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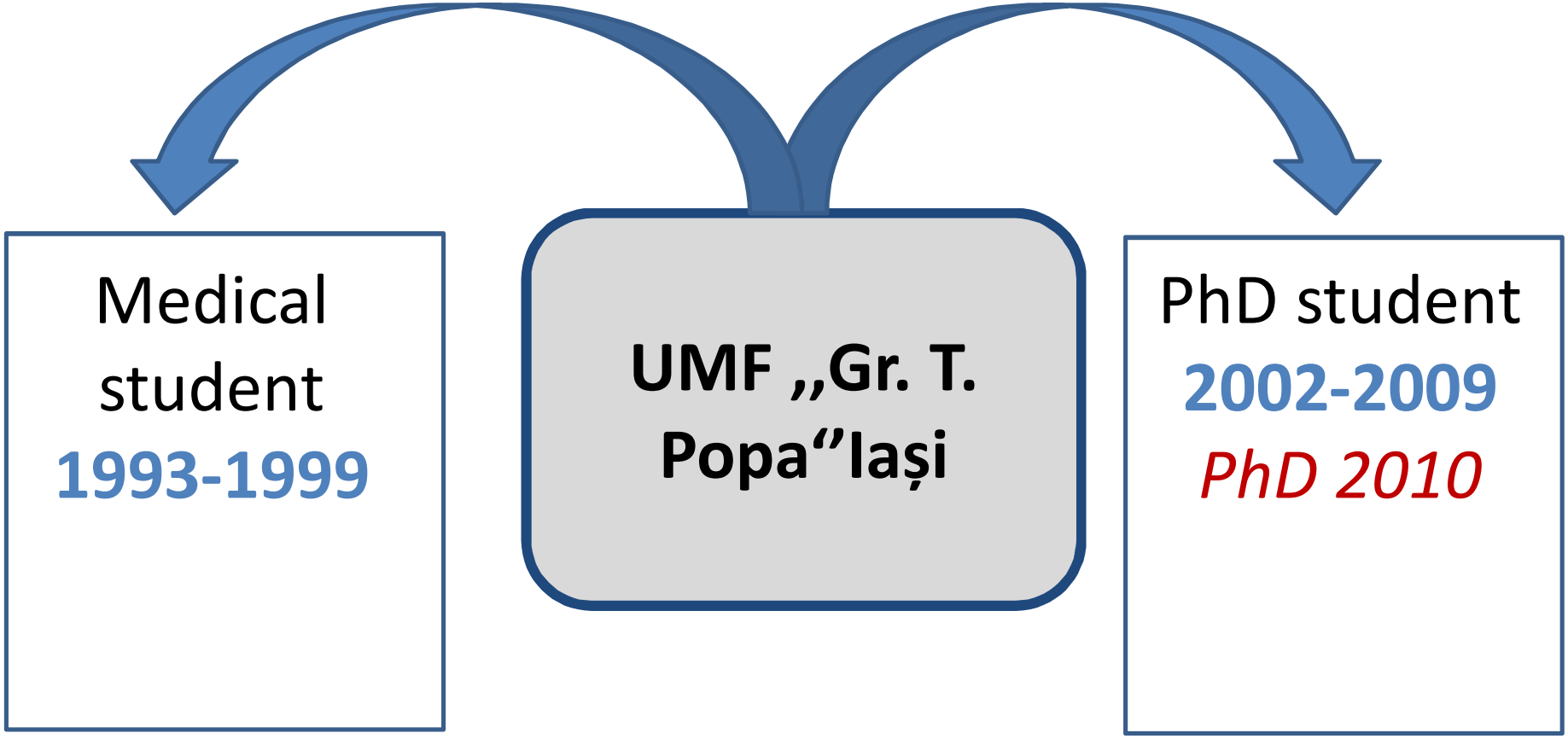
HABILITATION THESIS

THERAPEUTIC APROACH IN SCHIZOPHRENIA-FROM DIAGNOSIS TO RECOVERY

PETRU IULIAN IFTENI

2017

CAREER OVERVIEW



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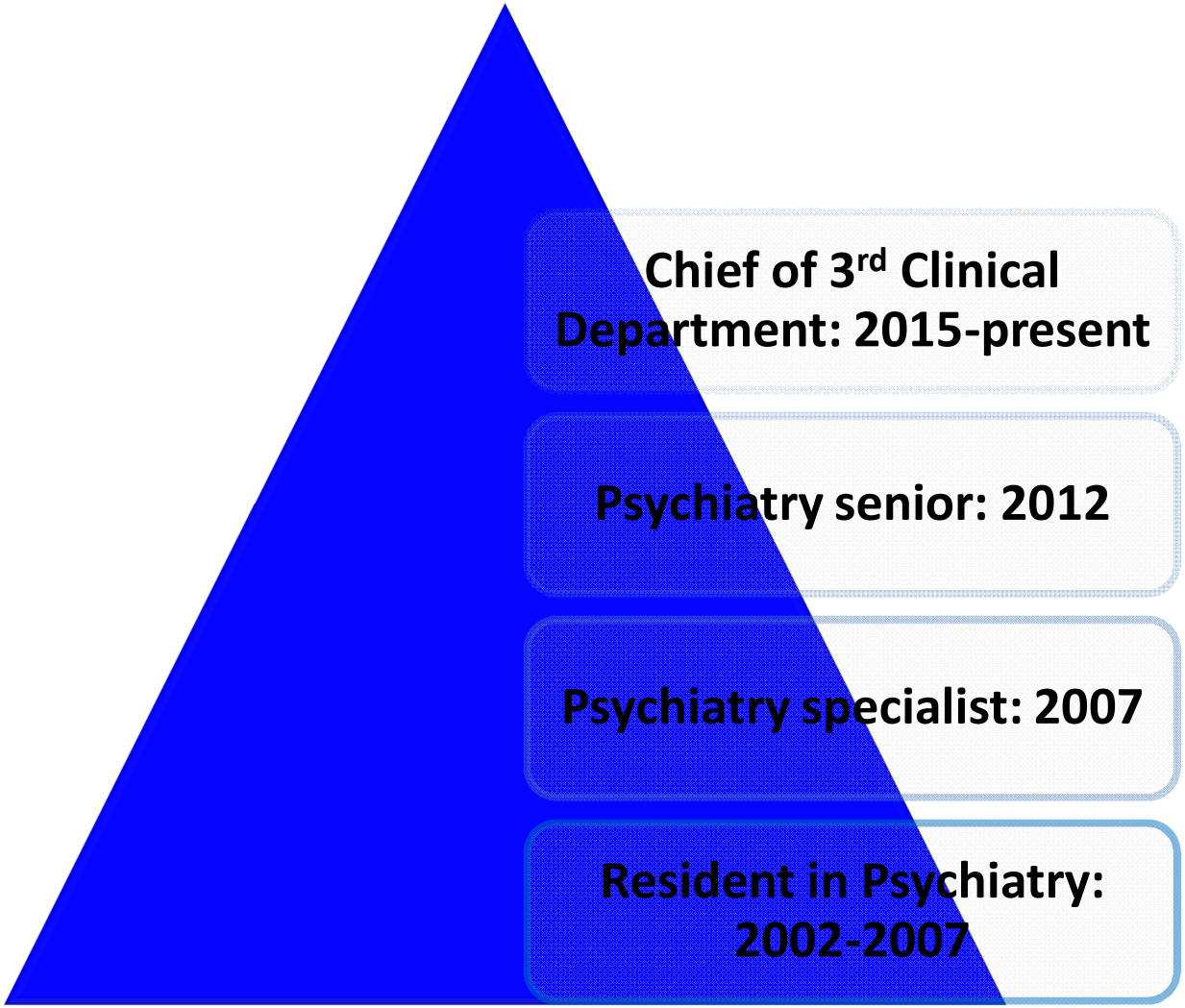
MEDICAL DEVELOPEMENT



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UNIVERSITARY TEACHING DEVELOPEMENT

