Ontario Psychiatric Association
DIALOGUE
THE NEWSLETTER OF THE ONTARIO PSYCHIATRIC ASSOCIATION / UNE PUBLICATION DE L'ASSOCIATION DES PSYCHIATRES DE L'ONTARIO
SPRING 2008

MESSAGE FROM THE PRESIDENT

Folie Adieux: Moving Beyond Stigmatization of Psychiatry

Dear Colleague,

As I take on the role of President of the Ontario Psychiatric Association, I am excited by the promise and potential the coming year holds for our profession. Under the careful guidance of Dr. Richard O'Reilly this past year, the OPA has continued to build relationships with other organizations and has been steadily advocating on behalf of psychiatric patients and psychiatrists on many fronts. Our association is stronger than ever, and I would like to thank Dr. O'Reilly for his principled and effective leadership over the past year. I am also thrilled that Dr. Paul Mulzer is now President-Elect of the OPA and will be assuming the role of President after my term ends in 2009. Our association and patients are certain to benefit from his talented advocacy and skills.

There are many foreseeable changes on the medical and mental health care horizon, from regionalization and LHINs, to the work of the Mental Health Commission, and others, and the OPA is well poised to play a leading role in shaping those changes for the benefit of our members and our patients. Still, while I look forward to the promise and potential of this coming and future years, I am also keenly aware of the risk of these promises remaining unfulfilled and potential unrealized. We have all seen examples of this over the years, of psychiatric issues remaining marginalized despite opportunities for positive change. Reflecting on the reasons for such continued marginalization has led to my presidential theme for the coming year, "Folie Adieux: Moving Beyond Stigmatization of Psychiatry."

Why a theme that looks at stigma? We've been talking about destigmatizing mental illness for years, if not decades, surely we don't need to keep beating the same drum? Certainly we have seen many positive initiatives in recent years on the destigmatization front. Senator Kirby's report on Mental Health in Canada, "Out of the Shadows at Last", truly did help bring the issue of mental health move into the light. We are also witness to Canada's first national Mental Health Commission, which has taken on destigmatization of mental health as one of its priorities. I think it is fair to say that, while stigma of psychiatric issues clearly persists, we are gradually seeing some positive changes in attitudes toward mental health.

This brings me to our first potential 'pitfall'. Destigmatization initiatives often focus on changing attitudes and then assuming such attitudinal change will naturally lead to further improvements. Unfortunately, history has shown that this is often not the case. Even with our initiatives at destigmatizing mental health, the legacy of that stigma remains entrenched in our institutions and programs. We often hear talk of destigmatization and giving increased priority to mental health, yet when it comes to action that stigma just gets embedded in a new way. It is essential that we broaden the discussion of stigma as being far more than just an attitude.

The recent Family Health Team funding model is probably the most poignant example of this. By comparing the worth of one patient's suffering to another's, the implications of the model go far deeper than funding and lay bare the institutionalized stigma beneath the funding model. We're increasingly seeing models of collaborative care throughout medicine that have the potential to help our patients more comprehensively than ever before, and on the surface at least these models acknowledge the importance of mental health services. However, if the same model continues to value the care of psychiatric patients 34% less than other patients, what have we really changed? Perhaps not new wine in old bottles, but rather old stigma in new models.

This leads to part of my presidential theme, of "Moving Beyond" stigmatization of psychiatry and ensuring our efforts go beyond simply words and attitudes, and actually change actions and practices.

Finally, "Folie Adieux" is of course a play on "Folie a Deux", and is meant to encourage a degree of self-reflection by reminding us that it usually takes two to tango. While it would be easy for us to simply project blame externally for the continued marginalization and entrenched effects of stigma on psychiatry, I believe the reality is more complex. Certainly we have much external resistance and many institutional barriers to overcome before our patients achieve the parity they deserve, but if we are to succeed I am equally certain we need to confront any of our own internalized stigmas about psychiatry and how they affect our decisions and expectations. If we undervalue the worth of what we do and complacently allow discriminatory models to persist, and perhaps even facilitate them, are we not simply playing our role in the 'folie a deux' and perpetuating the entrenched stigma of psychiatry? For meaningful change, psychiatrists need to take an active role in challenging and reversing such stigma wherever it exists, including at times in ourselves.

Over the past year, as President-Elect of the OPA, I have been tremendously encouraged by the response of members to the diverse areas the OPA is working in. There is increasing awareness of the important and relevant work the OPA is doing, both on behalf of Ontario psychiatrists and psychiatric patients. For those of you who are OPA members, thank you for supporting these initiatives, your colleagues, and your patients; if you have not yet joined the OPA, I would encourage you to join the OPA and also support the Coalition of Ontario Psychiatrists. For every psychiatrist who is not an OPA member, we lose a degree of legitimacy in advocating for the issues important to that psychiatrist. Any Association derives its strength from its members, please help us advocate more strongly on your behalf.

With the many opportunities before us we have the chance to move beyond attitude and push for change in action. I am honoured to have the chance to serve as your President this coming year, and look forward to working with you, OPA Council, and our partners, to ensure "Folie Adieux: Moving Beyond Stigmatization of Psychiatry" does not remain just a set of words on paper, but reflects a theme in action.

K. Sonu Gaind

2008 OPA President

Ontario Psychiatric Association Executive and Council

President
Dr. Sonu Gaind

President-Elect
Dr. Paul Mulzer

Past President
Dr. Richard O'Reilly

Secretary
Dr. Varinder Dua

Treasurer
Dr. Deborah Elliott

Dr. Nadia Aleem

Dr. Doron Almagor

Dr. Gary Chaimowitz

Dr. John Deadman

Dr. Alison Freeland

Dr. Anne Hennessy

Dr. Andrew Howlett

Dr. Sarah Jarmain

Dr. Vinay Lodha

Dr. Roumen Milev

Council Members can be contacted through the OPA Head Office

OPA Office: 344 Lakeshore Rd. E. Suite B
Oakville, Ontario L6J 1J6
Tel: (905) 827-4659
Email: opa@bellnet.ca
Fax: (905) 849-8606

Publisher: Dr. Varinder Dua
Editor: June Hylands
Design & Production: AEW Productions Inc.

FROM THE EDITOR

On behalf of myself and the staff at the OPA office, we welcome the opportunity to work with the new President, Dr. Sonu Gaind, focusing on this year's theme ***"Folie Adieux: Moving Beyond Stigmatization of Psychiatry."*** We also welcome our new Council members.

The Annual conference, held in February, was very successful and it is always a pleasure to see old friends and meet new colleagues. Dr. Roumen Milev has completed his term as the Chair of the Continuing Education Committee. Our thanks to Dr. Milev and the Committee for all their work over the last several years. Dr. Paul Mulzer and Dr. Jon Davine will Co-Chair the next Annual Conference in a new location - The King Edward Hotel in Toronto. Plans are already underway so mark your calendar for February 27th - 28th 2009 now and plan to attend.

We were not able to meet quorum for the Annual General Meeting. Quorum has been set quite high at 10% of members to begin the meeting. As our membership increases it becomes an even greater challenge. Within this issue of *Dialogue*, we review how we will proceed and we will be discussing throughout this year strategies to attain quorum for the next AGM, with a move to change the requisite number for subsequent years. If any member is concerned about the issue as it is reviewed in this newsletter, please contact either myself of Dr. Gaind to discuss this in more detail.

In this issue of *Dialogue* there is an update on the funding model for the Family Health Teams (FHTs). We continue to pursue this important issue, for both financial reasons and because it suggests a deeply embedded form of stigmatization as Dr. Gaind articulates so well in the President's message.

