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Management of Major Neurocognitive Disorders in African-Americans

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Abstract

This paper is a retrospective chart review study of African-American patients 55 years and older that were referred for psychiatric consultation after admission to a medical/surgical unit with integral psychiatric support at Jackson Park Hospital serving predominately African-Americans on Chicago's Southside. Thirty-two percent (39/121) were found to have Computerized Tomography scan brain pathology (cerebral atrophy, cerebral ischemia, or cerebral infarction). Based on clinical judgment, these patients and others who had clinical findings necessitating a diagnosis of Major Neurocognitive Disorder, with and without Computerized Tomography scan brain pathology, were given Selective Serotonin Reuptake Inhibitors (chiefly Escitalopram starting at 5 mg every morning and increasing the dose until the patient responded rarely over 10 mg). Of these 39, 29 were more agreeable and had brighter affects, although the Sensorium and Cognition of their mental status examinations did not change, four showed absolutely no change, and six were lost to follow up, but who were well enough to be psychiatrically cleared for discharge.

Key Words: *African-American, Neurocognitive disorders, Computerized tomography, Escitalopram, Point-prevalence, Major Depressive Disorder (MDD)*

Introduction

The rates of Major Neurocognitive Disorder (MNCD) (specifically Alzheimer's disease - AD) in African-Americans are reported to be twice as high as the rates in European-Americans. [1] The reasons for this health disparity are unknown, but that lack of understanding does not stop the influx of such patients to inpatient consultation and liaison services in general hospitals. Such patients are often referred for psychiatric evaluations from nursing homes because of aggressive behavior and a lack of cooperativeness. Unfortunately, the literature regarding African-American health and wellness is sparse and it is up to clinical research to fill this void until research that is more academic is available. [2] Further, clinical research often leads to the most pragmatic academic research. [3]

This brief report focuses on the prevalence and features of Neurocognitive Disorders in African-Americans admitted to Jackson Park Hospital – a hospital on Chicago's Southside serving a predominately low-income African-Population. Previous research on this patient population revealed 98% of the patients Jackson Park Hospital services resided in one of the three zip codes (60617, 60619, and 60649) on Chicago's South Side (Avalon Park, Burnside, Chatham, Greater Grand Crossing, and South Shore communities). [4] About 143,000 people live in these communities, and their median household income is $33,809. The patients sampled were hospitalized between May 1, 2017 to August 31, 2017.

Method

We sampled all patients admitted to Jackson Park Hospital's Medical/Surgical – Psychiatric Inpatient unit from May 1 to August 31, 2017 who where 55 and up, and who were asked to have psychiatric consultations by the medical/surgical staff. The fore mentioned patients' medical records were reviewed retrospectively, carefully examined and it was checked if a Head Computed Tomography (CT) scan without contrast was performed, as well as if Escitalopram or another Selective Serotonin Reuptake Inhibitor (SSRI) was utilized as part of the patient's medical treatment plan. From there, the patient's medical notes were further explored; the Head CT scans were viewed and examined in order to determine if the image demonstrated any pathology, such as cerebral atrophy, infarction and/or ischemia. Other factors were considered: 1) anti-psychotic use 2) employment of different selective serotonin reuptake inhibitors 3) if the patient was admitted from a nursing home and 4) if the patient was previously admitted to Jackson Park Hospital. The first author then conducted psychiatric evaluations for patients seeking services at the inpatient unit. The patients were admitted due to many different complaints, from aggressive behavior/altered mental status to unspecified "Dementia" (replaced in DSM-5 by Major Neurocognitive Disorder). Based on past clinical experience patients who were suspected of having central nervous system damage were given Escitalopram 5 – 10 mg, as it was the author's clinical experience that patients with suspected central nervous system damage did well on this particular selective serotonin reuptake inhibitor. [5] Jackson Park Hospital's

Institution Review board approved the project as the data was archival and all patient identifiers were stripped from their files.