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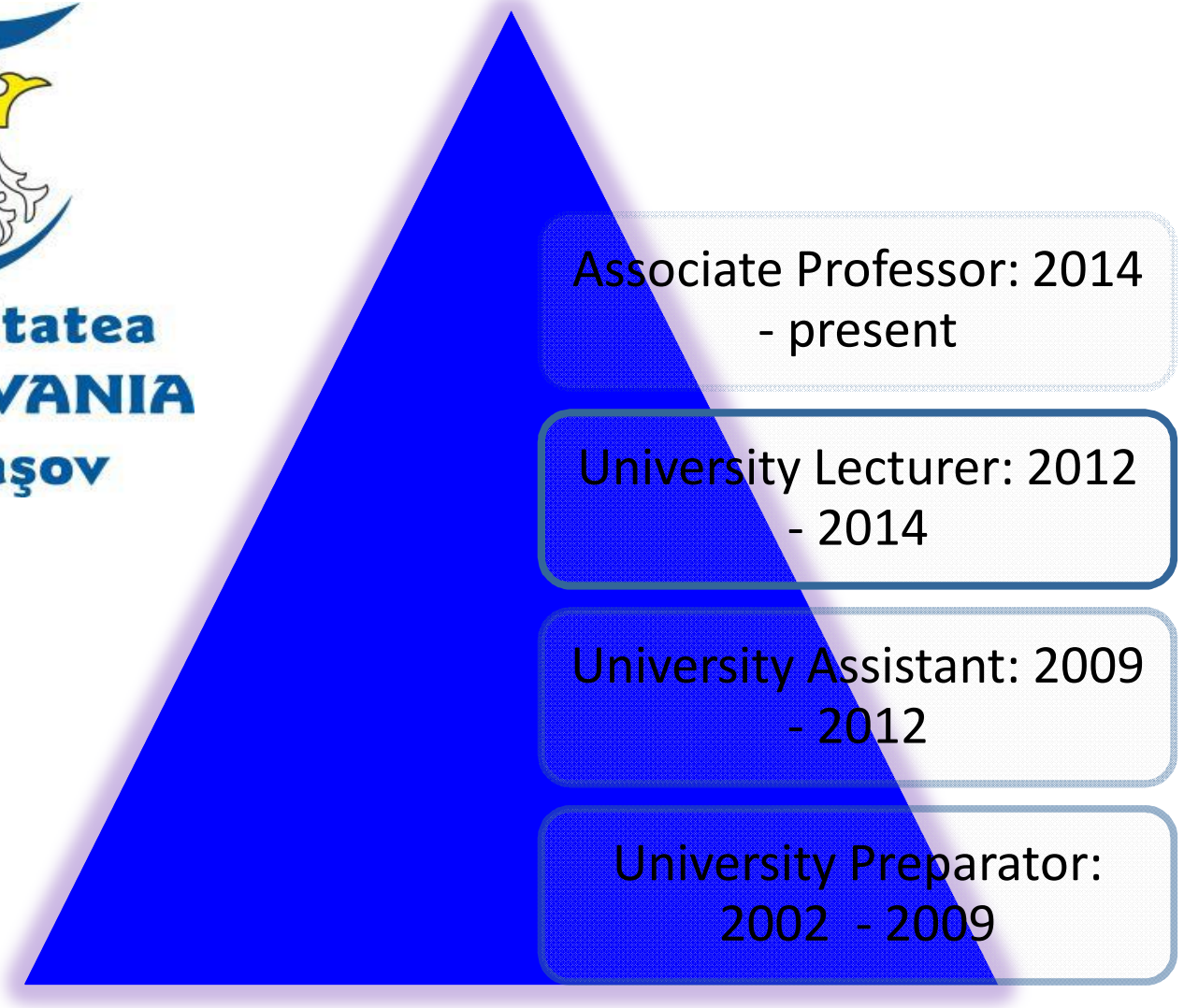

SCIENTIFIC ACHIEVEMENTS

SCIENTIFIC ACHIEVEMENTS

Scientific developments in the field of

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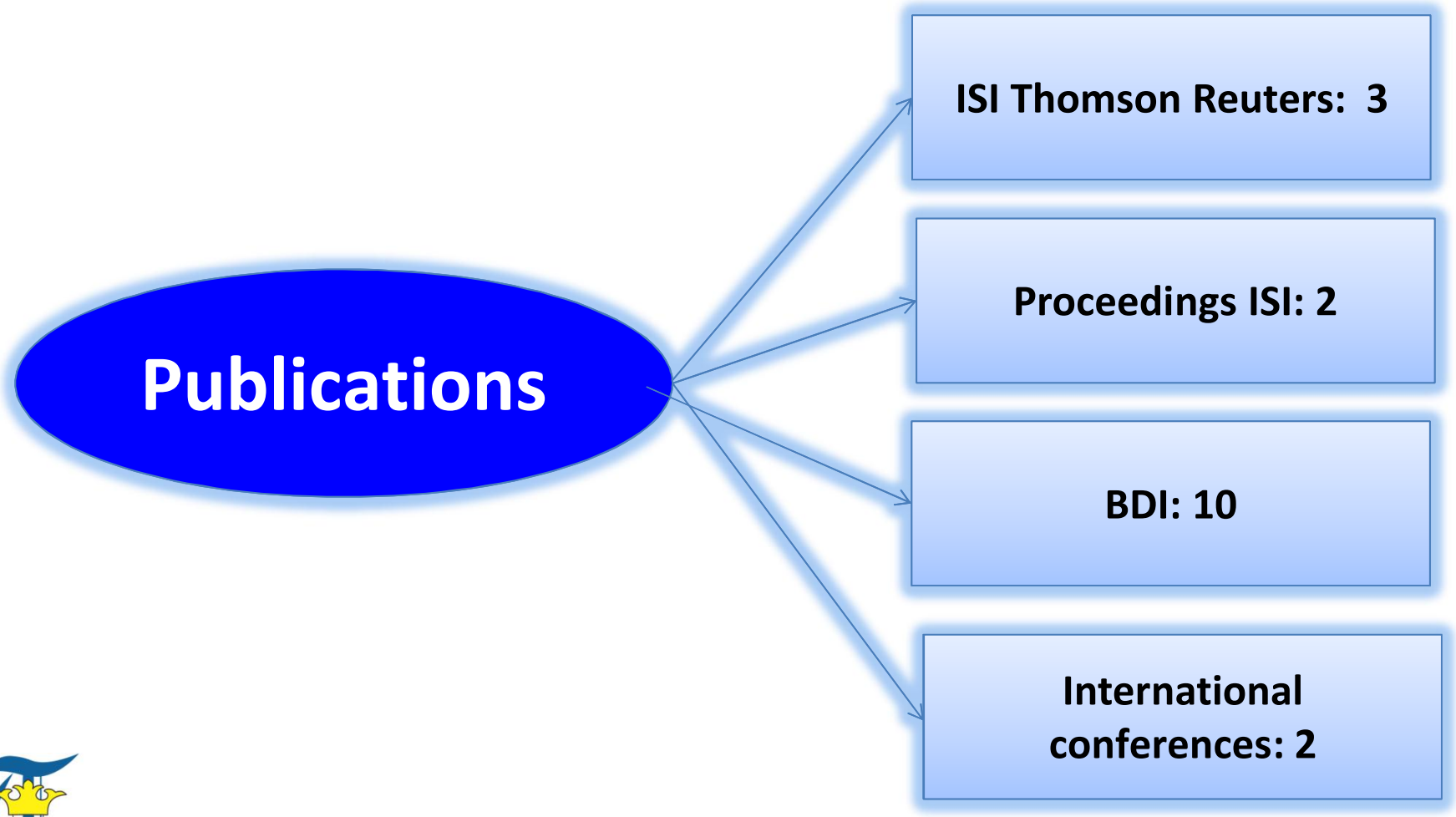
1. Scientific developments in the field of Affective Disorders



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PhD Thesis

„Corelatii somato-psihice si evaluari terapeutice in clinica si tratmentul tulburarilor depresive„-2010, UMF „Gr. T. Popa'' Iasi

The influence of metabolic syndrome in major depressive disorder outcome

[PDF] from wseas.us

Authors	Petru Ifteni, Victoria Burtea, Vasile Chirita, Corneliu Mosoiu
Publication date	2009/9/28
Conference	Proceedings of the 11th WSEAS international conference on Mathematical methods and computational techniques in electrical engineering
Pages	438-440
Publisher	World Scientific and Engineering Academy and Society (WSEAS)
Description	Abstract:-Major depressive disorder is the most prevalent psychiatric illness, affecting more than 12% of men and more than 21% of women in their lifetime [1]. Previous studies indicate that prevalence of major depression has increased during the past century, although these trends may, in part, be explained by methodological problems. Depression has been associated with a variety of diseases; specifically it has been implicated in the development of cardiovascular disease (CVD) and all-cause mortality. However, little is understood ...
Scholar articles	The influence of metabolic syndrome in major depressive disorder outcome P Ifteni, V Burtea, V Chirita, C Mosoiu - Proceedings of the 11th WSEAS international ..., 2009 Related articles - All 3 versions

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Affective disorders-refractory mania

Journal of Affective Disorders 166 (2014) 168–172

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Rapid clozapine titration in treatment-refractory bipolar disorder

Petru Ifteni[a,1], Christoph U. Correll[b,c,d,1], Jimmi Nielsen[e,f], Victoria Burtea[a], John M. Kane[b,c,d], Peter Manu[b,c,d,*]

[a] Faculty of Medicine, Transilvania University, Brasov, Romania
[b] Zucker Hillside Hospital, Glen Oaks, NY, USA
[c] Hofstra North Shore – LIJ School of Medicine, Hempstead, NY, USA
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[f] Clinical Department of Medicine, Aalborg University, Aalborg, Denmark

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Affective disorders-refractory mania (results)

Table 1
Demographic features and psychiatric characteristics.

Characteristic	Total ($N=67$)	Rapid clozapine titration ($N=44$)	Standard clozapine titration ($N=23$)	*p-Value*
Age, years ± S.D.	39.6 ± 13.0	41.3 ± 12.7	36.3 ± 13.0	0.14
Male gender, *N* (%)	37 (55.2%)	27 (61.4%)	10 (43.5%)	0.16
Smoking, *N* (%)	43 (64.2%)	28(63.6%)	15 (65.2%)	0.88
Body mass index, (kg/m^2 ± S.D.)	25.3 ± 3.1	25.3 ± 3.4	25.4 ± 2.7	0.97
Bipolar disorder subtype				
Manic episode	46 (68.7%)	30 (68.2%)	16 (69.6%)	0.91
Mixed episode	21 (31.3%)	14 (31.8%)	7 (30.4%)	0.91
Psychotic features	25 (37.3%)	13 (29.6%)	12 (52.2%)	0.07
Age of onset, years ± S.D.	28.0.0 ± 9.0	29.3 ± 9.8	25.5 ± 7.0	0.10
Substance use disorder				
Alcohol	27 (40.3%)	17 (38.6%)	10 (43.5%)	0.70
Drugs	5 (7.5%)	2 (4.6%)	3 (13.0%)	0.22
Duration of illness, years ± S.D.	11.6 ± 9.8	12.0 ± 9.0	10.8 ± 11.1	0.64
CGI_s at baseline, score ± S.D.	6.0 ± 0.6	6.0 ± 0.7	6.0 ± 0.4	0.99

CGI_s: Clinical Global Impression, severity.

