Ontario Psychiatric Association
DIALOGUE
THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION / UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO
MARCH
2006

MESSAGE FROM THE PRESIDENT

Dear Colleagues: I am very pleased to have the opportunity to write this as your President. As a longstanding member of the Ontario Psychiatric Association, I am conscious of the significant role the Association has played for the profession over the years, and I am therefore honoured to act in the capacity of President. Although we can be proud of the work done over the years, there is much to do given the current context. For the OPA to continue as a vibrant contributor to the practice of psychiatry in Ontario and the patients we care for, we must constantly look to the future. While this is a challenge, I have every confidence that the members of the OPA Council have the insight, experience and energy to take us through this important journey.

Council will begin this year with a strategic planning session to identify key issues and priorities. These will set the direction, and position us to work effectively on your behalf.

Given our decision to approach this planning with an open mind and a “clean slate”, my first decision as President was to break with the tradition of a President's theme. I am sincere in my belief that the theme for this year will naturally “fall out” of our process of visioning for the future. I will use the Message from the President this year to keep you apprised of our progress and priorities. We are eager to have your input - please let us know what you think the OPA should be doing by sending me an email at opa@bellnet.ca.

The world, of course, will not stand still in the meantime, especially during these times of transformative change and what often feels like frantic activity. We have many initiatives underway, and these will continue into this year.

The Advocacy Committee of the OPA has partnered with the Schizophrenia Society of Ontario to lobby MPPs for an increase in the base rate for ODSP funding for our patients in order that they might live with greater dignity.

I urge psychiatrists throughout the province to help in this campaign. In this issue of Dialogue, Dr. O'Reilly, Chair of the Advocacy Committee explains how you can become involved.

Our Continuing Education Committee, Chaired by Dr. Roumen Milev, held a highly successful Annual Meeting in January. Dr. Milev and the Committee are to be congratulated for designing a programme that was diverse and included important and timely topics. We were honoured to have Senator Michael J.L. Kirby at the conference as the T. A. Sweet Award recipient. The Jane Chamberlin lecture was given by Dr. Ruth Kajander, who recounted the history of psychiatry in Ontario. The Jane Chamberlin award was presented to The Honourable James Bartleman who shared some of his personal experiences with depression. The Continuing Education Committee is planning some significant changes for next year, and we look forward to hearing more about the changes over the next few months. Again, we welcome your input - let us know what would make the meeting more useful for you by contacting the OPA office.

Dr. Mamta Gautam, with her theme of Healthy Practices, has been a champion and an inspiration over the last year in raising awareness of physician health issues. Although her term as president is over, Dr. Gautam will continue to highlight this important issue this year.

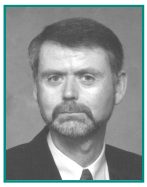
There are so many people, and so many projects underway, that I cannot mention them all. I can, however, assure you that the commitment and leadership of Council is extraordinary, and I thank each member for their unique and valuable contribution.

As we work together to craft a strategy for the future I invite and welcome your thoughts and input. Please contact me through the OPA office at any time - opa@bellnet.ca.

Susan Abbey, MD, FRCPC
2006 OPA President

Ontario Psychiatric Association Executive and Council

President
Dr. Susan Abbey



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Dr. Andrea Waddell

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FROM THE EDITOR

In this issue of Dialogue, we report on the highlights of the Annual Meeting and continue to address some initiatives underway for the upcoming year.

The Advocacy Committee, in its campaign to lobby MPPs to increase ODSP benefits, has been very active over the last few months. In this issue we ask for your assistance in lobbying efforts.

We have also included some examples of Healthy Practices, recognizing that this is an important and ongoing issue.

Finally, on a lighter note we hope you will enjoy seeing some familiar faces!

With major changes being announced by the Ministry of Health and Long Term Care through the LHINs, and interest in mental health on the part of the Ministry, it is important that the OPA look carefully at positioning psychiatry for the future. In the next issue of Dialogue, we will report on the outcome of Council's strategic plan.

As always, your comments, suggestions and ideas are welcome at any time.

June Hylands
Editor

INSIDE

IN EVERY ISSUE

IN THIS ISSUE

Mark Your Calendars for the OPA Psychotherapy Section's 2006 Fall Conference!

Date: Saturday, November 11th, 2006
Location: George Ignatieff Theatre, Trinity College
Featuring: ***Dr. Lewis Aron***
Topic: Relational Therapy

Registration will be limited...look for the brochure and registration in the mail.

CALENDAR OF EVENTS

Members! Contact the OPA with the details on upcoming educational events and we will do our best to include them in the *Dialogue.* Additional information on these events can be obtained from the OPA Head Office.

April 3, 2006 - **The OMA presents Patient Safety Series: Disclosure**
Disclosure of adverse events is a crucial step in the movement toward creating a culture of safety. This one-day conference will examine the many facets of disclosure.
Renaissance Toronto Airport Hotel - 801 Dixon Rd, Toronto
For more information and to register online go to: Browse to Professional Development

April 8, 2006 **- The CAPCT in association with the TCPP presents...A Conference with Anne Alvarez, Ph.D.**
Internationally renowned therapist in helping children affected by communication, trauma and relational difficulties.
This conference is for those who work with and want to understand the emotional worlds of children with autistic spectrum and other emotional difficulties.
For more information visit: http://tcpp-capct.ca/capct/conferences.php

May 6th, 2006 - **Presenting One of the World's Best-Known Psychiatrists and Founder of the William Glasser Institute - William Glasser, M.D.**
Dr. Glasser will be addressing parents and anyone working with youth.
Location: Living Arts Centre, 4141 Living Arts Dr. Mississauga, ON
Please contact Helen Jones at 905-272-3078 or helenj0000@aol.com, Cathy Dewar at cathy_dewar@yahoo.ca or Nancy Wright nancyw@aci.on.ca for information.
Also see www.wglasser.com and www.apsgo.ca for further details.
Don't miss this opportunity!

June 15-16, 2006 **- 17th Annual Trauma & Dissociation Conference**
"Attachment & Trauma: Treating Complex PTSD & Dissociation"
The Westin Hotel, Ottawa, ON
For more information visit: www.anxietyandtraumaclinic.com

November 5 - 8, 2006 - **Making Gains in Mental Health and Addictions**

2006 Call for Abstracts - The Fourth Annual Making Gains in Mental Health and Addictions Conference will be held in Toronto, ON, Canada, November 5-8, 2006. Hosted by Addictions Ontario, the Canadian Mental Health Association, Ontario, the Centre for Addiction and Mental Health, and the Ontario Federation of Community Mental Health and Addiction Programs.

Deadline for submissions is Fri. March 31, 2006.
For more information visit: www.makinggains.ca.

Why join the OPA?

Dedicated to excellence in psychiatric education, advocacy, representation and the advancement of public policy.

The Ontario Psychiatric Association was incorporated in 1956. Dr. Edward Ryan, Superintendent of Rockwood Hospital, established the Ontario Neuro-Psychiatric Association in 1920.

Objectives of the Ontario Psychiatric Association:

- **EXCHANGE** of scientific information
- **PROMOTE** an optimal level of professional development and practice
- **ADVOCATE** for persons with mental illness and their families
- **REPRESENT** the members in their relationships with governments at all levels, universities, other medical associations and other associations
- **PROMOTE** the prevention of mental disorders in Ontario

Member Benefits:

- Access to specialty Sections, workshops and courses
- Opportunities for networking
- Peer Mentorship Programme
- Registration discounts for the Annual Conference
- Complimentary membership for Residents and longstanding members
- Voting privileges at the Annual General Meeting and general meetings (Full Member, Life Member and Member in Training only)
- Opportunities for maintenance of competence and continuing education credits
- Effective representation to the Canadian Psychiatric Association
- Joint partnership, with the Ontario Medical Association Section on Psychiatry, by means of the Coalition of Ontario Psychiatrists
- *Dialogue* - the quarterly Association Newsletter provides up-to-date information on issues affecting psychiatry and psychiatric practice

Other Information:

- Standing Committees;
  Advocacy, Communications, Continuing Education,
  Finance/Audit, and Member Services
- Membership Categories:

Full Member - is a legally qualified practitioner who is licensed to practice medicine in Ontario and is:
(a) Registered as a specialist in psychiatry by the Royal College of Physicians and Surgeons of Canada, and is in active practice, or,
(b) Teaching psychiatry in a university or other senior psychiatric position.

Member-in-Training - is a person who is registered in an approved, psychiatric, post-graduate training programme, or, in an undergraduate medical programme, in Ontario.