Although it has seemed at times that winter would never end, the days are getting longer and the sun is shining a little stronger. We hope you have a pleasant and well-deserved springtime. As always, your comments, suggestions and ideas are welcome at any time.

June Hylands
Editor

INSIDE

Meet Your 2008 OPA Council

President:	Dr. Sonu Gaind
President-Elect:	Dr. Paul Mulzer
Past President:	Dr. Richard O'Reilly
Secretary:	Dr. Varinder Dua
Treasurer:	Dr. Deborah Elliott

Council Members:

Dr. Doron Almagor	Dr. Vinay Lodha
Dr. Gary Chaimowitz	Dr. John Deadman
Dr. Alison Freeland	Dr. Anne Hennessy
Dr. Sarah Jarmain	Dr. Roumen Milev

Thank you to Outgoing Council

The OPA would like to recognize the following outgoing Council members for their tireless efforts and contributions to the Ontario Psychiatric Association as Council Member:

Dr. Susan Abbey
Dr. Leslie Buckley
Dr. Paul Sedge
Dr. Andrea Waddell

Ontario Psychiatric Association
Council Meeting Agenda
Thursday, February 7th, 2008 - 1:00 - 4:00 pm
Toronto Marriott Eaton Centre Hotel, Carlton Room

1.0 Remarks form the President and Approval of Agenda	10 minutes	R. O'Reilly	
2.0 Approval of Minutes of November 23rd, 2007	5 minutes	All	
3.0 Business Arising			
3.1 President Theme 2008 Summary		3.1	S. Gaind
3.2 Election Results	30 minutes	3.2	R. O'Reilly
3.3 OPA AGM & Annual Report		3.3	R. O'Reilly
4.0 Treasurer's Report			
4.1 Year end and Budget	30 minutes	4.1	D. Elliott
5.0 Reports of Task Forces and Committees			
5.1 Advocacy Committee	45 minutes	5.1	D. O'Reilly
5.2 Communications Committee		5.2	V. Dua
5.3 Continuing Education Committee		5.3	R. Milev
5.4 Finance/Audit Committee		5.4	D. Elliott
5.5 Member Services Committee		5.5	R. A. Hennessy
6.0 Standing Reports			
6.1 CPA Reports			
6.1.1 Directors		6.1.1	
6.1.2 Council of Provinces		6.1.2	K. Anderson
6.1.3 Standing Committees	30 minutes		
6.1.3.1 Education		6.1.3.1	
6.1.3.2 Professional Standards & Practice		6.1.3.2	R. Milev
6.1.3.3 Scientific & Research		6.1.3.3	
6.2 OMA Section on Psychiatry		6.2	S. Abbey
6.3 Coalition		6.3	R. O'Reilly
6.4 Executive Director Report		6.4	J. Hylands
7.0 New Business	30 minutes		
7.1 Incorporating for charitable status		7.1	R. O'Reilly
7.3 Dates for next Annual Conference		7.3	All

Ontario Psychiatric Association
Annual General Meeting Agenda

Saturday, February 9th, 2008 - 8:15 - 9:00 am
Toronto Marriott Eaton Centre Hotel, Salon C/D

1.	Call to Order	S. Gaind
2.	Introducing of Guests	S. Gaind
3.	Approval of Agenda	
4.	Approval of Minutes of the February 24th, 2007 AGM	
5.	OPA President's Report	S. Gaind
6.	OPA Treasurer's Report	D. Elliott
7.	Appointment of Auditor	
8.	OPA President's Address	S. Gaind
9.	Presentation of 2008 Budget	D. Elliott
10.	Election Results for 2008 Council	S. Abbey
11.	Other Business	
12.	Adjournment	

Family Health Teams Update

As you will recall from previous updates on the Family Health Team (FHT) issue, we have been successful in having the Ontario Medical Association (OMA) formally adopt a policy seeking parity of specialist remuneration in the FHT model. However, the current funding model of remunerating psychiatric, paediatric, and geriatric services 34% less than internal medicine services remains in place. The Ministry of Health and Long-Term Care (MOHLTC) seems content to leave this issue for upcoming negotiations to resolve. In the meantime, the MOHLTC is continuing to attempt to recruit psychiatrists in the existing discriminatory funding model.

It is clear that the MOHLTC will see any new psychiatrist recruitment into the model as a sign that the existing model is acceptable, and this will only reduce any chance of successfully changing the model. It seems equally clear that if psychiatrists continue to refuse to sign on to the model the MOHLTC will have no choice but to eventually implement a parity-based model, especially now that the OMA supports a model of parity.

The OPA, the OMA Section on Psychiatry, and the Coalition of Ontario Psychiatrists continue to advise all Ontario psychiatrists to refuse to sign on to provide services to FHTs under the current funding model, and OMA policy is now also supporting a moratorium on new specialist recruitment to FHTs until the issue is resolved. In addition, we are trying to work with psychiatrists who had previously signed on to deliver FHT services to develop ways for them to add their voices to the demands for a parity-based model. If you are a psychiatrist who had already agreed to provide FHT services, please contact the OPA at (905) 827-4659 or me directly at psych@rogers.com to discuss how you can get involved.

Respectfully submitted,

K. Sonu Gaind
Tariff Chair, OMA Section on Psychiatry

NEWS FROM THE OPA ARCHIVES - WE HAVE RECEIVED A BURSARY.

The OPA has been awarded a bursary from the ***Hewson and Griffen Bursaries for Archival Research***. This will enable us to hire a person studying in the archival field to help us organize, catalogue and preserve the Association's Archives and make them more accessible to members and people interested in the history of psychiatry and mental health.

The OPA has a long and proud tradition among Canadian professional associations. It came into being as the *Ontario Neuropsychiatric Association* on the 28th of April, 1920. With a name change to the present *Ontario Psychiatric Association* in the 1950's, it has continued ever since. It is unquestionably the olderst psychiatric association in Canada; the Canadian Psychiatric Association was founded in 1951.

The OPA has been involved in every kind of professional issue. Although information and education have been major concerns, it has worked closely with the OMA Section of Psychiatry and the Coalition of Ontario Psychiatrists to protect your interests.

The old records and other documents that make up our archives contain an historic record of all the affairs of the OPA from the first meeting at the Rockwood Hospital in Kingston. I have recently undertaken to go through the archives and have them catalogued. The work I have done so far indicates that they are a very valuable part of our history and should be accessible to the membership and to researchers and others interested in this and other professional organizations.

We are proposing to set up the archives with stacks and a small reading area. We are looking for assistance in the cataloguing and maintainence of the archival centre. I am asking that any members who have an interest in such matters give me a call or an email as we are going to need all the help we can get. I would like to form an "Archives Committee" to oversee this work. The OPA is also seeking to have a foundation with charitable status so at that time we will need donations as well.

Also we ask all members, especially older members who have been on Council or Executive positions to see if you could make donations of any kind, as some of our records are fragmentary or incomplete. Please don't throw any OPA papers out before you contact me. I will be contacting older members to see if they have copies of minutes, reports etc. which may be used to complete our files.

Please get in touch with me or Sheryl Keenan at the OPA office if you can help in any way.

John Deadman deadmanj@mcmaster.ca
Sheryl Keenan opa@bellnet.ca

Call to Reduce Psychiatric Wait Times - Email your MPP Now!

At the Ontario Psychiatric Association Council Meeting of February 9, 2008 it was agreed by Council that the OPA would support the Psychiatric Wail Times Campaign of the Schizophrenia Society of Ontario. Please do what you can to support this worthwhile campaign. Accessibility to mental health services in an appropriate time frame will be of benefit to our patients. This Campaign is consistent with the guidelines produced by the Canadian Psychiatric Association.