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Bipolar disorder-clozapine

Neuropsychiatric Disease and Treatment

Dovepress
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Open Access Full Text Article

ORIGINAL RESEARCH

Switching bipolar disorder patients treated with clozapine to another antipsychotic medication: a mirror image study

This article was published in the following Dove Press journal:
Neuropsychiatric Disease and Treatment
23 January 2017
Number of times this article has been viewed

Petru Ifteni[1,2]
Andreea Teodorescu[1,2]
Marius Alexandru Moga[1]
Alina Mihaela Pascu[1]
Roxana Steliana Miclaus[1,2]

[1]Faculty of Medicine, Transilvania University of Brasov, Brasov, Romania; [2]Clinical Hospital of Psychiatry and Neurology Brasov, Brasov, Romania

Abstract: Bipolar disorder (BD) is associated with periodic symptom exacerbations, leading to functional impairment, and increased risk of suicide. Although clozapine has never been approved for the treatment of BD, it is occasionally used in severe mania. The aim of the study is to evaluate the risks and benefits of switching clozapine in remitted BD patients. This is an observational, mirror image study of 62 consecutive remitted BD outpatients treated with clozapine. Twenty-five patients were switched to another antipsychotic following a change in a drug reimbursement rule, while 37 continued on clozapine. The mean time in remission was shorter for the switched group (9.2±4 months vs 13±6 months, P=0.018), and the number of patients who relapsed was larger (n=21 vs n=8, P<0.0001). The results suggest that switch-

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Bipolar disorder-clozapine (results)

Table 2 Patient demographics

Characteristics	Non-switched group n=37, 59.7%	Switched group n=25, 40.3%	P-value
Gender, male, n=36, 58.1%	23	13	<0.05
Age (years)	38.94 (10.59)	38.76 (10.17)	0.846
Age of onset (years)	26.67 (8.17)	27.60 (7.71)	0.782
Duration of illness (years)	12.00 (7.68)	11.16 (5.51)	0.091
Number of hospitalizations (lifetime)	8.67 (5.38)	7.60 (3.65)	0.049
Days of hospitalizations (lifetime)	212.56 (123.90)	190.20 (90.76)	0.113
Clozapine before replacing, months, mean (SD)	13.91 (6.20)	14.32 (5.27)	0.408
Remission before clozapine discontinuation (months)	10.18 (5.55)	10.64 (4.58)	0.326
Remission after clozapine discontinuation (months)	12.93 (6.24)	9.24 (3.90)	0.018
Relapse after clozapine replacing	8 (21.62)	21 (77.77)	<0.0001
Hospitalization after clozapine replacing	8 (24.24)	25 (75.76)	<0.0001
Total amount of money/family	€780	€821	0.884
Number of persons who support patient's treatment	2,3	2.1	0.921

Note: Data presented as n (%) unless stated otherwise.

Abbreviation: SD, standard deviation.

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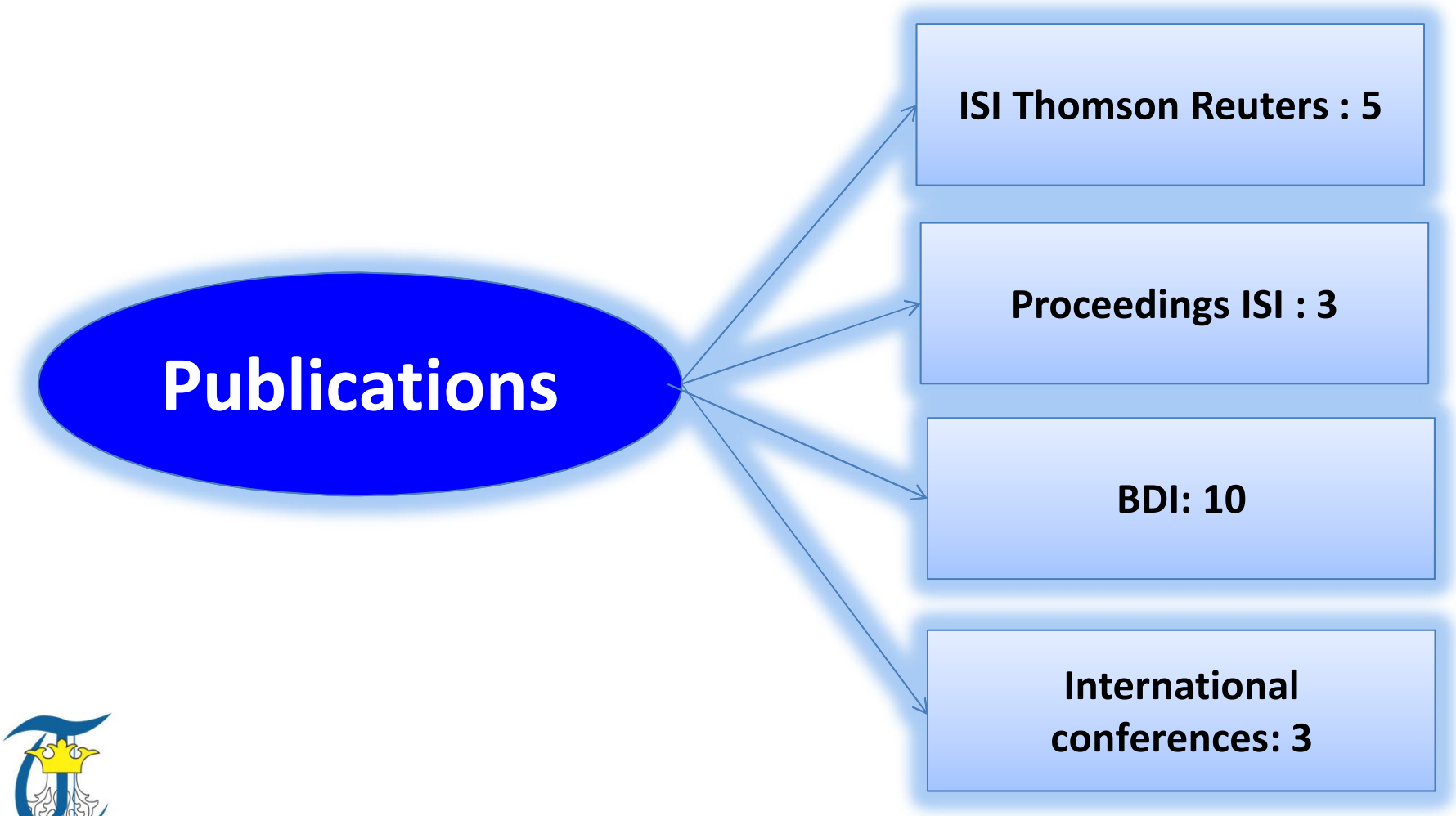
2. Scientific developments in the field of Schizophrenia



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Schizophrenia-clozapine rapid titration

Acta Psychiatrica Scandinavica

Acta Psychiatr Scand 2013: 1–5
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DOI: 10.1111/acps.12241

ACTA PSYCHIATRICA SCANDINAVICA

Effectiveness and safety of rapid clozapine titration in schizophrenia

Ifteni P, Nielsen J, Burtea V, Correll CU, Kane JM, Manu P. Effectiveness and safety of rapid clozapine titration in schizophrenia.

Objective: Clinical guidelines recommend slow clozapine dose titration in order to decrease the risk of seizures and hypotension. The recommendation may delay adequate control of severe psychotic symptoms. We evaluated the safety and effectiveness of rapid clozapine titration in patients who had been previously exposed to the drug and in patients who received clozapine for the first time after failing to respond to other antipsychotics.

P. Ifteni[1], J. Nielsen[2], V. Burtea[1], C. U. Correll[3,4,5], J. M. Kane[3,4,5], P. Manu[3,4,5]

[1]Faculty of Medicine, Transilvania University, Brasov, Romania, [2]Aalborg Psychiatric Hospital, Aarhus University Hospital, Aalborg, Denmark, [3]Zucker Hillside Hospital, Glen Oaks, NY, [4]Hofstra North Shore – LIJ School of Medicine, Hempstead, NY and [5]Albert Einstein College of Medicine, Bronx, NY, USA

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Schizophrenia-clozapine rapid titration (results)

Table 1. Demographic and psychiatric characteristics on admission

Characteristic	Total ($N = 111$)	Prior exposure to clozapine ($N = 73$)	No prior exposure to clozapine ($N = 38$)	P
Age, years ± SD	42.1 ± 11.3	42.6 ± 11.2	41.2 ± 11.6	0.536
Male Gender, N (%)	58 (52.2%)	39 (53.4%)	19 (50.0%)	0.731
Smoking, N (%)	99 (89.18%)	68 (93.15%)	31 (81.57%)	0.032
Schizophrenia type				
Paranoid	72 (64.9%)	52 (71.2%)	20 (52.6%)	0.073
Undifferentiated	20 (18.0%)	9 (12.3%)	11 (28.9%)	
Disorganized	19 (17.12%)	12 (16.44%)	7 (18.4%)	
Age of onset, years ± SD	23.5 ± 7.0	23.5 ± 7.4	23.5 ± 6.3	0.97
Duration of Illness, years ± SD	18.56 ± 9.5	19.1 ± 9.4	17.7 ± 9.7	0.461
GAF, score ± SD	21.4 ± 6.8	20.8 ± 6.9	22.4 ± 6.4	0.254
CGI, score ± SD	5.6 ± 0.6	5.7 ± 0.5	5.6 ± 0.6	0.481
PANSS, score ± SD	104.1 ± 3.8	104.3 ± 2.9	103.8 ± 5.1	0.483

GAF, global assessment of function; CGI, clinical global impression; PANSS, positive and negative symptom scale.

