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Correspondence

Boycott of Israeli Academics and the Position of the American Psychiatric Association

Dear Editor

It may interest your readers to learn that as of December 2006 the American Psychiatric Association (APA) has adopted an official position opposing the resolution at the time (May 29, 2006) of Great Britain's National Association of Teachers in Further and Higher Education, Britain's largest academic union, calling on its members to consider the appropriateness of a boycott of individuals and institutions in Israel that do not publicly dissociate themselves from Israel's policies regarding the Palestinians. By doing so, the APA joined several thousand academics in America and Great Britain, as reported in the journal *Science* (2 June 2006, vol 312, p. 1289), the American Association for the Advancement of Science and the Royal Society of the United Kingdom in condemning the proposal as antithetical to the role of free scientific inquiry. In 2005, the Association of University Teachers (AUT), another British academic union had rescinded their endorsement of a similar boycott in the face of legal objection.

The adoption of this position by the Board of Trustees of the APA came about last November as the result of an initiative by a number of current and immediate past members of the Assembly of the APA (the undersigned) who put forward the proposal for approval by the Assembly and successfully argued for its passage, which occurred, without significant opposition, by a clear majority in a voice vote. At its December meeting, the Board of Trustees, which must approve any official position, did so.

The central argument made in the Assembly proposal may also interest your readers:

"The field of psychiatry, as with other medical professions and the scientific disciplines upon which they rely, depends upon the ability of its practitioners and researchers to freely exchange scientific ideas and discoveries independent of any interference from politically or ideologically-motivated groups or movements. That free exchange has been threatened in recent years by organizations such as NATFHE and AUT and individuals who have declared their intent to boycott Israeli and other institutions of higher learning and research as well as individual Israeli and other academics, scientists and researchers that do not oppose certain Israeli policies. There is no credible evidence to suggest that the conduct of Israeli and other scientists and physicians and academic institutions that do not oppose certain Israeli policies warrants exclusion from the international community; rather, the boycotts propose to exclude Israeli and other scientists and physicians simply because they do not take a certain political stand. Such actions are anathema to our Association, the members of our profession and the patients we serve."

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Aripiprazole in a Patient Susceptible to Urinary Side Effects of Antipsychotics

Dear Editor

Neuroleptic induced anticholinergic effects such as urinary retention have been described with typical antipsychotics like thioridazine, chlorpromazine and loxapine and very rarely with atypical antipsychotics. We report on a patient who developed acute urinary symptoms with several antipsychotics, both typical and atypical, and responded to aripiprazole without developing any urinary symptoms.

Case report

A 27-year-old male diagnosed as Bipolar Affective Disorder, Manic with Psychotic Symptoms (F 31.2

ICD-10) was admitted and started on injectable haloperidol 20 mg/day to control his aggression. On the fourth day he developed marked urinary difficulties with incomplete voiding. Haloperidol was stopped and olanzapine 15mg started along with carbamazepine 800 mg, but he continued to complain of urinary hesitancy and incomplete voiding. Surprisingly, he had no other side effects including extrapyramidal syndrome and hence was never treated with any anti-parkinsonian medication. The patient was then given risperidone 3mg. His retention improved, but he continued to complain occasionally of hesitancy until discharge from hospital. At 6-month follow-up, the patient presented with a third manic episode attributable to poor drug compliance due to urinary side effects. Injectable haloperidol was restarted this time with just 10mg/day to control his agitation along with carbamazepine 800mg. However, on the third day, the patient developed acute urinary retention and he had to be catheterized. Haloperidol was stopped and he completely recovered in two days. Routine investigations including urine microscopy and culture, renal function tests and Xray KUB were within normal limits. Aripiprazole 5mg was started and later increased to 10mg and the patient was closely observed for the development of any side effects. However, he remained asymptomatic until discharge from hospital and at follow-up was well while still taking carbamazepine 800 mg and aripiprazole 10 mg.

Discussion

Urinary retention has been attributed both due to severity of psychosis (1) and to anticholinergic adverse effects of high and moderate potency typical antipsychotics. However, atypical antipsychotics such as risperidone and olanzapine too can cause urinary retention alone without the development of extrapyramidal syndrome due to either central or peripheral mechanism.

Many CNS transmitter systems are involved in the control of micturition (2). D1 receptor agonists suppress an overactive bladder and D2 receptor agonists stimulate bladder overactivity (3). Urinary retention in this patient may have been a consequence of a central D2 receptor blockade, with or without combination of central serotinergic blockade. Moreover, all of the above neuroleptics have considerable alpha 1 adrenergic action and may act as alpha 1 agonists on receptors spread widely over smooth muscle of trigone and detrusor muscle of bladder (4).

Aripiprazole has minimal effects on alpha 1 and no effects on alpha 2 adrenergic receptors and only a partial agonist action at central D2 receptors (5). This unique mechanism of action may explain the lack of urinary adverse effects in this patient as other mechanisms of urinary retention such as infection, use of other medications and urinary tract abnormalities had been ruled out.

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