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MINDS

Wellbeing begins in our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 6 *Issue 3* *March 2016*

From The Desk of the Editor: Taking Psychiatric Stigma Head On!

It is well recognized that psychiatric disorders are associated with considerable degree of stigma. But the big question is how do we address the stigma? Various interventions have been suggested, tried and tested, which aimed to reduce stigma towards patients with psychiatric disorders. These have included educational interventions through public campaigns, education of patient's family members, interactions of health-care providers and law enforcement personnel with patients with psychiatric disorders, and so on. These interventions have attempted to address the knowledge deficits as well skewed attitudes of the participants. Many interventions have been targeted at the medical professionals, as their attitudes are important in ensuring that the patient with psychiatric disorders is given adequate dignity while providing patient care. It has been heartening to see that the stigma towards psychiatric illnesses is gradually eroding over time, but more needs to be done. The information dissemination activities need to be scaled up so that misconceptions about psychiatric illnesses are reduced. Medical and nursing students should be given adequate exposure to psychiatry so that their hesitations towards psychiatric patients could be reduced. Liaison of mental health-care with other service providers and educational institutions may help in dispelling myths about psychiatric illnesses and encouraging those suffering from psychiatric illnesses to seek care. Probably, with multi-pronged approach, the stigma towards psychiatric illnesses can be tackled, as has been done for other disorders like tuberculosis and leprosy.

Siddharth Sarkar

Guest Column: Down The Memory Lane

Reflections on my college experience

I was not a bright student but still I used to secure first or second rank up to XI standard. I used to pay proper attention to the classroom lecture, occasionally missed homework and used to study regularly at home. I used to involve in physical activity, games, sports, music, reading books, magazines and newspapers etc. in my free time to keep myself physically and mentally engaged.

During my 1st year T.D.S. (XII) in college I paid less attention to the subject of chemistry. Annual exams were two months away. First time in my life I developed the fear of failure. However I put in extra efforts and passed my university exam to enter medical college.

During final year MBBS I didn't pay proper attention on my studies due to peer influence. Due to which I could pass final MBBS with second attempt. Thereafter I learnt to stay focused and assertive.

During my post-graduation at CIP, Ranchi I developed anxiety due to difficult and new subjects and also due to family and financial problems. However by the grace of God I kept patience and increased my efforts. I started paying attention to classroom lectures, clinics, self-studies, and group discussion with my batch mates. Adequate sleep, food, and extracurricular activities helped me to keep relaxed. By adopting the above measures I passed both the university exams in 1973 with good marks. During my student life I never remained awake at night for studies.

I just want to conclude with golden words by Willa Cather, 'There are some lessons you learn best in calm and some in storm'. Learning comes from mistakes & success comes from well learned lessons.

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Invited Article

Advent of rTMS as a neuromodulatory approach for managing neuropsychiatric conditions

Despite the considerable research on neuropsychiatric disorders over the past years, the understanding of the biological basis of these disabling disorders is still fragmentary. The effect of pharmacological intervention has pointed out role of specific neurotransmitter systems of etiological importance, but many symptoms in such disorders still do not respond to pharmacotherapy adequately. More recently brain imaging investigations, like Positron Emission Tomography (PET) and functional Magnetic Resonance Imaging (fMRI), have identified multiple structural and functional abnormalities, including changes in networks of brain regions.

Since its commercial advent in 1985, transcranial magnetic stimulation (TMS), a technique for stimulating neurons in the cerebral cortex through the scalp, safely and with minimal discomfort, has captured the imaginations of scientists, clinicians and lay observers. Initially, a laboratory tool for neurophysiologists studying the human motor system, TMS now has a growing list of applications in clinical and basic neuroscience. TMS is based on Faraday's principle of electromagnetic induction and features the application of rapidly changing magnetic fields to the scalp via a copper wire coil connected to a magnetic stimulator. These brief pulsed magnetic fields of 1-4 Tesla pass through the skull and create electric currents in discrete brain regions. The currents induced in the brain can be of sufficient magnitude to depolarize a population of neurons and evoke a certain phenomenon. Repetitive trains of TMS (rTMS) applied to targeted brain regions can suppress or facilitate cortical processes, depending upon stimulation parameters. In most instances, continuous low frequency (≤1Hz) rTMS decreases the excitability of the underlying cortex while bursts of intermittent high frequency (≥1Hz) enhance it. The fact that the modulatory effects of rTMS can outlast the duration of its application has led to the exploration of the technique as a potential treatment modality with promising results in various neuropsychiatric disorders. The after-effects of rTMS are influenced by the magnitude and duration of stimulation, the level of cortical excitability and the state of activity in the targeted brain region. It exerts its effect by increasing or decreasing the excitability of corticocortical or corticospinal pathways depending on multiple stimulation parameters like intensity, frequency and coil orientation.

In recent years, rTMS has shown some promise in treatment of varied neuropsychiatric disorders like auditory hallucinations, negative symptoms and cognitive functioning in schizophrenia, depressive disorders, obsessive compulsive disorders, Parkinson's disease, cognitive impairment in stroke and others.

rTMS is an underutilized treatment modality currently, being present at some institutions and in some geographical locations of the world. There is an urgent need to demonstrate its importance to the policymakers and clinicians alike for better use and favourable outcome in patient population.

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Consultation Liaison Psychiatry

Focus: 'Neurosurgery'

Psychiatric Sequelae of Head Injuries

Head injury is an important public health problem these days. It is a big burden on our economy as majority of the patients are from young earning age-group and the cost involved in the treatment of these patients is quite high. Significant numbers of these injuries occur when the driver is under influence of alcohol or other inebriant drugs.

