

Thanking Our Peer Reviewers

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Listed on the next page are those who served as peer reviewers this past year. Their efforts are crucial to the integrity of the content of Primary Psychiatry. In taking the opportunity to acknowledge our peer reviewers, it is also timely to remind our readers that all articles considered for publication are reviewed by myself and at least two experts on their subject. Any Continuing Medical Education supplements that are published go through a separate peer review/content validation by the Mount Sinai School of Medicine. I do not oversee those supplements, as they are supported via educational grants from industry, and I have elected to avoid even a perception that I might be in a position to influence the content of these supplements.

Many review articles and studies submitted to journals are funded by industry. Given the potential for content bias in these submissions, it is of particular importance that these papers be peer reviewed. In a more stringent policy, going forward, we will be asking authors of articles that acknowledge either funding or editorial assistance in manuscript preparation attest to the fact that the articles are not in fact ghost written. Our policy until now has been for authors to acknowledge either sources of funding or the assistance of professional medical writing services contributed to the research and writing of an article.

Two articles in this issue deal with cigarette smoking among psychiatric patients, in this case schizophrenic patients, and with the involvement of nicotinic receptors in schizophrenic disorders. Ingrid Bacher, PhD, and colleagues discuss ongoing research into the role of nicotinic acetylcholine receptors, particularly the targeting of nicotinic receptors for therapeutic treatment of mental disorders. This mechanism of neurotransmission is now being used to devise new treatment possibilities for patients. Among the neuropsychiatric disorders for which there is strong evidence of a nicotinic response are schizophrenia, major depressive disorder (MDD), Tourette's syndrome, attention-deficit/hyperactivity disorder, tobacco dependence, Alzheimer's disease, and Parkinson's disease.

Amanda L. Baker, BA (Hons.), and colleagues addresses the clinical problem of trying to get schizophrenic patients to stop smoking. Nicotine dependence among people with a psychotic disorder is ubiquitous and there is a need for comprehensive interventions aimed at smoking cessation and reduction. Many of these patients may be self-medicating. A neuronal nicotinic

receptor gene has been implicated in the pathophysiology of schizophrenia by genetic and pharmacologic studies. Smoking changes the expression of multiple genes and differentially regulates gene expression in schizophrenic hippocampus.

Just last month, a study in the *Archives of General Psychiatry*¹ examined the effectiveness of five smoking cessation pharmacotherapies in patients who were not currently psychotic or had a schizophrenia diagnosis. It assessed the relative efficacies of five smoking cessation pharmacotherapy interventions using placebo-controlled, head-to-head comparisons. It involved 1,504 adults who smoked at least 10 cigarettes per day during the past 6 months and reported being motivated to quit smoking. Participants were excluded if they reported using any form of tobacco other than cigarettes, current use of bupropion, or having medical contraindications for any of the study medications. Participants were randomized to one of six treatment conditions: nicotine lozenge, nicotine patch, sustained-release bupropion, nicotine patch plus nicotine lozenge, bupropion plus nicotine lozenge, or placebo. In addition, all participants received six individual counseling sessions. It was found that all pharmacotherapies differed from placebo when examined without protection for multiple comparisons (odds ratios, 1.63–2.34). With such protection, only the nicotine patch plus nicotine lozenge (odds ratio, 2.34, $P < .001$) produced significantly higher abstinence rates at 6-month postquit than did placebo. The authors concluded that while the nicotine lozenge, bupropion, and bupropion plus lozenge produced effects that were comparable with those reported in previous research, the nicotine patch plus lozenge produced the greatest benefit relative to placebo for smoking cessation.

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Dr. Sussman reports no affiliation with or financial interest in any organization that may pose a conflict of interest.

Adel Gabriel, FRCPC, MSc, DPIP, DPM, DTM&H, and Claudio Violato, PhD, note that large portions of patients with depression may not seek help, not know how to seek help, have negative attitudes to treatments, or be fearful of being stigmatized if they seek help. They examine published research on the subject and find widespread low levels of depression literacy. They conclude that overcoming literacy obstacles is needed.

James Ferguson, MD, and colleagues reported on the results of a study evaluating the efficacy, safety, and tolerability of desvenlafaxine in the long-term treatment of elderly outpatients with MDD. The article was presented at the American Association for Geriatric Psychiatry annual meeting in New Orleans, Louisiana, March 1–4, 2007. Given the potential for adverse events when elderly patients use antidepressants, it is always helpful to have information involving safety and efficacy in this population. This study finds that desvenlafaxine is safe and well tolerated among patients ≥ 65 years of age with MDD. Treatment was also associated with improvement in measures of depression and functional impairment that were sustained for up to 6 months. These findings are consistent with multicenter, randomized, placebo-controlled trials that showed the safety and efficacy of desvenlafaxine; however, unlike this study, these were short-term (8-week) studies in adults of all ages. The current study thus suggests that desvenlafaxine is safe and effective over

a period of 6 months in the elderly population. The study did have a high withdrawal rate due to adverse events (35%). The authors suggest that inclusion of desvenlafaxine 200 mg/day may have contributed to these discontinuations. This study was designed prior to studies demonstrating the efficacy of the 50 mg/day dose. Although clinical studies have demonstrated the efficacy of desvenlafaxine 50–400 mg/day, no additional efficacy benefit has been observed for doses >50 mg/day. Thus, the doses of desvenlafaxine used in this study are higher than the current recommended therapeutic dose of 50 mg/day.

Also bear in mind that this is an open-label trial, which, as the authors note, limits the broader interpretation of the results. The study also lacks a control or comparator group. This makes it impossible to compare the efficacy and safety of desvenlafaxine against placebo or other antidepressant treatment. Other limitations of the study include small patient population as well as exclusion of “real world patients” such as those with substance abuse and significant comorbid psychiatric and medical illness. *PP*

REFERENCE

1. Piper ME, Smith SS, Schlamm TR, Fiore MC, Jorenby DE, Fraser D, Baker TB. A randomized placebo-controlled clinical trial of 5 smoking cessation pharmacotherapies. *Arch Gen Psychiatry*. 2009;66(11):1253-1262.

We would like to thank the following peer reviewers who contributed to Primary Psychiatry in 2009:

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