide attempt was 0.7% in SERQUEL XR treated patients and 0.7% in placebo-treated patients. In a longer-term randomized withdrawal study in patients with MAD, the incidence during monotherapy treatment was 0.8% for SERQUEL XR and 0.3% for placebo. However, there is little experience with SERQUEL XR in patients with renal impairment, except in a few published single-dose studies with SERQUEL XR. SERQUEL XR should therefore be used with caution in patients with impaired renal function, especially during the initial dose titration period (see ADMINISTRATION). ADVERSE REACTIONS Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials: The most commonly observed adverse events associated with the use of SERQUEL XR, Incidence of at least 5%, and an incidence of at least 5% higher than that observed with placebo, during acute monotherapy with SERQUEL XR were dry mouth, sedation, constipation, dizziness and fatigue. Adverse Events Associated With Discontinuation in Short-Term Placebo-Controlled Clinical Trials: In placebo-controlled monotherapy MAD trials, 14.3% of patients on SERQUEL XR discontinued due to adverse events compared to 4.5% on placebo. In placebo-controlled monotherapy trial in elderly patients with
**SUPPLEMENTAL PRODUCT INFORMATION**

**Adverse Reactions**

The most frequent adverse events reported were headache, urge incontinence, and dry mouth in 1% of patients. In addition, the most frequent laboratory abnormalities were increased creatinine, decreased serum potassium, increased blood urea nitrogen, and increased serum uric acid. The most frequent clinical laboratory abnormalities were increased creatinine, decreased serum potassium, increased blood urea nitrogen, and increased serum uric acid.

**Drug Interactions**

Drug interactions with quinapril can occur with other drugs that affect blood pressure. The most frequent interaction is with diuretics, which may lead to a decrease in blood pressure. Other drugs that may interact with quinapril include ACE inhibitors, angiotensin receptor blockers, and beta blockers. These interactions can lead to a decrease in blood pressure and an increased risk of hypotension.

**Contraindications**

Quinapril is contraindicated in patients with a history of angioedema due to angiotensin-converting enzyme (ACE) inhibitors. Quinapril is also contraindicated in patients with a history of adrenal insufficiency, severe hypotension, or severe renal impairment.

**Warnings and Precautions**

Quinapril should be used with caution in pregnant women and in patients with a history of diabetes mellitus. Quinapril should also be used with caution in patients with a history of liver disease or alcoholic liver disease.

**Non-steroidal Anti-inflammatory Drugs**

Quinapril should be used with caution in patients taking non-steroidal anti-inflammatory drugs (NSAIDs), as these drugs may increase the risk of gastrointestinal bleeding. Quinapril should also be used with caution in patients taking cyclosporine, which may increase the risk of nephrotic syndrome.

**Overdose**

Overdosage may result in hypotension, bradycardia, and renal failure. In cases of overdose, supportive measures such as delayed gastric emptying and hemodialysis may be indicated.

**Administration**

Quinapril is administered orally as a single daily dose. The dose may be increased as needed to achieve the desired blood pressure and to keep the dose above 10 mg daily. The maximum recommended dosage is 150 mg daily.

**Usual Dose**

The recommended dose is 50 mg once daily. However, the dose may be increased to 100 mg once daily if necessary.

**Day 1**

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**References**


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Drug Interactions

Drug-drug interactions: The effect of SEROGLIDE XR on Other Drugs: Adverse effects of SEROGLIDE XR should be compared to the adverse effects of concomitant drugs. The recommended daily dose of SEROGLIDE XR as a monotherapy is 120 mg. When SEROGLIDE XR is used in combination with other drugs, the dosage of SEROGLIDE XR should not exceed 120 mg daily. The concomitant use of other drugs may affect the absorption, bioavailability, and disposition of SEROGLIDE XR. It is recommended that the concomitant use of other drugs be minimized to ensure that the benefits of SEROGLIDE XR are not outweighed by the risks associated with concomitant use. The following drugs have been shown to interact with SEROGLIDE XR: diuretics, beta-blockers, ACE inhibitors, angiotensin II receptor antagonists, calcium channel blockers, and potassium-sparing diuretics. The concomitant use of these drugs may increase the risk of hyperkalemia. Additionally, SEROGLIDE XR may interact with other drugs that affect the renin-angiotensin-aldosterone system, such as spironolactone, eplerenone, and sacubitril/valsartan. These drugs may increase blood pressure, increase the risk of hyperkalemia, and decrease the effectiveness of SEROGLIDE XR.

