

Jose de Leon, Editor:
**A PRACTITIONER'S GUIDE TO PRESCRIBING
ANTIEPILEPTICS AND MOOD STABILIZERS FOR
ADULTS WITH INTELLECTUAL DISABILITIES**

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Emotional, behavioral, and neuropsychiatric conditions are common in individuals with intellectual disabilities (IDs), most notably epilepsy, aggression, self-injurious behaviors, bipolar and other mood disorders. Despite the prevalence of such problems, there is a scarcity in the literature of reliable information on medical treatments for those with IDs.

This book provides a detailed framework for prescribing medications for this population. Featuring the most-up-to-date information on factors that inform prescribing, the *Guide* addresses basic issues and controversies in treating adults with cognitive deficits. Clients' specific needs are emphasized in developing appropriate and effective pharmacological intervention for improved outcomes and quality of life. Drugs discussed in the *Guide* include: Carbamazepine, Clonazepam, Diazepam, Ethosuximide, Felbamate, Gabapentin, Lacosamide, Lamotrigine, Levetiracetam, Lithium, Lorazepam, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Primidone, Rufinamide, Tiagabine, Topiramate, Valproate and Zonisamide. For each of these compounds, the guidelines cover:

- Indications for use, relative and absolute contraindications.
- Assessment during treatment; therapeutic drug monitoring; warning signs and symptoms for caretakers.
- Dosage: administration, initial and maximum recommended dosage; modifications associated with drug-drug interactions, personal characteristics, and (where appropriate) genetic variations.
- Adverse drug reactions: common, relatively uncommon, and potentially lethal; the risk of metabolic syndrome
- Guidelines for discontinuation
- References, tables and drug utilization reviews.
- Affecting the Metabolic syndrome concept, if present.

A Practitioner's Guide to Prescribing Antiepileptics and Mood Stabilizers for Adults with Intellectual Disabilities is an indispensable decision-making reference for psychiatrists, neuropsychologists, psychopharmacologists and neurologists.

Because of dearth of available literature on the population with intellectual disabilities, the author made

his own concept concerning information and reviewing literature on relevant neuropsychiatric disorders in populations without intellectual disabilities, and also his inestimable clinical work with IDs persons. This book has a pragmatically concept, where accurately interbreed the three important trends: evidence-based medicine, personalized medicine, and drug utilization reviews.

The idea of combining antiepileptics and mood stabilizers makes sense because there is obvious overlap between what the neurological literature calls antiepileptics and psychiatric literature calls mood stabilizers. Therefore, a total of 21 oral compounds, which are antiepileptics and/or mood stabilizers were reviewed. The only compound, that is widely acknowledged as a mood stabilizer, but is not an antiepileptic, is lithium. Besides, some authors consider lithium the only mood stabilizer. Other compounds that have been approved by the FDA for some indication in Bipolar disorder and have antiepileptic properties are: Carbamazepine, Lamotrigine and Valproate.

The list of antiepileptics is limited to those available in the USA in 2009. From the barbiturates, only phenobarbital and primidone were included. From the hydantoines, only phenytoin was included. From the succinimides, only ethosuximide was included. Benzodiazepines are used in the authors' facilities not only as antiepileptics, but also for other psychiatric uses. Based on the frequency of use, three benzodiazepines were selected: clonazepam, diazepam, and lorazepam.

A guideline was developed by the Working Group of the International Association of the Scientific Study of Intellectual Disability (2001), also based on experience with prior guidelines (de Leon et al. 2009, Sabaawi et al. 2006.) The World Psychiatric Association section in IDs has provided general guidelines for the use of psychotropic drugs in adults with IDs (Deb et al. 2009).

The first author prefers the concept of personalized prescription and uses it with implications beyond pharmacogenetics, including all scientific information for prescribing medication (de Leon 2008, 2009). The first FDA-approved attempt to use a pharmacogenetic test to exclude some patients from taking carbamazepine is described. Personalized prescription in the clinical environment can be expressed in two ways: as

personalized drug selection and as personalized dosing, particularly drug-drug interactions, or personal variables such as aging or renal impairment, which may impact dosing. A few chapters have genetic sections describing the preliminary studies using genetic variations to personalize dosing. They include: Clonazepam, Diazepam, Lorazepam, Phenobarbital, Phenytoin, and Valproate.

It is obvious that evidence-based approaches will never work particularly well in adults with IDs, and that personalizing their treatment is even more crucial than in other areas of medicine. To select any of these drugs to treat a patient, the clinician must consider many factors specific to this population, concerning the presence or absence of: epilepsy, mood disorders,

challenging behaviors, autistic spectrum disorder, other psychiatric disorder or genetic abnormalities that are associated with mental retardation.

This practical guideline helps clinicians to select the best antiepileptic/mood stabilizers for the patients with IDs, and monitor them adequately. It attempts to summarize information from complex literature for clinicians; one undeniable runs the risk of making arbitrary statements. This framework is not to replace, but to augment individual judgment and clinical expertise. Therefore, de Leon's book should be accessible to every mental health professional with an open mind that cares about persons with intellectual disabilities.

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