Results

Of 147 patient's (55 years or older) records were reviewed but 26 subjects were lost to follow up leaving a total population of 121 patients over 55. Of these, 50 had clinical indications to get CT scans without contrast and they were given Escitalopram starting out at 5 mg and given up to 10 mg depending on their over-all health. [5] Based on clinical judgment, 39 of the 121 patients (32.2%) were given Escitalopram, usually starting out with 5 mg every morning, and these patients showed CT pathology (cerebral atrophy, cerebral ischemia, or cerebral infarction). Of these 39, 29 were more agreeable and had brighter affect, although the Sensorium and Cognition of their mental status examinations did not change, four showed absolutely no change, and six were lost to follow up, but who were well enough to be psychiatrically cleared for discharge. Seven patients were ordered to have a CT scan but the CT scans were not available for review; of these, four improved in being agreeable and their affect was noticeably brighter, but not in mental status Sensorium or Cognition; and three stayed the same. Fourteen patients showed CT pathology but were not given SSRIs. There were eleven patients who did not get CT scans, but who were given Escitalopram. Ten patients demonstrated improvement with Escitalopram similar to the patients described above, while one patient was lost due to discharge by the weekend psychiatric coverage. Additionally, five patients were given Escitalopram but were lost to follow up as they were discharged. Seven other patients were administered other selective serotonin reuptake inhibitors, and two patients showed improvement with Sertraline and Fluoxetine; while the other five were lost due to being discharged or no follow-up was deemed warranted (Table 1).

Table 1.

Initials	Year of Birth	CT (Y/N, If Y=(NL), (NA), (A), (IS), (IN)	Lexap (Y/N, If Y = progress - other SSRI)	Diagnosis	Antipsychotic Use D/C	NH (Y/N)	Previous Admit	Race
A.A.	1959	Yes = A, IS	Yes (Other Psychiatrist cleared the patient)	Psychosis NOS	No	Yes	No	Black
A.K.	1938	Yes = NA	Yes(same)	MNCD	D/C risperidone	Yes	Yes	Black
A.N.	1961	Yes = A, IS	**NO NOTE AVAILABLE**					Black
A.S.	1959	Yes = NL	NO	MDD	Yes (ziprasidone, risperidone)	No	No	Black
B.A.	1961	Yes = NL	No	Psychosis NOS	ziprasidone by resident	Yes	No	White
B.A.	1959	No	No	EtOH	No	No	No	Black
B.A.	1961	Yes = A, IS	No	Depression NOS	No	No	No	Black
B.B.	1944	Yes = A, IS	Yes (Improved on previous admission)	MNCD	No	Yes	Yes	Latino
B.B.	1949	Yes = A	No	Psychosis NOS	Yes (Haloperidol)	No	Yes	Black
B.B.	1957	Yes = NL	No	Deferred (then other Psychiatrist)	Yes (Haloperidol)	No	No	Black
B.B.	1955	Yes = A, IS	Yes (Better)	MNCD	No	No	No	Black
B.C.	1960	No	No	Paranoid Schizophrenia (not enough history	Yes (Loxapine0	No	No	White
B.D.	1959	Yes = NL	No	PTSD (by history)	No	No	No	Black
B.J.	1940	No	No	Schizoaffective	Yes (risperidone)	Yes	No	Black
B.J.	1962	No	No	EtOH	No	No	No	Black
B.L.	1946	Yes = NL	No	No Psychiatric Diagnosis	No	No	No	Black
B.R.	1956	No	No	Intellectual Disability	No	Yes	No	Black
B.R.	1932	Yes = A	No	MNCD (Other Psychiatrist)	Yes (Quetiapine)	Yes	No	White
B.T.	1940	Yes = A, IS	No	Metastatic HPC	No	No	No	Black

