# TOP TEN TREATMENT UPDATES

## FROM THE PAST YEAR

**CHRIS AIKEN MD, April 2026**

Editor-in-chief, Carlat Report | Director, Psych Partners | Assit. Prof., NYU School of Med

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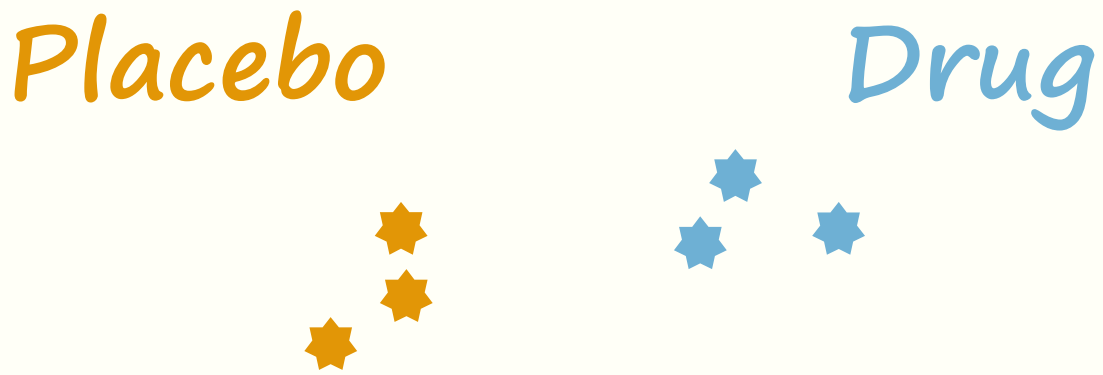
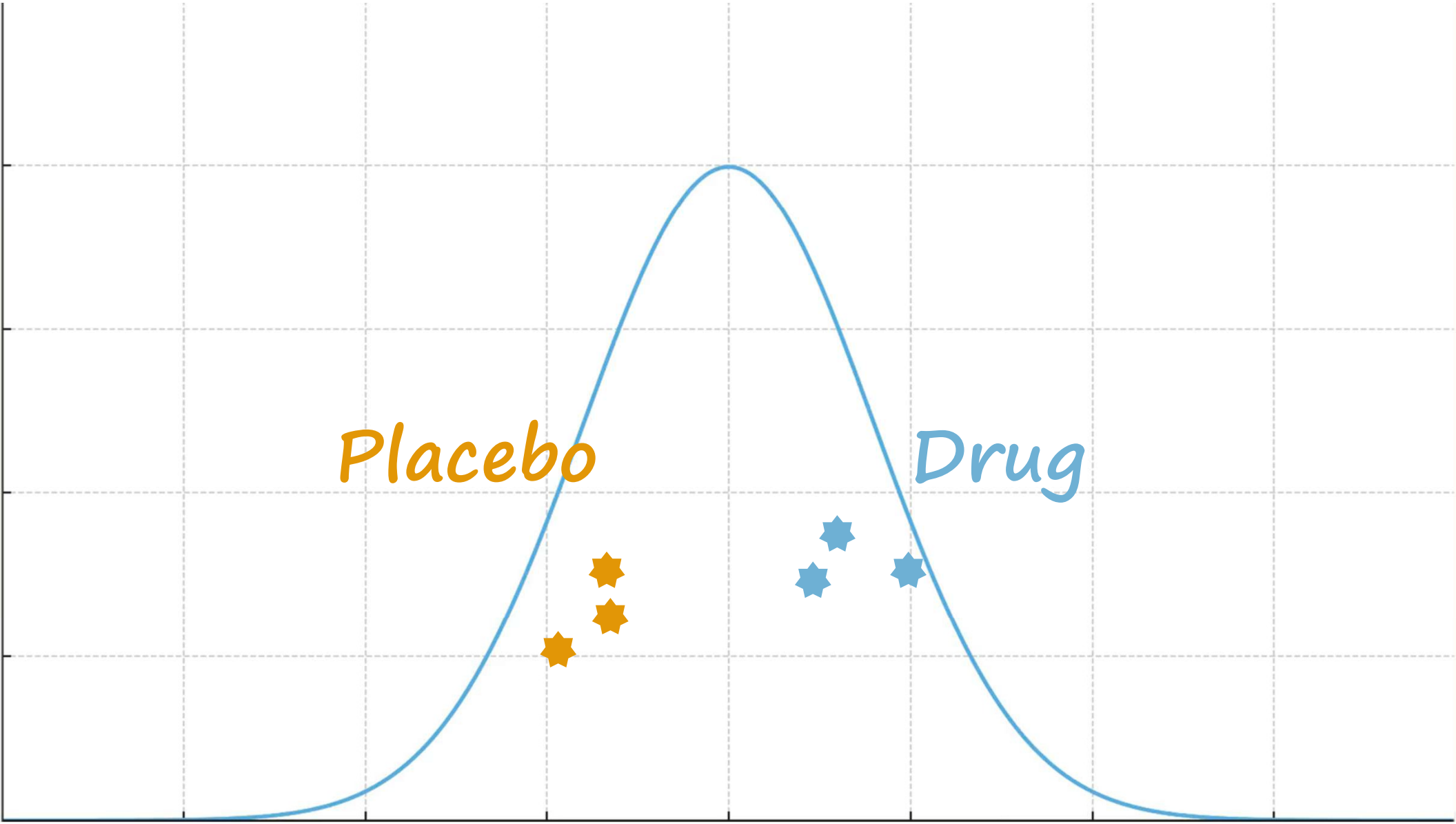

Placebo
Drug


Placebo
Drug

**Placebo controlled?**

**Double blind?**

**Size** (100-300)**?**

**Drop out rate** (<20%)**? Intent to treat?**

***Primary outcome* positive?**

**Other:** Enriched sample, randomization not concealed, cross-over trial

**Effect size** (average = 0.3-0.5) **or NNT?** (average = 5-10)

(Effect size: buspirone 0.2, SSRIs 0.3-0.4, benzos 0.5, amphetamine 0.9)

**Replicated?**

**Backed by basic science?**

## Randomized Placebo-Controlled Adjunctive Study of an Extract of *Withania somnifera* for Cognitive Dysfunction in Bipolar Disorder

JCP

***Method:*** Sixty euthymic subjects with *DSM-IV* bipolar disorder were enrolled in an 8-week, double-blind, placebo-controlled, randomized study of WSE (500 mg/d) as a procognitive agent added adjunctively to the medications being used as maintenance treatment for bipolar disorder. Study enrollment and data analyses were completed between December 2008 and September 2012. Cognitive testing at baseline and 8 weeks assessed primary efficacy outcomes. Psychopathology and adverse events were monitored at scheduled visits.

***Results:*** Fifty-three patients completed the study (WSE, n = 24; placebo, n = 29), and the 2 groups were matched in terms of demographic, illness, and treatment characteristics. Compared to placebo, WSE provided significant benefits for 3 cognitive tasks: digit span backward ($P = .035$), Flanker neutral response time ($P = .033$), and the social cognition response rating of the Penn Emotional Acuity Test ($P = .045$). The size of the WSE treatment effect for digit span backward was in the medium range (Cohen $d = 0.51$; 95% CI, 0.25–0.77). None of the other cognitive tasks showed significant between-group differences. Mood and anxiety scale scores remained stable, and adverse events were minor.

- ✔ Placebo control
- ✔ Double blind
- ✔ Effect size = medium
- ✔ Replicated (in healthy subjects)
- ✔ Backed by basic science

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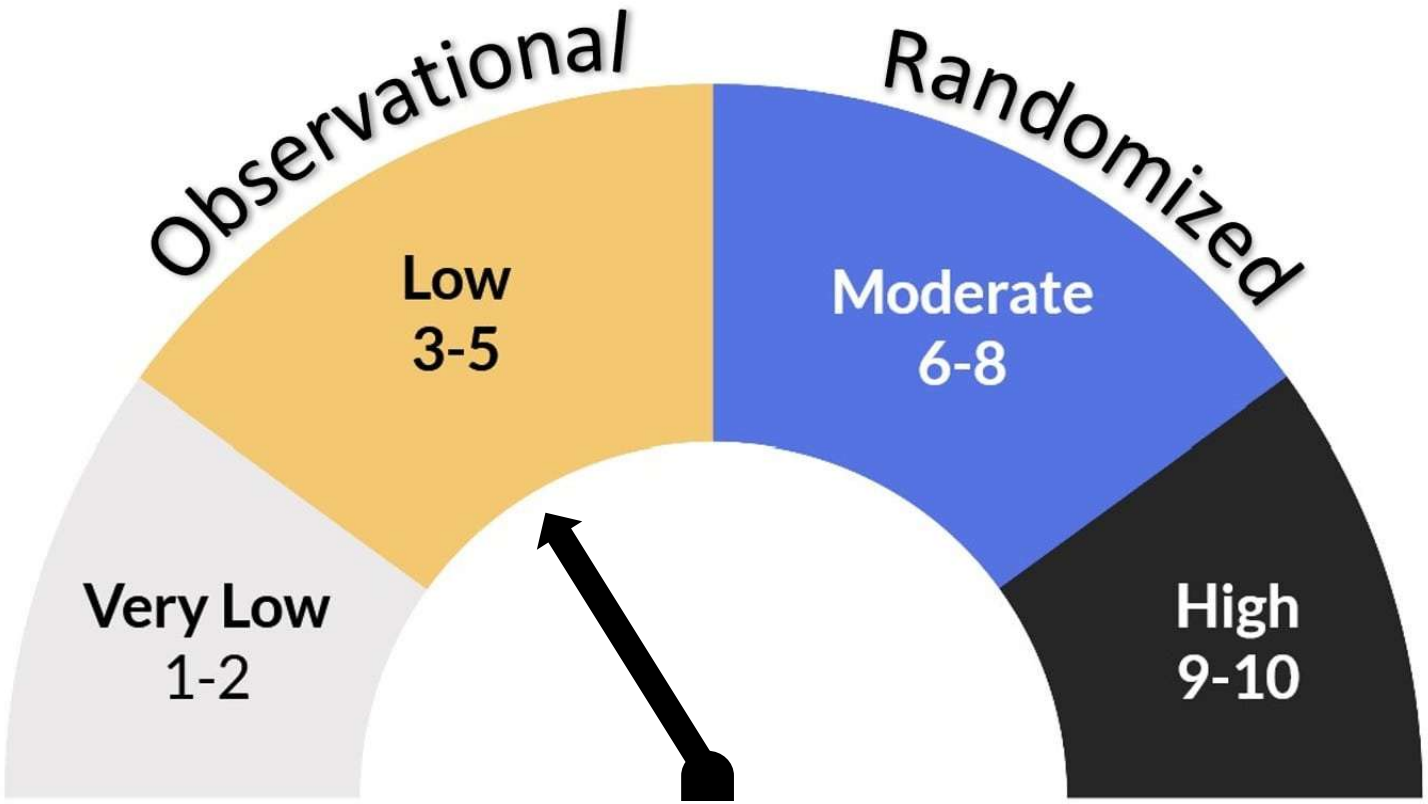
- ✔ Placebo control
- ✔ Double blind
- ✗ Size (60)
- ✗ Drop outs unaccounted (12%)
- ✗ Primary outcome not positive

Bonferroni: divide p cut-off by tests: 0.05/6 = 0.0083

- ✔ Effect size = medium
- ✔ Replicated (in healthy subjects)
- ✔ Backed by basic science




