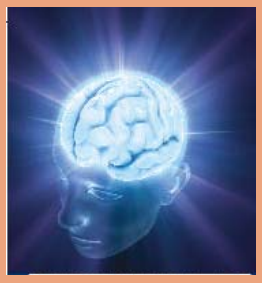

MIND

Your Wellbeing begins here…

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

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INAUGURATION

MIND Newsletter was inaugurated on 7th July 2011 by Dr.Shivaramu.M.G. Principal, AIMS. The Inaugural meet was attended by Heads of Department of all Specialties and other faculty of the Institute

Dear Sir / Ma'm,

This hardcopy is, to promote the MIND newsletter among medical undergraduates, post-graduates and faculty of various departments. This Monthly newsletter is available as FREE COLOURFUL E-COPY to all without any conditions by just e-mail request to editormind@gmail.com or unrestricted view in Facebook!

We are thankful for your support and co-operation.

From the desk of Editor

We are delighted to bring out a Monthly Newsletter "MIND" The Newsletter will focus on the interface between Psychiatry and other specialities i.e. Consultation Liaison Psychiatry (CLP) with a dedicated article from other specialities of the Institution in every issue. It will also be an interactive platform for kindling interest in Psychiatry among Undergraduates and Post-graduates. MIND Newsletter shall continue to 'reframe' itself with the feedbacks from its readers in due course of time. We are thankful to the Management, Principal, colleagues & beloved students for all the support. We look forward for your active involvement and valuable feedback.

Dr KISHOR.M & Dr VINAY.H.R
Department of Psychiatry, AIMS

NOTE: You can also connect us in Facebook! Just login into your facebook account and give a search for 'Mind Aims'. Send a request to join the group for getting more of MIND Newsletter

POINTS TO PONDER

By Aamina Nahid & Chaitra.C (5th Term Students, AIMS)

According to World Health Organization, One in four patients visiting health services has at least one Psychiatry disorder but most of them are neither diagnosed nor treated!

Prevalence of Schizophrenia is 6 times more common than Insulin Dependent Diabetes Mellitus!!

Invited Article

ETHICS & MEDICINE

- Dr.C.Shamasundar

Ethics relate to code of conduct according moral principles that have been the product of gradual evolution and refinement of man's quest to discover ways and means to safeguard the welfare of a society and its individual members. The core principles, transmitted from generation to generation, happen to be similar across cultures as different societies and religions seem to have arrived at similar conclusions. A cardinal feature of the ethical principles is its pervasive influence on all areas of society's functioning as well as on the life of each of its members. For example, judicial principles, principles of governance, **medical ethics**, and even **code of ideal human behavior are all based on ethics**.

Most of its core features, broken down into 'micro-components,' are currently being marketed as principles of 'business management' and 'public relations.' These micro-components also happen to be same as, or similar to the '**coping-skills**' or '**life-skills**' **that are emerging in the current medical literature as contributors to human wellbeing**. Moreover, the **components of ideal human behavior have already appeared in the guise of "desirable therapist qualities**" or '**non-specific therapeutic factors**' in psychotherapy outcome research. It has been established that the effectiveness of a therapist, irrespective of the method adapted, correlates with certain of his/her personal qualities called desirable therapist qualities. Examples of them are respect for the other's individuality, good will for others, empathy, honesty, genuinity (un-pretentiousness), tolerance, etc. The patients of very successful and popular general practitioners will consistently experience these qualities in their doctors.

Thus, whether we like it or not, it would be in our own interest to safeguard our own mental health or wellbeing by sincerely following ethical values. Our ethics would also help our patients to get better.

Dr.C.Shamasundar *is a distinguished former Professor of Psychiatry at National Institute of Mental Health & Neurosciences. He is a pioneer, who introduced formal Psychotherapy training at NIMHANS and also psychiatry training for general practitioners. He is well known for his keen interest in ethics. He can be contacted at* ***drshamasundar@yahoo.com***

FOOD FOR THOUGHT: FOR UGS, INTERNS, AND PGS OF AIMS - YOU CAN WRITE YOUR OPINION ON "SHOULD ETHICS BE TAUGHT IN MEDICAL COLLEGES?" IN NOT MORE THAN 250 WORDS AND WIN SURPRISE GIFT FOR THE BEST WRITE UP! LAST DATE FOR SUBMISSION AT DEPT. OF PSYCHIATRY IS 25TH AUG 2011

Consultation Liaison Psychiatry : Focus- Endocrinology

PSYCHIATRIC MANIFESTATIONS OF HYPOTHYROIDISM

- Dr. VIMALA. S. IYENGAR

A clinical syndrome of thyroid hormone deficiency is represented in the literature as a stereo typical cluster of symptoms and signs. But the clinical presentation is diverse, complicated and often overlooked. The hypothyroid state serves as a potential basis for multiple somatic complaints and psychological disturbances. At times psychiatric manifestations may be the presenting feature.

