12th Annual Primary Care Conference

January 9, 2021

Audience Questions and Faculty Responses

Depression in the Primary Care Setting – Dr. Rohini Mehta	
When is cytomel used for augmenting agent?	In the same STAR*D trial discussed in the presentation, Cytomel was an option for antidepressant augmentation in Step 3. It was effective in patients with treatment resistant depression, but in the interest of choosing lowest side effects medication first, alternative agents for augmentation should be considered first.
What are your thoughts on stimulants especially in elderly?	There is data to suggest that methylphenidate in combination with a SSRI has significant benefit and is fairly well tolerated in a geriatric population with depression. It may also paradoxically increase appetite. There are increased cardiac risks with stimulants, which may limit use. Here is a RCT in a well-respected journal on the topic: Lavretsky H, Reinlieb M, St Cyr N, Siddarth P, Ercoli LM, Senturk D. Citalopram, methylphenidate, or their combination in geriatric depression: a randomized, double-blind, placebo-controlled trial. Am J Psychiatry. 2015 Jun;172(6):561-9. doi: 10.1176/appi.ajp.2014.14070889. Epub 2015 Feb 13. PMID: 25677354; PMCID: PMC4451432.
What is the preferred treatment of insomnia in depression?	There isn't one that is necessarily preferred over others, and your choice will likely be guided by associated symptoms and goal to minimize polypharmacy. In some cases, you may opt for a sedating antidepressant to treat mood and insomnia symptoms together. In other cases, it may be preferable to use an additional agent specifically for insomnia in combination with an antidepressant.

How do you typically switch from an SNRI to SSRI? If pt on 60mg cymbalta but want to change to paxil would you switch with low dose or moderate/medium dose?	The data regarding best ways to switch between classes isn't particularly clear. What is considered to be best is cross-titration, as opposed to a direct switch. This is because it is safer when starting a new agent to start with a low dose and assess tolerance. So for example: Week 1: - Decrease duloxetine to 30mg and start paroxetine 10mg Week 2: - Stop duloxetine and increase to paroxetine 20mg Week 4 and beyond: - Optimize paroxetine further to achieve symptom remission by increasing dose by 10-20mg until max tolerated or max recommended dose
Does deep brain stimulation help?	Deep brain stimulation is an emerging treatment but not widely done for the indication of depression and is not FDA approved for depression. By contrast, ECT and TMS are less invasive and have much more evidence and are more widely available for the management of treatment-depression.
Are there any resources that PCP can reach a psychiatrist?	One lesser known resource is a website psychologytoday.com that has a profiles of therapists and psychiatrists that can be further stratified by location, insurance, types of care provided, etc. A link to the website is here: https://www.psychologytoday.com/us/psychiatrists
Substance Use Disorder Screening – Dr. Richard Amar	
On the CAGE screening, is a single positive response significant or must there be more than 1 positive response?	A single question positive CAGE has a sensitivity of 85%; two questions improves the specificity to 91% which increases the suspicion of at-risk drinking or an alcohol use disorder (AUD). In either case it is helpful to ask about at-risk drinking as well as point out to the patient if they have other stigmata of AUD, and then develop a plan to monitor or try to decrease at-risk drinking.
In view of the enormous stresses being experienced by medical practitioners in the setting of the COVID-19 pandemic right now, it would not be surprising if substance use were	For medical professionals, it is important to offer services that can be provided in a safe as well as confidential manner, as many of us are concerned about possible workplace or occupational