**chrisaikenmd.com/ebm**

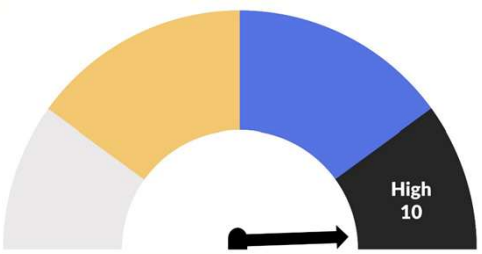

PRACTICE
CHANGING

1

# eCOT-AS in Mild TRD

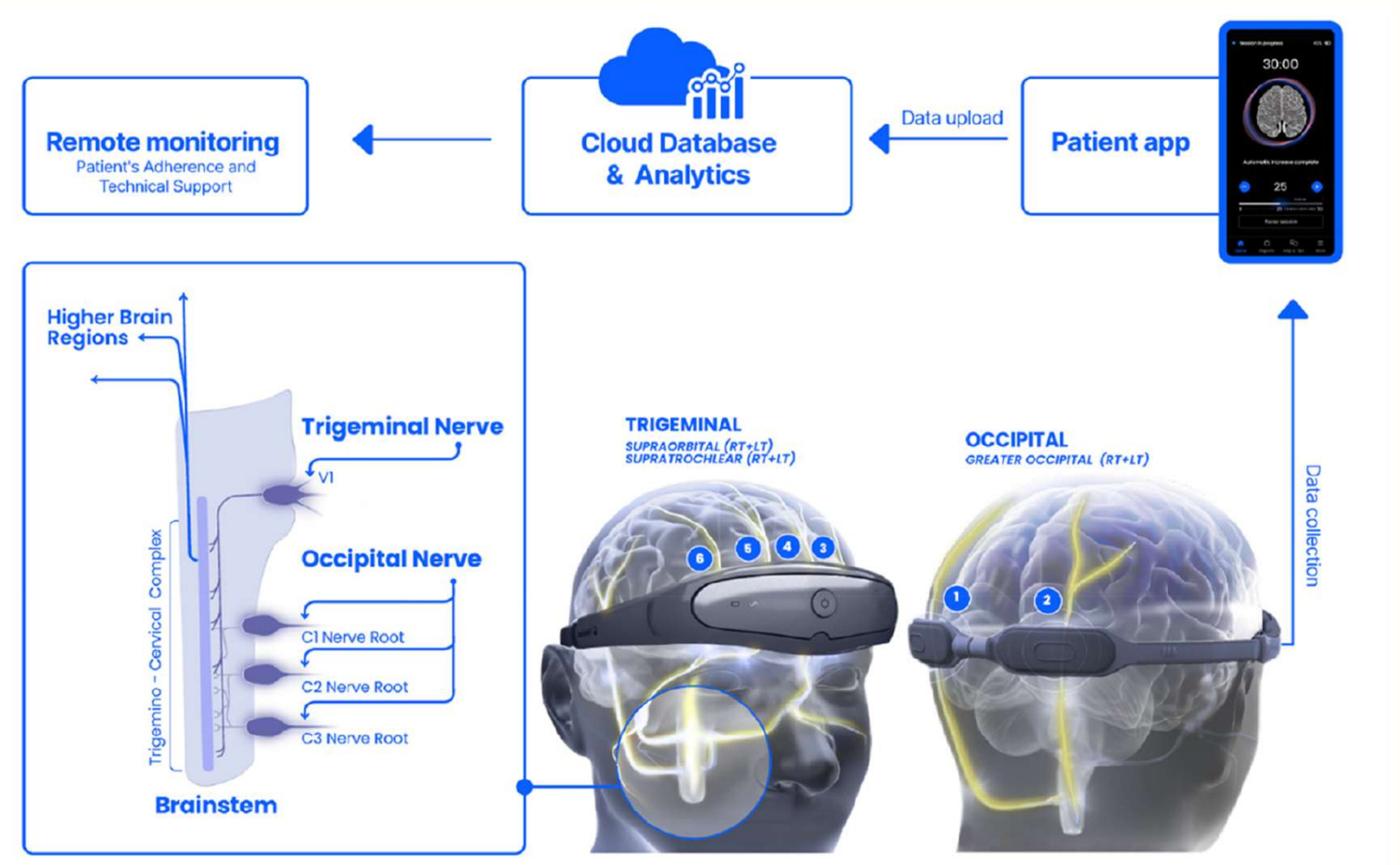
Stimulating cranial nerves at home treated depression after ≥ 1 antidepressant failure

| eCOT-AS (ProLivRx) in Mild TRD | |
|---|---|
| **Design** | Randomized double-blind sham-controlled trial |
| **Size** | 124 |
| **Population** | Adult MDD, failed ≥ 1 antidepressant trials (avg 1.8) |
| **Intervention** | external Combined Occipital and Trigeminal Afferent Stimulation 40 minutes BID |
| **Duration** | 8 weeks RCT, another 8 weeks open label |
| **Primary outcome** | Change in HDRS17 at 8 weeks |
| **Result** | Positive with large effect size (0.7-0.9) |
| **Limitations** | Excluded ≥ 1 antidepressant failures |
| **Risks** | None |
| **Funding** | Industry (Neurolief) |

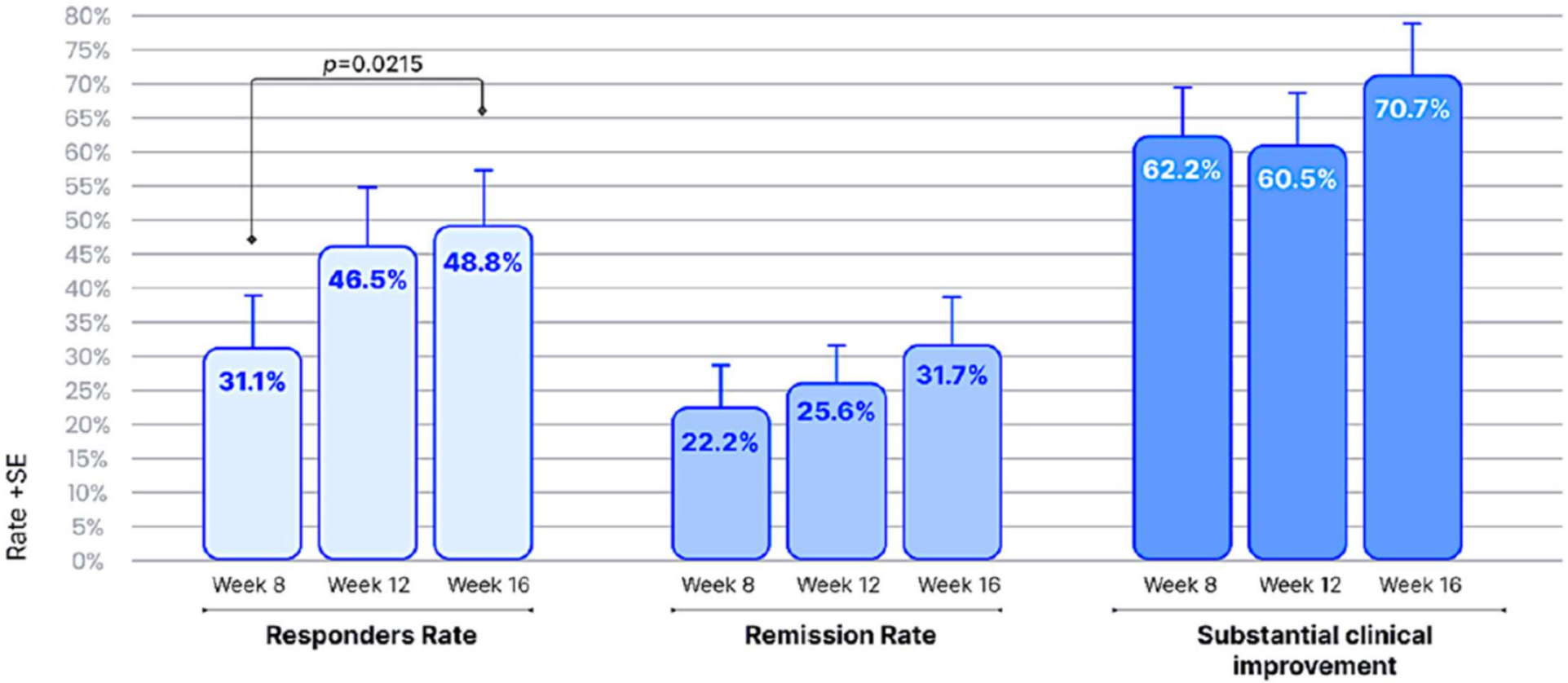



Carpenter LL et al, Brain Stimul 2025;18(5):1695-1704.

# eCOT-AS (ProLivRx) modulates cranial nerves



# eCOT-AS (ProLivRx) over 8-16 weeks

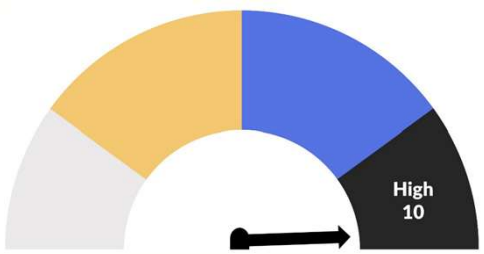


2

# Saffron in Subclinical Depression

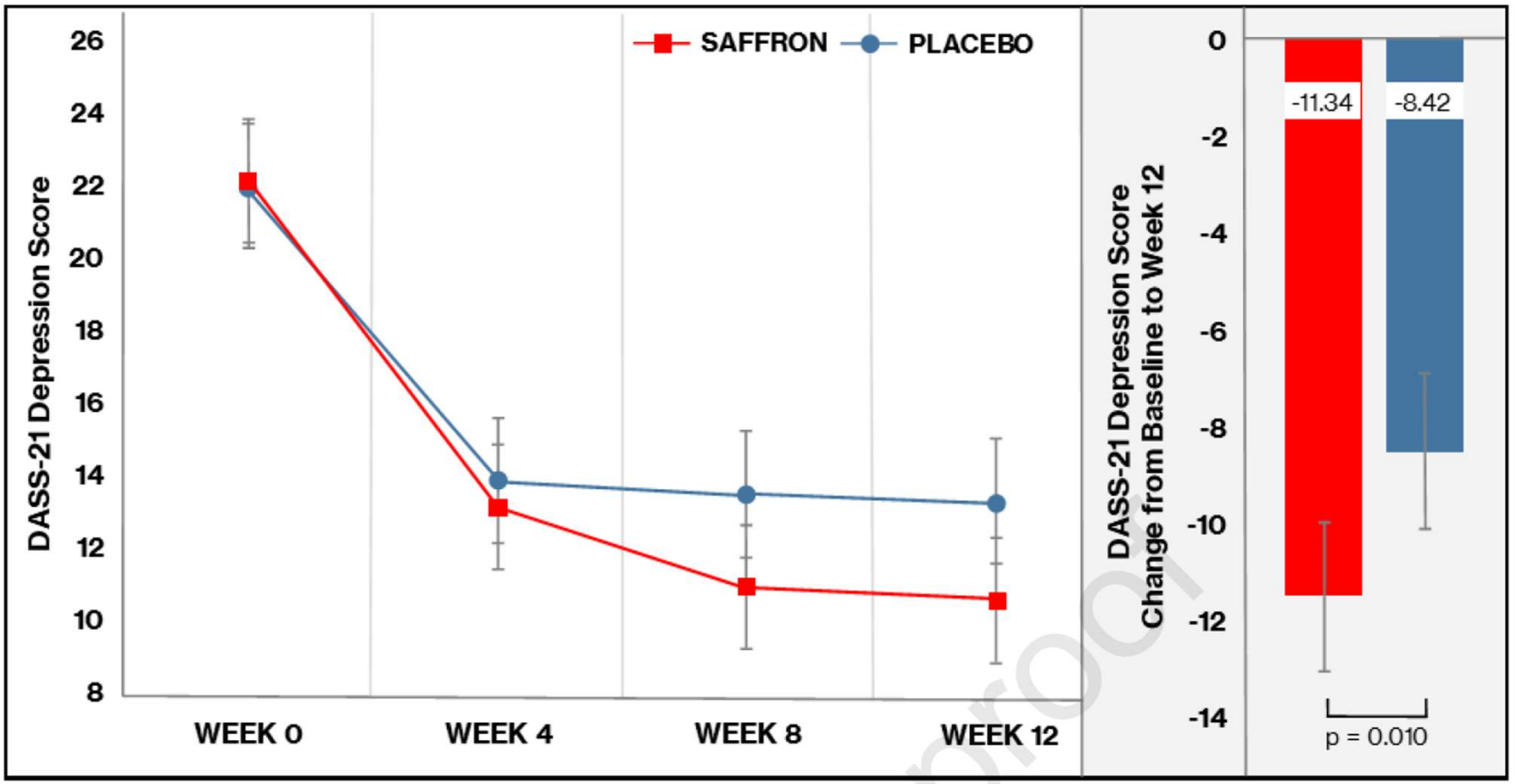
Low-cost herb effective in its largest trial to date