Table 2. Clozapine dosage and duration of hospitalization

Characteristic	Total ($N = 111$)	Prior exposure to clozapine ($N = 73$)	No prior exposure to clozapine ($N = 38$)	P
Dose on first day of treatment, mg ± SD	129.1 ± 75.4	115.1 ± 52.7	155.9 ± 101.9	0.006
Maximum dose, mg ± SD	371.9 ± 181.2	352.7 ± 176.1	408.6 ± 187.5	0.124
Duration of hospitalization, days ± SD	28.3 ± 13.6	25.3 ± 12.3	33.9 ± 14.4	0.001
PANSS at discharge, score ± SD	60.3 ± 6.1	60.5 ± 5.4	59.8 ± 7.4	0.539
Day of Maximum dose, days ± SD	5.1 ± 4.0	4.2 ± 3.1	7.1 ± 4.9	0.001
Dose at discharge (mg/day)	351.6 ± 140.5	333.6 ± 134.6	368.4 ± 149.9	0.06

PANSS, positive and negative symptom scale.

Significant outcomes

- Rapid increase in clozapine dose has not been associated with major adverse reactions in a consecutive cohort of patients with schizophrenia.
- With the use of this method, symptom control was obtained, on average, after 4 days in patients who had been previously treated with clozapine and after 1 week in patients treated for the first time with this drug.

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Schizophrenia-sudden death

Schizophrenia Research 155 (2014) 72–76

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Sudden unexpected death in schizophrenia: Autopsy findings in psychiatric inpatients

Petru Ifteni [a,1], Christoph U. Correll [b,c,d,1], Victoria Burtea [a], John M. Kane [b,c,d], Peter Manu [b,c,d,*]

[a] Faculty of Medicine, Transilvania University, Brasov, Romania
[b] Zucker Hillside Hospital, Glen Oaks, NY, United States
[c] Hofstra North Shore – LIJ School of Medicine, Hempstead, NY, United States
[d] Albert Einstein College of Medicine, Bronx, NY, United States

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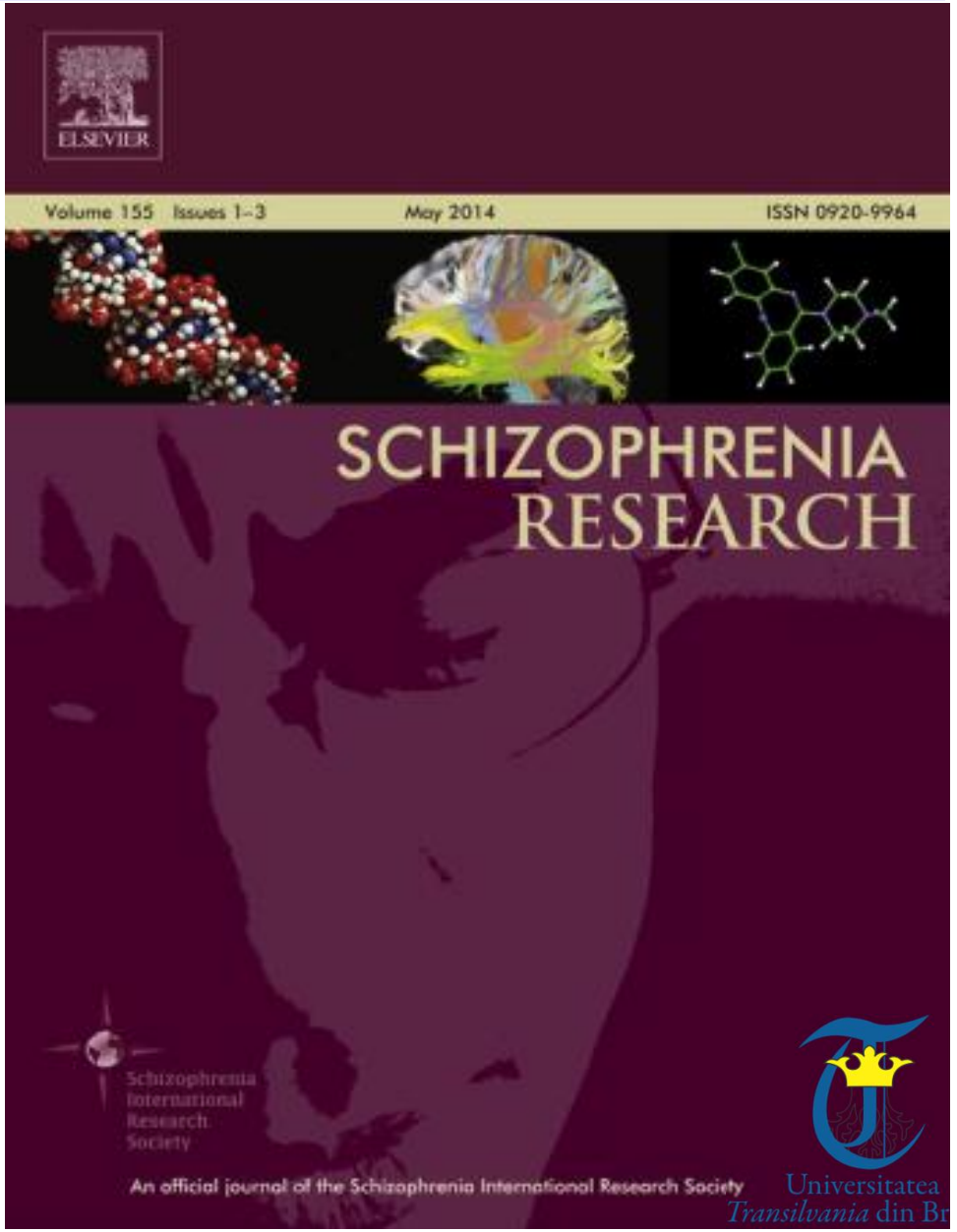
Schizophrenia-sudden death (results)

Table 2
Causes of sudden, unexpected death in schizophrenia inpatients who had a post-mortem examination.

Cause of death	N (%)	95% confidence interval
Cardiovascular disorders	32 (62.8%)	49.5–76.0%
Myocardial infarction	27 (52.9%)	39.2–66.6%
Myocarditis	3 (5.9%)	0–12.3%
Dilated cardiomyopathy	1 (2.0%)	0–5.8%
Hemopericardium	1 (2.0%)	0–5.8%
Respiratory disorders	11 (21.6%)	10.3–32.9%
Pneumonia	6 (11.8%)	2.9–20.6%
Airway obstruction	4 (7.8%)	0.5–15.2%
Pulmonary embolus	1 (2.0%)	0–5.8%
Neurological disorders	2 (3.9%)	0–9.2%
Hemorrhagic stroke	1 (2.0%)	0–5.8%
Brain tumor	1 (2.0%)	0–5.8%
Unexplained	6 (11.8%)	2.9–20.6%

Our findings suggest that a substantial decrease in the prevalence of sudden death in schizophrenia can be obtained only through programs aimed at the primary prevention of coronary artery disease and secondary prevention of myocardial infarction. In the Framingham Heart Study, from 1950 to 1999, such programs have proven their effectiveness among individuals without psychotic disorders by decreasing the risks of sudden death and non-sudden mortality related to coronary artery disease by 49% and 64%, respectively (Fox et al., 2004). Reductions of this magnitude will require not only early detection and treatment of coronary and diabetogenic risk factors in psychiatric settings, but also parity in access and quality of medical care for patients with schizophrenia. In order to achieve these important goals that have been highlighted for at least a decade now, provider, patient and system level barriers must be identified and addressed (De Hert et al., 2011b).



Schizophrenia-institutionalization

ACTUAL TENDENCY IN INSTITUTIONALIZATION OF PATIENTS WITH SCHIZOPHRENIA

Andreea SZALONTAY, Alina Mihaela PASCU,
Andreea TEODORESCU, Dan MINEA, Petru IFTENI

Revista de cercetare și intervenție socială, 2015, vol. 51, pp. 64-71

The online version of this article can be found at:

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Schizophrenia-institutionalization (results)

Table 1. *Demographics*

Variables	All patients N=322	Institutionalized patients				*p* value
		Group A 1995-2004 (N=150)		Group B 2005-2014 (N=177)		
		N	%	N	%	
Age (mean, SD)	53.45 (8.23)	57.08 (5.67)	-	51.15 (9.15)	-	$p<0.05$
Age of onset	20.95 (2.47)	21.73 (3.34)	-	23.56 (4.11)	-	NS
Age at institutionalization	45.78 (8.22)	49.34 (8.86)	-	42.22 (7.76)	-	$p<0.05$
Duration of illness	21.67 (9.33)	25.16 (7.56)	-	18.18 (8.54)	-	$p<0.05$
Patients with age below 40	40	12	8.00	28	16.2	$p<0.05$
Number of admission in 2 years period before institutionalization (mean)	-	6	-	7	-	NS
Type of schizophrenia						
paranoid	217	105	70.00	112	65.11	NS
disorganized	71	30	20.00	41	23.83	NS
undifferentiated	27	14	9.33	13	7.55	NS
other	7	1	0.66	6	3.48	NS
Place before institutionalization						
home	253	120	80.00	133	77.32	NS
hospital	50	20	13.33	30	17.44	NS
other	19	10	6.66	9	5.24	NS
Patient living						
alone	37	14	9.33	23	13.37	NS
with husband/wife	25	13	8.66	6.97	1.16	NS
with one parent	78	33	22.00	45	26.16	NS
with both parents	23	11	7.33	12	6.97	NS
with son/daughter	35	17	11.33	18	10.46	NS
with brother/sister	80	33	22.00	47	27.32	$p<0.05$
other	44	22	14.66	22	12.79	NS
Education						
1-4 years	45	23	15.33	22	12.79	NS
5-8 years	175	87	58.00	88	51.16	NS
9-12 years	80	33	22.00	47	27.32	NS
more than 12 years	22	9	6.00	13	7.55	NS