Associate Member - is any person who is a legally qualified medical practitioner or who occupies a position in nursing, psychology, social work, occupational therapy, or any other profession or occupation, closely related to psychiatry.

Life Member - is any Member who has reached the age of 65 and whose years of age and years of Full Membership totals 80 in the Association.

For more information about the OPA please visit our website at www.eopa.ca.

2006 OPA Presidential Address: Dr. Mamta Gautam, MD, FRCPC

It has been a real pleasure to serve as your President this past year. I am humbled by this experience. I feel privileged to have been a part of all that has happened this year, and want to credit the fantastic team of colleagues on the OPA Council without whom this could not have been achieved.

As a team, we have had an active and productive year. The President's report highlights many of the impressive projects and initiatives your Council undertook with success. I urge you to take a few minutes to read this. We hope to continue with a strategic exercise to plan and focus on future OPA endeavors.

I appreciate this opportunity to address the theme I chose for this year - Healthy Practices: Promoting Physician Health. As some of you may know, in my private practice of Psychiatry, I have had the privilege of treating physician colleagues for the past 15 years. I did not set out to focus on this group. In fact, I did my fellowship in Child Psychiatry. It is said that education is never a waste and this is certainly true of this - I use my child psychiatry skills every day in my practice!

I see daily how hard we work as doctors, how much we take on, how much of ourselves we put into our practices and caring for our patients, and the toll it can take on us. I have watched over the years as we cope with change in the health care system, taking on more and more, doing more with less, often at our own expense. Healthy Practices - both the medical practice, as well as our personal practices - are taking much more effort to achieve.

As physicians, we have specific personality traits in common. These have been well described, and include compulsive behavior, conscientiousness, perfectionism, need for control, and need for approval. These traits are essential to our success in medicine; however, they are the very traits that predispose us to stress.

This is a time of major and constant change in the health care system. We are being asked to do more with less. In the current ailing health-care system, many physicians face harsh realities, worsening work conditions, and feel a lack of control and input into government health legislation. This sense of lack of control is the very aspect that causes us stress. What do highly functioning people do when faced with stress - they do more! We take on more because we can and feel we should, because we want to fix the problems, because we want approval and do not want to disappoint. Yet, there is a limit to what we can do. At some point, we cannot do more. You can put any highly functioning, healthy person in an unhealthy environment, and they will become unhealthy. This is happening to colleagues at an unprecedented rate. A 2003 CMA survey showed that 45.7% of Canadian physicians, almost half, were at the last stage of burnout, at which they were disillusioned and considering leaving medicine. In our current situation of physician shortages, we cannot afford to lose even one physician.

Yet, we see that doctors who are not well do not seek help easily. There are many reasons for this. Our intellectual abilities assist us in using intellectual defenses to deny, rationalize, or minimize the problem. Our personality traits help us react by working harder. We feel that to get help is to be weak, to have failed. We fear being judged and doubted, being found out to be the imposters we think we are. It is not easy to know where to get help. There are concerns about confidentiality and lack of control. There is a real impact on our ability to obtain insurance. We think we are immune to this. After all, we are care givers, not care receivers.

The stigma of mental illness also holds us back. While mental illness is associated with stigma throughout our society, nowhere is this stigma greater than within medicine. The culture of medicine promotes the setting of very high expectations of one self and others. It rewards hard work, conscientiousness, perfectionism, and thoroughness. The “Ideal Physician” is one who comes in early and leaves late, does house calls, and is always available. This person pays attention to every detail, is responsible and reliable, is tough and in control and can handle it all, and takes care of others and helps whenever needed. This concept is reinforced by our teachers, our training, our peers, and our patients.

The stigma of illness fosters several assumptions within medicine.

1. It is wrong for doctor to get ill, and to need help. Doctors downplay signs and symptoms of illness, deny a problem, or wait until the illness is very severe, or clearly present before reaching for help.

   This is true for physical illnesses. This is even more so for mental illness. One physician tells of having a heart attack and being hospitalized, with his colleagues sending flowers and gifts and visiting him daily. Another colleague in the same department was hospitalized with depression in the same hospital, yet received no gifts or visitors.

2. It is weak to not work all the time. Doctors find it hard to take time off, go on holidays, go home early after call, or stay home when sick.

3. Taking care of your self is selfish. Doctors become good at delaying their own gratification, and put off doing the things that would help them feel better. They put themselves at the bottom of their priority list. Their needs are last, and often, lost.

4. It is wrong to admit you may need help. Doctors do not want others knowing if they require assistance. Many do not use provincial help lines, for fear of exposure. Workshops on physician health issues are not well attended, as they are akin to openly admitting you need help. Doctors find it hard to see a colleague in the hospital, especially a psychiatrist, or be seen leaving their office.

5. Requiring medications means that you are really sick. While doctors may seek advice from a colleague, accepting a need for medications, especially psychotropic medications, seems much worse, making them feel like a “real patient”. This is often met with denial and resistance. 'I'm not really that sick, am I?” Doctors often drive miles to a pharmacy in another neighborhood to get their prescriptions filled.

6. Diagnosing a mental illness is a negative judgment. This is true for themselves, but also for their patients. Giving such a diagnosis can have negative repercussions and many doctors avoid this in their charting. They feel a similar sense of being judged when they receive such a diagnosis. They worry that colleagues will think less of them and their abilities and competency.

Your OPA Council made concerted efforts during this past year to reduce the stigma of illness in medicine, and to promote physician health.

We worked to be included in the Mental Illness Awareness Week, Faces of Mental Illness campaign. An Ontario physician will be one of the four Faces this fall to highlight that physicians are people too, are not immune to mental illness, and can live and work successfully with this illness.

The issue of the impact of seeing a psychiatrist on a doctor's ability to get disability insurance was raised. This is a huge area to address and the insurance companies are powerful. It feels like David taking on Goliath, but we will continue to advocate for colleagues on this issue.

As well, in Ottawa in 2002, an initiative was undertaken to have a day in October be proclaimed as Physician Appreciation Day by the mayor of the city. The day serves as a reminder that physicians play key roles in our communities by providing access to top-notch clinical care, teaching medical students and residents, conducting medical research, leading in the administration of health care delivery, and volunteering in the community. The goal is to help doctors feel valued and to improve physician morale. The OPA is working with the provincial government to make this a province-wide proclamation.

Physician health is a field in its infancy. I am proud to say that Canada is the international forerunner in this area. In fact, Ottawa is excited to be hosting an International Conference on Physician Health this fall.

My personal dream is to have a culture in medicine in which doctors realize that that stress is normal; that getting help when needed is healthy. Doctors would learn that it is acceptable and good to take care of them selves, to have hobbies, slow down and pace themselves, take holidays, work fewer hours a week all without feeling guilty. Doctors will believe that it is not wrong to seek and receive help. What is wrong is not getting the help when it is required.

Thank you for giving me the opportunity to take a huge step towards this dream.

Ontario Psychiatric Association - Council Meeting AGENDA

Date: Wednesday January 25th 2006
Time: 1:00 - 4:00 P.M.
Location: Toronto Marriott Eaton Centre Hotel
525 Bay Street - Dundas Room

1.0 Remarks from the President and Approval of Agenda

2.0 Approval of Minutes of December 2nd 2005

3.0 Business Arising
- 3.1 President Theme 2005 Summary
- 3.2 Election Results
- 3.3 OPA Annual General Meeting & Annual Report
- 3.4 Strategic Planning

4.0 Treasurer's Report
- 4.1 Year end and Budget

5.0 Reports of Task Forces and Committees
- 5.1 Advocacy Committee
- 5.2 Communications Committee
- 5.3 Continuing Education Committee
- 5.4 Finance / Audit Committee
- 5.5 Member Services Committee
- 5.6 Governance Task Force

6.0 Standing Reports
- 6.1 CPA Reports
  - 6.1.1 Directors
  - 6.1.2 Council of Provinces
  - 6.1.3 Standing Committees
    - 6.1.3.1 Education
    - 6.1.3.2 Professional Standards & Practice
    - 6.1.3.3 Scientific & Research
- 6.2 OMA Section on Psychiatry
- 6.3 Coalition
- 6.4 Section Reports
- 6.5 Executive Director Report

7.0 New Business
- 7.1 Divestment of ACT Teams from hospitals to community Agencies

Ontario Psychiatric Association - Council Meeting AGENDA

Date: Saturday, January 28th 2006
Time: 12:00 - 1:30 P.M.
Location: Toronto Marriott Eaton Centre Hotel - 525 Bay St. Simcoe Room

	Item	Responsibility
1.	Remarks from the President - Approval of Agenda	S. Abbey
2.	Introduction of 2006 Council Members	S. Abbey
3.	Org Chart / Committee Membership of 2006	All
4.	Meeting dates for 2006 (including Strategic Planning Session)	All
5.	2006 Annual Meeting update	R. Milev
6.	Other Business	

Summary of the Annual General Meeting

Dr. Donald Millikin, President of the Canadian Psychiatric Association, provided an update on some of the work of the CPA including the redefinement of the core competencies of the general psychiatrist, assisting its members through the publication of physician papers and the production of clinical practice guidelines and lobbying with other organizations to present a unified voice for better services. Dr. Millikin noted that his presidential theme for 2006 would be entitled "Psychiatry in the Next Decade".