Leading up to the Ontario Election last fall, the Schizophrenia Society of Ontario (SSO) launched its Psychiatric Wait Times campaign calling on the Ontario government to improve access to mental health care by reducing psychiatric wait times.

Immediately following the election, the Liberal Government announced the addition of emergency room wait times to its overall wait time strategy.

Emergency room wait times are an important component of improving wait times for psychiatric care are treatment.

SSO is continuing to call on the Ontario Government to improve access to psychiatric care and treatment.

You can help with this important initiative!

To send an email to your MPP Copy and paste the following link into your browser: http://www.advocacyonline.net/cms/cmsloader?WfJVLp&view=521,81,2644,0,-html and tell him or her that psychiatric care and treatment need to be included as a priority in the government's Wait Time Strategy. Copies of your email will be sent to Premier Dalton McGuinty, Health Minister George Smitherman, and Finance Minister Dwight Duncan.

It only takes a couple of minutes and it's easy to do.

For more information on SSO's Psychiatric Wait Times campaign visit www.schizophrenia.on.ca.

Please feel free to circulate this Call to Action broadly and encourage others to email their MPP. Thank you for supporting SSO's call for Psychiatric Wait Times in Ontario. Contact the Schizophrenia Society of Ontario at 416-449-6830 or at sso@schizophrenia.on.ca

The OPA Congratulates Dr. Koka on receiving the Ontario Medal for Good Citizenship

Rick Bartolucci, M.P.P./DÉPUTÉ Sudbury
news release

For Immediate Release January 28, 2008

DR. RAYUDU KOKA RECEIVES ONTARIO MEDAL FOR GOOD CITIZENSHIP

"I am proud that the province is recognizing this outstanding member of our community," says Bartolucci.

Sudbury - Local psychiatrist and community leader Dr. Rayudu Koka is one of thirteen Ontarians who will be honoured with the Ontario Medical for Good Citizenship at a ceremony at Queen's Park on January 31 for his outstanding contribution to his community.

Specifically, Dr. Koka is being honoured for establishing local mental health clinics throughout the North, including First Nations communities.

"Dr. Koka's contribution to our community is immeasurable," says Bartolucci. "He is an exemplary ambassador for Sudbury, and an example of excellence to which we would all do well to aspire. He is a tireless, effective worker and deserves to be recognized for his selfless contributions to Sudbury and the North".

"Dr. Koka is truly an outstanding advocate for our community and its fundamental needs. He is most deserving of this award and I congratulate him," says longtime friend Gerry Lougheed Jr.

Honourable David C. Onley, Lieutenant Governor of Ontario, will be presenting the awards at the Queen's Park ceremony. The awards serve to recognize the outstanding achievements and contributions to our province and beyond.

"Dr. Koka continues to define himself as a great Sudburian with passion and a zest for life which is truly remarkable," says Meho Halimich President of the Sudbury Multicultural and Folk Art Association".

"There is no person more deserving for the Ontario Medal of Good Citizenship than Dr. Rayudu Koka. Dr. Koka is an honourable, humble and extremely strong advocate who works tirelessly for the medical and police professions while espousing the importance of multiculturalism and racial harmony in a diverse Ontario," says Ian Davidson City of Greater Sudbury Chief of Police.

"I am very pleased to receive the recognition of my community through this award. It is an honour and a privilege to be highlighted by the Province for work that I believe to be fundamental to a growing society," says Dr. Koka.

"I know I speak for our community when I say this is a proud moment for Sudbury," concludes Bartolucci. "To Dr. Koka I say, thank you for all you do. You are an inspiration to us all."

Contact:
Rick Bartolucci
675-1914

Report from the Co-Chair of the Continuing Education Committee

As President-Elect of the OPA and Co-Chair of our Continuing Education Committee I'm delighted to welcome Dr. Jon Davine as Co-Chair to our planning committee. We are delighted with our good fortune to procure a great venue, The King Edward Hotel, and our goal; to present first class CME in a stimulating environment that will promote networking and discussion.

Of course, being in the heart of an exciting city like Toronto accords rich opportunities for top-notch entertainment venues. For those who were fortunate to attend our conference this year you will be able to attest to the high quality speakers and exciting and thought-provoking topics provided. I'm very appreciative of the leadership Dr. Milev has provided to our past conferences and I'm thrilled abut this opportunity to build on his accomplishment by hosting yet another world class CME event!

Mark your calendars and join us for what promises to be our best conference yet!

Paul Mulzer
Co-Chair
Continuing Education Committee

Mark Your Calendars!

OPA 89th Annual Conference!

February 27th & 28th, 2009
Great new location:
Le Méridien King Edward
37 King Street East · Toronto, Ontario

OPA Psychotherapy Section's 2008 Fall Conference!

Saturday, November 1, 2008
Featuring ***Dr. Bruce Fink***
Speaking on Lacanian Theory

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

The T.A. Sweet Award

Presented to Mr. Michael Bay at the OPA Annual Dinner.

The T. A. Sweet Award is presented annually to individuals who have made a major contribution to the understanding of mental illness and its impact on individuals in society.

The OPA is delighted to announce this year's recipient was Mr. Michael Bay.

Mr. Michael Bay practices health law and is an educator, lecturer and consultant in the fields of mental health, consent, capacity and health privacy law. Engaged in the review of community treatment order legislation he established Ontario's Consent and Capacity Board, serving as its Chair and CEO. He was previously the Director of the province's Mental Health Law Education Project, consultant to the Ministry of Health, Chair of the Psychiatric Review Board (Toronto West), mental health counsel to the Ministry of Health, and Executive Assistant to the Minister of Health.

The OPA was pleased to recognize Mr. Bay at the OPA Annual Conference held this past February. We applaud Mr. Bay for all his work in the area of mental health.

The Dr. Ann Thomas Award

The OPA Annual Dr. Ann Thomas Award was presented at this year's Annual Conference held this past February.

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 Conference.

Congratulations to this year's winners:

Nicole Kozloff awarded the Dr. Ann Thomas Award for Best Resident Poster Presentation
Anne Marie O'Brien awarded the Dr. Ann Thomas Award for Best Poster Presentation

The OPA would like to acknowledge and thank our sponsors and exhibitors for their support for the OPA Annual Conference

Major Sponsors

Janssen-Ortho Inc.
Shire Biochem Inc.

Sponsors

AstraZeneca Canada Inc.
Eli Lily Canada Inc.
Lundbeck Canada

Exhibitors

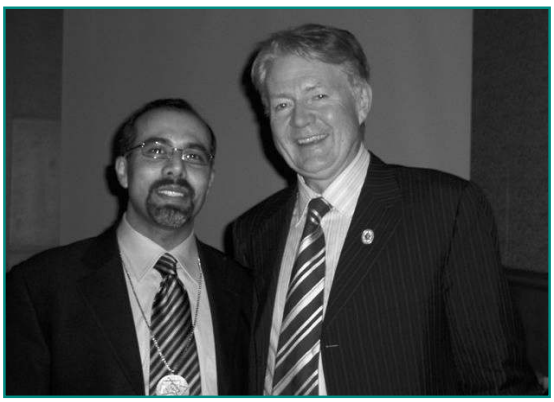
Biovail Pharmaceuticals Canada
Canadian Psychiatric Association
Caversham Booksellers
Diane A. Gagné Financial Services
Genpharm Inc.
MindCare Centres Ottawa
Northeast Mental Health Centre
Prestwick Pharmaceuticals
Schizophrenia Society of Ontario

OPA Collegiality

Dr. Keith Anderson
Dr. Anne Hennessy
Dr. Lou Faucher

OPA President-Elect Dr. Paul Mulzer
& spouse Sharon Mulzer

OPA Council member
Dr. John Deadman
with wife and friends



OPA President- Dr. Sonu Gaind
CPA President- Dr. Peter White

OPA Past President-
Dr. Richard O'Reilly
CPA President-
Dr. Peter White

T.A. Sweet Award Recipient
Mr. Michael Bay & family

Dr. Robert Buckingham
Dr. Susan Abbey

Ontario Psychiatric Association
Council Meeting
AGENDA

Date: Saturday February 9th, 2008
Time: 12:00 - 1:30 P.M.
Location: Toronto Marriott Eaton Centre Hotel 525 Bay St.