Initials	Year of Birth	CT (Y/N, If Y=(NL), (NA), (A), (IS), (IN)	Lexap (Y/N, If Y = progress - other SSRI)	Diagnosis	Antipsychotic Use D/C	NH (Y/N)	Previous Admit	Race
B.W.	1951	Yes = A, IS	Yes (fine, no longer agitated)	MNCD	Lurasidone by attending physician	Yes	No	White
B.W.	1940	No	Yes (calm)	Psychosis NOS	No	Yes	Yes	White
C.L.	1951	Yes = A	Yes (calmer, less confused)	MNCD	Quetiapine was discontinued	Yes	No	Black
C.L.	1951	Yes = NA	Yes (lowered, still lethargic)	MNCD	No	Yes	No	Black
C.M.	1958	No	No	Depression NOS	Yes (risperidone)	No	No	Black
C.P.	1955	No	No (was given Paroxetine by other Psychiatrist)	Major Depression by other Psychiatrist	No	No	No	Black
C.R.	1961	No	Yes (by other Psychiatrist)	Major Depression by other Psychiatrist	No	No	No	Black
C.S.	1954	Yes = NL	No	Adjustment	No	No	Yes	Black
C.W.	1939	Yes = NA	Yes (well)	Adjustment	No	Yes	No	Black
D.B.	1932	Yes=A, IS	Yes (“brighter”, brighter, more energy)	MNCD	No	Yes	Yes	Black
D.B.	1958	Yes = NL	No	Intellectual Disability	Yes (Chloropromazine, risperidone)	Yes	No	Black
D.G.	1951	Yes = IS, Volume Loss	Yes (better, brighter)	TBI	No	Yes	Yes	Black
D.J. was F.K.	1954	No	Yes (better)	MNCD	No	No	No	Black
D.L.				DECEASED				
D.M.	1952	Yes = A, IS	Yes (not talking)	MNCD	Haloperidol by Resident	No	No	Black
D.P.	1961	No	No	Substance Abuse	No	No	Yes	Black
D.S.	1935	Yes = NL	No	Mood Disorder NOS	Yes (Quetiapine)	Yes	No	Black
D.W.	1934	Yes = A, IS	Yes (Awake, better)	MNCD	D/C risperidone	Yes	Yes	Black
E.A.	1936	Yes = A, IS	Yes (“pretty good”)	MNCD	No	No	No	Black
E.D.	1951	No	No	Acute Psychosis	Quetiapine, ziprasidone (changed all to HS and D/C Benztropine)	No	No	Black
E.E.	1956	Yes = A, IS	Yes (little clamer)	MNCD	Clozapine (given by resident)	Yes	No	White
E.G.	1959	Yes = NL	No	Intellectual Disability	Quetiapine (given by resident)	No	No	Black
E.J.	1935	Yes = A, IS	Yes (Discharged)	MNCD	No	Yes	No	Black
F.H.	1943	Yes = NA	No	Schizophrenia by other Psychiatrist, Psychosis NOS	Lower Benztropine, risperidone by resident	Yes	Yes	Black
G.B.	1958	Yes = IS, IN	No	MDD	Loxapine	No	Yes	Black
G.C.	1947	Yes=A, IS	Yes (better, hungry)	Depression NOS	D/C Quetiapine	Yes	No	White
G.D.	1937	Yes = Lacune Rt Basal Ganglia	No	Anxiety Disorder NOS	No	No	No	Black
G.E.	1942	Yes = A	Yes (better. “think and realize”)	Psychosis NOS	No	No	Yes	Black