Dr. Gautam, in her President's address, summarized the work of the OPA relating to the President's theme of Healthy Practices. Dr. Gautam thanked the members for her year in office and thanked the Council in particular for their teamwork to move the OPA forward emphasizing the views and needs of psychiatry in Ontario.

Dr. Puddester was called upon to give the 2005 OPA Treasurer's Report. Dr. Puddester began by thanking the volunteers who work on the Finance and Audit Committee.

During the last year Dr. Puddester reported, on behalf of the Finance and Audit Committee, several actions were introduced to stabilize the OPA's finances. These actions were introduced as part of several important changes that were made to the OPA's financial structure. Most recently, motions were passed to ensure the OPA does not operate with a deficit and that travel reimbursements for Council and committee members will be issued as is possible within the operating financial guidelines of the OPA. The OPA is now replenishing its reserves and moving towards a model of increased financial sustainability. Copies of the 2005 OPA Treasurer's Report and the 2006 OPA Budget were available for each attendee.

A motion was carried for an increase to annual membership dues for full OPA members to an amount of $266 plus tax effective January 2007.

A motion was carried to accept the election results for the 2006 Council.

Dr. Bob Swenson, Chair of the Membership Services Committee, spoke to the assembly about the need for review of the guidelines around life-time membership in the OPA. A motion was carried to encourage all life-members who are still working to include a voluntary donation with their annual membership renewal.

The Annual General Meeting was followed by a presentation by theme speaker Dr. Michael Myers.

Meet Your New Council

The following are the 2006 Election results.

President:	Dr. Susan Abbey
President-Elect:	Dr. Richard O'Reilly
Past President:	Dr. Mamta Gautam
Secretary:	Dr. Keith Anderson
Treasurer:	Dr. Derek Puddester

Council Members:

Dr. Leslie Buckley	Dr. Anne Hennessy
Dr. Chiachen Cheng	Dr. Roumen Milev
Dr. Cinda Dyer	Dr. Paul Mulzer
Dr. Varinder Dua	Dr. Toba Oluboka
Dr. Deborah Elliott	

Member-in-Training Representatives:

Dr. Paul Sedge
Dr. Andrea Waddell

T.A. Sweet Award

Presented to Senator Michael Kirby at the OPA Annual Dinner/Dance

This award was established in 1975 in memory of Dr. Theodore Allen Sweet, and is presented annually to individuals who have made a major contribution to the understanding of mental illness and its impact on individuals in society. Dr. Sweet became Secretary of the Ontario Neuropsychiatric Association in September 1946 and continued in this capacity until 1959.

Senator Michael J. L. Kirby chairs the Standing Committee on Social Affairs, Science and Technology. Senator Kirby is a recognized national expert on public policy issues. He served as an advisor to several governments and has held or holds senior directorships on some of Canada's leading corporate boards. Since his appointment to the Senate in 1984, he has led a number of important inquiries into the banking industry and, more recently, the health care system.

During his term as chair of the Senate Social Affairs Committee, Canada's health care system has become the major focus of the Committee's work. It's two-year study of the hospital and doctor system culminated in an October 2002 report, Recommendations for Reform. Government is currently enacting many of these recommendations.

The Committee is now undertaking a similar study of Mental Health, Mental Illness and Addiction. The first three reports were released in November of 2004, and the Committee is currently undertaking cross-country hearings in every provincial and territorial capital. The final report is due to be released in Spring 2006.

The Association of General Hospital Psychiatric Services (AGHPS) provided the following update to the OPA on its past and future activities:

The AGHPS has been working on a committee with the MOHLTC to develop equitable criteria for the distribution of sessional fees and stipends. This work will continue in the upcoming year. In addition, The Ministry of Health has asked the AGHPS to review the issue of Suicide Prevention Strategies in general hospitals. The work will include a study of Coroners Reports, the development of a "Provincial Fast Track Model" for the Police Department's personnel who accompany patients at risk to the General Hospital's Emergency Department, the development of a framework for Departments of Psychiatry, and educational programs. The AGHPS has also been active in highlighting to the Ministry, the issues and challenges associated with the implementation of the RAI-MH. Given this ambitious agenda, and wanting to ensure we hear from psychiatrists and directors of mental health in general hospitals throughout Ontario, we have scheduled a number of issue related telephone meetings. We are including the information here, and invite you to participate by dialing in to any or all of these teleconferences.

Phone number: **1-866-518-0790 or 416-443-4587**
Conference ID code: **227048#**
** Refers to work being done with the Ministry of Health regarding the distribution of sessional fees and stipends*

Date	Time	Issue	Lead
March 8th	7:00 - 8:00	*Mental Health Funding Working Group	Dr. Gerry McNestry
April 12th	7:00 - 8:00	RAI-MH	Mr. Bruce Whitney
May 10th	7:00 - 8:00	*Mental Health Funding Working Group	Dr. Gerry McNestry
June 14th	7:00 - 8:00	Prevention of Suicide Project	Executive
September 13th	7:00 - 8:00	RAI-MH	Dr. Bruce Whitney
October 11th	7:00 - 8:00	*Mental Health Funding Working Group	Dr. Gerry McNestry
November 8th	7:00 - 8:00	Prevention of Suicide Project	Executive

Look Who “Brought a Buddy”!

Thank you to Dr. Derek Puddester for bringing new conference attendee Catharine Robertson to this year's Annual Conference.

The “Bring a Buddy” campaign was newly announced this year. This program is aimed at increasing attendance at the Annual Conference and saving registrants some money!
Any member that recruits a new registrant to the Annual Meeting will receive recognition through the “Bring a Buddy” campaign.

Winners of the 1st Annual Dr. Ann Thomas Award

The 1st annual Dr. Ann Thomas Award was presented at this year's Annual Meeting. The Dr. Ann Thomas Award was developed to honour Dr. Thomas for all of her efforts over a six year period in planning the OPA Annual Meeting.

Congratulations to this year's winners:

Dr. Fahad Aldosary awarded the Dr. Ann Thomas Award for Best Resident Presentation
Dallas Seitz awarded the Dr. Ann Thomas Award for Best Resident Poster Presentation

Jane Chamberlin Memorial Lecture and Award

The Jane Chamberlin Memorial Lecture is co-sponsored each year by the OPA and the AGHPS.
The speaker for this year was Dr. Ruth Kajander who spoke on Psychiatry in Ontario. Dr. Kajander provided a comprehensive history of how psychiatry has changed in Ontario over the years.

The Jane Chamberlin Memorial Award was presented by the AGHPS to *The Honourable James Bartleman* for his outstanding contribution in mental health.

The Honourable James Karl Bartleman was sworn in as the 27th Lieutenant Governor of Ontario on 7 March 2002. He is the province's 41st vice-regal representative since John Graves Simcoe's arrival in Upper Canada in 1792.

Born on 24 December 1939 in Orillia, Ontario, James Bartleman grew up in the Muskoka town of Port Carling, and is a member of the Mnjikaning First Nation. Mr. Bartleman earned a B.A.(Hon) in History from the University of Western Ontario in 1963. Despite his significant achievements, James Bartleman lives with depression and shared with the audience some of his personal experiences.

His Honour has identified three areas of focus for his mandate: to encourage aboriginal communities, especially young people; to speak out to reduce the stigma associated with mental illness; and to support initiatives that fight racism and discrimination.

He is fulfilling this mandate in many ways, including lending his name to the Centre for Addiction and Mental Health as Honorary Patron and speaking publicly about mental illness, to help reduce the stigma that surrounds it.