Brain has a unique sensitivity to thyroid hormones and to utilize it differently than from other system with hormone receptors being located within neural network throughout the brain. High concentration of T3 receptors are found in the amygdala and hippocampus. The effects of thyroid hormone deficiency on brain function are variable at different stages of life. The psychiatric disturbances may be in the form of affective disorders, anxiety disorders, cognitive dysfunction and even psychosis.

Affective disorders: (a) **Depression:** is one of the commonest forms of psychiatric manifestations. The origin of depression in hypothyroidism appears to relate to the role of thyroxine in serotonergic transmission, such that reduced thyroid input reduces serotonergic tone & lowers the threshold toward the development of depressive symptoms. Low mood, fatigue, anhedonia, reduced concentration, and hypersomnolence are the most commonly described features of the depressive syndrome in hypothyroidism. Thyroid hormone abnormities may occur without overt functional hypothyroidism. Designated as 'Subclinical Hypothyroidism', these scenarios can be further classified into elevated TSH without changes in thyroid hormones (grade II hypothyroidism), abnormal TSH response to stimulation with TRH (grade III), & the presence of antithyroid antibodies with no thyroid hormone system abnormalities (grade IV) . Grade II hypothyroidism has been associated with depressive disorders. .....Continued in page 3

Continued from page 2....

(b) **Bipolar disorder:** Hypothyroidism adversely affects the course of bipolar disorder and it may serve as a risk factor for the development of the rapid cycling form of bipolar disorder. There is also evidence that significant number of patients on lithium therapy for bipolar disorder have hypothyroid states which ranges from 'Minimal Thyroid Insufficiency (MTI)' to frank hypothyroidism.

The probability of underlying hypothyroid status is more when the presentation is only subsyndromal depressive symptoms; treatment resistant depression; rapid cycling affective disorder or atypical depression.

Anxiety disorders – though less common than seen in hyperthyroidism, around 30 % of hypothyroid patients tend to have anxiety symptoms in them, which should be probed.

Psychosis: The first description of myxoedema madness, a typical example of hypothyroid induced psychosis was given by Ashes (1949). There is considerable variation in clinical psychotic presentation. Psychosis typically occurs after the onset of physical symptoms, after a period of months to years. It can occur even in sub-clinical hypothyroidism indicating that psychosis maybe unrelated to the absolute degree of thyroid hormone deficiency. Onset is usually acute/subacute, fluctuating course with predominant paranoid feature. In clinical practice, it is likely that most of the psychotic symptoms in hypothyroidism will accompany a mood disorder (depression or mania), dementia or delirium.

Cognitive disorders: Cognitive decline due to hypothyroidism state can cause significant functional disability and it represents one of the reversible forms of dementia in the older age group.

Management: Investigations that would help in managing such cases are Thyroid profile - Measurement of thyroid hormones TSH, Free T4 & Free T3; Antimicrosomal & Antithyroglobulin for Autoimmune thyroid disease. The EEG-reduction in alpha wave activity and PET-decrease in cerebral blood flow and cerebral glucose metabolism serve as research tools to further understand the pathogenesis. While thyroid replacement (Thyroxine) forms the definitive treatment for overt hypothyroidism and selected cases of subclinical states, judicious use of antianxiety, antipsychotic and antidepressants carries significance in managing relevant psychiatric co-morbidity. Thyroid replacement should be started early as delay results in incomplete remission. Low starting dose and gradual titration of thyroid hormone is recommended or else an exacerbation of psychosis may occur.

Hypothyroidism has protean psychiatric manifestations which needs to explored and managed. Routine thyroid function testing of psychiatric patients is not necessary but certain population should be screened like:
a) Patient with signs and symptoms of overt hypothyroidism b) Rapid cycling bipolar disorder c) Treatment refractory depression d) Patient on Lithium e) Within 6 months of delivery or women older than 44years

Dr. VIMALA.S.IYENGAR
Associate Professor of Medicine,
Adichunchanagiri Institute of Medical Sciences (AIMS)