Actual incidence of head injury in India is not known, as we do not have any nationwide registry. The incidence of head injury is increasing due to increasing urbanization and increasing number of vehicles. Many patients who come to trauma centers with severe head injury have sustained injuries under the influence of alcohol or other drugs of abuse. The outcome of head injury is very dismal, with a reported good outcome in just 28% of patients. The mortality rate is about 22%, and about 19% of patients remaining vegetative.

Head injury can result in hematomas (extradural, subdural or intraparenchymal), bony fractures (depressed or compound) or diffuse axonal injury. Hematomas can be removed surgically, but there is yet no treatment available for diffuse axonal injury. Diffuse axonal injury might be the cause of various neurological deficits and disability, which are commonly seen in patients following head injury, even in patients who were treated successfully for hematomas.

Psychiatric sequelae of head injuries include changes in personality, occurrence of mood episodes, cognitive deficits, and even psychosis. It is difficult to determine the course and outcome of such psychiatric symptoms, but sometimes, the deficits and personality changes are stable. Behavioral changes like irritability, aggression are encountered, which might need psychiatric management in the form of medications and behavioral measures. Thus there is a need for liaison with the psychiatrists after the neurosurgical interventions have been conducted, preferably in a multi-disciplinary setting so that the behavioral issues after head injury are addressed effectively. Thorough evaluation, timely intervention, and holistic management is very important to prevent disability and regaining functionality of body and mind.

This is just to highlight the need to prevent head injury as despite best of treatment the morbidity and mortality is still very high. Driving under the influence of inebriant drugs should be avoided in all circumstances and traffic rules should be strictly enforced. Let's call for road safety. Join hands to help each other, as together we can make a difference.

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REFRAME -Let Awareness Reframe Assumption: **Myths & Facts about "Schizophrenia"**

- ☒ Individuals affected with schizophrenia are dangerous and violent.
- ✓ Violence is uncommon in patients with schizophrenia as compared to general population. They are actually more distressed and frightened about their condition.
- ☒ Schizophrenia has got no treatment.
- ✓ It can be treated with antipsychotic medications, family and social support and counseling.
- ☒ Schizophrenics cannot do any good with their life.
- ✓ If patients of schizophrenia are provided with better facility, they can do really good things in their life. One example being Dr. John Nash Nobel laureate in economics.

Compiled by Swapnil Tripathi, final year, MBBS student, AIIMS, Jodhpur, Rajasthan

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

MINDS Quiz

1. Antipsychotic drug induced parkinsonism is treated by:

a) Anticholinergics. b) Levodopa c) Selegiline d) Amantadine

2. Least severe type of alcoholism is

a) Beta. b) Alpha c) Gamma d) Epsilon

3. Nicotine dependence

a) Physical<psychological b) Psychological<physical c) Physical=psychological d) None

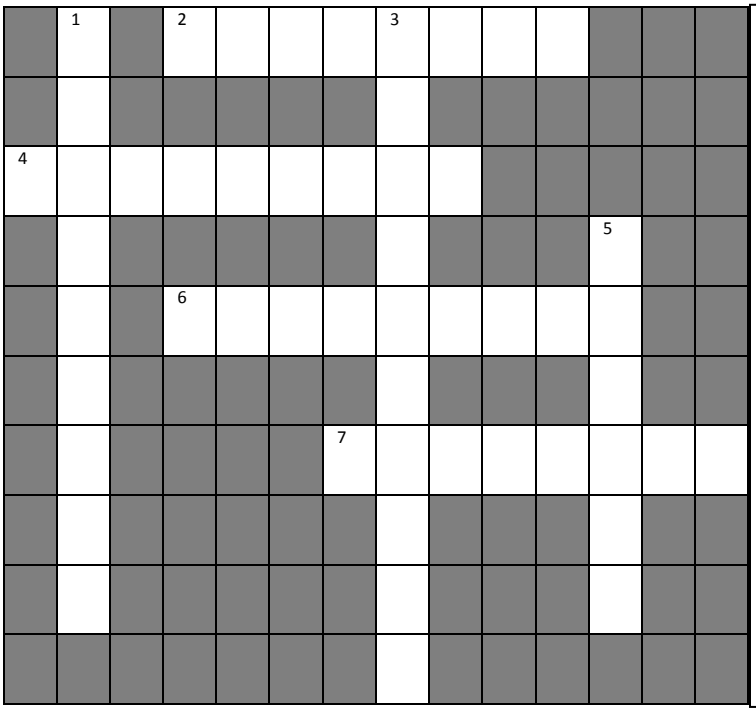
4. Following is cognitive disorder

a) Depersonalization. b) Intellectualization c) Delirium d) All of the above

5. Blood level in alcoholic intoxication is

a) 10 mg% b) 50 mg% c) 80 mg% d) 100 mg%

Compiled by Swapnil Tripathi, final year, MBBS student, AIIMS, Jodhpur, Rajasthan



Crosswords

Across

2. Cluster of personality in which there is hypersensitivity to rejection, social inhibition, desire relations with others
4. Believing that people are all good or all bad at different times due to intolerance of ambiguity.
6. Drug of choice for absence seizure.
7. Alleviating guilty feelings by unsolicited generosity towards others

Down

1. Antidepressant used in smoking cessation
3. One of the drug used in neuroleptic malignant syndrome
5. Avoiding the awareness of some painful reality

Compiled by Swapnil Tripathi, final year, MBBS student, AIIMS, Jodhpur, Rajasthan

Quick Response Code for the Website

ANSWERS

MINDS QUIZ

1. A
2. B
3. A
4. C
5. D

CROSS WORDS

ACROSS

2. Avoidant
4. Splitting
6. Valproate
7. Altruism

DOWN

1. Bupropion
3. Dantrolene
5. Denial

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Enjoy a new way of learning!!!!

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