We would like to acknowledge and thank our sponsors and exhibitors for their support of the Annual Meeting

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Dr. Sherry Tompalski Artist/Psychiatrist
Valeant Canada Limited
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Letter to OPA Members from the Advocacy Committee Re: ODSP Funds

Dear OPA Members:

Our organization has, in partnership with the Schizophrenia Society of Ontario, been actively lobbying MPPs asking for a 10% increase to the base rate of the Ontario Disability Support Programme (ODSP). Many of you have given generously of your time by visiting your MPPs office.

With the budget rapidly approaching, the next few weeks is the critical time when the Government will decide on details of the budget for 2006. ***We are asking all OPA members to call your MPPs office and talk to the staff person about the importance of raising ODSP rates.***

In order to assist you, we have two documents on the OPA web site (www.eopa.ca). The first titled "Call your MPP" contains a list of all MPPs' riding office phone numbers and the second, a letter used in the face-to-face lobby campaign, which outlines the importance of this issue and our request for a 10% increase.

As many of our patients understand the importance of this issue, we ask you to consider providing copies of this material to patients and their families. Also, if you work with other mental health professionals, you might consider sharing the material with these professionals and ask them to join in the telephone campaign.

Thank you for giving your time to this worthy cause.

Sincerely,

Susan Abbey
President
Ontario Psychiatric Association

Richard O'Reilly
Chair, Advocacy Committee

MEMBERS CORNER:

Members are invited to submit their personal articles, poetry etc.
These are members' features, and are not formally linked to the OPA or *Dialogue*.
The views expressed do not necessarily reflect the views of the OPA.

The following is a submission from Aydogan Ugur, MD

WHAT IS LOVE

Love is the best music of our heart,
Heart makes the love musical art.

It is also a musical poetry,
Sung by the birds on the top of the tree.

Love is the sunshine of our whole life,
Love is a best gift, doesn't need strife.

It gives always great happiness to us,
Best feeling of our life there is no fuss.

Love is the red rose without any thorn,
You had a lot of it when you were born.

Van Gogh said, “Love is always eternal”,
Keep it in your heart, never say farewell.

Love is the harmony of the heart and mind,
If you can make it, it will be the best kind.

Falling in love with someone is wonderful,
You'll be in the sky flying joyful.

You feel in heaven by being in love,
You can stay there if you know how.

Remain happy with your love always,
Living and loving are the best ways.

February 2005 Aydogan Ugur, M.D.

Look What OPA Members Are Up To...

Aydogan Ugur, 77, of Etobicoke, Ontario, waves a flag to spectators as he runs towards the finish line during the ninth mile of the 2005 Boilermaker 15K Road Race in Utica.

In keeping with Dr. Mamta Gautam's 2005 presidential theme "Healthy Practices", OPA member Dr. Aydogan Ugur ran the 15km 2005 Utica Boilermaker Road Race on July 10th, 2005.

Dr. Ugur is an inspiration to us all!

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2006 Annual Conference

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Seroquel

quetiapine fumarate tablets
25, 100, 150, 200 and 300 mg

THERAPEUTIC CLASSIFICATION Antipsychotic Agent

INDICATIONS AND CLINICAL USE **Schizophrenia** SEROQUEL (quetiapine) is indicated for the management of the manifestations of schizophrenia. The antipsychotic efficacy of SEROQUEL was established in short-term (6 week) controlled inpatient trials. The efficacy of SEROQUEL in long-term use, that is, for more than 6 weeks, has not been systematically evaluated in controlled trials of patients with manifestations of schizophrenia. **Bipolar Disorder - Mania** SEROQUEL is indicated as monotherapy for the acute management of manic episodes associated with bipolar disorder. The efficacy of SEROQUEL in bipolar disorder - mania was established in two 12-week clinical trials of bipolar patients. The safety and effectiveness of SEROQUEL for long-term use and for prophylactic use in bipolar disorder has not been evaluated.

CONTRAINDICATIONS SEROQUEL (quetiapine) is contraindicated in patients with a known hypersensitivity to this medication or any of its ingredients.

WARNINGS **Neuroleptic Malignant Syndrome (NMS)** Neuroleptic Malignant Syndrome is a potentially fatal symptom complex that has been reported in association with antipsychotic drugs, including SEROQUEL (quetiapine). The clinical manifestations of NMS are hyperthermia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. In arriving at a diagnosis, it is important to identify cases where the clinical presentation includes both serious medical illness (e.g., pneumonia, systemic infection, etc.) and untreated or inadequately treated extrapyramidal 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 SEROQUEL, and other drugs not essential to concurrent 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 pharmacological 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 recurrences of NMS have been reported. **Tardive Dyskinesia (TD)** A syndrome of potentially irreversible, involuntary, dyskinetic movements 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.

It has been hypothesized that agents with a lower EPS liability may also have a lower liability to produce TD. In controlled clinical trials with SEROQUEL, the incidence of EPS was not statistically significantly different than placebo across the recommended therapeutic dose range. This may predict that SEROQUEL has less potential than standard antipsychotic agents to induce TD. The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of 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 symptomatic suppression has upon the long-term course of the syndrome is unknown. Given these considerations, SEROQUEL 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 for whom alternative, equally effective, but potentially less harmful treatments are not available or appropriate. 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 SEROQUEL, drug discontinuation should be considered. However, some patients may require treatment with SEROQUEL despite the presence of the syndrome.

PRECAUTIONS **Hyperglycaemia** As with some other antipsychotics, exacerbation of pre-existing diabetes hyperglycaemia, diabetic ketoacidosis and diabetic coma including some fatal cases have been reported very rarely (<0.01%) during the use of SEROQUEL, sometimes in patients with no reported history of hyperglycaemia (see ADVERSE REACTIONS, Post-Marketing Experience). Appropriate clinical monitoring is advisable in diabetic patients and in patients with risk factors for the development of diabetes mellitus. **Hypotension and Syncope** As with other drugs that have high α1-adrenergic receptor blocking activity, SEROQUEL (quetiapine) may induce orthostatic hypotension, dizziness, and sometimes syncope, especially during the initial dose titration period. Syncope was reported in 1% (23/2371) of patients treated with SEROQUEL, compared with 0% (0/404) on placebo and 0.4% (2/527) on active control drugs. The risk of hypotension and syncope may be reduced by more gradual titration to the target dose (see DOSAGE AND ADMINISTRATION). SEROQUEL 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), cerebrovascular disease, or other conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications). **Cataracts The development of cataracts was observed in association with quetiapine treatment in chronic dog studies at 4 times the recommended human dose. Lens changes have also been observed in patients during long-term SEROQUEL treatment, but a causal relationship to SEROQUEL use has not been established. The possibility of lenticular changes during long-term use of SEROQUEL in man, thus can not be excluded at this time. Eye examinations (e.g., slit lamp exam) prior to or shortly after initiation of treatment with SEROQUEL and at 6 month intervals thereafter, are recommended. If clinically significant lens changes associated with SEROQUEL use are observed, discontinuation of SEROQUEL should be considered. Seizures** In controlled schizophrenia clinical trials, there was no difference in the incidence of seizures in patients treated with SEROQUEL or placebo (incidence of 0.4% or 2 events per 100 patient years in patients given SEROQUEL, compared with 0.5% or 6.9 events per 100 patient years for placebo). Nevertheless, as with other antipsychotics, caution is recommended when treating patients with a history of seizures or with conditions associated with a lowered seizure threshold. **Hypothyroidism** Clinical trials in schizophrenia demonstrated that SEROQUEL is associated with a dose-related decrease in total and free thyroxine (T4). On average SEROQUEL was associated with about a 20% mean reduction in thyroxine levels (both total and free). Forty-two percent of SEROQUEL-treated patients showed at least a 30% reduction in total T4 and 4% showed at least a 50% reduction. Maximum reduction of thyroxine levels generally occurred during the first two to four weeks of treatment with SEROQUEL. These reductions were maintained without adaption or progression during longer term treatment. Decreases in T_4 were not associated with systematic changes in TSH or clinical signs or symptoms of hypothyroidism. Approximately 0.4% (12/2595) of patients treated with SEROQUEL (schizophrenia and bipolar studies combined) experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. **Cholesterol and Triglyceride Elevations** In short-term placebo-controlled schizophrenia trials, SEROQUEL-treated patients showed mean increases from baseline in cholesterol and triglycerides of 11% and 14%, respectively, compared to mean decreases in the placebo treated patients. There was little relationship between these changes and weight changes observed during the trial. **Hepatic Impairment** Decreased clearance of SEROQUEL was observed in patients with mild hepatic impairment. Patients with mild hepatic impairment should be started on 25 mg/day. The dose should be increased daily in increments of 25 to 50 mg/day to an effective dose, depending on the clinical response and tolerability in the individual patient. No pharmacokinetic data are available for any dose of SEROQUEL in patients with moderate or severe hepatic impairment. However, should clinical judgement deem it necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see DOSAGE AND ADMINISTRATION). **Transaminase Elevations** During premarketing clinical trials, therapy with SEROQUEL was associated with elevation of hepatic transaminases, primarily ALT (SGPT). With a clinical trial database of 1892 SEROQUEL-treated schizophrenia patients with baseline ALT (SGPT) levels <60 IU/L, 3.3% (101/1892) had treatment-emergent ALT (SGPT) elevations to >120 IU/L, 1.3% (29/1892) had elevations to >200 IU/L, and 0.2% (2/1892) had elevations to >400 IU/L. No patients had values in excess of 500 IU/L. None of the SEROQUEL-treated patients who had elevated transaminase values manifested clinical symptomatology associated with liver impairment. The majority of transaminase elevations were seen during the first two months of treatment. Most elevations were transient (80%) while patients continued on SEROQUEL therapy. Of the 121 SEROQUEL-treated patients whose enzyme levels increased to >120 IU/L, 40 discontinued treatment while their ALT (SGPT) values were still raised. In 114 SEROQUEL-treated patients whose baseline ALT (SGPT) was >60 IU/L, only 1 experienced an elevation to >400 IU/L. In the bipolar disorder - mania trials, the proportions of patients with transaminase elevations of > 3 times the upper limits of the normal reference range, was approximately 1% for both SEROQUEL-treated and placebo-treated patients. Precautions should be exercised when using SEROQUEL 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 known or suspected abnormal hepatic function prior to starting SEROQUEL, standard clinical assessment, including measurement of transaminase levels is recommended. Periodic clinical reassessment 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 SEROQUEL therapy. **Hyperprolactinemia** Elevation of prolactin levels was not seen in clinical trials with SEROQUEL. Increased prolactin levels were observed in rat studies with this compound. As is common with compounds which stimulate prolactin release, the administration of SEROQUEL resulted in an increase in the incidence of mammary neoplasms in rats. The physiological differences between rats and humans with regard to prolactin make the clinical significance of these findings unclear. To date, neither clinical nor epidemiological studies have shown an association between chronic administration of drugs that stimulate prolactin release, and mammary tumorigenesis. Tissue culture experiments, however, indicate that approximately one third of human breast cancers are prolactin dependent in vitro, a factor of potential importance if preexposure of these drugs is contemplated in a patient with previously detected breast cancer.