Item	Responsibility
1. Remarks from the President - Approval of Agenda	S. Gaind
2. Introduction of 2008 Council Members	S. Gaind
3. Org Chart / Committee Membership for 2008	All
4. Finalize meeting dates for 2008	All
5. 2008 Annual Meeting update	
6. Other Business	

Report from Meeting Scheduled as the Annual General Meeting
Lack of Quorum
Saturday, February 9th, 2008
Toronto Marriott Eaton Centre Hotel

Dr. O'Reilly, OPA President, noted the there were insufficient members to constitute a quorum. The Bylaws state that *Quorum shall be 10% of Members at the beginning of the meeting and the meeting may continue even though members leaving may reduce the number to less than quorum.*

Dr. O'Reilly recommended to the membership that we proceed with the meeting to share information and ask those present to indicate their opinion / vote on motions. Although this would not be legally binding, it would assist in communication, transparency and assist to guide the Executive and Council on decisions.

We would also communicate to the membership through *Dialogue*. It was noted that the issue of requiring 10% of members present at the start of the meeting for quorum becomes increasingly challenging as the membership numbers increase. There was no objection from those present to proceeding as recommended. Dr. O'Reilly asked for changes or additions to the agenda. The agenda was accepted without change.

The following is a summary of what transpired during the meeting and is included here to ensure we are acting is a responsible manner by communicating to the membership issues that would have been included in a legally constituted Annual General Meeting.

Important message to all OPA members - in order to meet legal obligations under the Ontario Business Corporations Act we will be distributing a proxy form that includes the motions for the Annual General Meeting. We will ask all members to email of fax their form back to the OPA office. We will also provide notice of a specific date and time when any member may call into a telephone conference line to ask questions or note concerns.

1. Dr. P. White, President of the Canadian Psychiatric Association addressed the members in attendance.

Dr. White noted that Ontario can play an active role in leading initiatives given its size and numbers. Over half of Canadian psychiatrists live in Ontario. He encouraged Ontario of continue to act in this capacity as the CPA and provincial psychiatric associations strive to become more politically influential in policy decisions. Dr. White encouraged Ontario psychiatrists to join the Coalition of Ontario Psychiatrists as another opportunity to increase political influence among psychiatrists. He went on to congratulate several Ontario psychiatrists who have won awards over the past year. Dr. White also congratulated Dr. Susan Abbey on being elected for CPA president elect. Dr. White concluded his address by giving a brief overview of the work undertaken over the past year by the CPA.

2. Approval of Minutes of the February 24th, 2007 Annual General Meeting

Motion to accept the February 24th, 2007 minutes as distributed.
Moved by Dr. Mulzer.
Second by Dr. Faucher.
Motion Accepted by those present. No objections.

3. OPA President's Report

Dr. Richard O'Reilly, President reported to the membership. Dr. O'Reilly stated that it had been a busy year. He thanked Dr. Sonu Gaind, incoming president, for his work, especially related to the Family Health Team compensation. He thanked Council and commented on the exceptional Council we have. In order to have a clear and united presence, Dr. O'Reilly emphasized the need to encourage our colleagues to join the OPA and the Coalition. The complete President's report was included in the Annual Report.

4. OPA Treasurer's Report

Dr. Deborah Elliott, Treasurer, reported that we stayed within operating funds. Methods to increase revenue and reduce operating expenses continue to be examined. While we are financially stable, the reserves are not where they should be and should be increased over time. There was no request for a fee increase. The Treasurer report and audited financial statements were distributed/included with the Annual Report.

Motion to accept the 2007 audited financial statements and OPA Treasurer's Report as distributed.
Moved by Dr. Elliott
Seconded by Dr. S. Jarmain
Motion accepted by those present. No objections.

5. Appointment of Auditor

Motion to reappoint Charles Havill Chartered Accountants as accountant for the OPA for 2008.
Moved by Dr. Elliott
Seconded by Dr. R. Milev.
Motion accepted as presented. No objections.

6. Presentation of 2008 Budget

At the conclusion of the 2007 Treasurer's Report, Deborah Elliott invited OPA members to review the 2008 OPA Budget. Dr. Elliott brought to the attention of the membership two changes in the budget. The first was a partial reinstatement of honorarium for Council to attend full day meetings. This had been suspended when we were in significant financial difficulty. The second was an increase in management fees.

Motion to accept the 2008 OPA Budget as distributed.
Moved by Dr. R. Milev.
Seconded by Dr. J. Deadman.
Motion accepted by those present. No objections.

7. Elections Results for 2008 Council

Dr. Abbey, Chair of the Nominations Committee presented the slate for Executive and Council for 2008. The results were included tn the Annual Report. She announced that the President-Elect was Dr. Paul Mulzer.

Motion to accept the election results as stated for the 2008 council.
Moved by Dr. S. Abbey.
Seconded by Dr. A. Hennessy.
Motion was accepted by those present. No objections.

8. Incoming President's Address

Dr. Richard O'Reilly presented Dr. Karadeep Sonu Gaind with the Presidential chain of office and gavel. Dr. Gaind addressed the membership. He began by thanking Dr. O'Reilly for his outstanding contributions in his term of office as President. He also thanked the Continuing Education Committee and the OPA staff for the well-organized conference. Dr. Gaind announced his presidential theme.
Folie Adieux: Moving Beyond Stigmatization of Psychiatry
He noted that education and awareness of stigma was not enough to bring about change, and that we must address many issues around stigma that have been institutionalized and that even we may have internalized. Also, we must ensure that we go beyond ideas to real actions.

9. Other Business

Dr. O'Reilly thanked the Executive and Council. He noted that in his capacity as Past President he would be overseeing the nominations committee. Dr. O'Reilly thanked the membership and wished the group a wonderful day at the OPA conference. The meeting was declared adjourned.

New

Once Daily

Seroquel XR

quetiapine

Prescribing Summary

Patient Selection Criteria

SEROQUEL XR (quetiapine) is indicated for the management of the manifestations of schizophrenia. ***Geriatrics (> 65 years of age):*** SEROQUEL XR is not indicated in elderly patients with dementia. ***Pediatrics (< 18 years of age):*** The safety and efficacy of SEROQUEL XR have not been established.

CONTRAINDICATIONS

SEROQUEL XR (quetiapine) 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 be advised to avoid breast-feeding while taking SEROQUEL XR. ***Pediatrics (< 18 years of age):*** The safety and efficacy of SEROQUEL XR have not been established. ***Geriatrics (≥ 65 years of age):*** The number of patients ≥65 years of age exposed to SEROQUEL XR during clinical trials was limited (n=68). Mean plasma clearance of quetiapine was reduced by 30% to 50% in elderly subjects vs. younger patients. In addition, as this population has 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 XR in the elderly patient (see DOSAGE AND ADMINISTRATION). **Use in Geriatric Patients with Dementia: Overall Mortality: Elderly patients with dementia treated with various atypical antipsychotic drugs showed increased mortality compared to placebo. In two placebo-controlled trials with oral SEROQUEL in this population, the incidence of mortality was 5.5% for SEROQUEL-treated patients compared to 3.2% for placebo-treated patients. SEROQUEL XR is not indicated in elderly patients with dementia.** *Dysphagia:* Esophageal dysmotility and aspiration have been associated with antipsychotic drug use. Aspiration pneumonia 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 aspiration pneumonia.