Initials	Year of Birth	CT (Y/N, If Y=(NL), (NA), (A), (IS), (IN)	Lexap (Y/N, If Y = progress - other SSRI)	Diagnosis	Antipsychotic Use D/C	NH (Y/N)	Previous Admit	Race
G.G.	1961	Yes = NL	Yes (refused0	Intellectual Disability	No	Yes	No	Black
G.J.	1950	Yes = IS	No	Adjustment	No	Yes	No	Black
G.M.	1941	Yes = A, IS	Yes (“fine”)	MNCD	No	Yes	No	Black
G.R.	1957	? SI, HI; psych consult						
G.T.	1953	Yes = NL	No	EtOH	No	No	Yes	Black
G.V.	1939	Yes = A, IS, IN	No	Psychosis NOS	No	Yes	Yes	Black
H.B.	1955	No	No	Schizophrenia	Quetiapine (given by resident)	Yes	No	Black
H.C.	1959	No	No	Substance Abuse	No	No	No	Black
H.D.	1957	No	Yes (sleeping well)	Anxiety, MDD	Quetiapine (given by resident)	No	No	Black
H.E.	1957	No	Yes (much more responsive, whole new person)	Organic Brain Damage from CVA	No	No	No	Black
H.J.	1958			Not available, Patient refused			No	
H.L.	1952	Yes = IS	Yes (calmer)	Heroin Abuse	No	No	No	Black
H.M.	1954	Yes = IN	No	EtOH	No	No	No	Black
H.P.	1952	Yes = NA	Yes (much better)	Anxiety Disorder NOS	No	Yes	No	Black
H.R.		CURRENT						
H.T.	1954	Yes = NL	No	Psychosis NOS	Loxapine	No	No	Black
H.W.	1931	Yes = A, IS	Yes (more responsive)	MNCD	Olanzapine (given by resident)	Yes	Yes	Black
J.A.	1944	Yes = A	Yes	MNCD (Other Psychiatrist)	No	Yes	No	Black
J.D.	1940	Yes = A, IS	Yes (D/C Benzo, anxiety is gone & she’s happy)	MNCD	No	Yes	No	Black
J.L.	1956	Yes = NA	Yes (continues to refuse to talk)	MNCD	No	Yes	Yes	Black
J.W.	1957	Yes = NL	Yes (oriented and reasonable)	TBI	risperidone (given by resident)	Yes	Yes	White
K.N.	1956	Yes = Severe Volume Loss, IS	No	Adjustment	No	Yes	No	White
K.W.	1937	Yes = NA	Yes (well)	Anxiety	No	No	Yes	Black
L.B.	1950	Yes = A, IS	Yes (“fine”)	MNCD	No	Yes	No	Black
L.G.	1961	Yes = consistent with MS	Yes (same, calmer)	Intellectual Disability	No	Yes	No	Black
L.L.		CURRENT						
L.R.	1936	Yes = A	Yes (looks better)	Psychosis NOS	No	Yes	Yes	White
M.A.	1946	Yes = IS	No	Psychosis NOS	Loxapine	Yes	No	Black
M.E.	1960	Yes = NA	No	Intellectual Disability	risperidone by resident	Yes	No	Black
M.F.	1925	Yes = A, IS	?????????? Geriartric Physician					