Overdose

For management of suspected drug overdose, contact your regional Poison Control Centre.

Exposure: Clinical trials: The oral dose of SEROGLIDE XR has been shown to be safe and effective. The recommended daily dose is 120 mg. In overdose situations, supportive care is the primary treatment. If the patient is comatose, gastric evacuation may be performed. Activated charcoal may be given to prevent absorption of the drug. Hemodialysis or peritoneal dialysis may be considered for patients with renal failure. For patients with respiratory depression, naloxone hydrochloride may be administered. In cases of severe hyperkalemia, intravenous sodium bicarbonate solution may be administered to correct the acidosis. The patient should be monitored for signs of improvement.

AstraZeneca

Product: SEROGLIDE XR is available under the name of AstraZeneca. The product information is provided by AstraZeneca. For more information, please visit the AstraZeneca website.
SEROQUEL XR (quetiapine fumarate extended-release) is indicated for the symptomatic relief of major depressive disorder (MDD) when currently available approved antidepressant drugs have failed either due to lack of efficacy and/or lack of tolerability.

While there is no evidence that the efficacy of SEROQUEL XR is superior to other antidepressants, it provides a treatment option for patients who have failed on previous antidepressant treatments. Clinicians must take into account the safety concerns associated with antipsychotic drugs, a class of drugs to which SEROQUEL XR belongs. Safety concerns of this class include weight gain, hyperlipidemia, hyperglycemia, tardive dyskinesia, and neuroleptic malignant syndrome (see WARNINGS AND PRECAUTIONS). SEROQUEL XR should only be prescribed to patients with MDD by clinicians who are aware of the importance and are experienced in the early detection and management of the above-mentioned safety issues associated with this class.

Long-term safety of SEROQUEL XR in MDD has not been systematically evaluated. Thus, the physician who elects to use SEROQUEL XR in the treatment of MDD should use SEROQUEL XR for the shortest time that is clinically indicated. When long-term treatment is indicated, the physician must periodically re-evaluate the long-term usefulness of the drug for the individual patient keeping in mind the long-term risks. SEROQUEL XR is also indicated for the management of the manifestations of schizophrenia, as monotherapy for the acute management of manic episodes associated with bipolar disorder and as monotherapy for the acute management of depressive episodes associated with bipolar I and bipolar II disorder. Please consult the Product Monograph for complete prescribing information.

SEROQUEL XR (quetiapine fumarate extended-release) is contraindicated in patients with a known hypersensitivity to this medication or any of its ingredients.

During acute MDD therapy with SEROQUEL XR, the most commonly observed adverse events associated with the use of SEROQUEL XR (incidence of at least 5% and an incidence at least 5% higher than that observed with placebo) were as follows: Adverse: dry mouth (35%), dizziness (29%), akathisia (27%), drowsiness (17%), and headache (17%). Elderly: somnolence (33%), dry mouth (20%), headache (19%) and fatigue (8%).

Increases in blood glucose and hyperglycemia, and occasional reports of diabetes have been observed in clinical trials.

Eye examinations are recommended prior to, or shortly after, initiation of treatment and at 6-month intervals thereafter. Caution should be used in the elderly and those with a known hepatic and renal impairment.

Serious Warnings and Precautions

Increased Mortality in Elderly Patients With Dementia

Elderly patients with dementia treated with antipsychotic drugs are at an increased risk of death compared to placebo. A meta-analysis of 18 randomized, double-blind trials with various antipsychotic agents (mean duration of 10 weeks) in these patients showed a 1.5% increase in death rate in the drug-related patients. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature.

Please consult the Product Monograph for warnings, precautions and adverse events.


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