

accurate assessment advantage of in-person care. These patients listed concerns about body language, vital signs, and other physical symptoms.

**Conclusion.** With telehealth as a seemingly permanent aspect of medicine, the field of psychiatry must adapt. Expansion of broadband and increasing affordability of high-speed internet connection are practical solutions to technological issues with telehealth. For patients preferring to be seen virtually, a recommendation can be made to have at least the first visit in-person to establish a personal relationship. Vital signs can be checked at home with proper training. Telepsychiatry is likely to continue to be a part of our care delivery system. To that end, we must be vigilant and develop better strategies to improve the quality of patient care and patient satisfaction.

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## Profound Anemia Induced by Lamotrigine in a 16-Year-Old Female with Sick Cell Trait and Mood Disorder: A Case Report and One-Year Follow-Up

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### Abstract

**Introduction.** Lamotrigine is an antiepileptic drug of the phenyltriazine class with inhibitory effects on voltage-sensitive sodium channels, leading to an inhibition in the release of glutamate and resulting in a general inhibitory effect on cortical neuronal function. Lamotrigine is also a weak dihydrofolate reductase inhibitor. The drug is approved by the U.S. Food and Drug Administration for maintenance treatment of bipolar type I disorder in adults. There have been reports of hematologic adverse effects with lamotrigine therapy. This case report describes a 16-year-old female who developed profound anemia while on lamotrigine therapy.

**Method.** Ms. X was a 16-year-old African-American female with sickle cell trait and mood disorder referred by the Division of Youth Services (DYS). Her medication regimen included lamotrigine 200 mg in the morning, aripiprazole 5 mg in the morning, and mixed amphetamine salts extended-release 30 mg in the morning. While at DHS, she developed fatigue and headaches with exertion. Her blood work detected a very low hemoglobin level of 3.1 g/dL and a very low hematocrit of 10.9%. Her MCV, MCH, and MCHC were within the normal range. The remainder of her blood count and other labs were within normal limits. The patient's blood pressure was 105/70 mm Hg and her pulse was 109. The patient was sent to the local emergency room immediately; upon hospital admission, she received 4 units of packed red blood cells via transfusion.

**Results.** After a blood transfusion, the patient's hemoglobin level improved to 9.7 g/dL. The patient's symptoms had improved significantly; her headaches and fatigue with exertion were gone. It was suspected that her profound anemia was induced by

lamotrigine. She was discharged from the hospital with instructions to stop lamotrigine and visit a hematology specialist. Several weeks later, she underwent a hematologic evaluation, including a bone marrow biopsy and genetic testing, which were unremarkable. Her hemoglobin level remained stable.

**Conclusion.** The patient's anemia resolved after the discontinuation of lamotrigine. The patient was followed for 1 year with blood work performed every few months. Her hemoglobin level did not drop further and in fact slowly increased to 13.9 g/dL spontaneously over the next year. In the literature, there have been reports of blood dyscrasias that may or may not be associated with hypersensitivity syndrome in patients who take lamotrigine. Considering hematologic adverse effects, it may be prudent to consider a baseline blood count before starting lamotrigine and repeat this test 3 to 6 months after initiation. It remains unclear whether lamotrigine use with a background of sickle cell trait in this patient put her at an increased risk of profound anemia. Further studies are required to explore the effects of this commonly used medicine.

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## The Utility of Planned Deprescribing in Pandemics and Other Disasters: A Systematic Review

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### Abstract

**Background.** How can psychiatrists best provide care in complex, sometimes overwhelming disasters? COVID-19 strained every aspect of health care to the breaking point, from finances to pharmaceutical supply lines. We can expect more challenges to prescribing in the future, as shown by recent hurricanes in Puerto Rico, fires in California, and ice storms in Texas. When medications become scarce or inaccessible, then clinicians need to make difficult prescribing decisions. We suggest that a culture of deprescribing, a systematic approach to reducing or simplifying medications, could be applied to a wide variety of crises. Deprescribing is defined as the planned reduction of medications to improve patient health or to reduce side effects (see [deprescribing.org](https://www.deprescribing.org)). It has been used to reduce polypharmacy in geriatric and other complex populations. It provides evidence-based guidance for phasing out many classes of medications. It is part of the larger program to reduce waste in health care and to make pharmacy more rational. Disasters and resource scarcity, however, require a different approach. In contrast to routine care focused on individual patients, crisis standards of care (CSC) shift the clinical focus to the community. Instead of deprescribing guidelines for individual clinicians, CSC deprescribing would be national policies addressing shortages of important medications. We did a scoping review looking for studies of deprescribing in a crisis.

**Methods/Results.** We extracted 1340 references in Google Scholar 2016 to 2021 using (deprescribing) AND (disaster OR crisis OR climate OR pandemic OR supply lines). A scan of texts