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Or

1. Read each question carefully and circle the answer on the Registration Form.
2. Type or print the registration information in the spaces provided and complete the evaluation.
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- 1. According to Lieberman, in 1999, one fourth of all patients with schizophrenia were seen in primary care, and 7% obtained their care exclusively from a primary care physician.**
 - a. True
 - b. False
- 2. Data presented by Lieberman show that in recent years the total number of prescriptions issued by primary care physicians for psychotropic medications has:**
 - a. Increased
 - b. Decreased
 - c. Stayed the same
 - d. Decreased except for antidepressant prescriptions, which have increased
- 3. According to Lieberman, data show that primary care physicians are more likely than psychiatrists to prescribe antipsychotics for _____ and _____.**
 - a. Dementia and schizophrenia
 - b. Bipolar disorder and depression
 - c. Dementia and depression
 - d. Bipolar disorder and anxiety
- 4. According to Stahl, blockade of serotonin-2A receptors has little effect on which of the following dopamine pathways?**
 - a. Mesolimbic
 - b. Mesocortical
 - c. Nigrostriatal
 - d. Tuberoinfundibular
- 5. Stahl noted that negative and cognitive symptoms are associated with:**
 - a. Excessive dopamine in the mesocortical pathway
 - b. Excessive dopamine in the mesolimbic pathway
 - c. Deficient dopamine in the mesocortical pathway
 - d. Deficient dopamine in the mesolimbic pathway
- 6. According to Stahl, the increased risk of higher-potency antipsychotics to cause motor side effects in comparison to lower-potency antipsychotics supports the idea that:**
 - a. Rapid dissociation from 5-HT_{2A} receptors is responsible for reduced motor symptoms
 - b. Rapid dissociation from dopamine-2 receptors is responsible for reduced motor symptoms
 - c. Long-lasting blockade of 5-HT_{2A} receptors is responsible for reduced motor symptoms
 - d. Long-lasting blockade of dopamine-2 receptors is responsible for reduced motor symptoms
- 7. According to Sharif, questions used to determine the risk-benefit profile of a specific antipsychotic evaluate all of the following *except*:**
 - a. The most impairing or intolerable side effects
 - b. The likelihood that each side effect will occur
 - c. Which side effects are less common with other antipsychotics
 - d. Whether each side effect is reversible

8. According to Sharif, which of the following side effects seldom occurs with all atypical antipsychotics?
- Anticholinergic side effects
 - Tardive dyskinesia
 - QTc prolongation
 - Prolactin-related side effects
9. According to Sharif, what would be optimal medical monitoring for an overweight, African American patient with a family history of cardiovascular disease who is about to start treatment with an antipsychotic?
- An electrocardiogram and measurement of weight, hemoglobin A1C, and lipid levels
 - An electrocardiogram and measurement of weight, blood glucose, and lipid levels
 - Measurement of weight, blood glucose, and lipid levels
 - Measurement of weight, blood glucose, and hemoglobin A1C levels
10. According to Marder, the true measure of the effectiveness of an antipsychotic is measured in:
- How long the half-life is
 - How it treats positive symptoms
 - How a patient feels
 - How long it takes to work
11. According to Marder, Geddes et al. recommended that atypical antipsychotics should be used first in patients who have a history of movement disorders.
- True
 - False
12. According to Marder, atypical antipsychotics have advantages over conventional antipsychotics in which of the following areas?
- Cognition
 - Negative symptoms
 - Tardive dyskinesia
 - All of the above
13. According to Culpepper, an atypical antipsychotic in combination with a selective serotonin reuptake inhibitor may do all of the following *except*:
- Successfully treat psychotic depression
 - Create a synergistic antidepressant effect at relatively low doses
 - Have little or no effect on nonpsychotic or refractory depression
 - Produce fewer serious side effects than conventional antipsychotics used similarly
14. Culpepper noted that, up to the present, studies testing atypical antipsychotics as augmentation therapy for mood and anxiety disorders:
- Have found efficacy of some atypical antipsychotics in treating major depression, bipolar depression and mania, and combat-induced posttraumatic stress disorder, among others
 - Have been largely double-blind, placebo-controlled studies rather than small, open-label trials
 - Have found efficacy of some atypical antipsychotics in treating civilian posttraumatic stress disorder
 - Have shown efficacy in treating obsessive-compulsive disorder equivalent to that of atypical antipsychotic monotherapy
15. According to Culpepper, a dosage of atypical antipsychotic that would be subtherapeutic for a patient with schizophrenia is likely to be sufficient for a patient with a mood or anxiety disorder.
- True
 - False
16. In the article by Culpepper and Rakel, all of the following statements describe clinician-rated symptom assessment scales *except*:
- They may reassure the patient that he or she is receiving thorough, appropriate treatment
 - They include the 17- and 21-item HAM-D, the MADRS, CGI-S, CGI-I, and PHQ-9
 - They are used to measure severity of illness and/or change in symptoms over time
 - They are likely to be less accurate than patient-rated symptom assessment scales
17. According to Culpepper and Rakel, patients' premature discontinuation of antidepressant treatment:
- Is not a significant problem in primary care
 - Contributes to rates of relapse and recurrence among only partial responders
 - Reflects an antibiotic model of disease treatment
 - Improves prognosis
18. Culpepper and Rakel advise that a clinician encountering apparent treatment resistance in a depressed patient should initially:
- Refer the patient to a specialist
 - Screen the patient for comorbidities that may be impeding response to treatment
 - Switch the patient to an antidepressant of a different class for a 1- to 2-week trial
 - Consider augmentation strategies

CME REGISTRATION FORM

Using Atypical Antipsychotics in Primary Care, Part 1:
Evidence and Clinical Strategies

Circle the one correct answer for each question.

- | | |
|------------|-------------|
| 1. a b | 10. a b c d |
| 2. a b c d | 11. a b |
| 3. a b c d | 12. a b c d |
| 4. a b c d | 13. a b c d |
| 5. a b c d | 14. a b c d |
| 6. a b c d | 15. a b |
| 7. a b c d | 16. a b c d |
| 8. a b c d | 17. a b c d |
| 9. a b c d | 18. a b c d |

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Deadline for submission

For a credit certificate to be issued, please complete this Registration Form no later than May 31, 2004. Online submissions will receive credit certificates immediately. Faxed or mailed submissions will receive credit certificates within 6 to 8 weeks.

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No payment is necessary as this activity is free.

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1. Was the educational content relevant to the stated educational objectives? Yes No
2. Did this activity provide information that is useful in your clinical practice? Yes No
3. Was the format of this activity appropriate for the content being presented? Yes No
4. Did the method of presentation hold your interest and make the material easy to understand? Yes No
5. Achievement of educational objectives:
 - A. Enabled me to describe primary care populations in whom atypical antipsychotic treatment would be appropriate. Yes No
 - B. Enabled me to describe the pharmacology that characterizes an atypical antipsychotic. Yes No
 - C. Enabled me to discuss appropriate dosing strategies to maximize optimal safety and efficacy of atypical antipsychotics. Yes No
 - D. Enabled me to review the literature on using atypical antipsychotics in psychosis and mood and anxiety disorders. Yes No
6. Did this CME activity provide a balanced, scientifically rigorous presentation of therapeutic options related to the topic, without commercial bias? Yes No
7. Does the information you received from this CME activity confirm the way you presently manage your patients? Yes No
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