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Editor
Dr Naresh Nebhinani
MD, DNB
Assistant Professor
AIIMS Jodhpur (Raj)

Assistant Editor
Dr Siddharth Sarkar
MD, DNB
Assistant Professor
AIIMS. Delhi

Coordinator
Swapnil Tripathi
Final year, MBBS
AIIMS, Jodhpur (Raj)

E-mail
editormind@gmail.com

For free E-copy Just mail us or SMS MINDS & your Email ID to editor

Past Editors
Dr M Kishor
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MINDS

Wellbeing begins in our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

Volume 6 *Issue 4* *April 2016*

From The Desk of the Editor:

Taking care of medical students' mental health

Medical professional course is considered one of the toughest ones, and is consequently associated with considerable degree of stress. Some degree of stress might be constructive as it helps the student in improving their academic performance. However, increased pathological stress or distress can result in students becoming demotivated, lead to increased chances of developing anxiety and depression, and can foster a feeling of despair. Thus, cognizance of increased stress is important and so that students who experience such 'distress' are helped. The assistance to medical students can be in the form of counseling, relaxation measures, tips and sessions for time management and increasing academic yield, and in rare circumstances, medications. However, medical students are hesitant to seek help from mental health professionals, despite qualified professionals being available near them. Various factors including stigma can be attributable to this reluctance to seek help. So, it is important to disseminate correct information about psychiatric disorders in the undergraduate medical curriculum, give exposure to psychiatric patients in the rotations, and provide accessible care to medical students who need help. Stigma of seeking mental health help needs to be countered so as to make the psychiatric services more accessible to medical students.

Siddharth Sarkar

Guest Column: Down The Memory Lane

Smile, laughter and humor are the best medicine!

In every psychiatrist life, there are many cases, problems, conflicts or situations which are really taxing! The one lesson I have learnt is use of smile or laughter to take care of them. I have come across quite a few of my colleagues who feel that the medical practice, in general and the psychiatric practice, in particular are a serious business and it has no role for humor. Rather they suggest that medicine entails double lives – professional and personal. They believe that it may even be anti-therapeutic and unbecoming of a doctor! The life's journey has shown that those who use their 'smile' in interaction and humor in their dealings have invariably done well in their life and career. My wife and daughter believe that there is something wrong when there is less 'monkeying' by me at home. I try to use it as a routine in practice and can vouch for its effectiveness. The same principle applied to work - life and it surely helps in balancing! As once told by our 'Swamy' it helps break barriers, builds empathy, reduces conflicts, improves communication and makes us humane! My only advice 'the second best thing you can do with your lips is smile!'. So also always light the atmosphere with humor – it works wonders!.

Dr. T.S. Sathyanarayana Rao, Professor,
Dept. of Psychiatry, JSS Medical College Hospital, Mysore.
Editor, Indian Journal of Psychiatry. Email: tssrao19@gmail.com, raotss@yahoo.com

Invited Article

Delirium: Presentation and management

We all come across the presentation of **'altered sensorium'** in our day to day clinical practice. Typically, the patient presents with an acute/abrupt onset alteration in his cognitive functions such as decreased attention and concentration, disorientation to time, place and person in varying combination, altered level of arousal manifested by decreased or increased motoric activity accompanied by irrelevant speech, perceptual abnormalities and the classical fluctuation in clinical presentation i.e. evening worsening of symptoms. We call it 'delirium' or 'acute confusional state'.

Typically patient is an elderly with a host of medical co morbidities like chronic diseases diabetes mellitus, hypertension, coronary and/or cerebrovascular disease, on a host of medications who has a worsening of physical illness, superimposed infection, medication side effects, dehydration and/or fall/hidden injury. These patients generally have age related or more than age related cognitive decline, sensory deprivation, malnutrition and general neglect that predisposes them for such acute or at times insidious alteration in sensorium. Persons using or abusing various substances in their intoxication and/or withdrawal phase, post-operative patients, persons with CNS infections, sepsis, head injury or those in intensive care for any reason also constitute the common ones presenting with altered sensorium.