Safety Information

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions. Increased Mortality in Elderly Patients with Dementia: Elderly patients with dementia treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of thirteen placebo controlled trials with various atypical antipsychotics (modal duration of 10 weeks) in these patients showed a mean 1.6 fold 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.

General: ***Body Temperature Regulation:*** Disruption of the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing SEROQUEL XR 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. ***Acute Withdrawal Symptoms:*** Acute withdrawal symptoms, such as nausea, vomiting, and insomnia have very rarely been described after abrupt cessation of atypical antipsychotic drugs, including SEROQUEL XR. Gradual withdrawal is advisable. **Cardiovascular:** ***Hypotension and Syncope:*** As with other drugs that have high α_1 adrenergic receptor blocking activity, SEROQUEL XR may induce orthostatic hypotension, dizziness, and sometimes syncope, especially during the initial dose titration period. In placebo-controlled SEROQUEL XR trials, there was no difference in the adverse reaction reporting rate of syncope in patients treated with SEROQUEL XR (0.3%, 3/951) compared to patients on placebo (0.3%, 1/319). Syncope was reported in 1% (23/2371) of patients treated with SEROQUEL (quetiapine, immediate release formulation), compared with 0% (0/404) 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), cerebrovascular disease, or other conditions predisposing to hypotension (e.g., dehydration, hypovolemia and treatment with antihypertensive medications) (see OVERDOSAGE). ***Cholesterol and Triglyceride Elevations:*** In schizophrenia clinical trials, SEROQUEL XR treated patients had increases from baseline in mean cholesterol and triglycerides of 4% and 14%, respectively, compared to decreases from baseline in mean cholesterol and triglycerides of 2% and 6% for placebo treated patients. Uncommon cases of small elevations in non-fasting serum triglyceride levels and total cholesterol (predominantly LDL cholesterol) have been observed during treatment with quetiapine in several clinical trials (see ADVERSE REACTIONS). **Endocrine and Metabolism:** ***Hyperglycaemia:*** As with some other antipsychotics, hyperglycaemia, and diabetes mellitus (including exacerbation 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 SEROQUEL in post-marketing experience, sometimes in patients with no reported history of hyperglycaemia (see ADVERSE REACTIONS, Post-Market Adverse Drug Reactions). Increases in blood glucose and hyperglycaemia, and occasional reports of diabetes, have 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 hyperglycaemia-related adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent hyperglycaemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycaemia-related adverse events in patients treated with atypical antipsychotics are not available. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycaemia including polydipsia, polyuria, polyphagia, and weakness. Patients who develop symptoms of hyperglycaemia during treatment with atypical antipsychotics should undergo fasting blood glucose testing. In some cases, hyperglycaemia has resolved when the atypical antipsychotic was discontinued; however, some patients required continuation of anti-diabetic treatment despite discontinuation of the suspect 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:*** An elevation of prolactin levels was not demonstrated in clinical trials with SEROQUEL XR as compared with placebo. Increased prolactin levels with quetiapine were observed in rat studies. As is common with compounds which stimulate prolactin 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 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 tumourigenesis. Tissue culture experiments, however, indicate that approximately one third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if prescription 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 trial there were no differences in prolactin levels at study completion for SEROQUEL, across the recommended dose range, and placebo. ***Hypothyroidism:*** In SEROQUEL XR clinical trials, 0.5% (4/806) of patients on SEROQUEL XR compared to 0% (0/262) on placebo experienced decreased free thyroxine and 2.7% (21/786) on SEROQUEL XR compared to 1.2% (3/256) on placebo experienced increased TSH; however, no patients experienced a combination of clinically significant decreased free thyroxine and increased TSH. No patients had events of hypothyroidism. In clinical trials, 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 T_4 and 7% 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 adaptation 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 experienced persistent increases in TSH, and 0.25% of patients were treated with thyroid replacement. ***Weight Gain:*** In six-week placebo-controlled schizophrenia clinical trials, for patients treated with SEROQUEL XR mean weight gain was 1.77 kg (n=951) compared to 2.19 kg (n=414) in patients treated with SEROQUEL. For patients treated with placebo the mean weight gain was 0.26 kg (n=319). **Gastrointestinal:** ***Antiemetic Effect:*** Consistent with its dopamine antagonist effects, SEROQUEL XR 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 tumour or intestinal obstruction. **Hematologic:** ***Neutropenia:*** Severe neutropenia (<0.5 x 10^9/L) has been uncommonly reported in SEROQUEL clinical trials. There was no

apparent dose relationship. Possible risk factors for leucopenia and/or neutropenia include pre-existing low white cell count (WBC) and history of drug induced leucopenia and/or neutropenia. Quetiapine 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 Post-Market Adverse Drug Reactions). **Hepatic:** ***Hepatic Impairment:*** Decreased clearance of SEROQUEL was observed in patients with mild hepatic impairment. No pharmacokinetic data are available for quetiapine in patients with moderate or severe hepatic impairment. However, should clinical judgement deem treatment with SEROQUEL XR necessary, the drug should be used with great caution in patients with moderate or severe hepatic impairment (see DOSAGE AND ADMINISTRATION). ***Transaminase Elevations:*** Asymptomatic, transient and reversible elevations in serum transaminases (primarily ALT) associated with SEROQUEL XR have been reported. The proportions of patients with transaminase elevations of >3 times the upper limits of the normal reference range in a pool of 6-week placebo-controlled schizophrenia trials were approximately similar for both SEROQUEL XR and placebo (1%). During premarketing clinical trials, therapy with SEROQUELwas associated with elevation of hepatic transaminases, primarily ALT. Within a clinical trial database of 1892 SEROQUEL-treated schizophrenia patients, with baseline ALT levels <60 IU/L, 5.3% (101/1892) had treatment-emergent ALT elevations to >120 IU/L, 1.5% (29/1892) had elevations to >200 IU/L, and 0.2% (3/1892) had elevations to >400 IU/L. No patients had valuein excess of 800 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 101 SEROQUEL-treated patients whose enzyme levels increased to >120 IU/L, 40 discontinued treatment while their ALT values were still raised. In 114 SEROQUEL-treated patients whose baseline ALT was >90 IU/L, only 1 experienced an elevation to >400 IU/L. Precautions should be exercised when using SEROQUEL 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 known or suspected abnormal hepatic function prior to starting SEROQUEL XR, 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 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 SEROQUEL XR. 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 XR, 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):*** Tardive dyskinesia is a syndrome of potentially ineversible, 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. 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 increase. 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 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 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 XR, drug discontinuation should be considered. However, some patients may require treatment with SEROQUEL XR despite the presence of the syndrome. ***Seizures:*** In controlled clinical trials with SEROQUEL XR, there was no difference in the incidence of seizures in patients treated with SEROQUEL XR (0.1%, 1/951) or placebo (0.9%, 3/319). 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 (see ADVERSE REACTIONS). ***Potential Effect on Cognitive and Motor Performance:*** Somnolence was a commonly reported adverse event in patients treated with SEROQUEL XR, especially during the initial dose titration period. Since SEROQUEL XR 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 therapy with SEROQUEL XR does not affect them adversely. **Ophthalmologic:** ***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 XR 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 XR and at 6-month intervals thereafter, are recommended. If clinically significant lens changes associated with SEROQUEL XR use are observed, discontinuation of SEROQUEL XR should be considered. Psychiatric:** ***Suicide:*** The possibility of suicide or attempted suicide is inherent in schizophrenia, and thus close supervision and appropriate clinical management of high-risk patients should accompany drug therapy. **Renal:** There is little experience with SEROQUEL XR in patients with renal impairment, except in a low (subclinical) single dose study with SEROQUEL. SEROQUEL XR should thus be used with caution in patients with known renal impairment, especially during the initial dosing period (see DOSAGE AND ADMINISTRATION).