Schizophrenia-pregnancy

Therapeutics and Clinical Risk Management

Dovepress

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Open Access Full Text Article

CASE REPORT

Schizophrenia relapse after stopping olanzapine treatment during pregnancy: a case report

This article was published in the following Dove Press journal:
Therapeutics and Clinical Risk Management
23 October 2014
Number of times this article has been viewed

Petru Ifteni[1,2]
Marius A Moga[1]
Victoria Burtea[1,2]
Christoph U Correll[3,4]

Abstract: Women with schizophrenia have a high risk for symptom exacerbation or relapse during pregnancy and thereafter. Relapses are more frequent when antipsychotics are discontinued. This paper describes the case of a 28-year old woman with schizophrenia who continued treatment with olanzapine during the first trimester. Olanzapine, a second-generation antipsychotic, was administered at a therapeutic dose from week 1 of gestation until week 13 when she reported the

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Schizophrenia-pregnancy

Categories include A (no risk in well-controlled human studies), B (no risk in animal studies), C (adverse effect on the fetus in animal studies, but no adequate studies in humans and potential benefits may warrant use of the drug in pregnant women despite potential risks), D (adverse effect on the fetus in animal studies and human investigational or marketing experience, but potential benefits may warrant use of the drug in pregnant women despite potential risks), and X (adverse effect on the fetus in animal studies and human investigational or marketing experience, and risks clearly outweigh potential benefits).[5]

Conclusion

More studies are needed to determine the effects of antipsychotics, including olanzapine, on pregnant women and the developing fetus. Schizophrenia relapse during pregnancy may expose the mother and fetus to high risk if the antipsychotic is stopped. Antipsychotics should be used in pregnant women only if the risk–benefit assessment justifies the potential medication-related risk to the infant.

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Schizophrenia-cognition

BPI Bulletin of Integrative Psychiatry
Buletin de Psihiatrie Integrativă

Cognitive evaluation in patients with schizophrenia and persecutory delusion

Andreea Teodorescu, Petru Ifteni, Victoria Burtea, Liana Fodoreanu

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Schizophrenia-cognition (results)

Variables	HAL=29	QUE=7	CLZ=14	OLZ=37	ARI=9	RIS=13	AMI=11	p
	Mean	Mean	Mean	Mean	Mean	Mean	Mean	
TMT	74.14	76.57	86.50	79.89	85.67	64.62	80.36	0.50
BACS-SC	28.07	25.43	23.36	24.35	29.33	31.08	23.09	0.29
HVLT-R	23.00	21.43	20.79	21.68	27.11	22.08	21.36	0.05
WMS	11.52	11.14	10.64	11.27	12.44	12.77	10.73	0.93
LNS	11.72	10.43	11.64	11.22	13.56	12.23	11.45	0.91
NAB	8.07	6.86	9.21	7.70	9.22	10.38	6.91	0.82
BVMT-R	18.03	16.71	13.64	17.95	20.78	19.23	15.09	0.05
FLUENCE	16.24	19.29	15.00	16.51	16.00	16.31	14.64	0.05
PSWQ	52.28	49.29	50.21	53.95	45.67	50.85	55.00	0.88

TABLE IV. *MATRICS results and antipsychotic type*

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Schizophrenia-safety of antipsychotics

Archives of the Balkan Medical Union
vol. 48, no. 4, pp. 404-405
December 2013

ORIGINAL PAPER

THE QTC INTERVAL IN PATIENTS TREATED WITH ANTIPSYCHOTICS

VICTORIA BURTEA, P. IFTENI, ALINA PASCU

Transilvania University Braşov, Faculty of Medicine, Braşov, Romania

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Transilvania din Braşov

Schizophrenia-aggressive behavior

American Journal of Therapeutics 24, e222–e226 (2017)

FREE ACCESS

Reducing Restraint With Clozapine in Involuntarily Admitted Patients With Schizophrenia

Petru Ifteni, MD, PhD,[1,2]* Andreea S. Szalontay, MD, PhD,[3] and Andreea Teodorescu, MD, PhD[1,2]

Table 2. Use of restraint in involuntarily admitted subjects with schizophrenia.

	Total (n = 115)	Clozapine (n = 24)	Subgroup: CLZ-first AP (n = 13)	Non-CLZ (n = 91)	*P*, CLZ versus non-CLZ	*P*, CLZ-first versus others
Restraint anytime during hospitalization, n (%)	103 (89.5)	16 (66.6)	3 (23.0)	87 (95.6)	0.0003	<0.0001
Hours until restraint,* median (25th; 75th percentile; range)	3 (0.25; 48)	118 (24; 426)	408 (48; 540)	1.1 (0.2; 24)	<0.0001	<0.0001
Restraint during first 24 h, n (%)	71 (61.7)	5 (20.8)	1 (7.6)	66 (72.5)	<0.0001	<0.0001

*For subjects without any restraint, the length of stay is substituted as restraint-free period.

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Schizophrenia – clozapine

SpringerLink

CNS Drugs

February 2016, Volume 30, Issue 2, pp 149–161

Worldwide Differences in Regulations of Clozapine Use

Authors | Authors and affiliations

Jimmi Nielsen, Corina Young, Petru Ifteni, Taishiro Kishimoto, Yu-Tao Xiang, Peter F. J. Schulte, Christoph U. Correll, David Taylor

Review Article

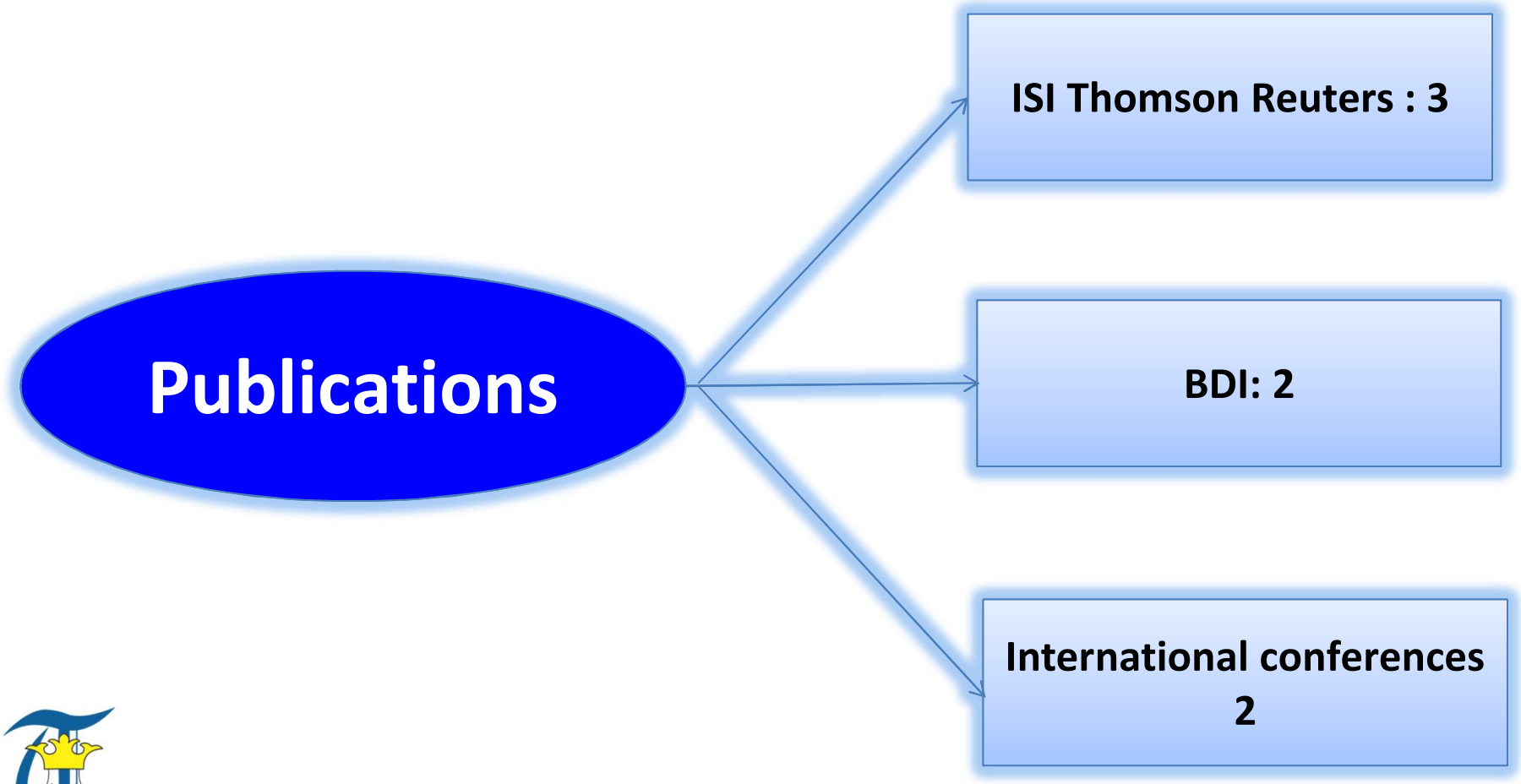
First Online: 16 February 2016

Universitatea *Transilvania* din Braşov

Schizophrenia – clozapine

Clozapine remains the drug of choice for treatment-resistant schizophrenia. As a consequence of its long history and complex pharmacology, we suspected wide variation in the regulations of clozapine use across different countries. The summaries of product characteristics (SPCs) from clozapine manufacturers, as well as local and national guidelines in the following selected countries, were reviewed: China, Denmark, Ireland, Japan, The Netherlands, New Zealand, Romania, the UK and the US. Clozapine is available as tablets in all countries, as an oral suspension in all included countries, with the exception of Japan and Romania, as orally disintegrating tablets in the US and China, and as an injectable in The Netherlands. General practitioner prescribing is only available in The Netherlands, New Zealand, the UK and the US, although with some restrictions in some of the countries. In Ireland and China, clozapine is only dispensed through hospital pharmacies. Hematological monitoring is mandatory in all countries but varies substantially in frequency, e.g. in Denmark hematologic monitoring is mandatory weekly for 18 weeks, followed by monthly monitoring, compared with Japan where blood work is required weekly for 26 weeks, followed by biweekly hematologic monitoring thereafter. In most included countries, with the exception of Denmark, Romania and The Netherlands, the manufacturer provides a mandatory hematological monitoring database, and dispensing of clozapine is not permissible without acceptable white blood count and absolute neutrophil count results. Local guidelines in New Zealand recommend echocardiography and