Initials	Year of Birth	CT (Y/N, If Y=(NL), (NA), (A), (IS), (IN)	Lexap (Y/N, If Y = progress - other SSRI)	Diagnosis	Antipsychotic Use D/C	NH (Y/N)	Previous Admit	Race
M.H.	1959	Yes = A, IS	Yes (better, more alert, not aggressive)	MNCD (unknown)	risperidone was lowered	Yes	Yes	Black
M.J.	1944	Yes = A	Yes (mood is okay)	Intellectual Disability	No	No	No	Black
M.K.	1945	Yes = NL	No (Mirtazapine)	Major Depression by other Psychiatrist		No	No	Black
M.L.	1957	No	No	EtOH	No	No	No	Black
M.M.	1961	Yes = NA	No (Sertraline)	Depression NOS	Quetiapine	No	Yes	Black
M.R.	1961	Yes = A	No	MDD, TBI	Quetiapine	No	Yes	White
M.R.	1955	Yes = IS, A	Yes (Alert)	Organic or MNCD	No	No	No	Black
M.R.	1947	Yes = NA	No	Psychosis NOS	Olanzapine by resident	Yes	Yes	Latino
M.S.	1956	Yes = Encaphalomalacia	No	Intellectual Disability, TBI	No	No	Yes	Black
M.V.	1952	No	No	Psychosis NOS	No	No	No	Black
M.W.	1957	Yes = NA	No	EtOH	No	No	No	Black
M.W.	1960	Yes = A, IN	Yes (Alert, responsive)	Organic Brain Damage	No	No	No	Black
N.C.	1962	No	No	Major Depression by other Psychiatrist		No	No	Black
N.E.	1949	No	Yes (better, thinking is much clearer)	MNCD	No	No	No	Black
N.J.	1939	Yes = A, IS	Yes (little better)	MNCD	Haloperidol by Resident	Yes	No	Black
N.Z.	1954	Yes = A,IS		????? Chief complaint was acute psychosis, an attending physician patient		Yes	No	
O.E.	1949	No	No (Paroxetine by resident)	TBI	No	Yes	No	White
O.F.	1961	No	No	Psychosis NOS	Loxapine, d/c Olanzapine	No	No	Black
O.J.	1961	No	No	Acute Psychosis	Loxapine	Yes	No	White
O.N.	1946	Yes = A, IS	Yes ("allright", better)	MNCD	No	Yes	Yes	Black
O.V.	1956	Yes = NA	Yes (did not get it)	Depression NOS	Continue Quetiapine	No	Yes	Black
P.D.	1940	Yes = A	Yes (no different)	MNCD	No	Yes	Yes	White
P.H.	1956	Yes = IS	No	Heroin, MDD	No	No	Yes	Black
P.J.	1951	No	No (fluoxetine)	MDD	ziprasidone by resident	Yes	No	White
P.J.	1937	Yes = IN	No	Psychosis NOS	Loxapine	Yes	No	White
P.M.	1938	Yes = A, IS, IN	Yes (other Psychiatrist cleared pt, "calm and coherent, no agitation or behavioral problems"	MNCD	No	Yes	No	Black
P.N.	1948	Yes = IS	No	Psychosis NOS	Loxapine refused	Yes	No	Black
P.R.	1952	Yes = NL	Yes (little better, flirts)	Psychosis NOS	risperidone	Yes	Yes	Black
R.B.	1937	Yes = A, IS	Yes (better)	MNCD	No	Yes	Yes	White