ADVERSE REACTION SERIOUSNESS AND INCIDENCE

Commonly Observed Adverse Events in Short-Term Placebo-Controlled Clinical Trials: During acute 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 sedation, dry mouth, somnolence, and dizziness. **Adverse Events Associated with Discontinuation: In short-term, placebo-controlled trials**, there was no difference in the incidence of adverse events associated with discontinuation of SEROQUEL XR (quetiapine) or placebo. Overall, 6.4% of SEROQUEL XR-treated patients discontinued treatment due to adverse events compared to 7.5% of placebo-treated patients (see SUPPLEMENTAL PRODUCT INFORMATION).

To report adverse events:
AstraZeneca Canada Inc.
Mississauga, Ontario L4Y 1M4
www.astrazeneca.ca T 1-800-433-0733 F 1-800-267-5743

DRUG INTERACTIONS

Drug-Drug Interactions: Given the primary central nervous system effects of quetiapine, SEROQUEL XR (quetiapine) should be used with caution in combination with other centrally acting drugs (see SUPPLEMENTAL PRODUCT INFORMATION).

Administration

Recommended Dose and Dosage Adjustment: SEROQUEL XR (quetiapine) should be administered once daily, generally in the evening. The daily dose of SEROQUEL XR at the start of therapy is 300 mg on Day 1, 600 mg on Day 2 and up to 800 mg after Day 2. The dose should be adjusted within the effective dose range of 400 mg to 800 mg per day, depending on the clinical response and tolerability of the patient. In a controlled clinical trial, the treatment effect size of 600 mg and 800 mg doses of SEROQUEL XR was greater than that of the 400 mg dose. The safety of doses above 800 mg/day has not been evaluated.

Recommended Initial Dosing Schedule			
	Day 1	Day 2	After Day 2
Once daily dosing	300 mg	600 mg	Up to 800 mg

Switching patients from SEROQUEL tablets to SEROQUEL XR tablets: For more convenient dosing, patients who are currently being treated with divided doses of SEROQUEL (quetiapine, immediate release formulation) may be switched to SEROQUEL XR at the equivalent total daily dose taken once daily. Individual dosage adjustments may be necessary. The need for continuing existing EPS medications should be re-evaluated periodically as SEROQUEL XR has not been associated with treatment-emergent EPS across the clinical dose range. **Dosing Considerations**

in Special Populations: ***Elderly:*** As with other antipsychotics, SEROQUEL XR should be used with caution in the elderly, especially during the initial dosing period. The rate of dose titration of SEROQUEL XR may need to be slower, and the daily therapeutic target dose lower, than that used in younger patients. Elderly patients should be started on the lowest available dose (i.e., 50 mg/day) of SEROQUEL XR. The dose can be increased in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerability of the individual patient. ***Hepatic Impairment:*** Quetiapine is extensively metabolized by the liver. Therefore, SEROQUEL XR 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 the lowest available dose (i.e., 50 mg/day) of SEROQUEL XR. The dose should be increased daily in increments of 50 mg/day to an effective dose, depending on the clinical response and tolerability in the individual patient. ***Renal Impairment:*** As clinical experience is lacking, caution is advised (see WARNINGS AND PRECAUTIONS, Renal). ***Missed Dose:*** SEROQUEL XR should be taken at the same time each day. If a previous days dose has been missed, administration should be resumed the next day at the normal administration time. ***Administration:*** SEROQUEL XR tablets should be swallowed whole and not split, chewed or crushed. SEROQUEL XR can be administered with or without food.

SUPPLEMENTAL PRODUCT INFORMATION

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. **Clinical Trial Adverse Drug Reactions:** 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 nondrug factors to the side effect incidence in the populations studied. The information below is derived from a clinical trial database for SEROQUEL XR consisting of 951 patients exposed to SEROQUEL XR (300 mg to 800 mg/day) for the treatment of schizophrenia in short-term placebo-controlled trials. This experience corresponds to approximately 82.9 patient-years.

Table 1 Adverse Events Reported For At Least 1% Of SEROQUEL XR-Treated Subjects (Doses Ranging From 300 To 800 mg/day) And For A Higher Percentage Of SEROQUEL XR-Treated Subjects Than Subjects Who Received Placebo In Short-Term, Placebo-Controlled Schizophrenia Phase III Trials

Body system and MedDRA Term**	Percentage of subjects with adverse events*	
	SEROQUEL XR (n = 951)	Placebo (n = 319)
Whole body		
Fatigue	3	2
Anxiety	2	1
Irritability	1	0
Pyrexia	1	0
Nervous system		
Sedation	13	7
Somnolence	12	4
Dizziness	10	4
Tremor	2	1
Restlessness	2	1
Gastrointestinal system		
Dry mouth	12	1
Constipation	6	5
Dyspepsia	5	2
Cardiovascular system		
Orthostatic hypotension	7	5
Hypertension	3	1
Tachycardia	3	1
Heart rate increased	4	1
Metabolic and nutritional disorders		
Increased appetite	2	0
Special senses		
Vision blurred	2	1

* Events for which SEROQUEL XR incidence was equal to or less than placebo are not listed in the table, but included the following: headache, insomnia, and nausea.