presently increasing among physicians. What do you think would be the most appropriate system-based response to this possibility for the care of physicians? What should individual physicians do for their own care?	consequences for seeking mental health or substance abuse treatment. For individuals who are having mild symptoms (e.g. adjustment disorder, at-risk drinking) in the backdrop of COVID stressors, in addition to working with their PCP there are free confidential support groups (I run one at 5pm ET on Thursdays) as well as pro-bono psychotherapy resources for first responders. An EAP may also offer confidential evaluation and treatment options for their employees, or COVID-related support groups. Additional referrals for more intensive or specialized treatment can then be generated, if clinically warranted. This now dove-tails with Dr. Mehta's presentation on screening for major depression and subsequent treatment. There has been quite a bit of focus on physician self-care (and burnout) in the past few years. Medical providers are helpers, and sometimes it comes at the expense of their own well-being. In a nutshell, it is important to identify one's limits and needs, and to attend to those without judgment. It is helpful to carve out time on a regular basis to engage in activities that make us feel whole or human. Everyone is different, but some examples of helpful (and evidence-based) activities include exercise, listening to music, engaging in hobbies or recreation, spending time in nature, yoga, meditation, spending time with friends and family, engaging with religious or spiritual resources. In addition to specific stress management techniques, the importance of proper nutrition, hydration, and sleep hygiene must be underscored as well.
Violence Prevention in Healthcare – Mike Hodges	
Where is the most violent industry and why?	The most violent industry in the US is healthcare. There are many reasons, the stress of the environment, disease progression resulting in aggressive outbursts, and cultural acceptance.
Other than sign on office door --no weapons or guns --why we do not have metal detectors at offices and hospitals?	Cost and efficacy issues mainly. The cost for implementation of metal detectors at entrances is extremely high, and most studies indicate that any kind of partial implementation negates any actual efficacy in use. So it becomes a 24/7, 365 all or nothing endeavor. That would include requiring employees to submit to the detection as well, and the implications for the brand as that becomes a primary part of our first contact with patients,

	guests and visitors. In all of our emergency departments our officers are utilizing some form of wand detection for high risk patient searches. I will also note Piedmont is taking a larger look at our access control processes which will include evaluation of metal detectors.
GA is a state that allows conceal weapons--correct?	All states all have conceal carry with various caveats. GA does allow with a license that can be obtained through the local court.
Why don't office have signs state no money on site or control substances.	That has not been discussed, but we would be happy to take a look at it.
Also as a check in matter just like a vital sign to have a question at check to determine mood (scale of happy and sad face) just like we like to know pain level. Also to leave on check in area of mood question an area patient can express concern that is affecting mood.	We are working on a clinical violence risk assessment tool for deployment in our practices through the system WPV team. More to come on this.
Does Piedmont have a predictive outlook on high risk areas or patients perhaps to have more patrol of police?	Our Public Safety department is investing heavily in the most modern protective and predictive intelligence operations to support our threat assessment initiatives. This includes partnership with state, local and federal law enforcement agencies across multiple jurisdictions. Police engagement is only one piece of the overall strategic plan.
Why do we not have more social workers and Psych out reach programs?	This is a question I am not qualified to answer, but I would love to see us invest more in these kind of resources.
Are we allowed to ask all patients to leave if they have guns including security officers/police who are off duty if we are not comfortable?	Guns are ancillary, if someone makes you uncomfortable you can ask them to leave (barring any EMTALA issues). Anyone with a firearm can be asked to leave, but you cannot restrict the right of a law enforcement officer from carrying his duty weapon unless he will be unable to maintain control of that weapon due to the nature of his visit/ medical procedure.
Everything About the Knee – Kelly Ward, PA-C	
Why are ORAL steroids given so often, they don't work	Oral steroids are indeed given frequently for symptomatic OA in primary care setting, however, I would agree that they only treat symptoms of pain and inflammation do not change the course of

	disease process. I would argue oral steroids should be an option for those that cannot tolerate NSAIDs and need short term relief. Probably better than starting narcotic pain meds.
Is Glucosamine good to suggest esp if elevated BMI or due to age to prevent cartilage wear down?	There is absolutely no Level I evidence to suggest Glucosamine prevents cartilage wear. There is anecdotal evidence that it might decrease symptoms? There is no evidence to suggest that it is harmful. I discuss that option with patients, but cannot recommend based off evidence.
Is tumeric good?	I believe there is good evidence to say a general anti-inflammatory diet is a good idea. However, in looking for Level I evidence the use of turmeric for symptomatic OA does not exist.
Exercise is Medicine – Joel Hardwick	
Does the Inversion table help with lower back pain?	The Inversion table does provide pain relief in the acute period but serves as a "band-aid" much like massage therapy. Ultimately, the inversion table does not address the true cause of non-specific low back pain which is muscular imbalance.
What is your stand on chiropractic adjustments?	Chiropractic adjustments, in theory, operate in the same way as the inversion table via manipulation or decompression of the spine. Pain relief is experienced but, again, the root cause of non-specific low back pain is not the lumbar spine itself but the surrounding structures (musculature, ligaments, etc.). Care must be taken to address the imbalance or deficits in core stability to provide the necessary support that is required for a healthy low back.