Possible manifestations associated with elevated prolactin levels are amenorrhea, galactorrhea, and menorrhagia, in the multiple fixed-dose schizophrenia clinical trials, there were no differences in prolactin levels at study completion for SEROQUEL across the recommended dose range, and placebo. **Weight Gain** In controlled schizophrenia clinical trials (up to 6 weeks), mean weight gain was approximately 2.3 kg compared to a mean weight gain of 0.1 kilograms in patients taking placebo (n=127). In open-label extension trials, after 9 to 13 weeks of quetiapine monotherapy the mean weight increase was 1.58 kg (n=173). After 58 to 78 weeks of treatment, the mean weight increase was 1.96 kg (n=137). These data are obtained from uncontrolled, open-label trials; the relevance of these findings to clinical practice is unknown. Weight change over time appeared to be independent of quetiapine dose (see ADVERSE REACTIONS). In the acute placebo-controlled bipolar mania clinical trials (up to 12 weeks), mean weight gain in patients taking SEROQUEL was 1.8 kg compared to a mean weight loss of 0.1 kg in patients taking placebo. In patients completing the entire 12 weeks of treatment, mean weight gain in patients taking SEROQUEL was 2.8 kg.

Potential Effect on Cognitive and Motor Performance Somnolence was a commonly reported adverse event in patients treated with SEROQUEL, especially during the initial dose titration period. Since SEROQUEL may cause sedation and impair motor skill, patients should be cautioned about performing activities requiring mental alertness, such as operating a motor vehicle or hazardous machinery, until they are reasonably certain that a SEROQUEL therapy does not affect them adversely. **Antiemetic Effect** Consistent with its dopamine antagonist effects, SEROQUEL may have an antiemetic effect. Such an effect may mask signs of toxicity due to overdosage of other drugs, or may mask symptoms of disease such as brain tumor or intestinal obstruction. **Body Temperature Regulation** Although not reported with SEROQUEL, disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SEROQUEL for patients who will be experiencing conditions which may contribute to an elevation of core temperature, e.g., exercising strenuously, exposure to extreme heat, receiving concomitant medication with anticholinergic activity or being subject to dehydration. **Suicide** The possibility of suicide or attempted suicide is inherent in bipolar disorder and schizophrenia, and thus close supervision of all appropriate clinical management of high-risk patients should accompany drug therapy. **Drug Interactions** Given the primary central nervous system effects of quetiapine, SEROQUEL should be used with caution in combination with other centrally acting drugs. **The Effect of SEROQUEL on Other Drugs** *Alcohol:* SEROQUEL potentiated the cognitive and motor effects of alcohol in a clinical trial in subjects with psychotic disorders. Alcoholic beverages should be avoided while taking SEROQUEL. *Antihypertensive Agents:* Because of its potential for inducing hypotension, SEROQUEL may enhance the effects of certain antihypertensive agents. *Levodopa and Dopamine Agonists:* As it antagonizes dopamine, SEROQUEL may antagonize the effects of levodopa and dopamine agonists. *Lithium:* The single dose pharmacokinetics of lithium were not altered when coadministered with SEROQUEL. *Valproate:* SEROQUEL did not affect the single dose pharmacokinetics of valproate. *Divalproex:* Co-administration of SEROQUEL (750 mg bid) and divalproex (500 mg bid) increased the mean oral clearance and the mean maximum plasma concentration of total valproic acid (administered as divalproex) by 14%. These changes were not clinically relevant. **The Effect of Other Drugs on SEROQUEL** *Hepatic Enzyme Inducers:* Concomitant use of SEROQUEL with hepatic enzyme inducers such as carbamazepine may substantially decrease systemic exposure to quetiapine. In a multiple dose trial in patients to assess the pharmacokinetics of quetiapine given before and during treatment with carbamazepine (a known hepatic enzyme inducer), co-administration of carbamazepine significantly increased the clearance of quetiapine. This increase in clearance reduced systemic quetiapine exposure (as measured by AUC) to an average of 13% of the exposure during administration of quetiapine alone; although a greater effect was seen in some patients. As a consequence of this interaction, lower plasma concentrations can occur, and hence, in each patient, consideration for a higher dose of SEROQUEL, depending on clinical response, should be considered. It should be noted that the recommended maximum daily dose of SEROQUEL is 800 mg/day and continued treatment at higher doses should only be considered as a result of careful consideration of the benefit-risk assessment for an individual patient. Co-administration of SEROQUEL and another microsomal enzyme inducer, phenytoin, caused five-fold increases in the clearance of quetiapine. Increased doses of SEROQUEL may be required to maintain control of psychotic symptoms in patients co-administered SEROQUEL and phenytoin and other hepatic enzyme inducers (e.g. barbiturates, rifampicin, etc.). The dose of SEROQUEL may need to be reduced if phenytoin or carbamazepine or other hepatic enzyme inducers are withdrawn and replaced with a non-inducer (e.g., sodium valproate). *CYP 3A4 Inhibitors:* CYP 3A4 is the primary enzyme responsible for cytochrome P450-mediated metabolism of quetiapine. Thus, co-administration of compounds (such as ketoconazole, erythromycin, diltiazem, fluoxetine, verapamil or fluvoxazine), which inhibit CYP 3A1, may increase the concentration of SEROQUEL. In a multiple-dose trial in healthy volunteers to assess the pharmacokinetics of quetiapine given before and during treatment with ketoconazole, co-administration of ketoconazole resulted in an increase in mean C_{max} and AUC of quetiapine of 235% and 522%, respectively, with a corresponding decrease in mean oral clearance of 84%. The mean half-life of quetiapine increased from 2.6 to 6.8 hours, but the mean t_{max} was unchanged. Due to the potential for an interaction of a similar magnitude in a clinical setting, the dosage of SEROQUEL should be reduced during concomitant use of quetiapine and potent CYP3A4 inhibitors (such as azole antifungals and macrolide antibiotics). Special consideration should be given to elderly and debilitated patients. The risk-benefit ratio needs to be considered on an individual basis in all patients. *Divalproex:* Co-administration of SEROQUEL (750 mg bid) and divalproex (500 mg bid) increased the mean maximum plasma concentration of quetiapine by 17% without changing the mean oral clearance. *Cimetidine:* In a clinical study examining the pharmacokinetics of SEROQUEL following coadministration with cimetidine, a non-specific P450 enzyme inhibitor, no clinically significant interaction was observed. *Thioridazine:* Coadministration of thioridazine (200 mg b.i.d.) with SEROQUEL (300 mg b.i.d.) increased the clearance of SEROQUEL by 65%. *Fluoxetine, Imipramine, Haloperidol, and Risperidone:* Fluoxetine (60 mg daily), imipramine (75 mg b.i.d.), haloperidol (7.5 mg b.i.d.), and risperidone (3 mg b.i.d.)