| Saffron in Subclinical Depression | |
|---|---|
| **Design** | Randomized double-blind controlled trial |
| **Size** | 202 healthy adults with depressive symptoms (not in full episode) |
| **Intervention** | Saffron extract 28 mg (Affron brand) |
| **Duration** | 12 weeks |
| **Primary outcome** | Self-report DASS-21 (mix of depressive/stressed symptoms)<br>Blind intact (participants could not tell) |
| **Result** | Significant improvement (effect size 0.4) |
| **Limitations** | High placebo response in first month<br>Secondary outcomes negative (except insomnia) |
| **Funding** | Industry (Pharmactive Biotech Products) |




Lopresti AL et al. An Examination into the Effects of a Saffron Extract (Affron) on Mood and General Wellbeing in Adults Experiencing Low Mood: A Randomized, Double-Blind, Placebo-Controlled Trial. J Nutr. 2025:S0022-3166(25)00306-2.

# Saffron in Subclinical Depression



# 800 BCE: Persia

Saffron used for melancholy

Antioxidant
Anti-inflammatory
Increases melatonin

*Modulates:*
Stress hormones (HPA-axis)
Dopamine
Glutamate
Opioid

# Saffron

## Randomized trials in psychiatry

- Depression (mild-moderate): 22 RCTs involving 1,620 subjects
- Including adolescents (12-18) and elderly
- Deepens sleep quality in large placebo RCTs
- Improves sexual function in men and women in small trials

- OCD: 2 small trials compared to SSRIs
- ADHD: 2 small trials compared to methylphenidate
- Opioid Use Disorder: 1 small trial (augmented MAT)

Dold M et al, Eur Arch Psychiatry Clin Neurosci. 2023;273(7):1615-1628



# Affron
# Proprietary extract

chrisaikenmd.com/supplements

3

# Pramipexole in Treatment Resistant Depression

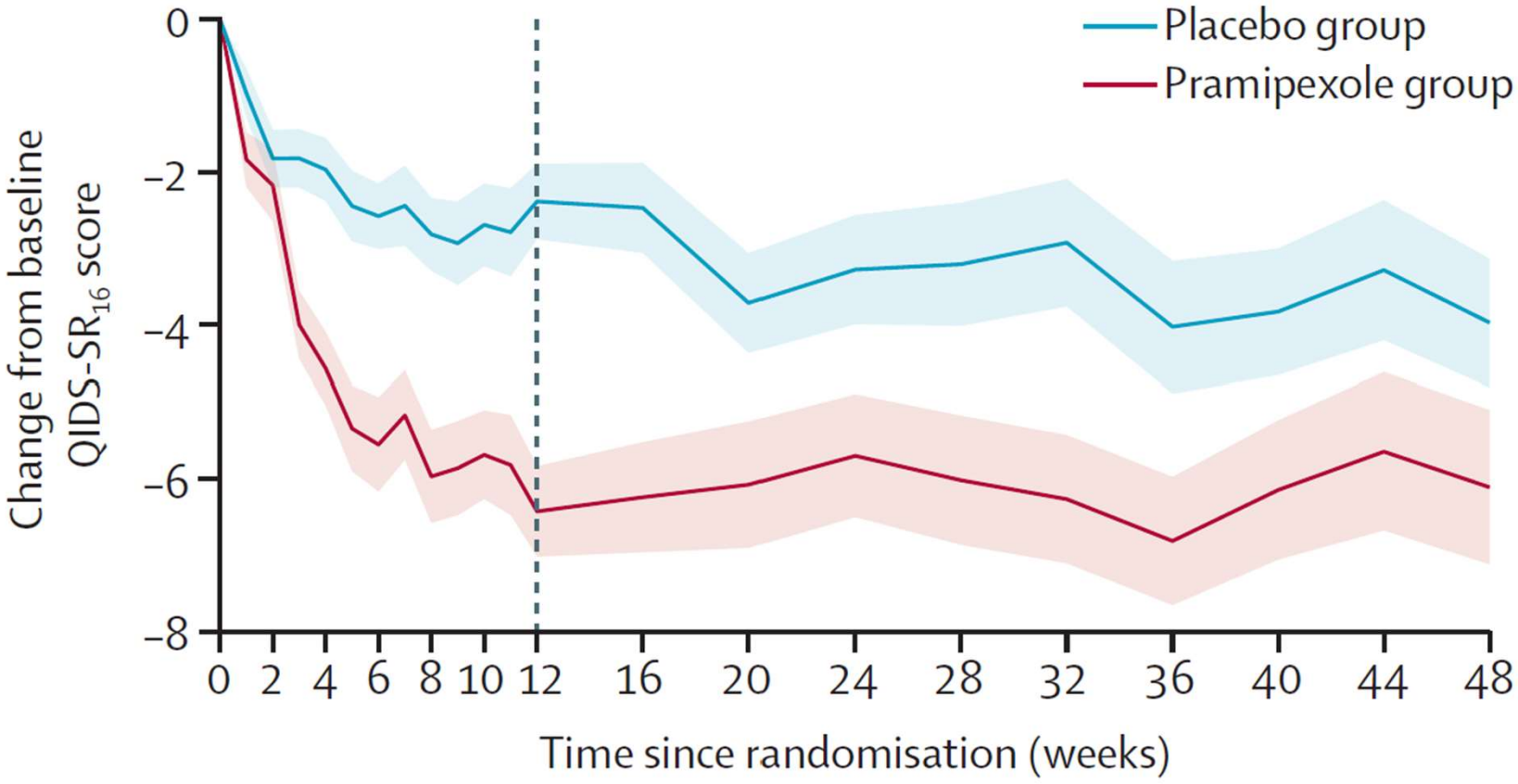
Large effect size sustained over 48 weeks for this dopaminergic D3-selective agonist

| Pramipexole Augmentation in TRD | |
|---|---|
| **Design** | Randomized double-blind placebo-controlled trial |
| **Size** | 150 |
| **Population** | Adult MDD, failed ≥ 2 antidepressant trials (avg 3.5)<br>21% failed augmentation strategies |
| **Intervention** | Pramipexole 2.5 mg target (avg 2.3 mg)<br>(start 0.25 mg qhs, raise by 0.25 q3 days) |
| **Duration** | 48 weeks |
| **Primary outcome** | Change in QIDS at 12 weeks |
| **Result** | Positive on all measures, large effect size (0.87) at 12 weeks |
| **Limitations** | Unblinding (70-77% correct guess) |
| **Risks** | Higher dropout due to AEs (20% vs 5%)<br>Somnolence (16%), nausea (26%), orthostasis, impulsivity (3%), psychosis (1%) |
| **Funding** | UK government (NIHR) |


Functional unblinding

Browning M et al, Pramipexole augmentation for the acute phase of treatment-resistant, unipolar depression: a placebo-controlled, double-blind, randomised trial in the UK. Lancet Psychiatry, 2025.

# Pramipexole Augmentation in TRD



# Pramipexole

Target 1-3 mg hs (average 1.5)

Start 0.125-0.25 mg,
raise by 0.125-0.25mg q3-7 days,
raise faster after 0.75 mg

**Large effect in RCTs of unipolar (4) and bipolar (2) depression**

**Prefer for anhedonia, inflammation, bipolar spectrum, comorbid restless leg syndrome**

**Tolerability**
Nausea, sedation
No weight/sexual/cognitive

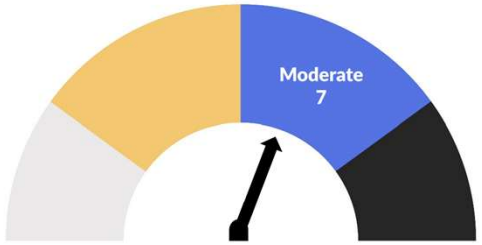
**Risks**
Hedonic dysregulation (approx. 1-3%)
Hallucinations (rare at dose < 2 mg)
Hypotension

# 4 Psychodynamic Therapy in Depression

Brief Dynamic Interpersonal Therapy is comparable to CBT but with more lasting effects

## Dynamic Interpersonal Therapy in Depression

| | |
|---|---|
| **Design** | Randomized unblinded comparator trial (no placebo) |
| **Size** | 240 adults with moderate MDD, in Iran<br>(94% retention at 12 mth) |
| **Intervention** | 16 weeks of<br>• Dynamic Interpersonal Therapy (DIT)<br>• CBT<br>• Antidepressant |
| **Duration** | 16 weeks treatment, 12 months follow-up |
| **Primary outcome** | HAM-D 17 (therapist rated) |
| **Result** | All equal at 16 weeks, but DIT more sustained at 12 months<br>DIT also superior at 12 mth on secondary measures of<br>• Sleep quality<br>• Cognition (Stroop test) |
| **Funding** | None |