Initials	Year of Birth	CT (Y/N, If Y=(NL), (NA), (A), (IS), (IN)	Lexap (Y/N, If Y = progress - other SSRI)	Diagnosis	Antipsychotic Use D/C	NH (Y/N)	Previous Admit	Race
R.B.	1948	No		Schizophrenia by other Psychiatrist	Quetiapine by resident	Yes	No	Black
R.C.	1948	Yes = Hemorrhage in 2008	No	MNCD secondary to CVA (BASED ON PREVIOUS ADMISSION	No	Yes	Yes	Black
R.D.	1953	No	No	EtOH, Paranoid Schizophrenia	Quetiapine given by resident	No	Yes	Black
R.F.	1953	Yes = A, IS	Yes (no progress note)	Organic/TBI	D/C Quetiapine	Yes	Yes	P Rican
R.I.	1947	Yes = A, IS, IN	Yes (same, then increased to 10mg, then lost)	MDD, Rule out MNCD	No	Yes	Yes	Black
R.J.	1953	Yes = NA	Yes (calmer, not as rambuctious)	Intellectual Disabilty, Depression NOS	No	No	Yes	Black
R.J.	1955	Yes = A, IS	Yes (LOST)	MNCD		No	No	Black
R.J.	1930	No	Yes (Prior admision was effective)	MNCD	No	Yes	No	Black
R.S.	1943	Yes = NL in 2011	No	Intellectual Disability	Quetiapine by attending	No	No	**Black**
S.E.	1948	Yes = NL	No	MNCD secondary to CVA	No	No	No	Black
S.G.	1958	No	No	Major Depression by other Psychiatrist	No	No	No	Black
S.G.	1961	Yes = NA	No	Mood Disorder NOS	risperidone, Loxapine, Benztropine by resident	Yes	Yes	White
S.M.	1959	Yes = NA	No	Epilepsy	Haloperidol Deconoate	No	Yes	Black
S.R.	1960	No	Yes (little better, less voices)	Depression NOS	Haloperidol by Psychiatrist	No	No	Black
S.R.	1952			Schizoaffectve (by other Psychiatrist)				
S.R.	1947	Yes = NL in 2008	No (Sertraline by resident, discharged)	Depression NOS	Quetiapine by resident	No	Yes	Black
S.S.	1957	Yes = A, IS	Yes (“well”, polite but still delusional)	Psychosis NOS	D/C risperidone, Added Loxapine	Yes	No	Black
S.S.	1949	Yes = A, IS, IN	No	Adjustment Disorder NOS	No	Yes	No	Black
S.T.	1958	No	No	Adjustment	No	Yes	No	White
T.A.	1955	No	No	EtOH	Quetiapine	No	Yes	Black
T.C.	1959	Yes = NL in 2012	No (fluoxetine by resident)	Mood Disorder NOS	No	No	No	White
T.G.	1955	No	Yes (no voices, no aggression)	Acute Psychosis	Lowered Benztropine, Loxapine	Yes	No	Black
T.J.	1948	Yes = NA	No (was stable)	Paranoid Schizophrenia	No	Yes	Yes	Black
T.P.	1959	Yes = IN	No	EtOH	No	No	No	Black
T.R.	1962	No	No	Depression NOS	risperidone by resident	Yes	No	Black
T.R.	1953	Yes = A, IS	Yes (slightly better, more alert)	Psychosis NOS	No	No	No	White

Initials	Year of Birth	CT (Y/N, If Y=(NL), (NA), (A), (IS), (IN)	Lexap (Y/N, If Y = progress - other SSRI)	Diagnosis	Antipsychotic Use D/C	NH (Y/N)	Previous Admit	Race
T.R.	1958	No	No	Epilepsy	Loxapine	No	No	Black
T.R.	1953			Decreased, no psychiaric diagnosis, Guillain Bairre				
V.A.	1957			Other Psychiatrist (In April for EtOH)		No	Yes	
W.A.	1958	?	NO NOTE AVAILABLE	Consult was ordered, EtOH				
W.B.	1958	Yes = A, IS	No (fluoxetine, much better)	Heroin	No	No	Yes	Black
W.C.	1946	No	Yes (much less cranky and was pleasant)	MNCD	No	Yes	No	Black
W.D.	1957		No	Intellectual Disability	No	No	No	Black
W.K.	1956			Other Psychiatrist				
W.L.	1951	?						
W.M.	1928	Yes = A, IS, IN	Yes (lethargic)	MNCD	No	Yes	No	Black
W.P.	1953	No	Yes (affect brighter)	Psychosis NOS	No	Yes	No	Black
W.R.	1962	No	Yes (better, clamer)	Anxiety	No	No	No	Black
W.R.	1948	Yes = A, IS, IN	Yes (same)	MNCD, EtOH	Quetiapine by resident	Yes	No	White
W.T.	1961	Yes = A	Yes (better)	MNCD	Quetiapine by resident	Yes	Yes	White

Total Subjects = 147

Lost Subjects = 26

CT performed and given Escitalopram = 50,

CT path & given Escitalopram = 39; 29 showed improvement

CT path, given Escitalopram & showed no change = 4

CT path, given Escitalopram, but were lost = 6

CT was ordered but not available and given Escitalopram = 7 (4 with improvement, 3 were the same