did not significantly alter the steady-state pharmacokinetics of SEROQUEL. **Use in the Elderly** The number of patients 65 years of age or over, with schizophrenia or related disorders, exposed to SEROQUEL during clinical trials was limited (n=38). 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 a more frequent hepatic, renal, central nervous system, and cardiovascular dysfunctions, and more frequent use of concomitant medication caution should be exercised with the use of SEROQUEL in the elderly patient. (see DOSAGE AND ADMINISTRATION). **Use in Pregnancy** Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during treatment with SEROQUEL. The safety and efficacy of SEROQUEL during human pregnancy have not been established. Therefore, SEROQUEL should only be used during pregnancy if the expected benefits justify the potential risks. **Use in Nursing Mothers** The degree to which quetiapine is excreted into human milk is unknown. Women who are breastfeeding should therefore be advised to avoid breast feeding while taking SEROQUEL.

ADVERSE REACTIONS The stated frequencies of adverse events represent the proportion of individuals who experienced, at least once, a treatment-emergent adverse event of the type listed. An event was considered treatment-emergent if it occurred for the first time or worsened while receiving therapy following baseline evaluation. The prescriber should be aware that the figures in the tables and tabulations cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those that prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The figures cited, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the side effect incidence in the populations studied. **Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials** *Schizophrenia:* The following treatment-emergent adverse events, derived from Table 1, commonly occurred during acute therapy with SEROQUEL (quetiapine) (incidence of at least 5%, and an incidence at least 5% higher than that observed with placebo): somnolence, dizziness, dry mouth, postural hypotension, and elevated ALT (SGPT) levels. *Bipolar Disorder - Mania:* In the bipolar mania studies, the following treatment-emergent adverse events, commonly occurred during acute therapy with SEROQUEL (incidence of at least 5%, and an incidence at least 5% higher than that observed with placebo): somnolence, dry mouth, and weight gain. **Adverse Events Associated with Discontinuation** Short-Term Placebo-Controlled Clinical Trials:

Schizophrenia: Overall, 2.9% of SEROQUEL treated patients (n = 570) discontinued treatment due to adverse events compared with 2.3% of placebo treated patients (n=206). Somnolence, the single most common adverse event leading to withdrawal from quetiapine treatment, led to the withdrawal of four quetiapine-treated patients and no placebo-treated patients. Postural hypotension, hypotension and/or tachycardia led to withdrawal of 1.8% of quetiapine-treated subjects, compared to 0.5% of placebo-treated subjects. *Bipolar Disorder - Mania:* Discontinuations due to adverse events were similar for SEROQUEL (5.7%) and placebo (5.1%). Combined Short- and Long-term Controlled Trial Database in Schizophrenia: In a pre-marketing controlled clinical trial database of 1710 SEROQUEL-treated patients 5% discontinued due to an adverse event. Somnolence was the single most common adverse event leading to withdrawal of 24 patients from SEROQUEL, and was the only adverse event leading to withdrawal that occurred in more than 1% of patients. Cardiovascular adverse events (e.g. postural hypotension, hypotension, tachycardia, dizziness) accounted for 20% of all subjects withdrawals from quetiapine treatment. Seizure (0.9%) of quetiapine-treated subjects were withdrawn due to elevated liver enzymes. Four quetiapine-treated subjects were withdrawn because of leucopenia. Two of these subjects had at least one clinically significant, non-baseline low neutrophil count. Two quetiapine-treated subjects were withdrawn from the trial because of suspected neuroleptic malignant syndrome (NMS). **Incidence of Adverse Events in Placebo-Controlled Clinical Trials** Certain portions of the discussion below relating objective or numeric safety parameters are derived from studies in patients with schizophrenia and have not been disclosed for bipolar mania trials. However, this information is also generally applicable to bipolar mania. Table 1 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred during acute therapy (up to 6 weeks) of schizophrenia in 1% or more of patients treated with SEROQUEL (doses of 150 mg/day or more) where the incidence in patients treated with SEROQUEL was greater than the incidence in placebo-treated patients.

Weight Gain: During acute therapy (up to 6 weeks) in placebo-controlled schizophrenia clinical trials, mean weight gain in patients taking SEROQUEL was 2.5 kilograms compared to a mean

Table 1 Adverse Events Reported For At Least 1% Of Quetiapine-Treated Subjects (Doses > 150 mg/day) And For A Higher Percentage Of Quetiapine-Treated Subjects Than Subjects Who Received Placebo In Short-Term, Placebo-Controlled Schizophrenia Phase II-III Trials

Body system and COSTART Term	Percentage of subjects with adverse events*	
	Quetiapine(n = 449)	**Placebo(n = 202)**
Whole body		
Headache	20	17
Abdominal pain	4	1
Back pain	2	1
Fever	2	1
Nervous system		
Somnolence	18	11
Dizziness	10	4
Digestive system		
Constipation	9	5
Dry mouth	7	2
Dyspepsia	6	2
Gamma glutamyl transpeptidase increased	2	1
Cardiovascular system		
Postural hypotension	8	2
Tachycardia	7	5
Palpitation	1	0
Metabolic and nutritional disorders		
SGPT increased	7	2
SGOT increased	4	1
Weight gain	2	0
Endocrine system		
Hypothyroidism	1	0
Skin and appendages		
Rash	4	3
Respiratory system		
Rhinitis	3	1
Hemic and lymphatic system		
Leucopenia	2	0
Special senses		
Ear pain	1	0

*Subjects may have had more than one adverse event.

