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USING THE KENNEDY AXIS V TO TRACK MEDICATION CHANGES

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There are ongoing concerns about serious side effects of the medications that we use in psychiatry, especially when these medications are being used in conjunction with ever-growing combinations of medications. Because of these potentially serious side effects, drug interactions, and rising costs, we as psychiatrists are increasingly being asked to justify continued use of individual, as well as combinations of psychotropic medications.

Also, as the number of medication options increase, so does the potential for never ending trials of various medications and combinations of medications. It is not unusual to have to try to tease out whether the current combination of medications is better than:

1) A single medication that the patient had been on in the past

2) A previous combination of medications

3) The potential benefits of a new medication

4) The potential benefits of a new combination of medications

You may be trying to make these comparisons for medications that the patient may have been taking two or three years ago and/or two or three psychiatrists ago. On the other hand the effect of new medications or new combinations of medications may not be realized while the physician who prescribed the medications is treating the patient, i.e., the effects of a medication may not occur until after the patient is discharged from the care of the physician who first prescribed the medication.

Further complicating the issue is the fact that as Psychiatrists, we are often asked to increase a patient's medication or add in a second or third psychotropic medication when a patient is in a period of crisis. Once the crisis is over, it is often assumed that the medication changes during the crisis accounted for the improvements and the patient is continued on any medications started during periods of crises.

These changes can be the result of the medication changes; however, following crises, regardless of treatment, there is often a tendency of a return to the patient's baseline level of functioning. This return to baseline can easily be mistaken as a sign that an increase in dosage of a particular medication and/or the addition of another medication has lead to improvement, rather than simply a return to the patient's previous baseline functioning. This return to baseline may have occurred independent of any medication changes.

It has been my experience that in some cases this can lead to patients being on high doses and complex combinations of medications. Clinicians are often afraid to reduce or discontinue medications during periods of stability for fear that the medications are necessary for the patient's continued stability; therefore, the medications may be continued despite their potential for serious side effects.

It is felt that the Kennedy Axis V (K Axis) may be a useful tool to help establish a baseline level of functioning and then help to track over time a patient's response to medication changes. It is felt that in many cases, two Subscales can be especially useful:

1) Subscale #1 Psychological Impairment

2) Subscale #3 Violence

It is felt that of the seven Subscales, these two Subscales are often the most sensitive to clinical changes in response to medication adjustments. Changes in the other Subscales may be secondary and much more delayed. These secondary changes, though very important, are less likely to give clinicians early indications as to whether a particular medication change is helpful. Therefore, rating the full K Axis might be done much less frequently than the Subscales #1 Psychological Impairment and #3 Violence.

Once you know the patient and his/her current clinical status, rating these two Subscales can often be made within one or two minutes. This should allow one to easily make ratings prior to any medications changes, as well as when following up to help determine whether there has been a response to the medication. If this is done over time, including times when the patient is transferred from one psychiatrist to the next, this may allow for a more standardized method than you are currently using to convey how a patient has responded over extended periods.

For further information on using the K Axis to track medication changes, see “Evidence Based Tracking of Medication Changes” in Chapter 1 of Mastering the Kennedy Axis V, Kennedy, James A., American Psychiatric Publishing, Inc. 2003. In Chapter 5 “Problem Description Section of the Scoring Sheet,” see how the Problem Description (focused progress notes) can act as an adjunct to the K Axis scores to help track a patient’s response to various medication changes.

If you have had any experience using outcome measures, including the K Axis, to track effectiveness of medication changes, I would appreciate your feedback. Please click on “Requests/Comments” on the Navigational Bar to your left to convey your comments.

Above comments by James A. Kennedy, MD