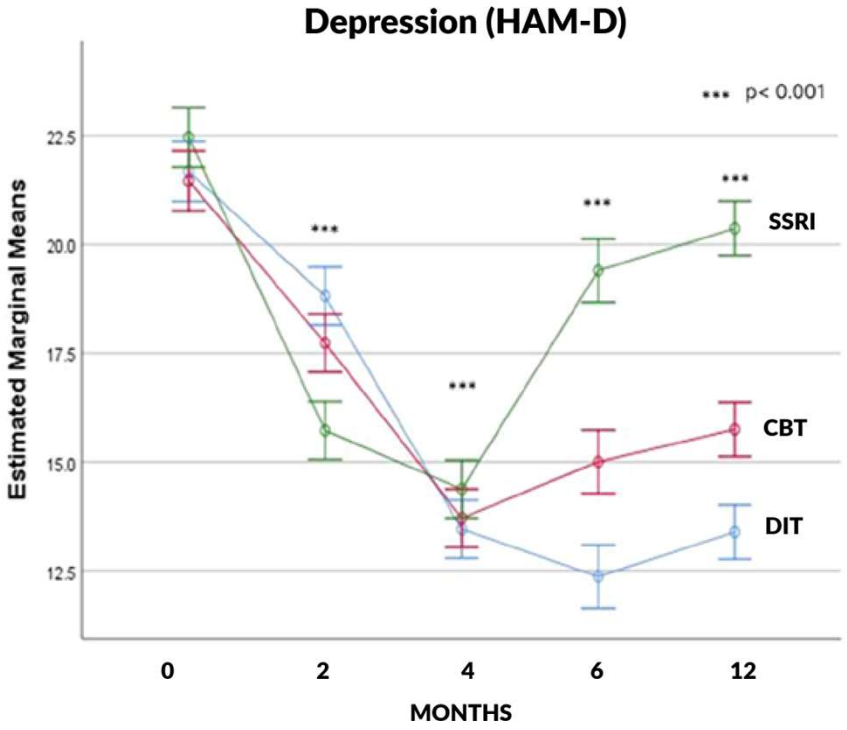


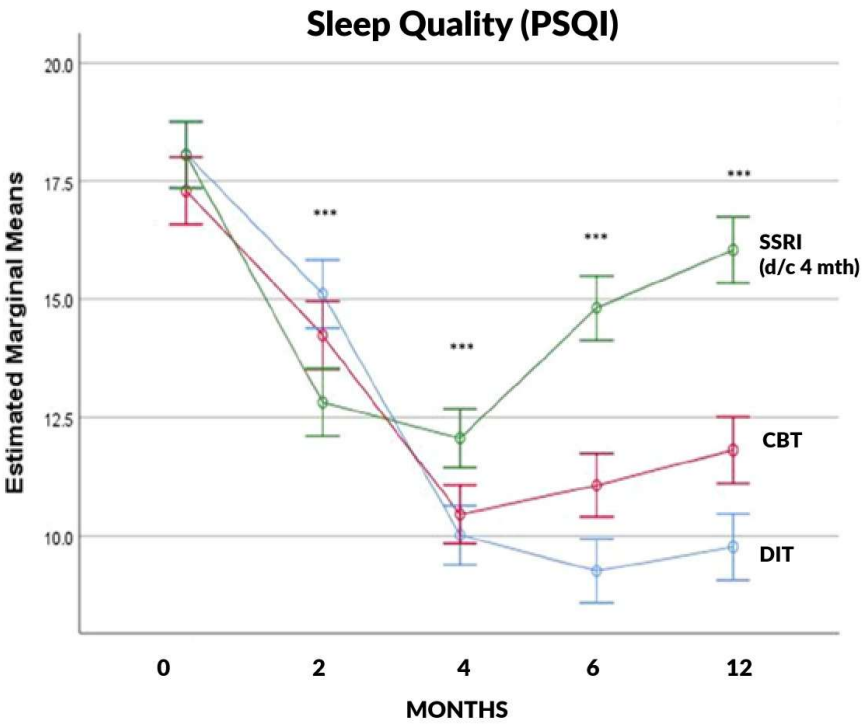

No placebo

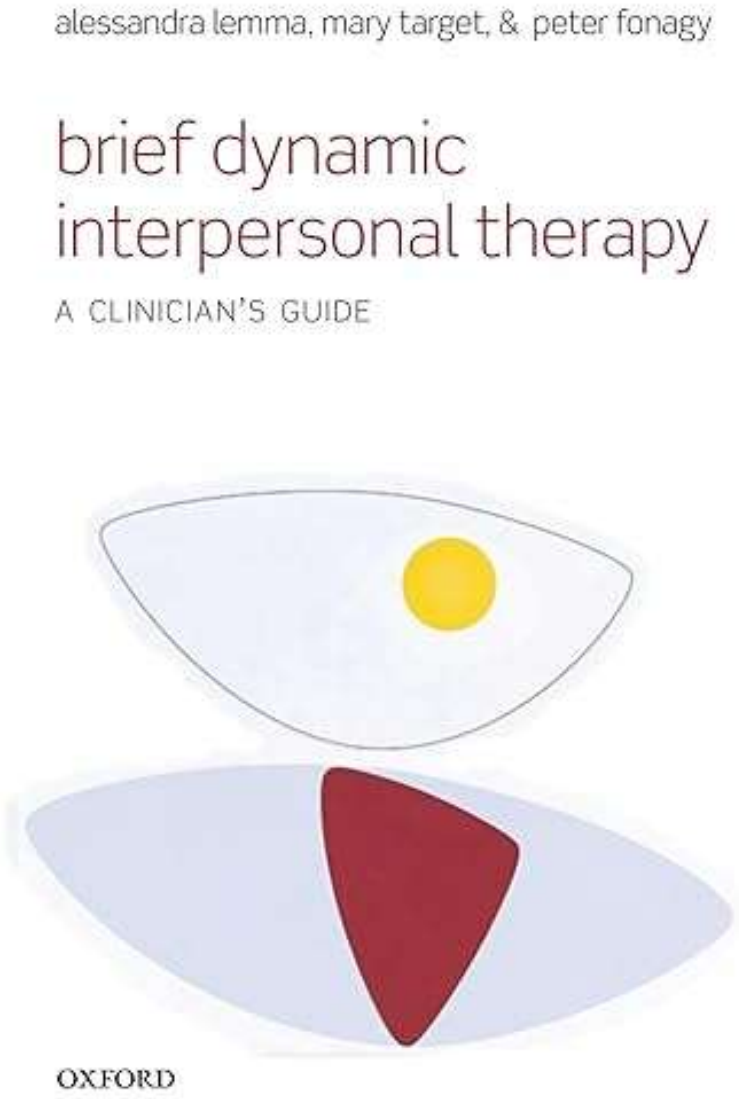
No blinding

Yari-Renani H, Zare T. Advancing depression treatment: a multi-center randomized controlled trial of dynamic interpersonal therapy versus CBT and pharmacotherapy on symptoms, sleep, and cognition. Psychiatry Res. 2025;354:116775.

# DIT vs CBT vs Antidepressant






*Focus on*

1. Attachment
2. Relationship patterns
3. Transference
4. Resistance
5. Mentalization

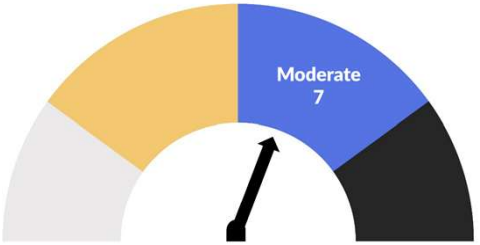
5

# GLP-1 Agonists in Alcohol Use

A mix of positive and negative data challenges the hype

## Semaglutide in Alcohol Use Disorder

| | |
|---|---|
| **Design** | Randomized double-blind, placebo controlled trial |
| **Size** | 48 with moderate alcohol use disorder, mean BMI 32 |
| **Intervention** | Semaglutide<br>(0.25 mg/wk x4 wks, 0.5 mg/wk x4 wks, then 1mg/wk) |
| **Duration** | 9 weeks |
| **Primary outcome** | Alcohol self-administration in lab<br>(they could earn money to delay time to drinking) |
| **Result** | Reduction in<br>• Alcohol use in lab (medium to large effect size)<br>• Drinks per day, heavy drinking days, cravings<br>• Cigarettes<br>• Not in average drinks per day or number of drinking days |
| **Funding** | Government (National Institute on Alcohol Abuse and Alcoholism) |



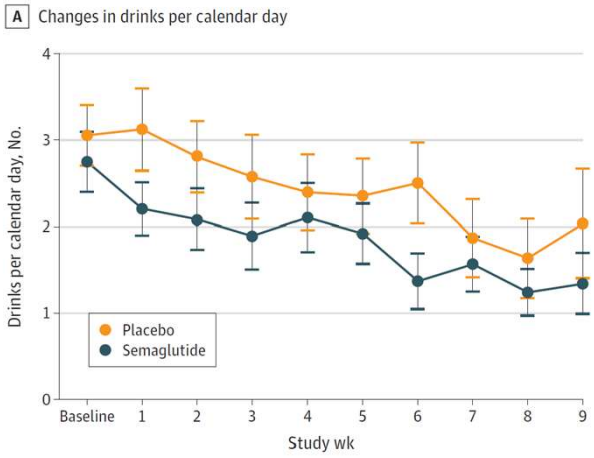

Small Sample

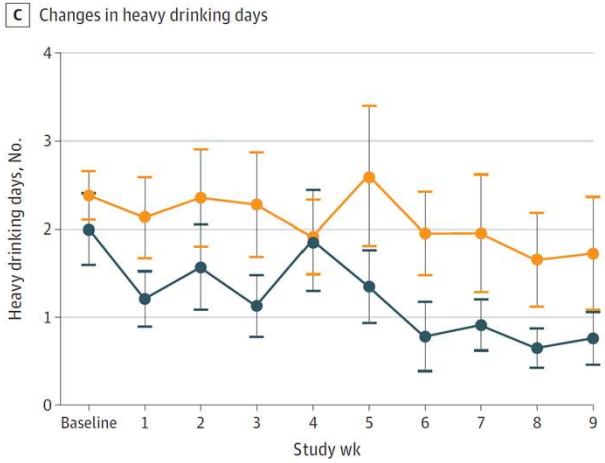
Not treatment-seeking

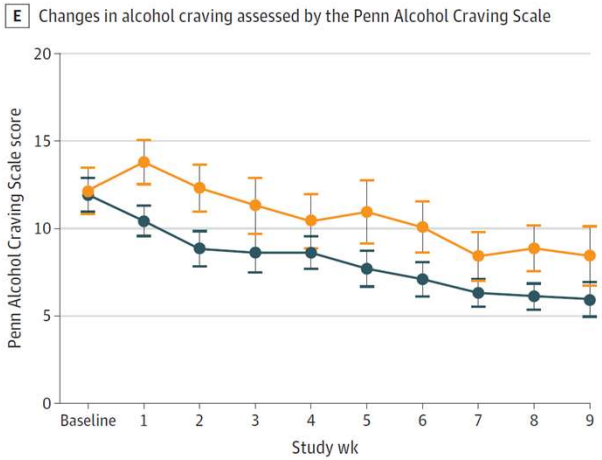
Not real-world outcome

Hendershot CS et al, Once-Weekly Semaglutide in Adults With Alcohol Use Disorder: A Randomized Clinical Trial. JAMA Psychiatry. 2025;82(4):395-405.