weight gain of 0.1 kilograms in patients taking placebo. In open-label extension trials with quetiapine monotherapy, mean weight gain after 9 to 13 weeks was 1.58 kg, after 14 to 26 weeks, 0.26 kg, after 27 to 39 weeks, 1.86 kg, after 40 to 52 weeks -1.53 kg and after 53 to 78 weeks, 1.38 kg (see PRECAUTIONS). In the acute placebo-controlled bipolar mania clinical trials (up to 12 weeks), mean weight gain in patients taking SEROQUEL was 1.6 kg compared to a mean weight loss of 0.1 kg in patients taking placebo. In patients completing the entire 12 weeks of treatment, mean weight gain in patients taking SEROQUEL was 2.9 kg. **Seizures:** There have been occasional reports of seizures in patients administered SEROQUEL, although the frequency was no greater than that observed in patients administered placebo or controlled clinical trials (see PRECAUTIONS). **Priapism:** There have been very rare reports of priapism in patients administered SEROQUEL. **Somnolence:** Somnolence may occur, usually during the first two weeks of treatment, which generally resolves with the continued administration of SEROQUEL. **Neuroleptic Malignant Syndrome:** As with other antipsychotics, rare cases of neuroleptic malignant syndrome have been reported in patients treated with SEROQUEL (see WARNINGS). **Vital Signs:** As with other antipsychotics with α1 adrenergic blocking activity, SEROQUEL may induce postural hypotension, associated with dizziness, tachycardia and, in some patients, syncope, especially during the initial dose titration period (see PRECAUTIONS). In placebo-controlled clinical trials in schizophrenia, postural hypotension was reported with an incidence of 8% in SEROQUEL-treated patients compared to 2% in placebo-treated patients. SEROQUEL was associated with a mean baseline to endpoint increase in heart rate of 3.9 beats per minute, compared to 1.6 beats per minute among placebo-treated patients. **Laboratory Changes:** As with other anti-psychotics, leucopenia and/or neutropenia have been observed in patients administered SEROQUEL. Occasionally, eosinophilia has been observed. There were no cases of persistent severe neutropenia or agranulocytosis reported in controlled clinical trials with SEROQUEL. Asymptomatic elevations in serum transaminases (SGOT (AST), SGPT (ALT)) or γ GT levels have been observed in some patients administered SEROQUEL. These elevations were usually reversible on continued SEROQUEL treatment (see PRECAUTIONS). Small elevations in non-fasting serum triglyceride levels and total cholesterol have been observed during treatment with SEROQUEL (see PRECAUTIONS). SEROQUEL treatment was associated with small dose related decreases in thyroid hormone levels, particularly total T_4 and free T_4. The reduction in total and free T_4 was maximal within the first 2 to 4 weeks of quetiapine treatment, with no further reduction during long-term treatment. There was no evidence of clinically significant changes in TSH concentration over time. In nearly all cases, cessation of quetiapine treatment was associated with a reversal of the effects on total and free T_4, irrespective of the duration of treatment (see PRECAUTIONS). Smaller decreases in total T_3 and reverse T_3 were seen only at higher doses. Levels of TBG were unchanged and in general reciprocal increases in S-4 were not observed, with no indication that SEROQUEL causes clinically relevant hypothyroidism. **Peripheral Oedema:** As with other antipsychotic agents, rare cases of peripheral oedema have been reported in patients treated with SEROQUEL. **Hypersensitivity:** Very rarely, hypersensitivity including angioedema has been reported. **ECG Changes:** Between group comparisons for pooled placebo-controlled trials reveal no statistically significant SEROQUEL/placebo differences in the proportions of patients experiencing potentially important changes in ECG parameters, including QT, QTc, and PR intervals. However, the proportions of patients meeting the criteria for tachycardia were compared in four 3- to 6-week placebo-controlled clinical trials for the treatment of schizophrenia revealing a 15% (47/299) incidence for SEROQUEL compared to 0.6% (1/166) incidence for placebo. SEROQUEL use was associated with a mean increase in heart rate, assessed by ECG, of 7 beats per minute compared to a mean increase of 1 beat per minute among placebo patients. This slight tendency to tachycardia may be related to SEROQUEL's potential for inducing orthostatic changes (see PRECAUTIONS). In bipolar disorder - mania trials the proportion of patients meeting the criteria for tachycardia was 0.3% (1/392) for SEROQUEL compared to 0% (0/178) for placebo. **Extrapyramidal Symptoms (EPS):** Table 2 enumerates the percentage of patients with treatment-emergent extrapyramidal symptoms in a short-term acute phase clinical trial in patients with schizophrenia comparing five fixed doses of SEROQUEL with placebo (n = ~ 50 patients per group), as assessed by: 1) spontaneous complaints of parkinsonism (extrapyramidal symptoms: hypersonia, tremor, and cogwheel rigidity) or akathisia; 2) Simpson Angus scores (mean change from baseline); and 3) use of anticholinergic medication to treat emergent EPS

Table 2 Treatment-Emergent Extrapyramidal Symptoms, Assessed by Spontaneous Reports, Simpson Scale, and Incidence of Anticholinergic Use

	placebo	SEROQUEL				
		75mg	150 mg	300 mg	600 mg	750 mg
Spontaneous Reports of Parkinsonian Syndrome*	13%	6%	4%	4%	8%	4%
Spontaneous Reports of Akathisia	8%	2%	2%	3%	0%	2%
Simpson Scale	- 0.6	- 1.0	- 1.2	- 1.6	- 1.8	- 1.8
Incidence of Anticholinergic Use	14%	11%	10%	8%	12%	11%

*Patients may have had more than one parkinsonism adverse event

There were no differences between the SEROQUEL and placebo treatment groups in the incidence of EPS or concomitant use of anticholinergics and no evidence of dose-related increase in EPS or in the use of concomitant anticholinergics across the dose range of 75 – 750 mg/day. In 2 bipolar disorder - mania placebo-controlled clinical trials using variable doses of SEROQUEL, there were no differences between the SEROQUEL and placebo treatment groups in the incidence of EPS, as assessed by Simpson-Angus total scores and Barnes Akathisia rating scale, spontaneous complaints of EPS and the use of concomitant anticholinergic medications to treat EPS.

Post-Market Experience During post-marketing experience, leucopenia and/or neutropenia have been reported during SEROQUEL treatment. Resolution of leucopenia and/or neutropenia has followed cessation of therapy with SEROQUEL. Possible risk factors for leucopenia and/or neutropenia include pre-existing low white cell count and history of drug induced leucopenia and/or neutropenia. As with some other antipsychotics, exacerbation of pre-existing diabetes, hyperglycaemia, diabetic ketoacidosis, and diabetic coma including some fatal cases, have been reported very rarely (<0.01%) during the use of SEROQUEL sometimes in patients with no reported history of hyperglycaemia. A causal relationship to SEROQUEL has not been established.

SYMPTOMS AND TREATMENT OF OVERDOSAGE **Clinical Trials** In clinical trials experience with SEROQUEL (quetiapine) in overdosage is limited. Estimated doses of up to 20 g of SEROQUEL have been taken, no fatalities were reported and patients recovered without sequelae. **Postmarketing** In postmarketing experience, there have been cases of coma and death in patients taking a SEROQUEL overdose. The lowest reported dose associated with coma has been in a patient who took 5 g and had a full recovery within 3 days. The lowest reported dose associated with a death was in a patient who took 13.6 g. In general, reported signs and symptoms were those resulting from an exaggeration of the drug's known pharmacological effects (e.g. drowsiness and sedation, tachycardia and hypotension. **Treatment** There is no specific antidote to quetiapine. In cases of severe intoxication, the possibility of multiple drug involvement should be considered, and intensive care procedures are recommended including establishing and maintaining a patent airway, ensuring adequate oxygenation and ventilation, and monitoring and support of the cardiovascular system. Close medical supervision and monitoring should be continued until the patient recovers.

DOSAGE AND ADMINISTRATION **Schizophrenia** The usual starting dose of SEROQUEL (quetiapine) is 25 mg b.i.d., titrated with increments of 25-50 mg b.i.d. per day, as tolerated, to a target dose of 300 mg/day given b.i.d. within four to seven days. Further dosage adjustments may be indicated depending on the clinical response and tolerability in the individual patient. Dosage adjustments should generally occur at intervals of not less than 2 days, as steady state for SEROQUEL would not be achieved for approximately 1-2 days in the typical patient. When adjustments are necessary, dose increments/decrements of 25-50 mg b.i.d. are recommended. SEROQUEL can be administered with or without food. Clinical trials suggest that the usual effective treatment dose will be in the range of 300-600 mg/day. However, some patients may require as little as 150 mg/day. The safety of doses above 800 mg/day has not been evaluated. The need for continuing existing EPS medications should be re-evaluated periodically as SEROQUEL has not been associated with treatment-emergent EPS across the clinical dose range.

Bipolar Disorder - Mania Usual Dose: The titration rate, based on the clinical trials is shown in the table below

Day	1	2	3	4	5	6
BID	100 mg/day	200 mg/day	300 mg/day	400 mg/day	Up to 600 mg/day	Up to 800 mg/day

Dosage adjustments should be made depending on the clinical response and tolerability in the individual patient. Approximately 85% of patients responded between 400 and 800 mg/day, while over 50% of patients responded between 600 and 800 mg/day, the average median dose for responders during the last week of treatment was approximately 600 mg/day. The safety of doses above 800 mg/day has not been evaluated. **Elderly** In clinical trials, 38 patients with schizophrenia or related disorders, 65 years of age or over, were treated with SEROQUEL (see PRECAUTIONS). Given the limited experience with SEROQUEL in the elderly, and the higher incidence of concomitant illness and concomitant medication in this population SEROQUEL should be used with caution. The mean plasma clearance of SEROQUEL was reduced by 30% to 50% in elderly subjects when compared to younger patients. The rate of dose titration may thus need to be slower, and the daily therapeutic target dose lower, than that used in younger patients. **Hepatic Impairment** Quetiapine is extensively metabolized by the liver. Therefore, SEROQUEL should be used with caution in patients with mild hepatic impairment, especially during the initial dosing period. Patients with mild hepatic impairment should be started on 25 mg/day. The dose should be increased daily in increments of 25 to 50 mg/day to an effective dose depending on the clinical response and tolerability in the individual patient. No pharmacokinetic data are available for any dose of SEROQUEL in patients with moderate to severe hepatic impairment. However, should clinical judgement deem treatment with SEROQUEL necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see PRECAUTIONS). **Renal Impairment** As clinical experience is lacking, caution is advised (see PRECAUTIONS).