Important here is the issues of non-identification of this even in specialized settings leave alone the primary care setting. This presentation is an indicator of the severity of underlying condition, increased hospital stay, mortality and cost of care. Aging population is increasing and so is the number of persons surviving with chronic diseases and road traffic accidents (RTA) as well as substance use. So, this is an important clinical presentation across all strata of health care and more so as first encounter with GPs.

So, its early and timely recognition is the most important first step paving the way for identification of predisposing, precipitating and perpetuating factors. Predisposing factors have already been discussed. In management, it is the precipitating factors which generally clinicians look for immediate respite. Only in very lucky ones a definite cause can be found out otherwise a multi-factorial etiology generally explains the disturbance of which a combination of metabolic, infectious and organ dysfunction is the commonest finding.

Treatment of the underlying causes generally clears the sensorium but it is important to be aware of the fact that there is a lag period of varying duration between correction of etiology and achievement of clear sensorium which again depends upon a varying combination of factors discussed above. Family members must be explained the reason for altered sensorium and behavior and must be told that patient is not having a major mental disorder rather it's the bra manifestation of underlying physical abnormalities and will get better as these are treated.

Use of benzodiazepines is considered in substance related phenomenon, otherwise low dose antipsychotics are preferred in general scenario to manage behavioral disturbances especially agitation. But the behavioral management is helpful in every case which includes orientation cues, minimizing overstimulation and under stimulation both, ensuring safety of patient, proper exposure to light at various times of day and minimal change of immediate environmental settings.

Dr. Akhilesh Sharma, MD
Assistant Professor, Department of Psychiatry
PGIMER, Chandigarh
Email: drakhileshsharma@gmail.com

Psychological impact of hair loss

Hair plays an important role in determining the appearance, personality, self-image, and social perception. Hair style, length and volume are an important factors in determining a person's identity. Hair loss or alopecia can result in dissatisfaction in appearance, self-esteem, and impaired psychosocial functioning in both men and women. Alopecia is broadly classified into scarring and non-scarring types. Among scarring alopecia most common causes include trauma, lichen planus, discoid lupus erythematosus, infections etc. In non-scarring types androgenetic (patterned hair loss), alopecia areata and telogen effluvium are most common.

Effects of alopecia on mental health

In males the most common cause of alopecia is androgenetic alopecia or male pattern baldness. This is characterized by thinning and loss of hair over fronto-temporal and vertex regions. This is mediated by the hormone dihydrotestosterone (DHT). It usually leads to poor self- esteem and depression. In females' femininity, beauty, sexual attractiveness, and personality are related to hair. Hair loss can therefore seriously affect their self-esteem and body image.

Effect of mental health problems on hair loss

Obsessive compulsive disorder can be associated with frequent plucking out of one's own hair (trichotillomania). Stressful events can lead to excess hair shedding (telogen effluvium) and also can exacerbate some hair related disorders like alopecia areata, lichenplanus etc.

Management of hair loss

Adequate treatment of the hair loss problem with restoration of hair, results in improvement of patient's self-image in many if not all patients. In some cases like in alopecia areata proper medical treatment can result in complete cure of the disease process. In others cases like in androgenetic alopecia surgical treatment with hair transplantation can solve the cosmetic problem and enhance the personality and self-image. Other options to cover baldness include camouflaging with microtattooing, hair pieces etc.

Psychiatrist's liaison is vital for patients with depression, anxiety, social phobia, and identity issues. Management plan includes psychological approaches like cognitive behavior therapy and pharmacotherapy eg. antidepressants especially SSRIs and anxiolytics in specific cases with depression and anxiety.