** Patients with multiple events falling under the same preferred term are counted only once in that term.

Other Adverse Events: ***Weight Gain:*** In six-week placebo-controlled schizophrenia clinical trials, for patients treated with SEROQUEL XR mean weight gain was 1.77 kg (n=951) compared to 2.19 kg (n=414) in patients treated with SEROQUEL (quetiapine, immediate-release formulation). For patients treated with placebo the mean weight gain was 0.26 kg (n=319). ***Seizures:*** There have been uncommon reports (≥0.1% - <1%) of seizures in patients administered SEROQUEL XR, although the frequency was no greater than that observed in patients administered placebo in controlled clinical trials (see WARNINGS AND PRECAUTIONS, Neurologic). ***Restless Legs Syndrome:*** There have been uncommon cases of restless legs syndrome in patients administered SEROQUEL XR. ***Priapism:*** There have been rare reports (≥ 0.01% - <0.1%) of priapism in patients administered quetiapine. ***Somnolence:*** Somnolence may occur, usually during the first two weeks of treatment, which generally resolves with the continued administration of SEROQUEL XR. ***Neuroleptic Malignant Syndrome:*** As with other antipsychotics, rare cases of neuroleptic malignant syndrome have been reported in patients treated with quetiapine (see WARNINGS AND PRECAUTIONS, Neurologic). ***Vital Signs:*** As with other antipsychotics with α1 adrenergic blocking activity, SEROQUEL XR may induce postural hypotension, associated with dizziness, tachycardia and, in some patients, syncope, especially during the initial dose-titration period (see WARNINGS AND PRECAUTIONS, Cardiovascular). In placebo-controlled clinical trials in schizophrenia, postural hypotension was reported with an incidence of 8% in SEROQUEL (quetiapine, immediate-release formulation)-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. ***Peripheral Edema:*** As with other antipsychotics, common cases (≥1% - <10%) of peripheral edema have been reported in patients treated with quetiapine. ***Mild Asthenia:*** As with other antipsychotic agents, common cases of mild asthenia have been reported in patients treated with quetiapine. ***Rhinitis:*** There have been common reports of rhinitis in patients administered quetiapine. ***Hypersensitivity:*** Uncommon cases of hypersensitivity including angioedema have been reported. ***ECG Changes:*** 0.8% of SEROQUEL XR patients, and no placebo patients, had tachycardia (>120 bpm) at any time during the trials. SEROQUEL XR was associated with a mean increase in heart rate, assessed by ECG, of 7 beats per minute compared to a mean decrease of 1 beat per minute for placebo. This is consistent with the rates of SEROQUEL. The slight tendency to tachycardia may be related to the potential of SEROQUEL XR for inducing orthostatic changes (see WARNINGS AND PRECAUTIONS, Cardiovascular). ***Extrapyramidal Symptoms (EPS):*** In three-arm, placebo-controlled clinical trials for the treatment of schizophrenia, utilizing doses between 300 mg and 800 mg of SEROQUEL XR, the incidence of any adverse events potentially related to EPS was 7.5% for SEROQUEL XR, 7.7% for SEROQUEL, and 4.7% in the placebo group and without evidence of dose response. In these studies, the incidence rates of the individual adverse events (eg. akathisia, extrapyramidal disorder, tremor, dyskinesia, dystonia, restlessness, and muscle rigidity) were generally low and did not exceed 3% for any treatment group. At the end of treatment, the mean change from baseline in SAS total score and BARS Global Assessment score was similar across the treatment groups. The use of concomitant anticholinergic medications was infrequent and similar across the treatment groups. The incidence of EPS was consistent with that seen with the profile of SEROQUEL in schizophrenic patients. The incidence of EPS did not increase with the dose of SEROQUEL XR. ***Abnormal Hematologic and Clinical Chemistry Findings:*** As with other antipsychotics, common cases of leucopenia and/or neutropenia have been observed in patients administered quetiapine. Uncommon cases of eosinophilia have been observed. In three-term, SEROQUEL XR placebo-controlled monotherapy clinical trials, among patients with a baseline neutrophil count ≥ 1.5 X 10^9/L, the incidence of at least one occurrence of neutrophil count <1.5 X 10^9/L was 1.5% in patients treated with SEROQUEL XR and 1.5% for SEROQUEL, compared to 0.8% in placebo-treated patients. In all placebo-controlled monotherapy clinical trials among patients with a baseline neutrophil count ≥1.5 x 10^9 /L, the incidence of at least one occurrence of neutrophil count <1.5 x 10^9 /L was 1.72% in patients treated with SEROQUEL, compared to 0.73% in placebo-treated patients. In clinical trials conducted prior to a protocol amendment for discontinuation of patients with treatment-emergent neutrophil count <1.0 x 10^9/L, among patients with a baseline neutrophil count ≥1.5 x 10^9/L, the incidence of at least one occurrence of neutrophil count <0.5 x 10^9/L was 0.21% in patients treated with SEROQUEL and 0% in placebo treated patients and the incidence ≥0.5 - <1.0 x 10^9/L was 0.75% in patients treated with SEROQUEL and 0.11% in placebo-treated patients. (See WARNINGS AND PRECAUTIONS, Hematologic) Common cases of asymptomatic elevations in serum transaminases (AST, ALT) or uncommon cases of γGT levels have been observed in some patients administered quetiapine. These elevations were usually reversible on continued quetiapine treatment (see WARNINGS AND PRECAUTIONS, Hepatic). 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 direction of treatment. 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 TSH were not observed and there was no indication that SEROQUEL causes clinically relevant hypothyroidism (see WARNINGS and PRECAUTIONS, Endocrine and Metabolism). ***Hyperglycaemia:*** Blood glucose increases to hyperglycaemic levels (fasting blood glucose ≥7.0 mmol/L or a non fasting blood glucose ≥11.1 mmol/L on at least one occasion) have been observed commonly (≥1% - <10%) with quetiapine in clinical trials. In 2 long-term bipolar maintenance placebo-controlled adjunct clinical trials, mean exposure 213 days for SEROQUEL (646 patients) and 152 days for placebo (680 patients), the exposure-adjusted rate of any increased blood glucose level (≥7.0 mmol/L) for patients more than 8 hours since a meal was 18.0 per 100 patient years for SEROQUEL (10.7% of patients) and 9.5 for placebo per 100 patient years (4.6% of patients). In short-term (12 weeks duration or less) placebo-controlled clinical trials (3342 treated with quetiapine and 1490 treated with placebo), the percent of patients who had a fasting blood glucose ≥7.0 mmol/L or a non fasting blood glucose ≥11.1 mmol/L was 3.5% for quetiapine and 2.1% for placebo. In a 24 week trial (active-controlled, 115 patients treated with SEROQUEL) designed to evaluate glycemic status with oral glucose tolerance testing of all patients, at week 24 the incidence of a treatment-emergent post-glucose challenge glucose level ≥11.1 mmol/L was 1.7% and the incidence of a fasting treatment-emergent blood glucose level ≥7.0 mmol/L was 2.6%. (See WARNINGS AND PRECAUTIONS, Endocrine and Metabolism). ***Cholesterol and Triglyceride Elevations:*** Uncommon cases of small elevations in non-fasting serum triglyceride levels and total cholesterol (predominantly LDL cholesterol) have been observed during treatment with quetiapine in several clinical trials (see WARNINGS AND PRECAUTIONS, Cardiovascular). In one 24-week clinical trial, where LDL cholesterol was directly measured as opposed to calculated, there was a slight mean increase in total cholesterol in patients administered SEROQUEL, which was driven by increases in LDL cholesterol. The mean LDL level increased at Week 24 by 10% in patients administered SEROQUEL, which was statistically significant. The total cholesterol/HDL ratio did not change significantly during therapy with SEROQUEL. Furthermore, triglycerides did not increase significantly nor did HDL cholesterol decrease during therapy. (See WARNINGS AND PRECAUTIONS, Cardiovascular). ***Post-Market Adverse Drug Reactions:*** 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. (See WARNINGS AND PRECAUTIONS, Hematologic). As with some other antipsychotics, hyperglycaemia and diabetes mellitus (including exacerbation 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 SEROQUEL, sometimes in patients with no reported history of hyperglycaemia. (See WARNINGS AND PRECAUTIONS, Endocrine and Metabolism). Anaphylactic reactions have been reported very rarely in post-marketing reports, including a case with a fatal outcome, possibly related to SEROQUEL treatment. The reporting rate of anaphylaxis associated with SEROQUEL use, which is generally accepted to be an underestimate due to underreporting, does not exceed the background incidence rate estimates. Estimates of the background incidence rate (all cause) of severe life-threatening anaphylaxis in the general population range between 80 and 210 cases per million person-years, and the incidence rate of drug-induced anaphylaxis is reported to be 16 cases per million person-years. In addition, the all cause fatal anaphylaxis rate is reported to be one per million person-years while the drug-induced fatal anaphylaxis is estimated to be 0.3 cases per million person-years. If a patient develops anaphylaxis after treatment with SEROQUEL XR, the drug should be discontinued and an alternative treatment started.

