Questionnaire, assessing quality of life. Pain was assessed using the Visual Analog Scale.

Tender-point count was performed manually. The patient was asked to indicate when the sensation altered from pressure to definite pain at predefined anatomical sites according to the American College of Rheumatology classification criteria for fibromyalgia. All points were painful.

The patient was treated with creatine monohydrate for 4 weeks (3 g daily in the first week, then 5 g daily). Ongoing psychotropic treatment was not altered during the study.

The patient showed improvement in the symptoms of depression (Hamilton depression scale scores decreased from 24 to 16) and fibromyalgia (Visual Analog Scale score decreased from 80 to 40). This moderate recovery may be ascribed to the improvement of her sleep patterns and somatic symptoms (directly affecting the outcome of her Hamilton depression scale scores). Her quality of life improved as well, measured by a change of 30% on her total Short Form-36 score. Although the number of her tender points remained constant, they were less tender, and she was able to function more and sleep better, without being disturbed by pain. By request, she continued to consume creatine following the termination of the study, and 8 weeks following recruitment to the study, the beneficial effect remained.

In our case report, a patient with PTSD and comorbid depression and fibromyalgia demonstrated improvement in both conditions following treatment with creatine.

Creatine supplementation has been shown to augment brain utilization of oxygen (6). Lyoo and colleagues (7) demonstrated that oral creatine administration for 2 weeks significantly increased brain creatine levels. A creatine effect reported in fibromyalgia, if true, is indeed not well understood, since energy metabolism was suggested not to be involved in fibromyalgia (8), and one should consider this finding an empirical one at the moment. This report may indicate that creatine may confer a beneficial effect of concomitant depression and fibromyalgia.

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Lingual Lesions With Orally Disintegrating Risperidone

TO THE EDITOR: There are reports of oral lesions occurring with the use of orally disintegrating atypical antipsychotic tablets. The reports of adverse reactions caused by orally disintegrating olanzapine indicate that mouth ulcerations and tongue edema are infrequent events, and glossitis and tongue discoloration are rare (1). Paresthesia or anesthesia of the mouth, palate, or tongue; tongue discoloration; tongue edema; and taste loss have also been reported with the use of orally disintegrating mirtazapine (1, 2). To our knowledge, no case of oral lesions associated with the use of orally disintegrating risperidone (Risperdal M-tab) has been reported. There is documentation of rare events of tongue discoloration, tongue edema, and gingivitis, but these are not specifically referenced to orally disintegrating risperidone (1). We report two cases of lingual lesions occurring during treatment with orally disintegrating risperidone.

"Ms. A," a 44-year-old woman diagnosed with psychotic disorder, not otherwise specified, was given orally disintegrating risperidone (1 mg every morning, 2 mg at bedtime). After 3 days of treatment, she complained of tongue paresthesia, and multiple erythematous sloughing lesions were noted at the lingula tip and bilateral anterior areas. A physical exam was otherwise unremarkable. Concomitant medications included valsartan, 80 mg/day. Her medical history was significant for hepatitis C, hypertension, asthma, and a benign subependymoma. Orally disintegrating risperidone was discontinued, and the patient switched to risperidone tablets 3 mg/day (swallowed whole). The lesions resolved within 3 days.

"Mr. B," a 22-year-old man with schizophrenia, was given orally disintegrating risperidone (1 mg b.i.d.). After 3 days of treatment, he complained of tongue anesthesia and tongue swelling. On day 4 of treatment, multiple erythematous lesions were noted at the lingula tip. A physical exam was otherwise unremarkable, and no concomitant medications were used. A medical history was noncontributory, and laboratory values were within normal limits. Orally disintegrating risperidone was discontinued, and the patient switched to risperidone tablets 2 mg/day (swallowed whole). The lesions resolved within 3 days.

We identified no case reports of lingual lesions associated with the use of orally disintegrating risperidone (3). In our reported cases, oral lesions resolved after switching to the swallow formulation. Hence, a possible explanation for the induction of oral lesions may be related to the mechanism of disintegration and formulation constituents (1). These cases

illustrate the risk of developing oral lesions when treating patients with orally disintegrating risperidone. Clinicians should be mindful of these potential adverse effects. Based on our experience, resolution of symptoms is probable after discontinuation of the orally disintegrating formulation; however, new concerns are raised regarding potential interference with treatment compliance. This may be noteworthy, since orally disintegrating risperidone is marketed as a possible means for enhancing medication compliance.

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The Internet as Collateral Informant

TO THE EDITOR: In this letter, we describe a novel and potentially important way in which the Internet has influenced our practice of clinical psychiatry—the use of the Internet as a collateral informant in the psychiatric encounter.

"Mr. J" is a 38-year-old man who came to our crisis response center with suicidal ideation without a plan. Recently, the patient had been kicked out of his girlfriend's house because of his ongoing abuse of crack cocaine. The resident on-call performed a medical history and physical examination, including a suicide risk assessment, but the patient's denial of prior suicide attempts led the resident to believe that the patient was at low risk for suicide overall. While writing the patient's medical history and physical examination results, the resident decided to perform an Internet "Google" search on the patient and discovered a newspaper article from 3 months earlier detailing how Mr. J was pulled by police from a nearby river and admitted to a local psychiatric hospital after he jumped off a major bridge in what was described as a suicide attempt.

Internet search engines such as Google process billions of websites in a matter of milliseconds to produce a hierarchical arrangement of "hits" that match the search criteria. Thus, entering an individual's name into a search engine can reveal interesting results, ranging from newspaper articles to personal Web pages to court cases that are a matter of public record. In the case presented, a single Internet search, performed in a matter of milliseconds, revealed information that would be vital to determining the patient's ultimate disposition.

While Internet-based mental health screening (1) and treatment (2, 3) applications have been examined, there has been, to our knowledge, no investigation into the role of Internet-accessible personal information in the clinical evaluation of psychiatric patients. Our case illustrates some of the ways in which the Internet can be used to aid decision making in clinical situations. Although the information gleaned from the Internet frequently has, at best, an adjunctive role, this data can be, at times, invaluable in the decision-making process.

What are the implications of having these new and powerful, fast, and free data sources at our disposal? Should all of our new patients be "Googled"? Should they be informed that we are indeed "Googling" them? How should we assess the quality and accuracy of Internet data? What about other potentially useful, although perhaps more controversial, sources of information on the Internet? Many states now have websites that list parole absconders and wanted fugitives and offer online registries of sex offenders. In addition, elements of patients' financial, criminal, and civil histories can be obtained on the Internet. What, if any, role could and should this sort of information have in clinical evaluations, and what are the ethics of this? We hope that this letter is only the beginning of further exploration and discussion of these complicated and exciting new issues involving the role of the Internet in clinical psychiatry.

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Corrections

The articles selected for CME courses in the June and July issues did not include all of the author's disclosure statements because of an inadvertent omission during the Journal's production. The authors had previously disclosed all conflicting interests, as requested. Authors whose disclosure data were not published are presented here.

Omega-3 Fatty Acids and Mood Disorders (Am J Psychiatry 2006; 163:969–978): Dr. Parker reports receiving payment for lectures and chairing and membership of Advisory Boards for several Australian pharmaceutical companies. Dr. Hadzi-Pavlovic reports a relationship with Eli Lilly involving a lecture to psychiatry trainees on statistics. Drs. Gibson, Brotchie, Heruc, and Rees report no competing interests.