Mental Health Webinar Questions & Answers: Calgary Zone

Date Updated: Nov 14, 2022

Speakers: Dr. David Tano, Dr. Lisa Stevenson, Dr. Janet Reynolds, Dr. Steve Congly, Dr. Yael Shrom, Dr. Christine Luelo

General themes covered by this document:

- BPD vs Bipolar vs ADHD
- New breast cancer screening guidelines
- Iron Deficiency Anemia pathway

Please see the accompanying slides / webcast video for full context.

Question	**Answer**
Theme: BPD vs Bipolar vs ADHD	
1. Curious about complex PTSD on the differential?	Trauma can affect all conditions, not specifically PTSD. It is definitely part of it.
2. Where can we send these patients for DX and treatment if we have difficulty in diagnosing?	Very good question, difficult with limited resources recently. Can try ACCESS mental health, as several of the mental health clinics in AHS now have streams for psychiatric assessments, I hear SKY psychiatry in the TELUS Sky building will do one off consults, shared care if you have access to this, Otherwise, there are more private psychiatrists in the community that may do these as numerous psychiatrists have left the system over the past couple of years.
3. How helpful would mental health questionnaires could be to helpful to discern this a bit better? How do we standardize these assessments a bit better?	Those are more useful to reflect treatment response so use them as a guide
4. What is incidence of true mania? are we "seeing it" where it is isn't?	Incidence of bipolar disorder in the community is about 1%. I find when people are truly manic, there is no doubt, kind of like psychosis. It is the hypomanic people or the people with depression that have never had a manic episode but have family hx etc that are difficult.
5. How much can family hx help you in dx of these conditions?	ADHD and Bipolar d/o can have link to fhx but not so much with BPD

Theme: New breast cancer screening guidelines	
1. Where can I find the new guidelines?	https://screeningforlife.ca
2. Can you clarify, as I did not think the use of oral contraceptives was associated with increased risk of breast cancer.	I want to clarify this further. Although it is mentioned in screening for life that the bcp may increase the relative risk of breast cancer by a **very small amount** it is not mentioned in our current guideline. We didn't include mention of birth control pills in the guideline because: 1) it's such a small risk factor 2) it's reversible after stopping the pill (for 10 yrs) and 3) most importantly, it's such a small risk factor and such an important medication that we really wouldn't recommend anyone stop taking it just to lower their risk of breast cancer. Furthermore, most of our knowledge about breast cancer risk and hormones came from older women who were on hormone replacement therapy for menopausal symptoms. But the risk of BCP use re breast cancer could be much different as the dosages, type of hormones, and pattern of use (for example, sugar pills between cycles) for BC purposes are different from how hormone replacement is used. In addition, the sensitivity of breast tissue to exogenous hormone for younger women may be different from older women in the context of breast cancer risk.
3. Can you comment on the recommendations on the imaging reports to do annual imaging depending on breast density irrespective of age	Just to clarify these are recommendations for the average risk population. There will still be individual cases that a radiologists may make recommendations that are different from the guidelines in their clinical judgement. We hope that the majority of cases will follow the guidelines recommendations. If any women is found to have extremely dense breasts on her mammogram irrespective of her age, annual mammograms will be recommended and consider adding a supplemental ultrasound.
4. Just wondering how these guidelines work with the CTFPHC ones?	The CTFPHC guidelines have their recommendations, and we have ours looking at the current evidence, using Alberta numbers and the modeling data. Every province makes their own screening recommendations. We are the first to start at age 45+ but we believe other provinces will soon be following our lead.
5. How do you track the shared decision making process?	There is no way to track this other than right now, if a women at age 40 has screening she must have discussed it with a physician to get that req thus assuming a SDM process was undertaken.
6. Any idea why some radiology companies do mammogram & u/s on the same day when you order "complete breast assessment", and others will	The correct process is to NOT do supplemental US on the same day. Clinics should be basing this decision on the results of the mammogram and calling them back if US is indicated. If a radiologist is available right away sometimes for convenience they may suggest the additional testing to be done before the patient leaves. If you already know the previous mammogram showed Volpara D breast density then you could put that on the req and ask for screening mammogram and bilat supplemental screening breast US so they are booked for both at the same visit.

start with mammo then make pt return for u/s?	
7. To double check, radiology will also contact the 45-49 group directly no referral needed. Assuming they would send report to FP if the patient gives our name? The unattached?	So it is the ABCSP that will send out invitations for women to start mammograms at age 45 or they can book by calling any radiology clinic without a req from a physician once they are 45. The radiology clinic will ask who their PCP is so they can send them results. If they do not have a family doctor I think the radiology clinics have a process of recalling the pts as needed and can refer pts directly to the breast cancer assessment clinic if the biopsy is abnormal.
8. Alcohol is the new cigarette - how much additional risk with alcohol- is it quantifiable at this point?	Increased risk of breast ca with 3-6 drinks per week compared with abstainers (RR 1.15, 95% CI 1.06-1.24). There was a 10 % increase in risk with each 10 grams per day of alcohol intake. Alcohol is linked to many cancers, and any amount increase relative risk slightly but for breast cancer healthy eating and exercise are more important modifiable risk factors.
9. So if women don't do self breast exam regularly, how do they know what's changed, whether it's palpation to feel a lump, or observation for skin changes etc.	We promote breast awareness (knowyourlemons.org) rather than systematically and regularly checking one's own breasts (BSE). Women should be familiar with how they breasts look and feel but they shouldn't rely on self breast exam to screen or find cancers, only mammograms have proven to be an effective screening tool.
10. What about unattached patients without FP who get screening done. Will radiology make appropriate referrals, or, are they going to send pt to a walk-in clinic?	See answer to question 7
Theme: Iron Deficiency Anemia pathway	
1. Where is the IDA pathway?	https://www.specialistlink.ca/assets/pdf/IronDeficiencyAnemia_pathway.pdf
2. How do I get my patient IV iron?	Via physicians with hospital privileges, private infusion clinics, already connected specialists (gyne/gi), internal medicine
3. In patient with Normal Hb but ferritin 20- 50 who says they are very fatigued and can afford the Monoferric, ok to	Would be ok; monoferric might be too much iron, consider venofer

send these for infusion in private?	
4. Use of IM iron?	IV so much more effective but if IM comfortable can do so but likely by the time referral done, IV will be required
Theme: Dynalife labs (from APL)	
1. Would we get a new lab stamp for Connect Care ID from Dynalife or we order them privately ourselves?	No need for changes to stamps, Dynalife doing work of drawing blood but processing in the background not that much different; EMRs have already added CC ID to requisitions