AWARENESS REFRAMES ASSUMPTION: SUICIDE - MYTHS & FACTS

-- Compiled by **Dr B.N.Hanumanthappa**, Resident,AIMS

- ✘ Suicide is more common in women
- ☑ Suicide attempts are three times more common in women but men complete suicide more often.
- ✘ People who talk about suicide don't complete suicide
- ☑ Many people who die by suicide would have given definite warnings of their intentions. Any comment about suicide should be explored seriously.
- ✘ Suicidal people are fully intent on dying.
- ☑ Most suicidal people are undecided about living or dying, which is called suicidal ambivalence. This ambivalence can be used in suicide prevention strategies to build Hope.
- ✘ Suicidal acts are 'out of blue' and risky, cannot be assessed.
- ☑ Risk factors for suicide that can be assessed are Past attempt, Family history of suicide, Psychiatric disorder especially Depression, Alcoholism, Chronic illness like cancer, Recent life events like death/loss of close ones.
- ✘ Enquiring about death wishes and suicidal ideas will increase risk of suicide
- ☑ Most patients wish to talk about their feelings, which should be actively explored in patients at risk.
- ✘ There are no protective factors against suicide
- ☑ Apart from absence of said risk factors, additional protective factors are: Hopefulness, access to health care that is also oriented about mental health issues, having responsibility of children less than 18yrs & having good social support.

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

MIND QUIZ

1. Drug of choice among SSRI in management of Obsessive Compulsive Disorder (OCD) _____
2. Who won Noble prize for using surgical intervention in Psychiatric illness?
3. World Mental Health Day is on _____
4. Which is the official Indexed journal of Indian Psychiatry?
5. Disulfiram, a drug used in Alcohol De-addiction acts by inhibiting _____

Answers at the bottom of page

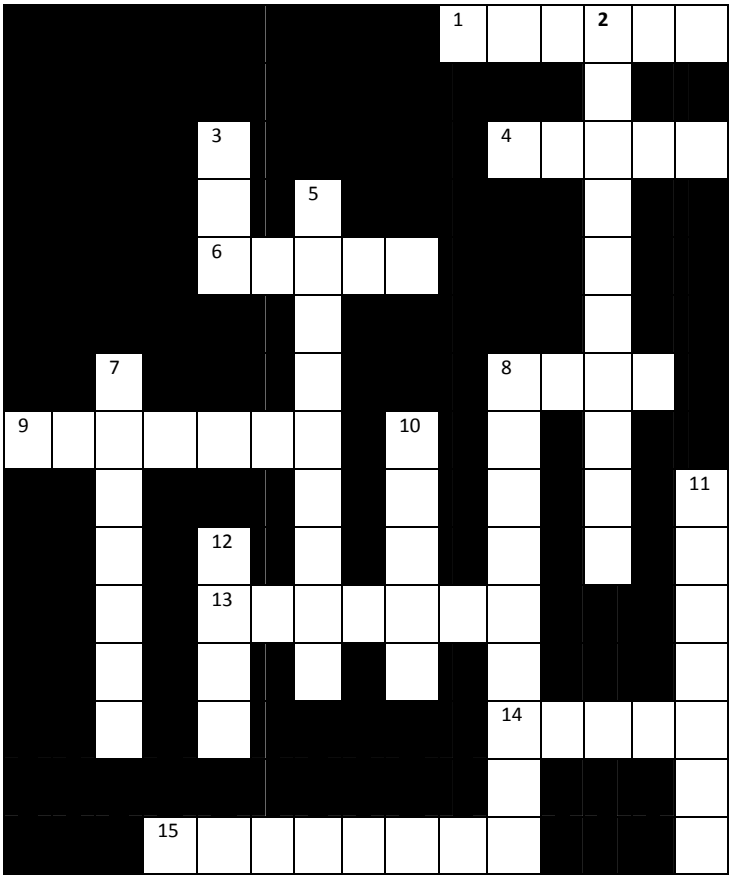
Can you CROSS the CROSSWORD?? !!

Across:

1. Stagger after getting drunk
4. Sudden appearance of anxiety
6. Disorder of inappropriate of answers.
8. Depression a disorder of…..
9. Lightest metal used for treatment of Bipolar disorder
13. The most common Psychiatry emergency condition
14. Latin word for seizure
15. A state of confusion with clouding of consciousness

Down:

2. Fear of strangers
3. Electrical activity of Brain
5. Compulsive buying, a Impulse control disorder?
7. Morbid Jealousy also called
8. Franz Mesmer described it
10. Opposite of Depression
11. Loss of Memory
12. Commonly used Class of drug in Depression



LEVEL: NOT SO EASY ANSWERS: GIVEN BELOW

Created by **Dr. Aashish S Nayak** (Intern), AIMS

Answers

Mind Quiz

1. Fluvoxamine
2. Egas Moniz
3. 10th Oct
4. Indian Journal of Psychiatry
5. Aldehyde dehydrogenase

Cross Words:

Across

1. Ataxia
4. Panic
6. Ganser
8. Mood
9. Lithium
13. Suicide
14. Ictus
15. Delirium

Down:

2. Xenophobia
3. EEG
5. Oniomania
7. Othello
8. Mesmerism
10. Mania
11. Amnésia
12. SSRI

Your opinion is important to us, so feel free & write about the MIND Newsletter to editormind@gmail.com