# Semaglutide in Alcohol Use Disorder? Maybe

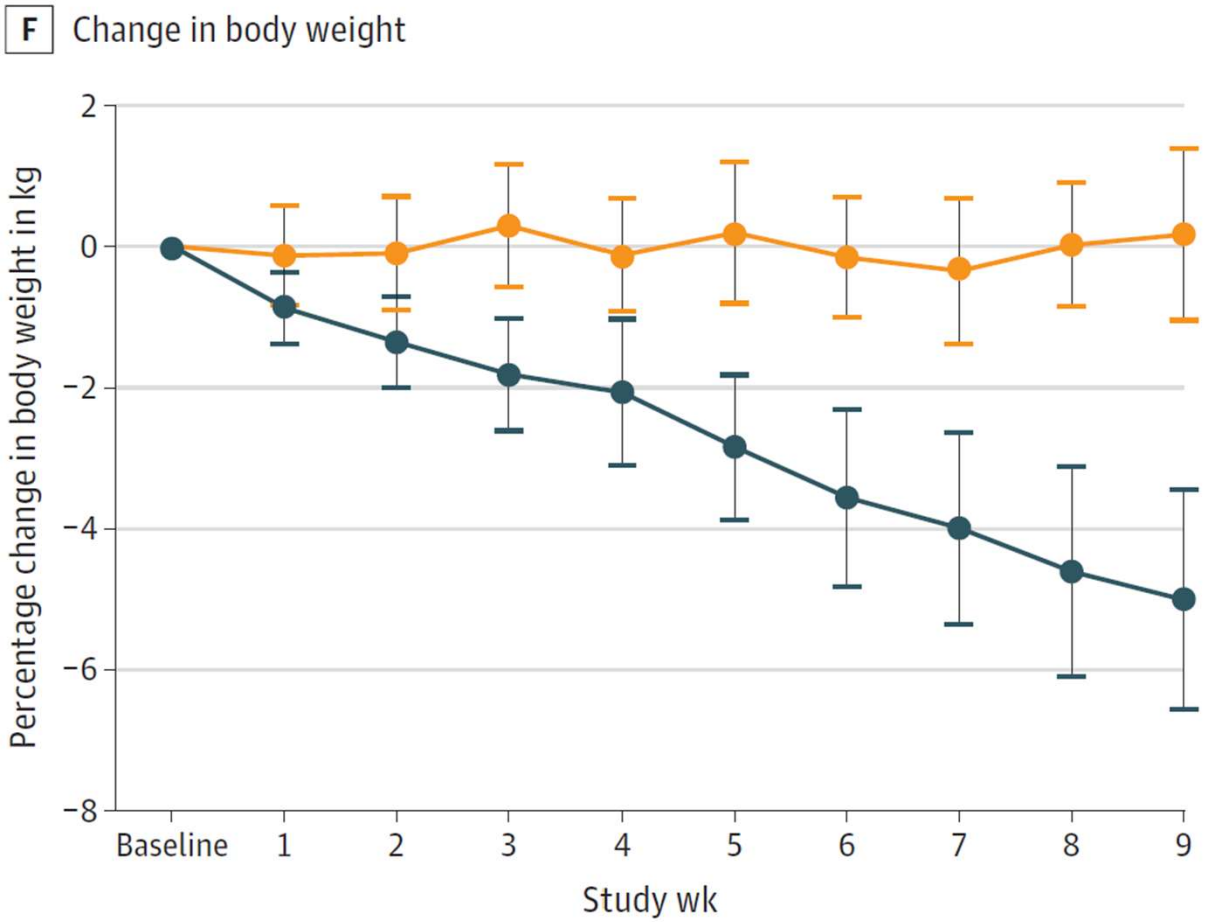



(3 out of 5 of real-world outcomes positive)

# Semaglutide in Weight Loss? Definitely



# GLP-1 Score Card in Alcohol Use Disorder

| Outcome | Med | Grade |
|---|---|---|
| **Negative** | Exenatide | Moderate 8/10 |
| **Positive** | Semaglutide | Moderate 7/10 |
| **Positive** | Dulaglutide | Low 5/10 (secondary smoking trial) |

Klausen MK et al, JCI Insight 2022;7(19):e159863
Probst L et al, JCI Insight 2023;8(22):e170419

6

# Lithium-GLP1 Interaction

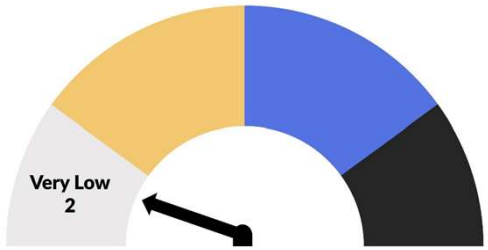
Levels can double with GLP-1s, particularly semaglutide, though unclear how often and who is at risk

**Lithium-Semaglutide Interaction**

| Age | Risk Factors for Toxicity | Weeks to toxicity | Li Level | Cr |
|---|---|---|---|---|
| 41 F | Stage II CKD | 1 | 0.9 → 2.4 | 0.9 → 1.1 |
| 63 M | Stage III CKD, DM, proteinuria | 2 | 0.9 → 1.8 | 1.6 → 1.3 |
| 59 M | 10 lb weight loss | 6 | ? → 2.6 | ? → 2.0 |
| 62 M | Stage IIIa CKD, DM, HTN, proteinuria | 2-3 | 1.0 → 1.8 | 1.4 → 1.3 |
| 23 F | Vomiting | "recently" | ? → 2.1 | ? → 1.1 |
| 22 M | None (lithium lowered 2100 → 1200 mg while starting semaglutide). | n/a | 1.1 → 0.8 | 1.1 → 1.8 |

All GLP-1's used for obesity.

One case of toxicity with tirzepatide on Reddit, and *in press* of toxicity after switching from semaglutide to tirzepatide.




Al-Soleiti M et al, J Clin Psychopharmacol. 2025;45(6):613-618; Arriola-Montenegro J et al, J Am Soc Neph, 2025;36(10S); Onggo S et al, J Clin Psychopharmacol 2025;45(4):393-395

# When to use GLP-1's for antipsychotic weight

| BMI cut off | Population |
|---|---|
| 30 | Any patient (FDA indicated) |
| 27.5 | South Asian, Chinese, other Asian, Middle Eastern, Hispanic, Black African, or African-Caribbean descent |
| 27 | At least one component of metabolic syndrome: Hypertension, dyslipidemia, excess abdominal fat (waist circumference > 102 cm in men or > 88 cm in women), diabetes or borderline diabetes) |
| 24.5 | Ethnic background as above with at least one component of metabolic syndrome |

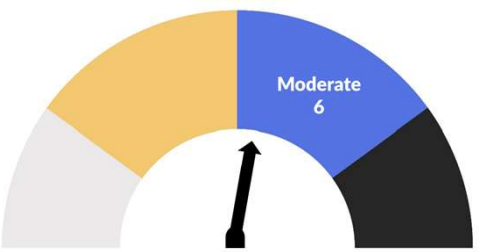
McCutcheon RA, Pillinger T, Varvari I, et al. INTEGRATE: international guidelines for the algorithmic treatment of schizophrenia. Lancet Psychiatry. 2025;12(5):384-394.

7

# TRD: Quetiapine vs Lithium

**The antipsychotic took the lead in a one year trial of Treatment Resistant Depression**

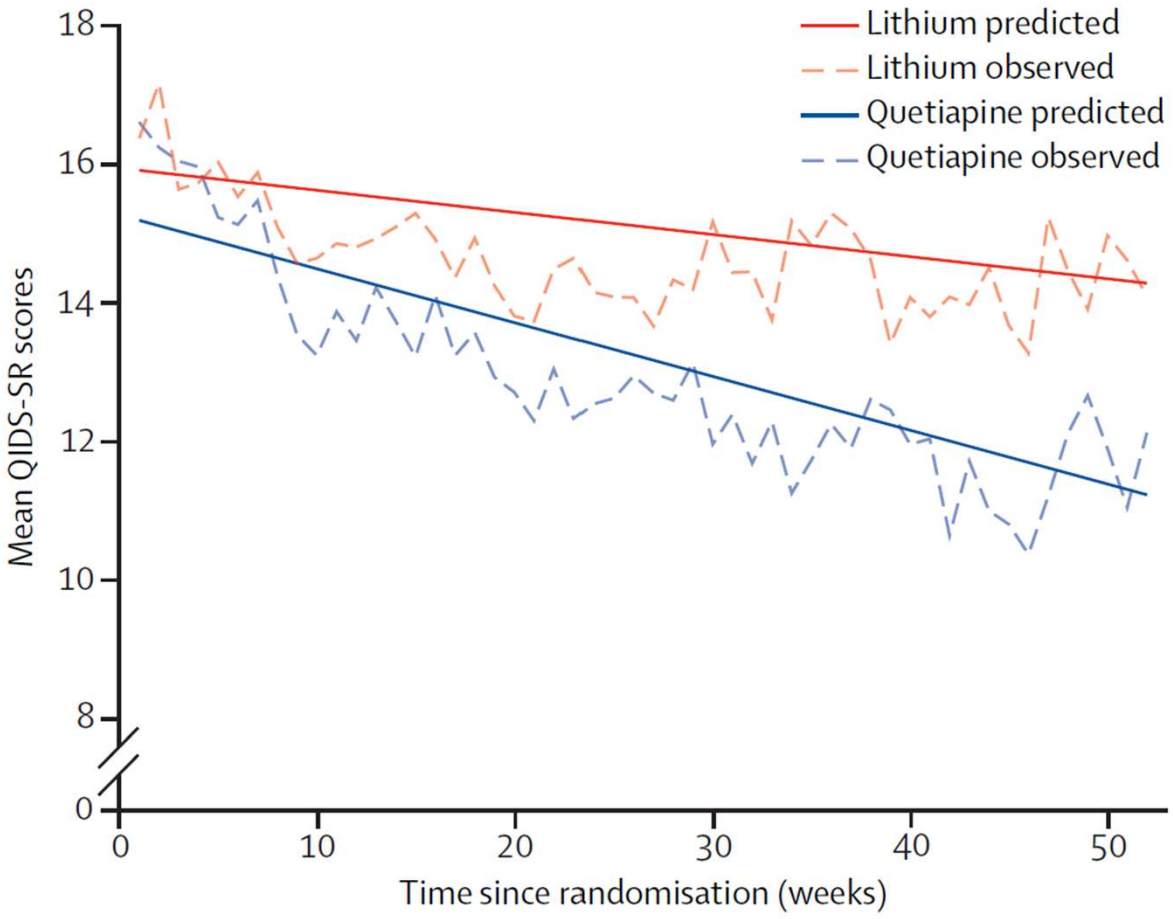
| Quetiapine vs Lithium Augmentation in TRD | |
|---|---|
| **Design** | Randomized open-label controlled trial |
| **Size** | 212 with TRD (60% failed > 2 trials)<br>Mean 42 years |
| **Intervention** | Lithium (mean 0.85 mmol/L)<br>Quetiapine (mean 195 mg) |
| **Duration** | 12 months |
| **Primary outcome** | Self-report QIDS and time to discontinuation |
| **Result** | Quetiapine = lower depressive burden (p=0.03)<br>Similar time to discontinuation |
| **Limitations** | Higher drop out on lithium (40% vs 27%)<br>Not blinded, no placebo |
| **Funding** | Government (UK NIH) |




No placebo
High drop out
Not blinded

Cleare AJ et al, Clinical and cost-effectiveness of lithium versus quetiapine augmentation for treatment-resistant depression: a pragmatic, open-label, parallel-group, randomised controlled superiority trial in the UK. Lancet Psychiatry. 2025;12(4):276-288.

# Quetipine vs Lithium Aug in TRD




Lithium had more drop-outs early on, but quetiapine was superior when analyzing only those who stayed with their med as well as with intent-to-treat population.

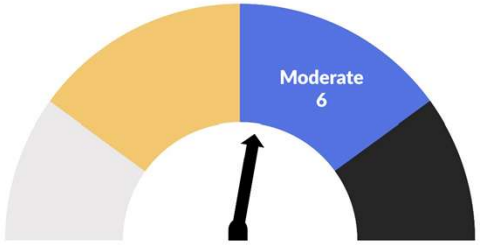
In secondary analysis, quetiapine's superior efficacy was limited to patients with high anxiety, even though both meds reduced anxiety at similar rates.