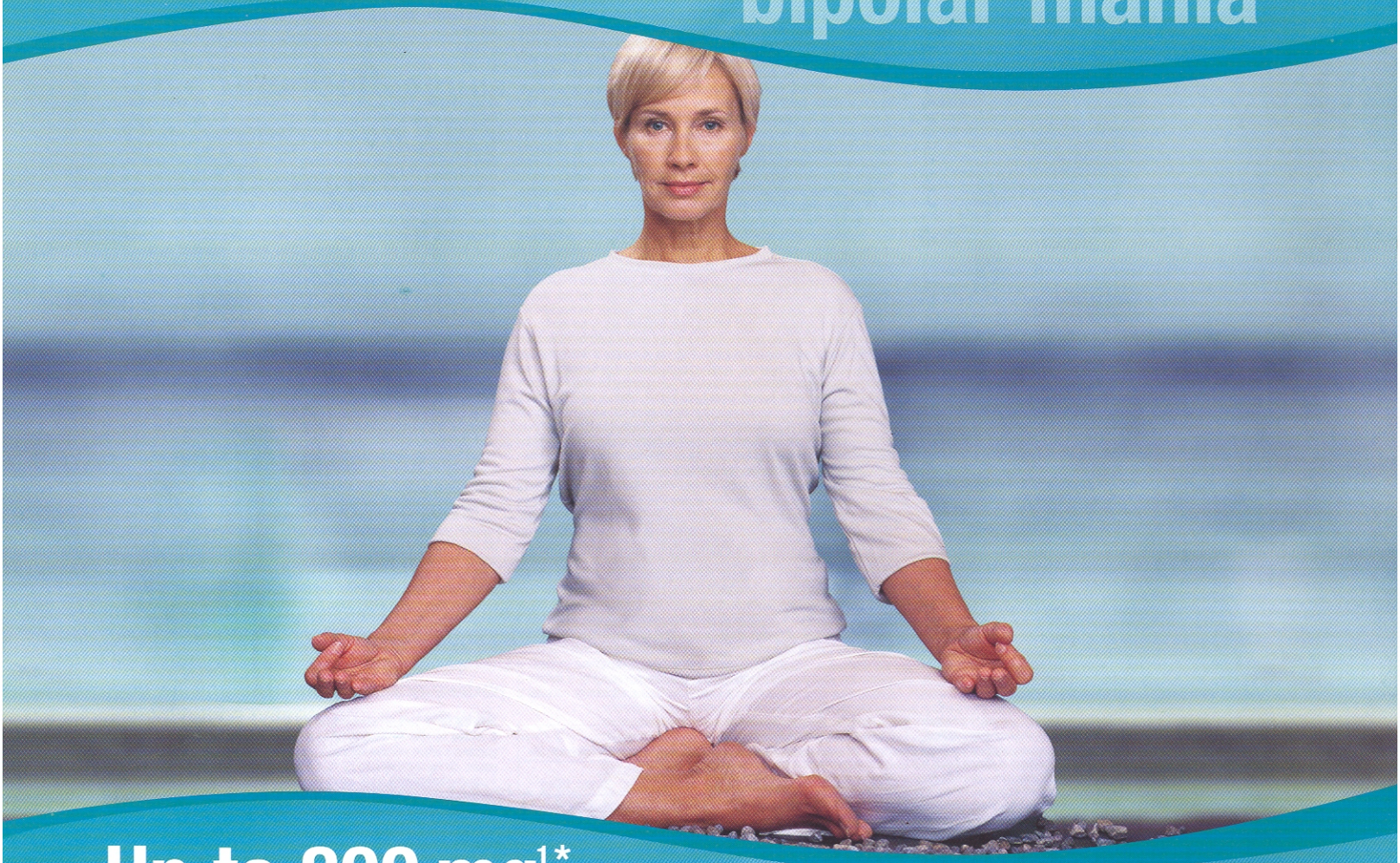
PHARMACEUTICAL INFORMATION **Composition** SEROQUEL is available in 5 strengths containing 25, 100, 150, 200 or 300 mg quetiapine (as fumarate). The core of the tablet contains the excipients povidone, calcium hydrogen phosphate, microcrystalline cellulose, sodium starch glycolate type A, across-linked hydrated magnesium stearate. The coating of the tablet contains hydroxypropyl methylcellulose 2910 polyethylene glycol 400 titanium dioxide, yellow ferric oxide (25 mg, 100 mg and 150 mg tablets) and red ferric oxide (25 mg tablets).

AVAILABILITY OF DOSAGE FORMS SEROQUEL (quetiapine) is available as film-coated tablets containing quetiapine fumarate equivalent to 25 mg, 100 mg, 150 mg, 200 or 300 mg of quetiapine free base as follows: 25 mg quetiapine tablets are peach coloured, round, biconvex, imaginated with 'SEROQUEL' and '25' on one side and plain on the other, available in blister packages of 60 tablets and high-density polyethylene (HDPE) bottles of 100 tablets. 100 mg quetiapine tablets are yellow coloured, round, biconvex, imaginated with 'SEROQUEL' and '100' on one side and plain on the other, available in blister packages of 60 tablets and HDPE bottles of 100 tablets. 150 mg quetiapine tablets are pale yellow coloured, round, biconvex, imaginated with 'SEROQUEL' and '150' on one side and plain on the other, available in HDPE bottles of 100 tablets. 200 mg quetiapine tablets are white, round, biconvex, imaginated with 'SEROQUEL' and '200' on one side and plain on the other, available in blister packages of 60 tablets and HDPE bottles of 100 tablets. 300 mg quetiapine tablets are white, capsule-shaped, biconvex, imaginated with 'SEROQUEL' on one side and '300' on the other, available in HDPE bottles of 100 tablets.

Full Product Monograph available upon request.

REFERENCES: 1. Seroquel® Product Monograph. AstraZeneca Canada Inc., November 2005. **2.** Arvanitis LA, Miller BG. Seroquel Trial 13 Study Group. Multiple fixed doses of "Seroquel" (quetiapine) in patients with acute exacerbation of schizophrenia: a comparison with haloperidol and placebo. *Biol Psychiatry* 1997;42(4):233-46. **3.** Small JG, Hirsch SR, Arvanitis LA *et al.* Quetiapine in patients with schizophrenia. A high- and low-dose double-blind comparison with placebo. *Arch Gen Psychiatry* 1997;54:549-57. **4.** Velligan DI, Newcomer J, Pultz J *et al.* Does cognitive function improve with quetiapine in comparison to haloperidol? *Schizophrenia Research* 2002 56 239 46.

bipolar mania



Up to 800 mg[1]*

...and who knows how many peaceful moments?

Showed significant and sustained efficacy:

- Seroquel® demonstrated a significant change from baseline YMRS** total score at day 21 in a 12-week study[1†]
- Of patients with clinical response, 87% received doses between 400 and 800 mg per day (day 84 data)[1]
- In two individual studies, 52% and 81% of responders attained clinical response with 600-800 mg per day (day 84 data)[1‡]
- Dosage adjustments should be made depending on the clinical response and tolerability in the individual patient[1]

Trusted tolerability profile[1]:

Incidence of adverse events reported in schizophrenia is expected to be generally applicable to bipolar mania[1]:

- EPS profile was no different from placebo across the dose range[1]
- Elevation of prolactin levels was not seen in clinical trials[1]

Seroquel® is indicated as monotherapy for the acute management of manic episodes associated with bipolar disorder.

The efficacy of Seroquel® in bipolar disorder – mania was established in two 12-week clinical trials of bipolar patients. The safety and effectiveness of Seroquel® for long-term use, and for prophylactic use in bipolar disorder has not been evaluated.

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 known hepatic or renal impairment. Common adverse events occurring during Seroquel® monotherapy in bipolar mania (incidence of at least 5%, and an incidence of at least 5% higher than that observed with placebo): somnolence, dry mouth, and weight gain.

*Seroquel® should be initiated in BID doses totaling 100 mg/day on day 1, increased to 400 mg/day on day 4, in increments of 100 mg/day in BID divided doses. Dosage adjustments up to 800 mg/day by day 6 should be in increments of no greater than 200 mg/day. Dosage adjustments should be made depending on the clinical response and tolerability in the individual patient. Clinical trials suggest that the usual effective treatment dose is 400 – 800 mg/day. Safety has not been evaluated beyond 800 mg/day.

**Young Mania Rating Scale

†Results of two 12-week, multi-centre, double-blind, placebo-controlled studies. LOCF data.

‡Responders (defined as a 50% decrease from baseline YMRS Total Score) in two, 12-week, multi-centre, double-blind, placebo-controlled studies.

1. Seroquel® Product Monograph. AstraZeneca Canada Inc. November 2004.

AstraZeneca

℞ Seroquel®
Quetiapine