3. Scientific developments in the field of Dementia



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Dementia-institutionalization

PREDICTORS OF INSTITUTIONALIZATION IN DEMENTIA

ANDREEA SZALONTAY, VICTORIA BURTEA, PETRU IFTENI

Revista de cercetare și intervenție socială, 2015, vol. 49, pp. 249-256

The online version of this article can be found at:

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Dementia-institutionalization (results)

Table 1. *Demographics*

Variables	All patients N=127	Discharged patients				p value
		HD (N=98)		INS (N=29)		
		N	%	N	%	
Age (mean, SD)		70.6 (5.1%)		76.4 (5.5%)		0.005
Type of dementia						
AD	70	65	72.8	5	27.2	0.005
VaD	40	23	42.5	17	57.5	0.83
Other	17	10	58.8	7	41.2	0.19
Place before hospitalization						
home	110	95	86.7	16	13.3	0.005
hospital	5	2	40.0	3	60.0	0.27
care facility	15	9	60.0	6.	40.0	0.27
other	7	3	42.8	4	57.2	0.33
Pacient living						
alone	24	17	70.0	7	30.0	0.15
with husband/wife	67	65	97.0	2	3.0	0.001
with son or daughter	26	10	38.5	16	61.5	0.17
other	10	6	60.0	4	40.0	0.26
Caregiver						
Husband/wife	67	65	97.0	2	3.0	0.001
Son or daughter	20	8	40.0	12	60.0	0.005
relatives	30	17	56.6	13	43.4	0.45
employed caregiver	10	8	80.0	2	20.0	0.01
Education						
1-4 years	39	19	48.7	20	51.3	0.32
5-8 years	46	42	91.3	4	8.7	0.001
9-12 years	30	27	90	3	10.0	0.001
more than 12 years	12	10	83.3	2	16.7	0.18

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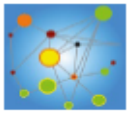
Dementia-identification and diagnosis

Pascu *et al. Int J Ment Health Syst (2015) 9:33*
DOI 10.1186/s13033-015-0026-6



INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS

CASE STUDY **Open Access**

Delayed identification and diagnosis of Huntington's disease due to psychiatric symptoms

Alina Mihaela Pascu[1], Petru Ifteni[1,2*], Andreea Teodorescu[2], Victoria Burtea[1] and Christoph U. Correll[3,4]

Abstract

Huntington's disease (HD) is a progressive neurodegenerative illness that affects 2–9/100.000 of the general population. The usual onset is at around age 35–40 years, but there were cases with onset above 55 years. The disease manifests clinically with many neurological and psychiatric symptoms, leading in advanced phases to dementia, but cognitive symptoms are frequently present much earlier in the disease course. HD is caused by an expanded polyglutamine stretch in the N-terminal part of a 350 kDa protein called huntingtin (HTT). This stretch is encoded by a trinucleotide CAG repetition in exon 1 of HTT. An expansion of greater than 36 repeats results in HD. The number of repeats is inversely correlated with the age of onset of motor symptoms, and disease onset during childhood or adolescence is associated with more than 60 CAG repeats. Mood disturbances may be one of the earliest symptoms of HD and may precede the onset of the motor pheno-type for almost 10 years. Neuropsychiatric symptoms may delay the appropriate diagnosis of HD and have major implications for disease management, prognosis and quality of life for patients and families. This case study is about a 58 years old female patient with late identification of Huntington's disease after two admissions to psychiatric inpatient units, for the treatment of behavioral disturbances.

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Dementia-sudden death

RESEARCH ARTICLE

International Journal of Geriatric Psychiatry

Haloperidol and sudden cardiac death in dementia: autopsy findings in psychiatric inpatients

Petru Ifteni[1], Eugene Grudnikoff[2], Jeremy Koppel[3,4,5], Neil Kremen[2,3], Christoph U. Correll[2,3,5,6], John M. Kane[2,3,5,6] and Peter Manu[2,3,6]

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[4]The Litwin-Zucker Research Center for the Study of Alzheimer's Disease, Manhasset, NY, USA
[5]The Feinstein Institute for Medical Research, Manhasset, NY, USA
[6]Albert Einstein College of Medicine, Bronx, NY, USA
Correspondence to: P. Manu, MD, E-mail: pmanu@nshs.edu

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Dementia-sudden death (results)

Table 1 Demographic and psychiatric features of dementia inpatients who died suddenly

Characteristic	Total ($N = 55$)	Death due to acute structural pathology ($N = 37$)	Sudden cardiac death ($N = 18$)	p
Age, (years ± SD)	79.7 ± 6.5	79.1 ± 6.6	80.8 ± 6.5	0.36
Male gender, *N* (%)	35 (63.6)	26 (70.3)	9 (50)	0.15
Type of dementia, *N* (%)				
Alzheimer	25 (45.5)	13 (35.1)	12 (66.7)	0.027
Vascular	30 (54.6)	24 (64.9)	6 (33.3)	0.027
Psychotic features, *N* (%)	12 (21.8)	7 (18.9)	5 (27.8)	0.46
Duration of dementia-related behavioral disturbance (years ± SD)	3.1 ± 1.3	2.9 ± 1.3	3.6 ± 1.5	0.092
Length of stay (days ± SD)	5.9 ± 3.0	5.9 ± 3.0	5.8 ± 3.0	0.87
Haloperidol use, *N* (%)	27 (49.1)	17 (45.9)	10 (55.6)	0.50
Haloperidol dose at the time of death (mean ± SD/day) and range (mg/day)	2.2 ± 2.1 0.5–9	2.5 ± 2.17 1–9	1.75 ± 2.00 0.5–6	0.382
Psychotropic co-medications at the time of death, *N* (%)				
Benzodiazepine	30 (54.6)	22 (59.5)	8 (44.4)	0.25
Mood stabilizer	6 (10.9)	6 (16.2)	0 (0)	0.024
Antidepressant	1 (1.8)	1 (2.7)	0 (0)	0.37

SD, standard deviation.

Table 2 Medical history of psychiatric inpatients with dementia who died unexpectedly

Organ/system involved, *N* (%)	Total ($N = 55$)	Death due to acute structural pathology ($N = 37$)	Sudden cardiac death ($N = 18$)	p
Heart disease	29 (52.7)	15 (40.5)	14 (77.8)	0.0094
Neurological disease	12 (21.8)	9 (24.3)	3 (16.7)	0.51
Kidney disease	8 (14.6)	6 (18.2)	2 (11.1)	0.061
Malignancy	7 (12.7)	4 (10.8)	3 (16.7)	0.55
Diabetes	6 (10.9)	3 (8.1)	3 (16.7)	0.35
Liver disease	1 (1.8)	1 (2.7)	0 (0)	0.37

Another projects

- Sudden death in general population
- Suicide
- Alcohol addiction
- Long acting antipsychotics injectables
- Mental retardation

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Sudden death

THE AMERICAN JOURNAL OF
FORENSIC MEDICINE
AND PATHOLOGY

< Previous Abstract | Next Abstract >

Sudden Cardiac Death: Autopsy Findings in 7200 Cases Between 2001 and 2015

Ifteni, Petru MD, PhD; Barabas, Barna MD, PhD; Gavris, Claudia MD, PhD; Moga, Marius MD, PhD; Burtea, Victoria MD, PhD; Dracea, Laura MD, PhD

American Journal of Forensic Medicine & Pathology: March 2017 - Volume 38 - Issue 1 - p 49–53
doi: 10.1097/PAF.0000000000000274
Original Articles

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Long acting antipsychotic injectable

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Prevention of Catatonia With Olanzapine Long-Acting Injectable

American Journal of Therapeutics. Publish Ahead of Print():, AUG 2016

Petru-Iulian Ifteni; Andreea Teodorescu

DOI: 10.1097/MJT.0000000000000479

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Suicide

Revista de cercetare și intervenție socială

ISSN: 1583-3410 (print), ISSN: 1584-5397 (electronic)

Selected by coverage in Social Sciences Citation Index, ISI databases

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SOCIOECONOMIC STATUS AND PSYCHOLOGICAL FACTORS INVOLVED IN SUICIDE

Marius MOGA , Victoria BURTEA, Petru IFTENI

Revista de cercetare și intervenție socială, 2014, vol. 45, pp. 230-239

The online version of this article can be found at:

www.rcis.ro, *www.doaj.org* and *www.scopus.com*

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FUTURE RESEARCH DIRECTIONS

Future research directions

- Recovery in schizophrenia
- Prevention of relapses
- Reducing treatment resistant schizophrenia
- Reducing time until LAIs
- Reducing the number of antipsychotic trials until clozapine
- Inflammation theory in schizophrenia- potential treatments