CT with pathology but were not given Escitalopram or any type of SSRI = 14

Subject did not undergo CT but was given Escitalopram = 10

CT (Y/N, If Y=Normal(NL)

Not Available (NA)

Atrophy (A)

Ischemia (IS)

Infarction (IN)

Discussion

Serious scientific research has failed to show any serious prevention strategies for Alzheimer's disease. [6] However, as previously mentioned, African-Americans have been reported to have twice the Alzheimer's disease as European-Americans. [1] Apolipoprotein E is a risk allele for late onset Alzheimer's disease and compared with Caucasians, the allele frequency is higher among African Americans, and thus thought to be a significant risk factor for the development of Alzheimer's disease. [7] Unfortunately, as this was a retrospective study, the authors did not have a measure of the APOE genotype of all the study participants. Point prevalence studies on the prevalence of coma in African-American populations reveals high rates of coma in this population. [8] Having a loss of consciousness resulting in a coma from a traumatic brain injury is another risk factor for the development of Alzheimer's disease that is of interest to researchers, but which has yet to show a conclusive link between the two. [9] Other studies have shown that Alcohol-related Organic Brain Syndromes have been predisposed to misdiagnosis. [10] A review of the literature on coma illustrates this phenomena is frequently found in African-American communities and was hypothesized to contribute to the high rates of violence seen in such communities. [11-13] Another study that is more recent has revealed a high prevalence of Neurobehavioral Disorders associated with Prenatal Alcohol Exposure (ND-PAE) are found in poor African-American communities. [4] Accordingly, nearly 1/3 of this predominately low-income African-American population having a Major Neurocognitive Disorder from cerebral atrophy, cerebral ischemia, or cerebral infarction is not surprising. However, these patients' extremely positive response to Escitalopram is surprising. Past experience with patients who had Alzheimer's disease, Cerebrovascular infarcts, or traumatic brain injuries leads one to believe there is not much that can be done for such patients. Escitalopram and other SSRIs do not improve their cognition. They reduce the patient's anxiety helping them to be less of a management problem for staff, while, at the same time, not leaving the patient lethargic and sleepy. Most times these patients' affects were noticeably brighter and they were more socially engaged despite not knowing the year or the president.

Much to the author's astonishment selective serotonin reuptake inhibitors (SSRIs) have been shown to reduce amyloidal deposits in brain, [14] and they do more to help patients with Major Neurocognitive Disorders than the usual donepezil or memantine which are seen as an unnecessary waste. It may well be that SSRI's are more effective at reducing and preventing amyloid formation in the damaged brain than the medications that have been approved for treating Alzheimer's disease. As the SSRI's are being prescribed for the patient's anxiety, they are not being used off label.

Another interesting long-term prevention strategy involved the use of prenatal choline. There is some indication that giving choline to pregnant women may prevent the development of Alzheimer's disease as well as other neurodevelopmental disorders. [15, 16] The schizophrenia research group at the University of Denver is recommending prenatal choline to prevent schizophrenia, autism and ADHD. [17, 18] Recently, the American Medical Association's House of Delegates provided advocacy to included recommended adequate doses of choline during pregnancy. [19] As of yet, there are no solid links between the high rates of ND-PAE and the high rates of Alzheimer's disease in African-Americans, but by virtue of the reality that adequate doses of prenatal choline are protective against both neuropsychiatric disorders, it would not surprise us.

Conclusions

Elderly African-American patients (55 years and older) referred for psychiatric consultation on a medical/surgical unit with psychiatry as an integral part of the treatment team often have cerebral pathology resulting in a diagnosis of Major Neurocognitive Disorders. In many instances the cerebral pathology can be documented by a CT scan without contrast. Although the congitive and sensorium of such patients is not significantly altered with an SSRI (most notably Escitalopram), there is a vast improvement in these patient's anxiety resulting in brighter affect and more agreeable behavior.

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