# 8 Mentalization Therapy for Antisocial Personality

Challenges “deviancy training” idea that group therapy worsens antisocial by allowing them to learn new antisocial skills from each other

## Mentalization Therapy in Antisocial

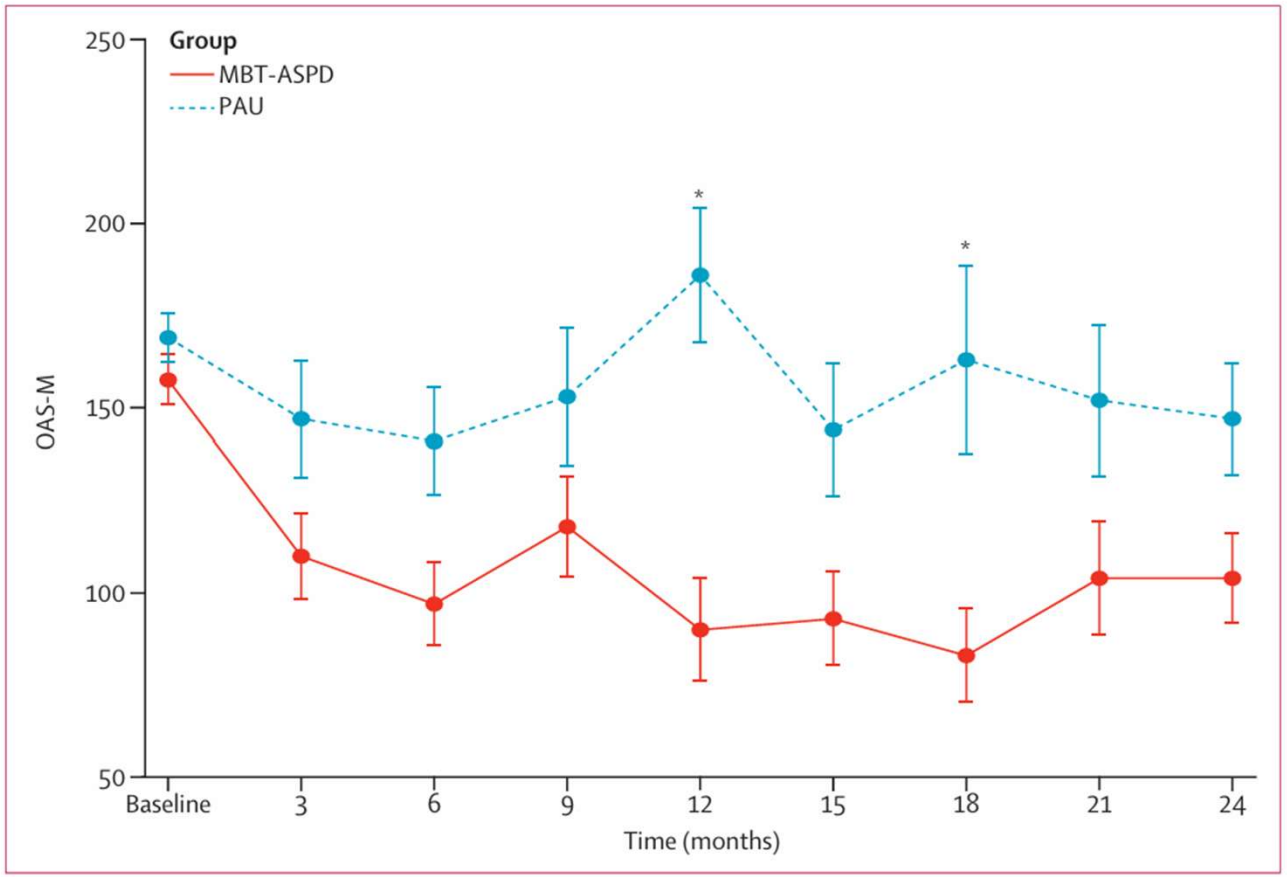
| | |
|---|---|
| **Design** | Randomized assessor-masked vs probation as usual |
| **Size** | 313 men with ASPD who committed recent crime |
| **Intervention** | 12 months of Mentalisation-based treatment (MBT) tailored for antisocial personality disorder<br>Weekly group (75 min)<br>Monthly individual (50 min) |
| **Duration** | 12 months treatment, 36 months follow-up |
| **Primary outcome** | Aggression at 12 mth (OAS-M) |
| **Result** | Reduced aggression (effect size 0.74)<br>Improvements in secondary outcomes: violent behaviors, communication skills, mentalising<br>No change in alcohol use and drug use, self-harm, or suicidal behavior |
| **Funding** | National Institute for Health Care Research (UK) |




Inactive comparison
Single blind
High drop out
(41-45% @ 1 yr))

Fonagy P, et al. Mentalisation-based treatment for antisocial personality disorder in males convicted of an offence on community probation in England and Wales (Mentalization for Offending Adult Males, MOAM): a multicentre, assessor-blinded, randomised controlled trial. *Lancet Psychiatry*. 2025;12(3):208-219.

# Mentalization vs Parole as Usual




**Manual**

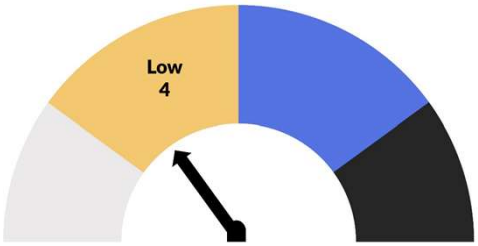
Google “mentalization therapy for antisocial personality manual pdf”

9

# Cannabis-Induced Psychosis

1 in 3 developed independent psychosis
1 in 2 developed a 2nd cannabis-psychosis
And antipsychotics prevented both

| Cannabis-Induced Psychosis | |
|---|---|
| **Design** | Prospective cohort study |
| **Size** | 1,772 |
| **Population** | Patients with cannabis-induced psychosis diagnosed in Swedish National Patient Database<br>Mean age 27, range 16-64, 84% men<br>No prior history of bipolar or psychotic disorders |
| **Duration** | 8 years (mean) |
| **Primary outcome** | Hospitalization for any psychosis |
| **Result** | Hospitalized for 2nd psychosis: 51%<br>Among hospitalizations, 23% were cannabis-induced<br>2nd episode of cannabis-psychosis: 52%<br>Took antipsychotics: 76%<br>Antipsychotic associated with 25% reduction in psychotic hospitalization and 22% reduction in substance use complications (particularly LAIs, clozapine, and oral aripiprazole) |
| **Limitations** | Not randomized<br>No information on continued cannabis use (but 70% were re-diagnosed with cannabis use disorder)<br>Duration of antipsychotic use not analyzed |
| **Funding** | Government (Swedish Research Council) |




Observational
(but large, prospective)

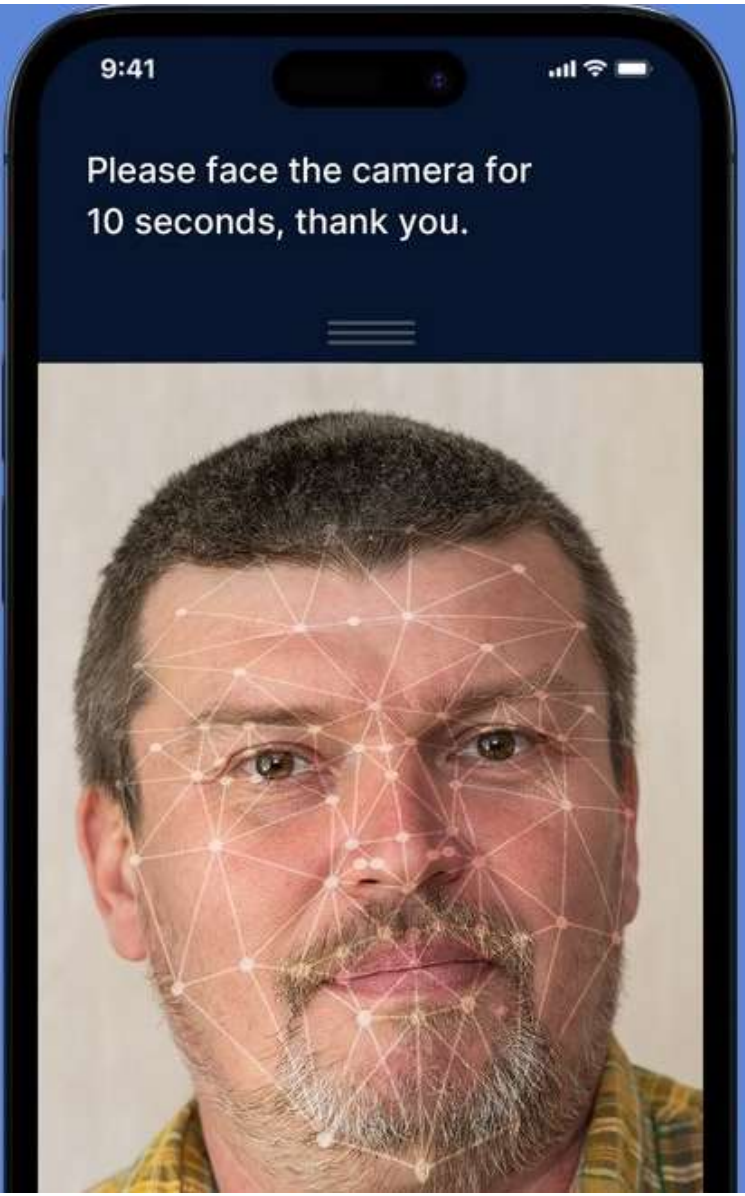
Mustonen A et al. Real-world effectiveness of antipsychotic medication in relapse prevention after cannabis-induced psychosis. Br J Psychiatry. 2025 May 6:1-7.

# 10 AI App Screens for TD

The free app outperformed trained psychiatric clinicians

| Tardive Dyskinesia App | |
|---|---|
| **Design** | Comparative study |
| **Size** | 351 recruited from public clinics, taken antipsychotic > 3 mth<br>75% had TD |
| **Intervention** | Video based TDScreen app (home and clinic) |
| **Primary outcome** | Sensitivity, specificity, area under the curve (AUC)<br>Standard = consensus on AIMS by trained clinicians who watched same app videos |
| **Result** | AUC: 0.85 to 0.98 (improved as more training data added)<br>Sensitivity 0.82, Specificity 0.82<br>App outperformed human raters (on Cohen κ) |
| **Limitations** | Did not include leg, trunk, toes<br>17% of subjects excluded due to poor video quality |
| **Funding** | Government (NIMH) |

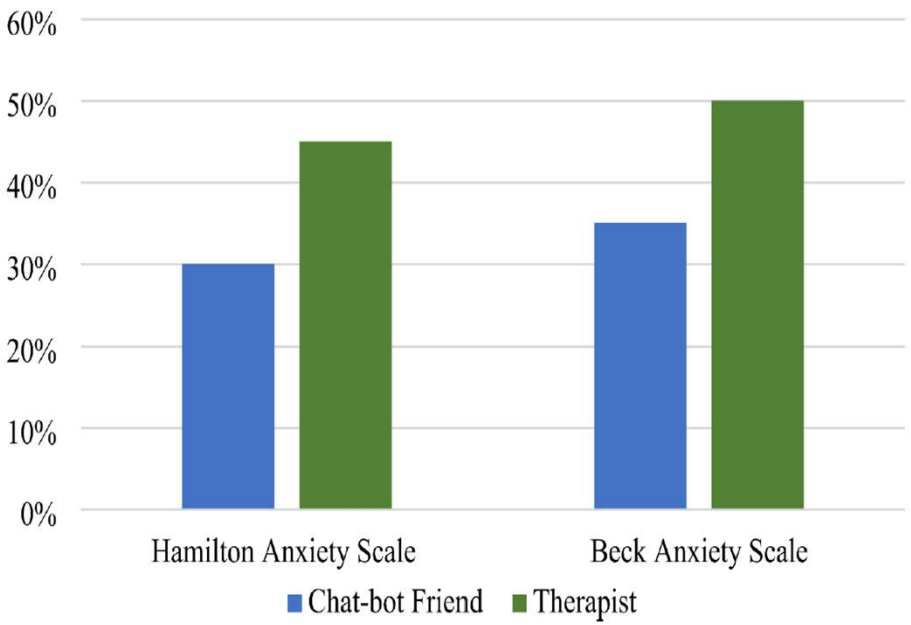
Sterns AA et al, Detecting Tardive Dyskinesia Using Video-Based Artificial Intelligence. J Clin Psychiatry. 2025 May 28;86(3):25m15792.