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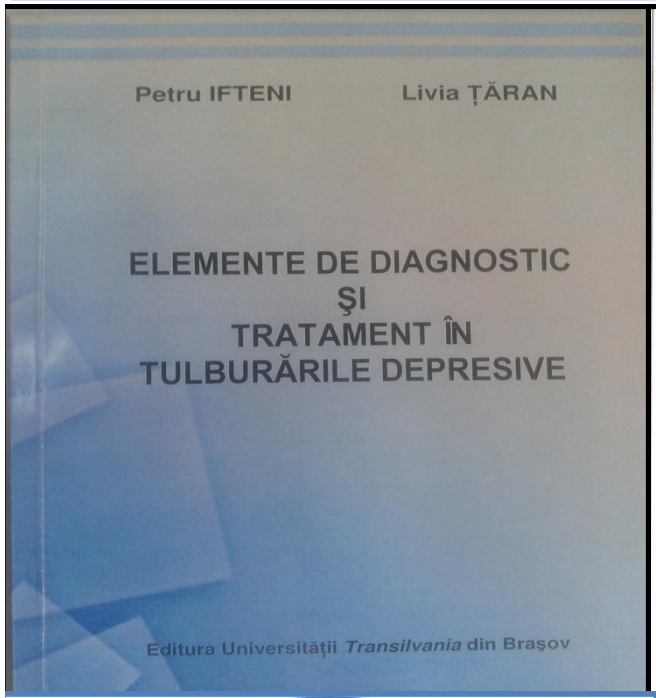
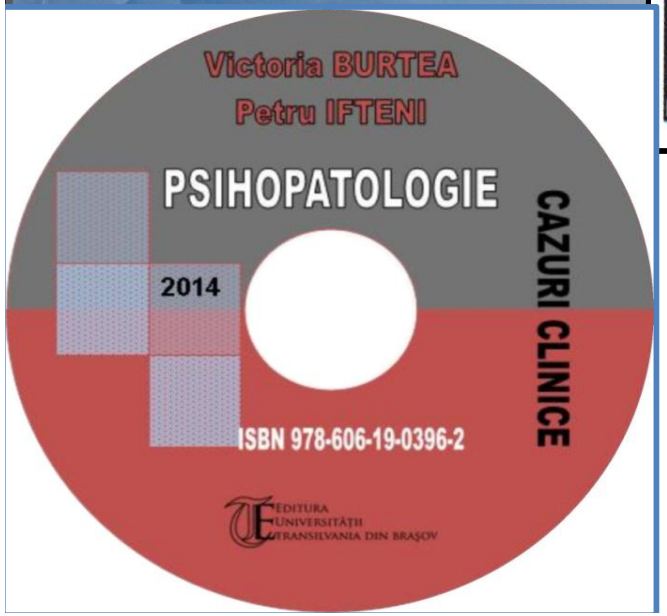
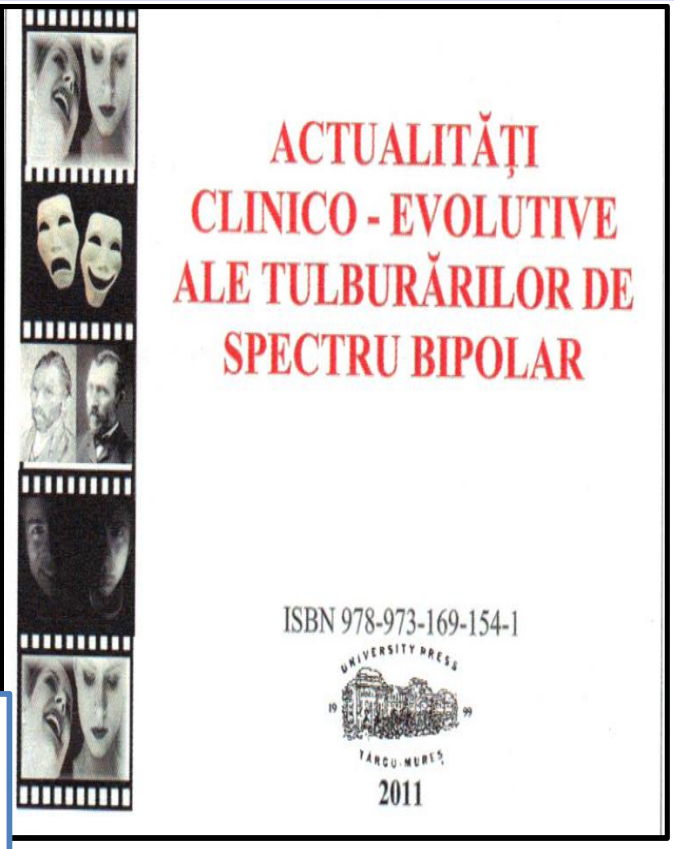
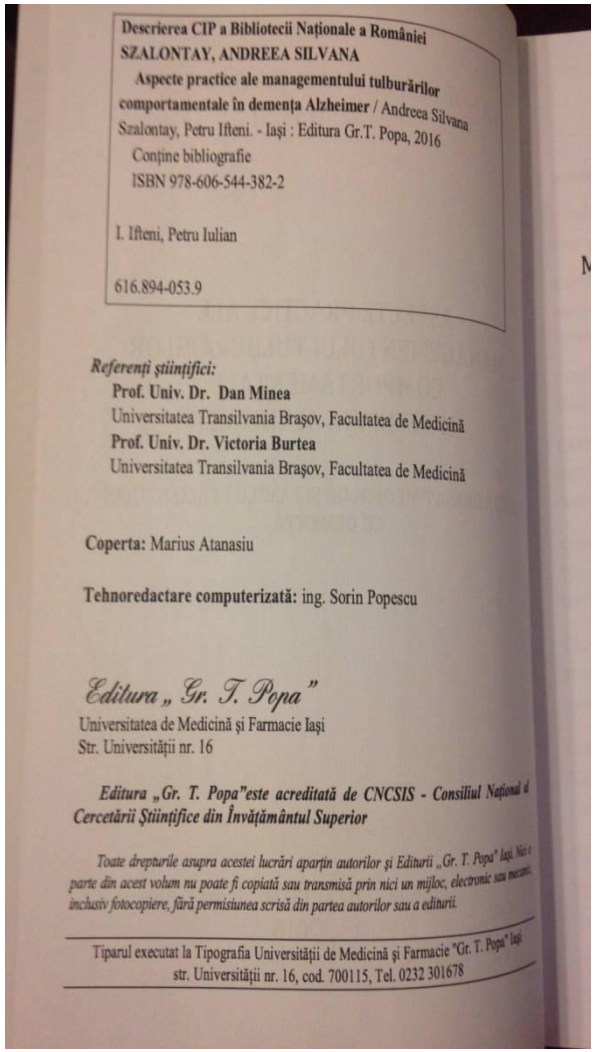
ACADEMIC ACHIEVEMENTS

Books









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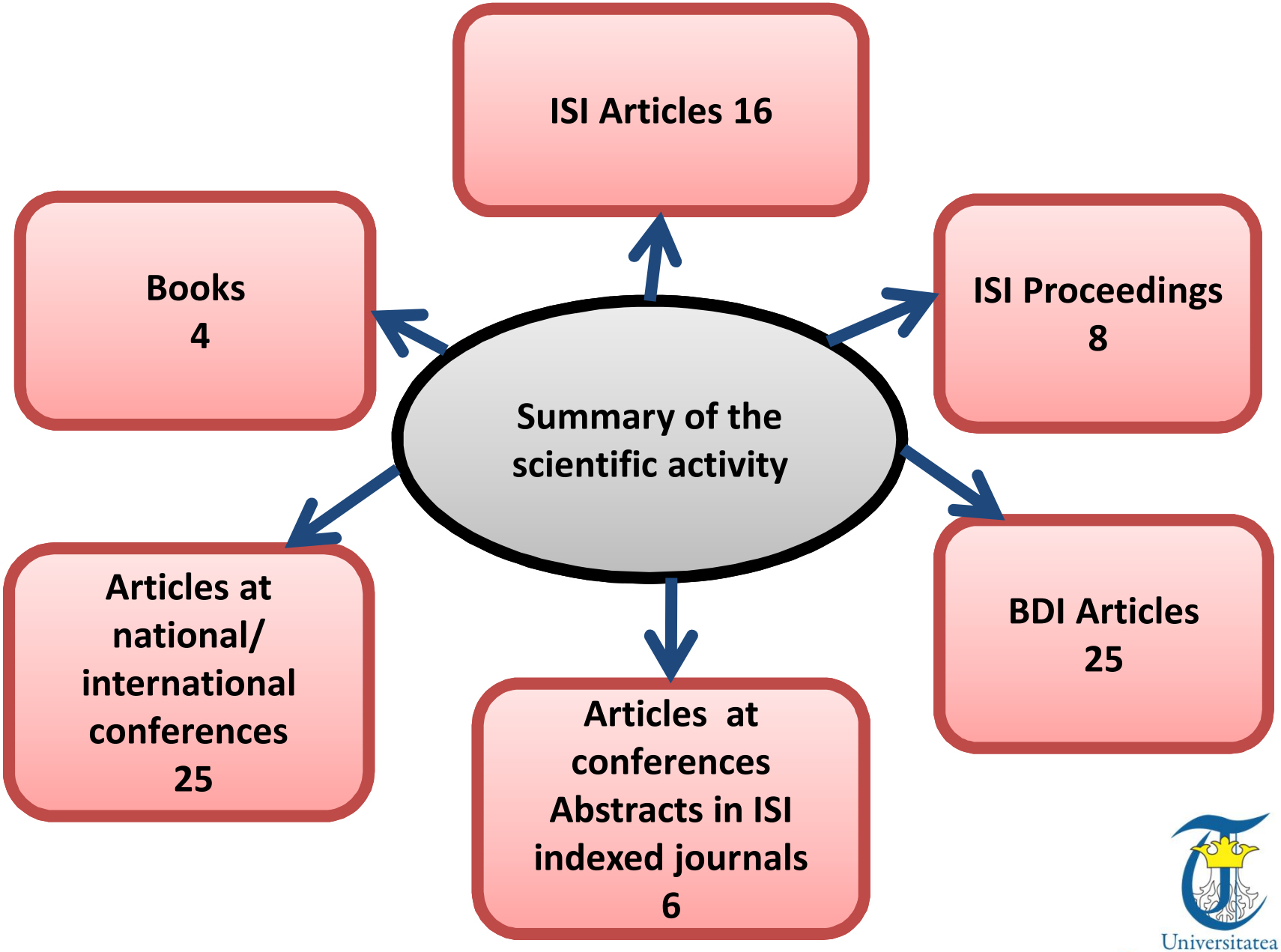
Publications