DRUG INTERACTIONS

Drug-Drug Interactions: **The Effect of SEROQUEL XR on Other Drugs:** ***Alcohol:*** SEROQUEL (quetiapine, immediate-release formulation) 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 XR. ***Antihypertensive Agents:*** Because of its potential for inducing hypotension, SEROQUEL XR may enhance the effects of certain antihypertensive agents. ***Levodopa and Dopamine Agonists:*** As it exhibits in vitro dopamine antagonism, SEROQUEL XR may antagonize the effects of levodopa and dopamine agonists. ***Lithium:*** The single dose pharmacokinetics of lithium were not altered when co-administered with SEROQUEL. ***Antipyrine:*** SEROQUEL did not induce the hepatic enzyme systems involved in the metabolism of antipyrine. ***Lorazepam:*** SEROQUEL did not affect the single dose pharmacokinetics of lorazepam. ***Divalproex:*** Co-administration of SEROQUEL (150 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 11%. These changes were not clinically relevant. **The Effect of Other Drugs on SEROQUEL XR: Hepatic Enzyme Inducers:** Concomitant use of SEROQUEL XR 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 SEROQUEL 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 XR, depending on clinical response, should be considered. It should be noted that the recommended maximum daily dose of SEROQUEL XR 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 threefold increases in the clearance of quetiapine. Increased doses of SEROQUEL XR may be required to maintain control of psychotic symptoms in patients co-administered SEROQUEL XR and phenytoin and other hepatic enzyme inducers (e.g., barbiturates, rifampicin, etc.). The dose of SEROQUEL XR 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, clarithromycin, diltiazem, verapamil, or nefazodone), which inhibit CYP 3A4, may increase the concentration of SEROQUEL XR. In a multiple-dose trial in healthy volunteers to assess the pharmacokinetics of SEROQUEL 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 XR should be reduced during concomitant use of quetiapine and potent CYP 3A4 inhibitors (such as azole-antifungals, macrolide antibiotics, and protease inhibitors). Special consideration should be given in elderly and debilitated patients. The risk-benefit ratio needs to be considered on an individual basis in all patients. ***Divalproex:*** Co-administration of SEROQUEL (150 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 co-administration with cimetidine, (a non-specific P450 enzyme inhibitor), no clinically significant interaction was observed. ***Thioridazine:*** Co-administration of thioridazine (200 mg bid) with SEROQUEL (300 mg bid), increased the clearance of SEROQUEL by 65%. ***Fluoxetine, Imipramine, Haloperidol, and Risperidone:*** Fluoxetine (60 mg daily), imipramine (75 mg bid), haloperidol (7.5 mg bid), and risperidone (3 mg bid) did not significantly alter the steady state pharmacokinetics of SEROQUEL. **Drug-Food Interactions:** SEROQUEL XR can be taken with or without food. **Drug-Herb Interactions:** Interactions with herbal products have not been established. **Drug-Laboratory Interactions:** Interactions with laboratory tests have not been established.

OVERDOSAGE

Experience: ***Clinical Trials:*** One death has been reported in a clinical trial following an overdose of 13,600 mg of quetiapine alone, however, survival has also been reported in acute overdoses of up to 30,000 mg of quetiapine. Most patients who overdosed reported no adverse events or recovered fully from the reported events. ***Post-Marketing:*** In post-marketing experience, there have been cases of coma and death in patients taking a SEROQUEL (quetiapine immediate-release formulation) overdose. The lowest reported dose associated with coma has been in a patient who took 5,000 mg and had a full recovery within 3 days. The lowest reported dose associated with a death was in a patient who took 6,000 mg. Patients with pre-existing severe cardiovascular disease may be at an increased risk of the effects of overdose (see WARNINGS AND PRECAUTIONS, Cardiovascular, Hypotension and Syncope). **Symptoms:** 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.

Product Monograph is available upon request from AstraZeneca Canada Inc.

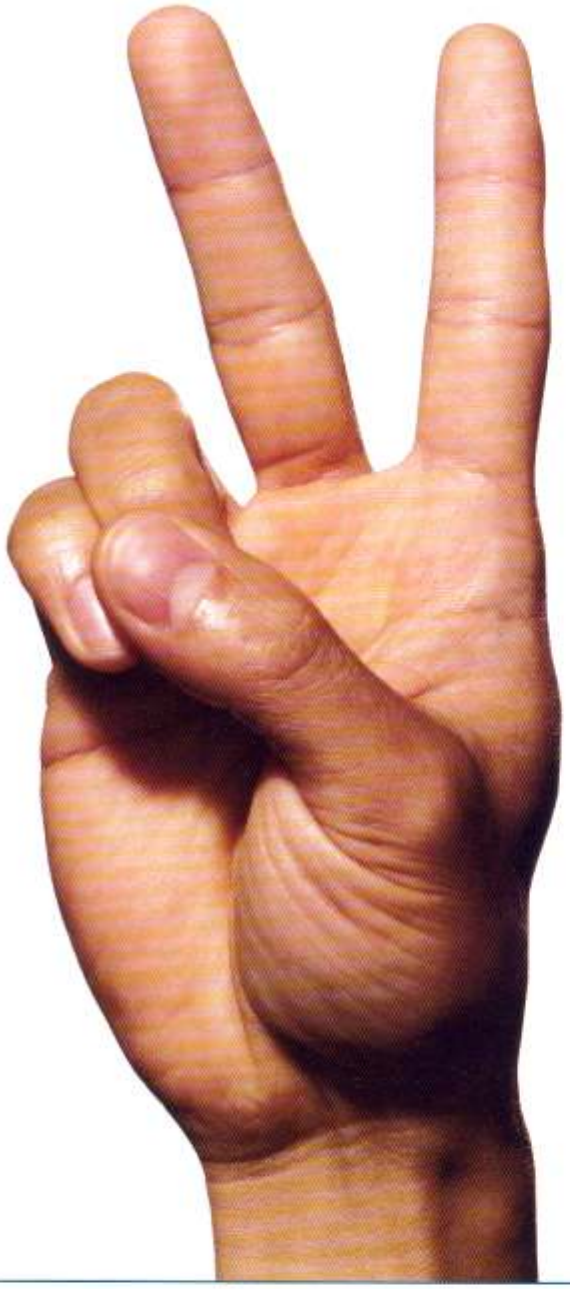
SEROQUEL XR® and the AstraZeneca logo are trade-marks of the AstraZeneca group of companies.

Revision Date : October 22, 2007

AstraZeneca

AstraZeneca Canada Inc.
Mississauga, Ontario L4Y 1M4
www.astrazeneca.ca

New
Once Daily
Seroquel XR
quetiapine



days

to a therapeutic dose

With new **SEROQUEL XR**, **a therapeutic dose of 600 mg/day** can be reached by **day 2**† in schizophrenia. SEROQUEL XR was generally well-tolerated, with simple, once-a-day dosing for you and your patients.[1,2]

New Once Daily Seroquel XR™ quetiapine

SEROQUEL XR™ is indicated for the management of the manifestations of schizophrenia.[2]

The most common adverse events in schizophrenia with incidences ≥5% and an incidence at least 5% higher than that observed with placebo: sedation (13%), somnolence (12%), dry mouth (12%), and dizziness (10%). Please see Product Monograph before prescribing.[2]

Increases in blood glucose and hyperglycemia, and occasional reports of diabetes have been observed in clinical trials.[2]

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.[2]

Serious Warnings and Precautions. Increased Mortality in Elderly Patients with Dementia: Elderly patients with dementia treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of thirteen placebo-controlled trials with various atypical antipsychotics (modal duration of 10 weeks) in these patients showed a mean 1.6-fold 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.[2]

† See Product Monograph for complete dosing recommendations.

1. Kahn RS *et al.* Efficacy and Tolerability of Once-Daily Extended Release Quetiapine Fumarate in Acute Schizophrenia: A Randomized, Double-Blind, Placebo-Controlled Study. *J Clin Psychiatry* 2007;68:6:832-42.
2. SEROQUEL XR® (quetiapine fumarate extended-release tablets) Product Monograph, AstraZeneca Canada Inc. October 22, 2007.

AstraZeneca