# tdscreen.ai


TRENDS

# AI Therapy




- 49% of people with psychiatric disorders use Chat-GPT for therapy
- 3 trials found benefit with AI therapy, though human therapist superior
- AI therapy app Woebot closed

Spytska L, BMC Psychol. 025;13(1):175

https://sentio.org/ai-blog/ai-survey

# Non-Medical Ketamine & Psilocybin

- Ketamine use rose 37% in NYC nightclubs from 2017-2024
- Recent psilocybin use rose 44% (age 18-29) and 188% (age > 30), 2019-23
- 1 in 8 US adults report lifetime psilocybin use

Palamar JJ, *Int J Drug Policy*. 2025;140:104825.
Rockhill KM et a, *Ann Intern Med*. April 22, 2025.

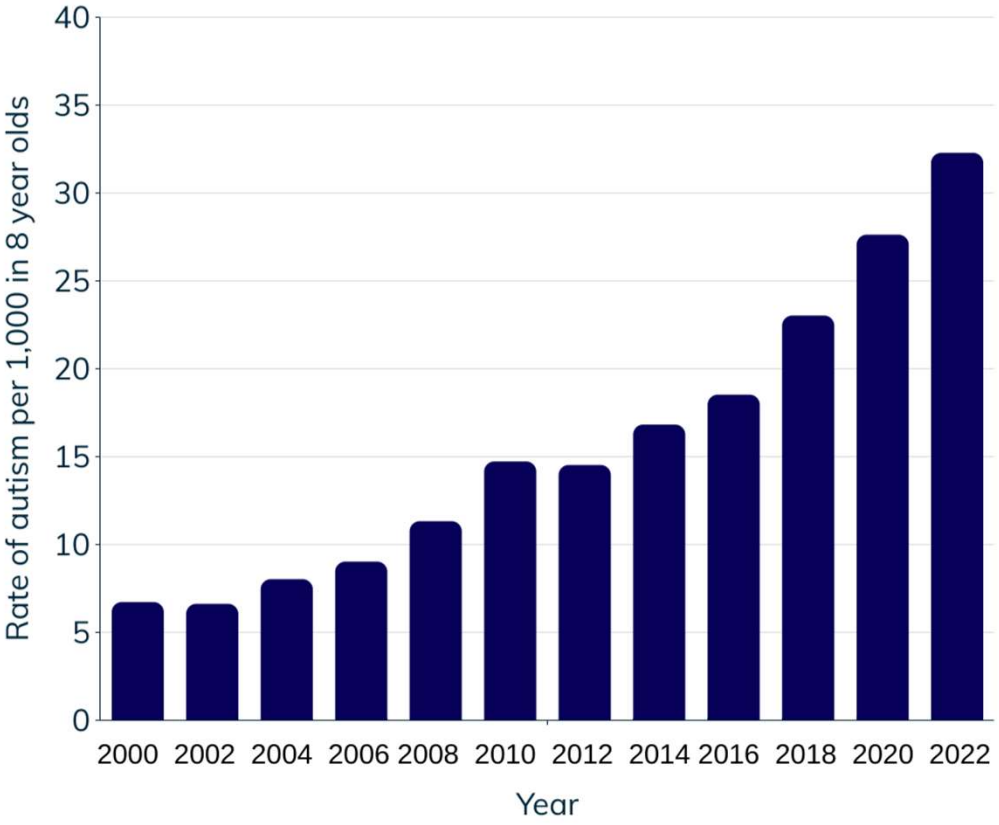
# Accidental Exposures in Children

- Accidental cannabis ingestion is rising in children, causing fatigue, nausea, and in worst case respiratory depression and seizures

- Psilocybin poison calls rose 723% in children 2019-2023

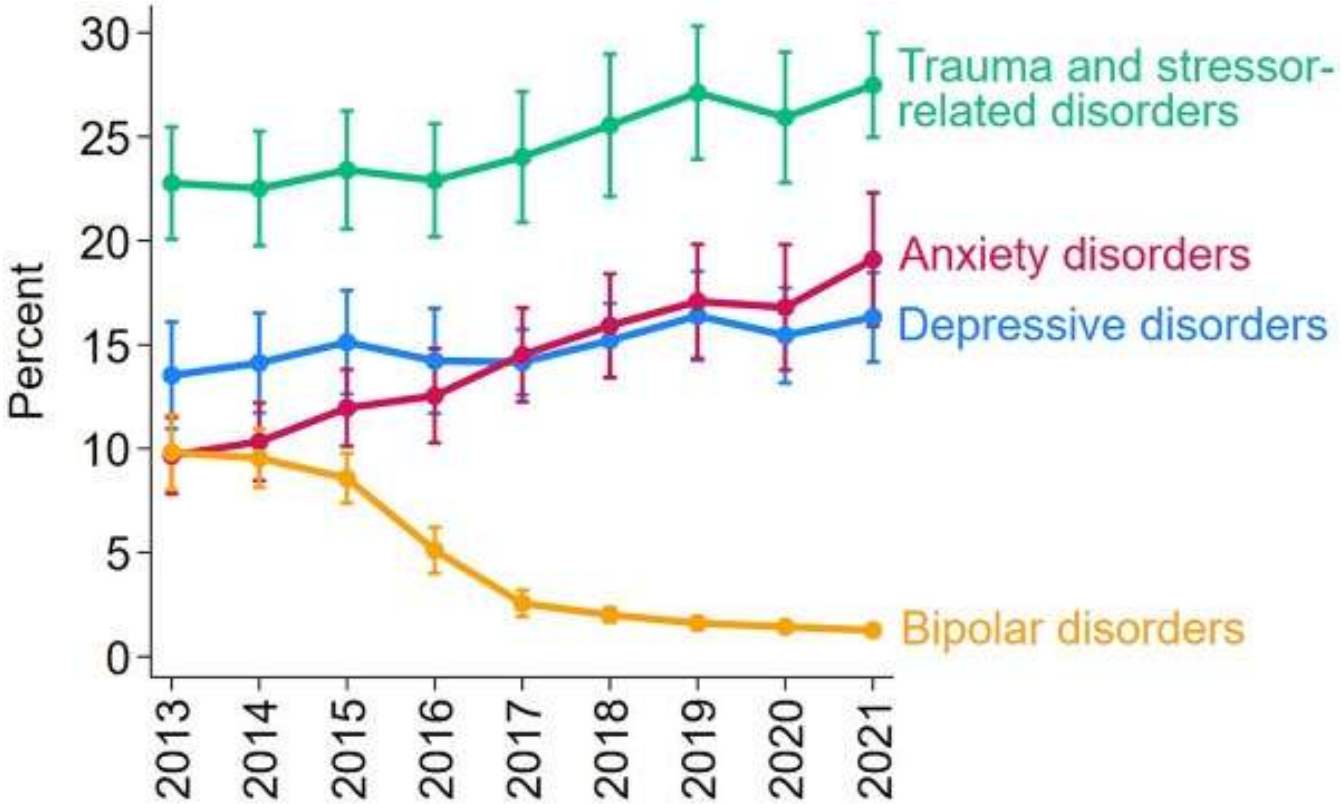
Rockhill KM et a, *Ann Intern Med*. April 22, 2025.

# Autism Diagnosis in Children




Shaw KA, CDC *Surveillance Summaries*, April 17, 2025, 74(2);1–22
https://www.cdc.gov/mmwr/volumes/74/ss/ss7402a1.htm

# Bipolar Diagnosis in Children




Mojtabai R, Olfson M. *J Am Acad Child Adolesc Psychiatry*. August 28, 2024.

# Antipsychotic Overuse in Non-Whites

- *Schizophrenia:* Blacks and hispanics prescribed...
  More older antipsychotics (30-50%)
  Less clozapine (55-60%) and newer-but-generic second generations (50%)

- *Mood Disorders:* Black, hispanics, and asians prescribed...
  More antipsychotics (30-50%)
  Less mood stabilizers (45-63%)

From 224,212 in Mount Sinai Health System EHR

Medina C et al, *Schizophrenia (Heidelb)*. 2024;10(1):48.