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Citations

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Petru Ifteni

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Sudden unexpected death in schizophrenia: autopsy findings in psychiatric inpatients P Ifteni, CU Correll, V Burtea, JM Kane, P Manu Schizophrenia research 155 (1), 72-76	27	2014
Rapid clozapine titration in treatment-refractory bipolar disorder P Ifteni, CU Correll, J Nielsen, V Burtea, JM Kane, P Manu Journal of affective disorders 166, 168-172	22	2014
Effectiveness and safety of rapid clozapine titration in schizophrenia P Ifteni, J Nielsen, V Burtea, CU Correll, JM Kane, P Manu Acta Psychiatrica Scandinavica 130 (1), 25-29	20	2014
Worldwide differences in regulations of clozapine use J Nielsen, C Young, P Ifteni, T Kishimoto, YT Xiang, PFJ Schulte, ... CNS drugs 30 (2), 149-161	14	2016

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International conferences
EPA 2012

Poster Acceptance Notification

20th European Congress of Psychiatry

Prague, Czech Republic, 3-6 March 2012

Dear PETRU IFTENI,

We thank you for your interest in the forthcoming 20th European Congress of Psychiatry, organized in Prague, Czech Republic, 3-6 March 2012. On behalf of the Scientific Programme Committee, we are pleased to inform you that your abstract A-426-0043-00615 entitled "**Mood stabilizers and benzodiazepines in patients with schizophrenia treated with antipsychotics**" has been accepted for **POSTER PRESENTATION** at EPA 2012.

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International conferences
EPA 2013

Abstract Presentation Notification
21st European Congress of Psychiatry
Nice, France, 6-9 April 2013

Dear Petru Ifteni,

We thank you for your interest in the forthcoming 21st European Congress of Psychiatry, organized in Nice, France, 6-9 April 2013.

On behalf of the Scientific Programme Committee (SPC), we are pleased to inform you that your abstract A-495-0065-01763 entitled **"EFFECTIVENESS AND SAFETY OF RAPID CLOZAPINE DOSE TITRATION "** has been accepted for **POSTER PRESENTATION** at the EPA2013.

E-POSTERS

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International conferences
EPA 2014

22nd European Congress of Psychiatry (EPA 2014)
Munich, Germany, 1-4 March 2014

Dear Dr Petru Ifteni,

We thank you for your interest in the forthcoming 22nd European Congress of Psychiatry (EPA 2014), organised in Munich, Germany, 1-4 March 2014.

On behalf of the Scientific Programme Committee (SPC), we are pleased to inform you that your abstract entitled **ABUSE OF ALCOHOL IS LINKED WITH YOUNGER AGE OF SUICIDE** has been accepted for **Oral Presentation** at the EPA 2014.

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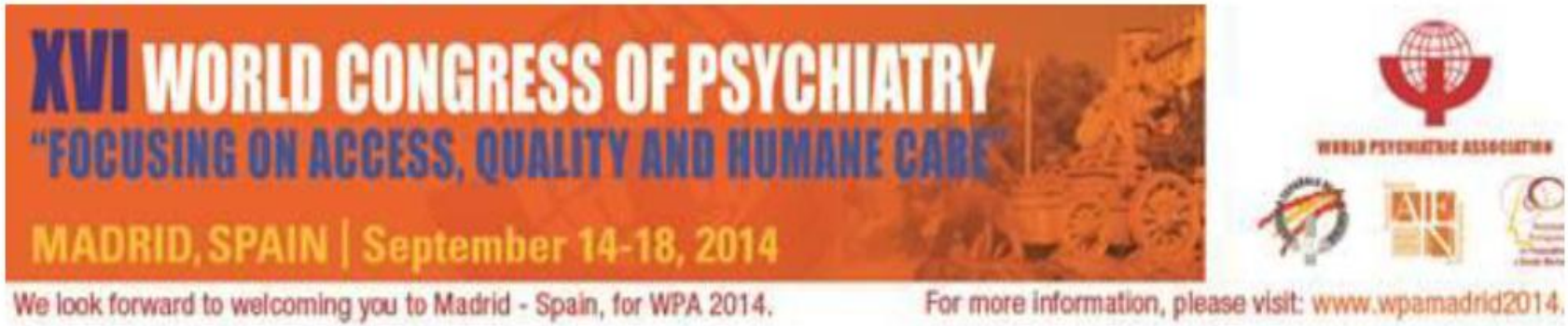
International conferences
WPA 2014



Final Oral Presentation's Details **DATE: 12 August 2014**

Ref: 4384

Dr. Petru Ifteni
Transilvania University, Faculty Of Medicine
BRASOV ROMANIA
petru_ifteni@yahoo.com

Dear Dr. Ifteni,

Please take note of the Final Details regarding your Oral Presentation and please **read carefully** the Instructions attached in this email.

Universitatea *Transilvania* din Braşov

International conferences
EPA 2015

23rd European Congress of Psychiatry (EPA 2015)

Vienna, Austria, 28-31 March 2015

Dear Dr Petru Ifteni,

We thank you for your interest in the forthcoming 23rd European Congress of Psychiatry (EPA 2015), organised in Vienna, Austria, 28-31 March 2015.

On behalf of the Scientific Programme Committee (SPC), we are pleased to inform you that your abstract entitled **Haloperidol use and unexpected death in dementia: autopsy findings in psychiatric inpatients** has been accepted as a **e-Poster** at the EPA 2015. It will be available for viewing during the whole Congress on stations throughout the Congress centre.

Instructions on how to prepare e-posters will be included in the scheduling letter you will receive in the coming weeks.

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International conferences
EPA 2017

LEARN MORE

25th European Congress of Psychiatry (EPA 2017), Florence, Italy, 1-4 April 2017

Dear Associate Prof Petru Ifteni,

On behalf of the Scientific Programme Committee (SPC), we are pleased to inform you that your abstract has been accepted for the EPA 2017. Your poster will be available for viewing during the whole Congress on stations throughout the Congress centre.

Abstract Title: Switching Bipolar Disorder Patients Treated With Clozapine to Another Antipsychotic Medication: a Mirror Image Study

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Projects

National Grants
Director: **1**
Member:**4**

International Grants
Member:**2**

Programul/ Proiectul	Funcţia	Perioada	Valoare
1.Studiu asupra sigurantei si eficacitatii titrarii rapide a clozapinei in schizofrenie, PN-II-RU-TE-2014-4-0596 – **Director de proiect** (in proces de evaluare).	Director	2015-2017	500000 lei
2. Impactul activitatilor recreative din siturile Natura 2000 de pe teritoriul judetului Brasov asupra persoanelor cu grad ridicat de stres de pe piata muncii din judetul Brasov, proiect cu terti, valoare 10000 EUR - **Director de proiect**.	Director	2015	10000 Euro
3. Enhancing patients acces to medical services: the development of Unique Centers of Patients Programming-UCPP, supported by CNCS-UEFISCDI project number PN-II-IDEI/WE017/2011-membru.	Membru	2011-2013	

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Projects

National Trials

Primary investigator: **3**

International Trials

Primary investigator : **7**

Investigator:**15**

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Membership in the Scientific Committee at scientific events

Simpozionul National de Psihiatrie ,,Zilele dialogului social – Socola Iasi 2016”

Iasi

Al IX-lea simpozion National de Psihiatrie, Miercurea Ciuc, 2016

Miercurea Ciuc

New Trends on Sensing-Monitoring telediagnosis for Life Science

2016

Brașov

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Membership in Journal's Review board

Publicații românești

- *Bulletin of the Transilvania University of Braşov.*
- *Jurnal Medical Brașovean*

Publicații internaționale

- *BMC Psychiatry*
- *International Journal of Mental Health systems*

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SCIENTIFIC, PROFESSIONAL AND ACADEMIC FURTHER DEVELOPEMENT PLANS

Development directions for the professional career

- Teaching activity
- Research activity
- Academic activity
- Student activity
- Academic and professional structures activity

Life long learning

Doctoral field

- **Coordination and monitoring of future research of doctoral students**

Cooperations

- Collaborations with national and international universities
- Involvement in international and national programs and projects

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Improve the professional visibility

In the scientific comitee of national and international conferences

Editorial and scientific boards of ISI journals

In the professional structures

International scientific structures

As keynote speaker and moderator

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Development directions for the scientific activity

Research

- **Participation in national and international grants**
- **Participation in national and international conferences, networking**
- **Continuing the ongoing researches and developing new ones**

Publishing

- **Books, book chapters**
- **Articles in journals indexed in ISI Thomson Reuters DB and BDI with high index of visibility**
- **Articles published in conference proceedings**

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Development directions for teaching activity

Modern and attractive teaching classes
Keeping up-to-date
Encouraging research activity among students
Teaching in English - for foreign students and students visiting our University through ERASMUS or other types of mobilities
Organizing and participating to post-graduate training programs dedicated to physicians and to medical personnel

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Multumesc!