Dr. Kavish Chouhan, MD
Consultant dermatologist and Hair transplant surgeon
Dermaclinix, New Delhi
Email: kavish_chouhan@yahoo.com

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

- ☒ Individuals with anorexia are just trying to get attention
- ✓ Although it is maladaptive, anorexia can sometimes serve as a person's way to cope with something painful in his/her life.
- ☒ Anorexia nervosa is only seen in women
- ✓ Although rare but anorexia nervosa can also be seen in men
- ☒ Anorexia nervosa is associated only with psychological symptoms
- ✓ Disorder is associated with under nutrition, secondary endocrine and metabolic changes, and disturbance of bodily functions are also reported.
- ☒ Anorexia nervosa is self-limiting condition
- ✓ It is not self-limiting. It needs to be treated properly with medications and psychotherapy

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. Language function is preserved in

a) Autism b) Asperger's syndrome c) Rett's syndrome d) Tourette syndrome

2. Strong belief about something but which lack complete conviction

a) Delusion b) Phobia c) Illusion d) Overvalued ideas

3. Which one of the following is NOT a somatic symptom?

a) Ahnedonia b) Constipation c) Impotence d) Numbness

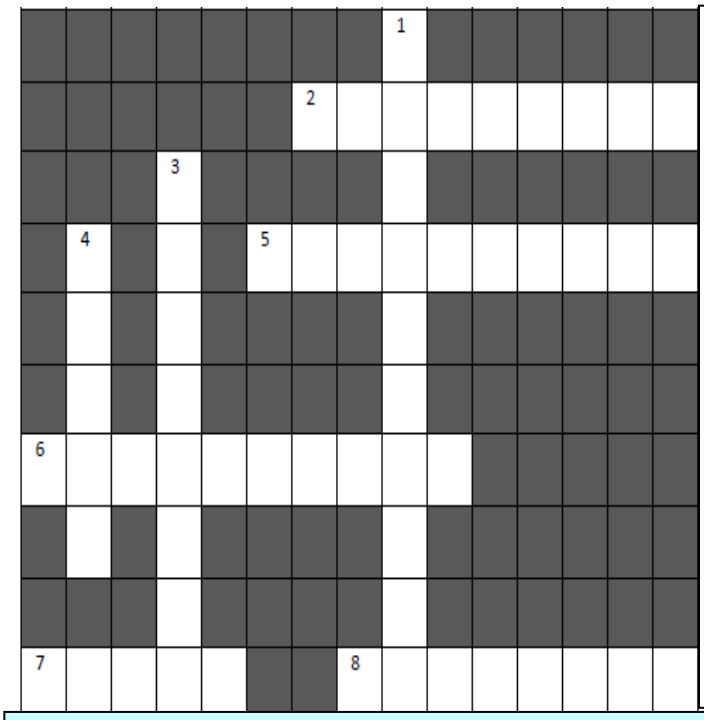
4. Suicide risk includes all except

a) Social isolation b) Male sex c) Drug dependence d) Somatization disorder

5. Drug of choice in psychosis in Parkinson's disease is

a) Clozapine b) Haloperidol c) Lithium d) Chlorpromazine

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



Crosswords

Across

2. Tendency to observe unsuspecting persons naked, disrobing or engaged in sexual activity.
5. Another name for sleep talking
6. Involuntary withholding an idea or feeling from conscious awareness
7. Appreciating the amusing nature of an anxiety provoking situation
8. Voluntary social withdrawal, limited emotional expression, content with social isolation (personality cluster)

Down

1. Hallucination that occurs while going to sleep.
3. Conscience, formed during latency period, right vs. wrong
4. Response to loss of someone

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

Quick Response Code for the Website

ANSWERS

MINDS QUIZ

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

CROSS WORDS

ACROSS

2. Voyeurism
5. Somniloquy
6. Repression
7. Humor
8. Schizoid

DOWN

1. Hypnagogic
3. Superego
4. Grief

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Enjoy a new way of learning!!!!

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