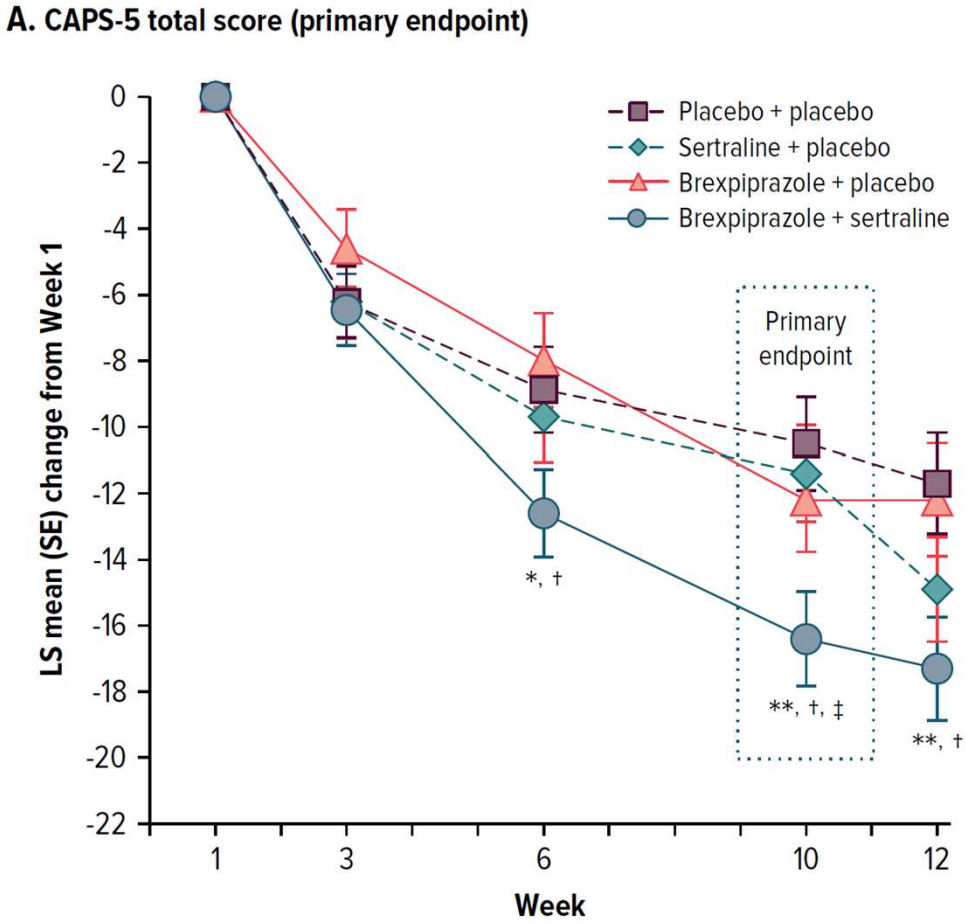

NEWS

# Brexpiprazole Rejected in PTSD

Conflicting results

Trial designs that don’t translate well to real-world

# Brexpiprazole in PTSD (aug / mono) (phase II)

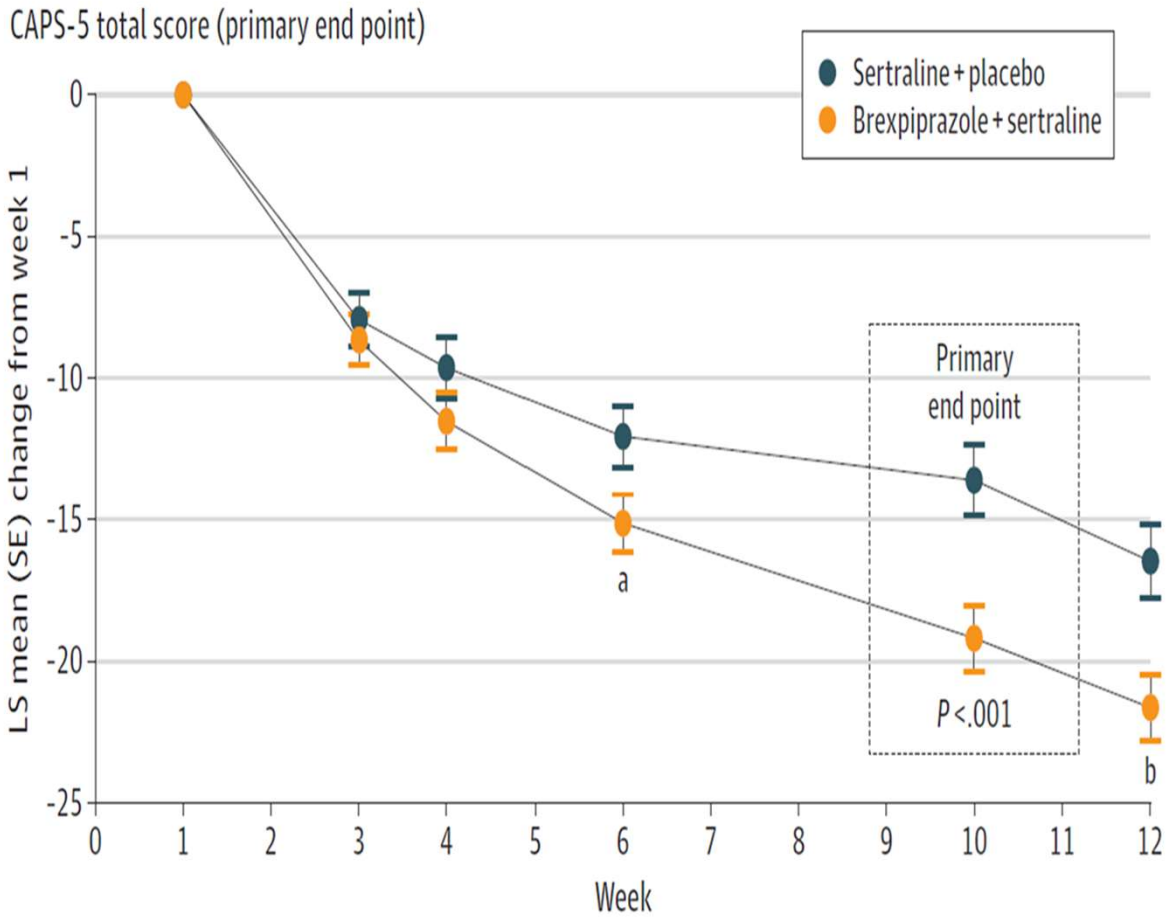



n = 80 per arm

28% drop out

Hobart M et al. Brexpiprazole in Combination With Sertraline and as Monotherapy in Posttraumatic Stress Disorder: A Full-Factorial Randomized Clinical Trial. *J Clin Psychiatry*. 2025;86(1):24m15577.

# Brexpiprazole augmentation in PTSD (phase III)

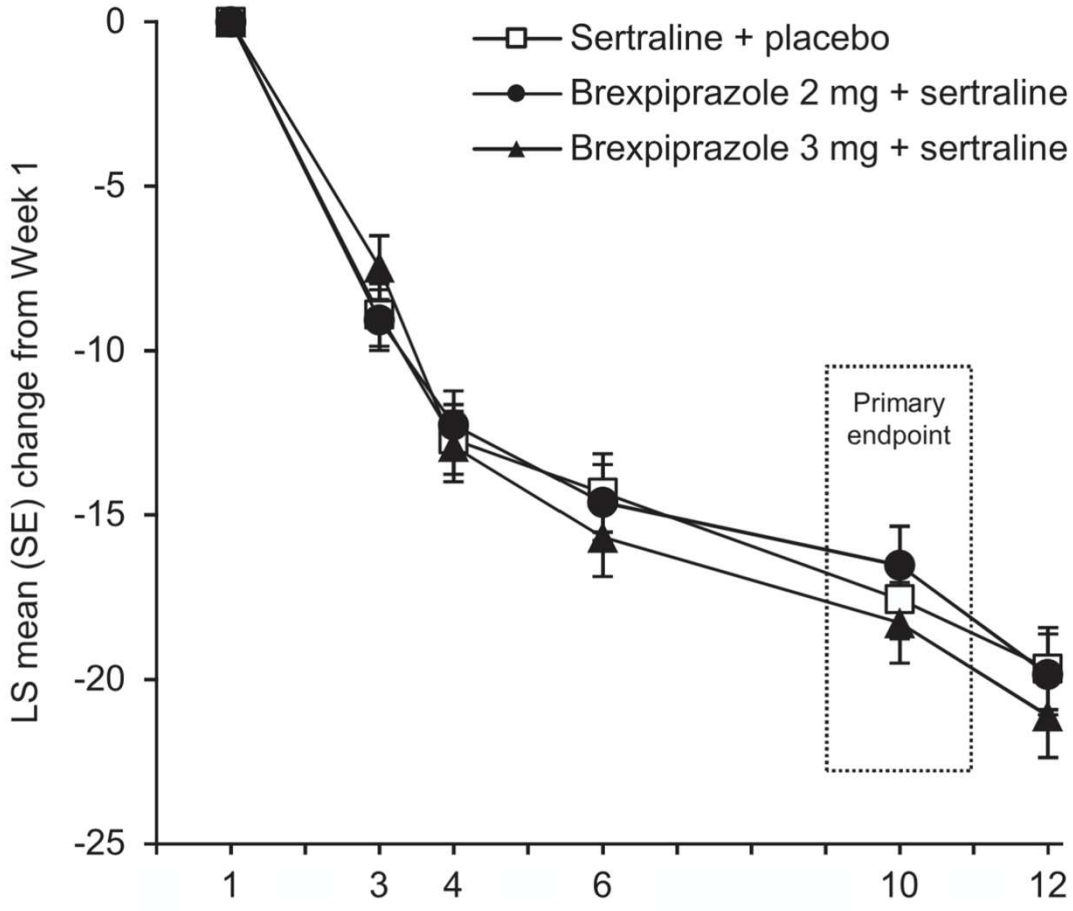



n = 416

40% Drop out

Davis LL, Behl S, Lee D, et al. Brexpiprazole and Sertraline Combination Treatment in Posttraumatic Stress Disorder: A Phase 3 Randomized Clinical Trial. JAMA Psychiatry. 2025;82(3):218-227.

# Brexpiprazole augmentation in PTSD (phase III)




n = 553

30% Drop out

Davis LL et al. Fixed-Dose Brexpiprazole and Sertraline Combination Therapy for the Treatment of Posttraumatic Stress Disorder: A Phase 3, Randomized Trial. J Clin Psychopharmacol. 2025;45(6):580-589.

## Results do not generalize. Exluded were…

- Depression and comorbidities
- Disability
- Trauma before age 16 (or more than 9 years ago)
- Ongoing trauma
- Limitation of combat-related trauma to 20%
- Placebo-responders

*Also most participants treatment-naive*

# Small Scale Hope

| Treatment | Condition | Study |
|---|---|---|
| **Viloxazine** | ADHD (stimulant augmentation)<br>100-400 mg | RCT n=56, 6-17 yr, open-label<br>PMID: 40014428 |
| **Varenicline** | Alcohol use disorder | RCT n=384, 4-arm study<br>PMID: 40487775 |
| **Levetiracetam** | Mania (augmentation) 250 mg qhs | RCT n=65<br>PMID: 40447146 |
| **Prazosin** | Depression with trauma history, 0.5-1 mg hs augmentation | RCT n=59<br>PMID: 39340191 |
| **Memantine** | Autism (child, normal IQ) social responsiveness<br>20 mg qd | RCT n=42<br>PMID: 41032298 |
| **Guanfacine** | Self-injury and aggression in Prader-Willi, 3-4 mg XR | RCT n=16<br>PMID: 40395104 |
| **Naproxen** | OCD (augmentation) 250 mg bid | RCT n=96<br>PMID: 39354696 |
| **SAINT-TMS** | Prevention of TRD (100%) given as needed (avg 1 day/month) | Uncontrolled 1 year, n=21<br>Stimpson K, Brain Stim v18, 1p228-229, 2025 |
| **tDCS** | Major depression | RCT n=174 (largest to date)<br>PMID: 39433921 |

# Large Scale Failures

| Treatment | Failures | Study |
|---|---|---|
| **Antipsychotics** | Suicide in MDD<br>Mortality in MDD (increased 27%) | Large cohort study<br>PMID: 40197402 |
| **Semaglutide** | Depression and cognition in MDD | RCT (n=72)<br>PMID: 41218611 |
| **Semaglutide** | Cognition in Alzheimer's | Two large RCTs (Evoke) |
| **Brexpiprazole** | Maintenance in MDD (augmentation) | Large 6 mth phase-3 RCT<br>PMID: 39415650 |
| **Cobenfy** | Augmenting antipsychotics in schizophrenia | Phase-3 ARISE RCT n=386<br>NCT05145413 |
| **Pimavanserin** | Negative symptoms of schizophrenia<br>Antidepressant augmentation | Phase-3 trial n=484<br>PMID: 40181715 |
| **Ketamine** | Inpatient MDD (vs IV midazolam) | RCT n=65<br>PMID: 41123905 |
| **Doxazosin** | PTSD | 3 small RCTs<br>PMID: 41042258 |
| **Vagal Nerve Stimulation** | Depression | Large, 12 mth sham RCT<br>PMID: 39706521 |
| **Psilocybin** | Alcohol use disorder | Small RCT |
| **Microdose LSD** | ADHD | Phase-2a RCT, n=53<br>PMID: 40105807 |
| **Orexin antagonist (tebideutorexant)** | Depression and anxiety during insomnia | Phase-2a RCT n=222<br>PMID: 40215570 |

# FDA Updates 5/2025 to 4/2025

5 6 7 8 9 10 11 12 1 2 3 4

**Zulresso**
Brexanolone discontinued

**Alzheimer's Blood Test**
Lumipulse for ß-amyloid

**Antidepressants in Pregnancy**
Advisory panel recommends stricter warnings (9/10 members have anti-med bias)

**FDA Adopts AI**
To speed scientific reviews

**Brexpiprazole Rejected in PTSD**
by FDA advisory panel

**Tonmya**
Cyclobenzaprine SL for fibromyalgia

**KetaRx**
Ketamine IM approved for surgical pain

**NRX-101**
Ketamine IV fast-tracked for depression

**Accelerated Deep TMS**
4 per day protocol cleared for depression

**Lumateperone (Caplyta)**
Approved MDD aug

**Cariprazine (Vraylar)**
Peds approvals:
Bipolar I 10+
Schizophrenia 13+

**Flow**
tDCS approved for major depression

**ProLivRx**
eCOT-AS approved for MDD after one antidepressant failure

**Cannabis**
Proposed moving to schedule III

**Bysanti**
milsaperidone approved based on iloperidone's trials

**FDA Changes**
1, not 2, trials for approval

**Centanafadine**
Fast-tracked for ADHD

**Leucovorin**
Approved for central folate deficiency

# Daily updates (@ChrisAikenMD)

LinkedIn, X, Facebook, or BlueSky