I Anxiety Disorders

1] For trichotillomania, "the evidence-base for psychotherapy for trichotillomania is small but suggest behavioral therapy may be the most promising approach." Habit reversal therapy gets the most focus in this article. As to meds, "there are currently no pharmacotherapies that would be universally accepted as first-line treatment. "Clomipramine has demonstrated some benefit in treating trichotillomania, and SSRIs have not. Authors suggest that N-acetylcysteine, 1200 mg BID, might help. NIH researchers also added Alpha Lipoic Acid. 600mg /day to facilitate crossing the Blood -Brain Barrier

II Reconsidering the use of an old Favorite: Hydroxyzine

Trade name Vistaril , Atarax
Administration Oral, IM
Dosage 25-100 mg/day
Usage: anxiolytic and Hypnotic

Hydroxyzine) is a first-generation antihistamine of the diphenylmethane and piperazine class. It was first synthesized by Union Chimique Belge in 1956 and was marketed by Pfizer in the United States later the same year,[2] and is still in widespread use today.

Due to its antagonistic effects on several receptor systems in the brain, hydroxyzine has strong anxiolytic and mild antiobsessive as well as antipsychotic properties.[3] Today it is used primarily for the symptomatic relief of anxiety and tension associated with psychoneurosis and as an adjunct in organic disease states in which anxiety is manifested. Because of its antihistamine effects it can also be used for the treatment of severe cases of itching, hyperalgesia and motion sickness-induced nausea; it has also been used in some cases to relieve the effects of opioid withdrawal.

Even though it is an effective sedative, hypnotic, and anxiolytic, it shares virtually none of the abuse, dependence, addiction, and toxicity potential of other drugs used for the same range of therapeutic reasons. Hydroxyzine has also been used to potentiate the analgesia of opioids and to alleviate some of their side effects, such as itching, nausea, and vomiting.

III Opiate Use Disorders

1 For a great review article on how to treat people with opioid-use disorders, pull up:

http://www.nejm.org/doi/full/10.1056/NEJMra1604339

2 Of psychiatric conditions, one of the more lethal is opioid use disorder. CDC announced its mortality rate was increasing at a faster rate than any other condition. For management of opioid use disorder, resources mentioned in [JAMA, 19 July 2016].

A CDC recommended guidelines for prescribing guidelines
1] For acute pain, prescribe lowest dose possible of immediate-release opioids.
2] Obtain a drug urine test and review patient's history of prescribed and non-prescribed use of opioids.
3] Opioids and benzodiazepines should not be prescribed concurrently.

B Canadian Resource Materials
1 A Guideline from Canada to treat opioid addiction: www.vch.ca/media/opioid-addiction-guideline.pdf.

IV Unusual Uses for Naltrexone

Posted in: Basics of mental health-Jan 06, 2014 Comments: Low-dose Naltrexone therapy is an exciting, relatively new concept being used for a variety of treatment resistant psychopathology. There is data that it is effective for a range of psychiatric diseases including major depression, Bipolar disorder, panic/anxiety, OCD, opiate/alcohol post-withdrawal symptoms and cravings and eating disorders. Usually treatments with such a broad range of effectiveness are suspect, however the unique nature of this treatment makes this treatment able to cast such a wide net in an efficacious fashion.

Naltrexone is an opiate receptor antagonist which blocks both ingested opiates (heroin or pain pills) and endogenous opiates better known as "Endorphins" from binding to our own receptors and having an effect. Naltrexone has been traditionally used in full dose strength at 50mg per day to treat cravings in alcohol addiction and opiate addiction. It has however been extremely disappointing in terms of its benefit when used in these modalities. It enjoys great success also as a reversal for heroin and pain pill over-dose in which it is a life saving measure however not applicable for the majority of people.

Low-dose Naltrexone in the range of 0.5-2.5mg per night induces our own neuro-circuitry to produce increasing amounts of endorphins and not rely directly on the

drug for effect. Your brain produces its maximum number of endorphins from 10Pm-2AM each night and the mechanism of action for Naltrexone is as follows: By blocking your opiate receptors (in which endorphins bind to and produce a positive effect on mood, relief of anxiety and even healing inflammation and other disease processes) in very small amounts, it essentially masks a percentage of receptors from your brain's ability to see them. When your brain sees that there are fewer receptors than there should be, your brain starts to produce an increase in Endorphins to make-up for the lack of receptors by making sure the available receptors are fully activated by maximum amount of endorphins. Given the dose of Naltrexone used is so low, the blocking effect is very transient and within hours the receptors are again exposed and now the plethora of extra endorphins floating around can bind to and activate the many receptors.

Essentially "tricking" your brain into thinking you have a deficit in endorphin related circuits and thus you will activate these pathways. I have had great success in treating many disorders resistant to traditional medication treatment and there is a lot of hope for using low dose naltrexone in disorders in which traditional pharmacotherapy is not effective. Especially alcohol and opiate addiction, eating disorders and bipolar depression. Given its healing benefits there is also wide-spread thought that it can drastically help with MS, fibromyalgia, chronic fatigue and potentially even cancers and other inflammatory conditions. There is not hard data however and it is all speculation at this point.
Given the side-effect profile is almost non-existent due to the extremely small dose, the potential risk-benefit ratio is well worth it for the majority of people, especially if you have failed traditional treatment. Michael Yasinski MD