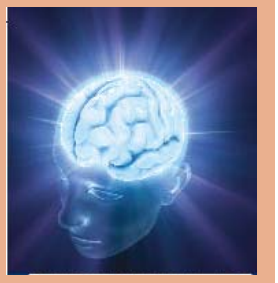

MIND

Your Wellbeing begins here…

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

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From the desk of Editor

Towards an i4 Class!

This is an age of iPods, iPad, iPhones & already iPhone4s,the latest version of smart phones is available! The current trend of utilization of high end technology products will only increase over a period of time . Most of the kindergarten & schools in cities have already incorporated smart classes with use of information technology, which are a highly interactive and intelligent way of teaching. It may not be long before this trend will engulf higher education. This will also bring in new challenges in teaching and may widen the gap between young technology savvy students and teachers.

An ideal theory class has to incorporate products from the real world. Can teaching be inclusive , integrated, intelligent & ideal ? Something like an i4 Class! Teachers may not be able stop students from using gadgets. But world over, people are making use of technology for the purpose of teaching. Thousands of e-books and 3D teachings aids are available free of cost. Certain websites like www.khanacademy.org offer thousands of teaching videos for students on numerous topics ,which are just like a theory class on a blackboard! More ever students can make groups with their teachers and can learn, can get assessment done, all at their own pace. An ideal theory class can make use of the existing intelligent technology, delivered by well trained teachers who blend perfectly, the theoretical requirements and the clinical skills in each topic, integrating information from all sources and based both on the students needs and the prescribed academic schedules. This can be achieved with a constant effort at upgrading the infrastructure in Institutions, keeping abreast of the changing technology.

Dr.Kishor.M, Asst. Professor of Psychiatry, AIMS

Guest Column: Down the Memory Lane……

How do I Understand This Case ?

On an Out-patient day at NIMHANS, a PG presented the history of a male patient in his mid-30s with complaints of bouts of abnormal behavior. He had delayed milestones of development, could not progress beyond 8th standard and had mild mental retardation. The clinical features of his bouts of abnormal behavior were suggestive of Temporal Lobe Epileptic phenomena.

Before referring him to the neurologist, I wanted to probe a little deeper into a part of his history that interested me. It was that he was married about 8 years previously to an academically brilliant girl, a rank student. Moreover, she wanted to pursue her studies into engineering or medical, and did not want to get married so soon. However, she had yielded to her parents' wishes and had agreed to marry. She came to know of her husband's illness after the marriage. I asked her about the possible consequences of the above set-backs on her life. For some reason that I could not identify at that time, I was thrilled by her answer.

She answered (non-literal English translation): "My disappointment increased after knowing about my husband's abnormality. But, I gradually became happier after realizing his virtues. He is more loving and caring than even my parents, the like of which I had never experienced during my childhood. If I am ill with fever, etc., he nurses me with tender care. He also looks after and plays with our two children, I could not have been happier."

If she had pursued her studies, she might have become a great achiever. But, I believe her current contentment as the greatest achievement. Or, has she wronged (or, deceived) herself by becoming contended?

By Dr. C. Shamasundar
Retired Prof. of Psychiatry,NIMHANS, Bengaluru

NOTE: You can also connect us in Facebook! Just login into your facebook account & give a search for 'Mind Aims' & join the group Or **Just email /SMS your email ID to get FREE Colorful e-copy of MIND Newsletter** Or contact Dr. Kiran Kantanavar, Intern (7411569877) our coordinator.

INVITED ARTICLE

Late onset Depression

It is a major misconception among many that depression is a normal phenomenon in the aged population. However, it is not true, as a majority of the aged population enjoy a sense of wellbeing as all others. Late onset depression is considered a distinct clinical entity and is defined as Depression with onset in old age (>65 yrs) , without prior history of hypomania or mania or depression. The prevalence of late onset depression is 2-5%.This is of great concern as the aged population is increasing around the globe. The numbers will increase further, as in a few years from now, India will witness a phenomenal increase in population, and become one of the most populated countries, overtaking China by 2025.

Late onset depression is more likely to manifest with certain unique features and characteristics when compared to depression in young, as they are more likely to be associated with the following features - structural changes in the brain, without a family history of mood disorders, insidious in onset, more of an irritable mood than low mood, heightened & excess concern with their health, loss of weight, feelings of guilt, suicidal ideations and more likely to have psychotic symptoms. Whether they have more cognitive impairment is not certain.

Management of late onset depression is a challenge right from diagnosis to treatment. Diagnosis can be difficult when the condition is associated with physical illness or organic brain disorders like Dementia. It may be more important to sensitize physicians about identification of the conditions as most aged population are assessed by them initially. Management involves investigation, when organic causes are suspected. CT Scan may suffice in majority of suspected cases. Addressing the co morbid conditions adequately can make management of depression more meaningful and complete. Multiple medications, decreased body mass, liver & kidney status in aged can add up to challenges when Antidepressants are prescribed. Choice of antidepressants should be made keeping the side effect profile in mind. It may be fruitful to utilize the side effect profile of the antidepressant – for example, using mirtazepine in those with poor sleep. Sertraline may be a safer choice in cardiac patients. Non pharmacological intervention such as supportive therapy, cognitive behavioral therapy and interpersonal therapy are important aspects of management, and should not be neglected.

More studies on late onset depression from urban and rural India may be necessary to address this challenge in years to come.

Dr.Kasthuri Pandiyan MD
Assistant Professor of Psychiatry, Bangalore Medical College & Research center

REFRAME:

AWARENESS REFRAMES ASSUMPTION

ANOREXIA NERVOSA: MYTHS & FACTS

- ✘ Anorexia nervosa is seen only in young women
- ☑ Anorexia nervosa seen also in men but rare.
- ✘ Anorexia nervosa is an anxiety disorder
- ☑ Anorexia nervosa is not anxiety disorder. It is classified under behavioural syndrome associated with physiological disturbances and physical factors according to WHO ICD 10
- ✘ Anorexia nervosa is seen only western countries
- ☑ It is seen across the world and cause is considered to be interaction of biological and sociocultural factors
- ✘ Anorexia nervosa is self limiting condition in particular age groups
- ☑ It is not self limiting. Condition needs to be treated although it occurs mostly in adolescent girls and young women but rarely boys and men, children approaching puberty and older women up to menopause have reported. Considerable number of patients have chronic form.
- ✘ Anorexia nervosa is associated only with psychological symptoms
- ☑ Disorder is associated with under nutrition, secondary endocrine and metabolic changes, also disturbances of bodily functions.
- ✘ Anorexia nervosa cannot be treated
- ☑ It can be treated. Management involves restoring patients' nutrition status; dehydration, starvation, and electrolyte imbalances. Cognitive behavioral therapy & medications for co-morbid conditions.

Definite diagnosis of Anorexia nervosa is based on Body weight which is at least 15% below expected and is self induced by vomiting, purging etc, with body-image distortion wherein overvalued idea of 'fatness ' & endocrine disturbances.
If onset is prepubertal, the sequence of pubertal events are delayed or arrested.

By Ms.Gowthami Chowdary Ravuri, 9th Term Student AIMS

FOOD FOR THOUGHT: FOR UGS, INTERNS - YOU CAN WRITE ON "GERIATRIC PSYCHIATRY, AN EMERGING SUBSPECIALITY " IN NOT MORE THAN 500 WORDS AND BEST WRITE UP WILL BE POSTED IN MIND NEWSLETTER GROUP OF FACEBOOK. LAST DATE FOR SUBMISSION IS 25TH, FEB 2012

THE BEST WRITE UP ON "SPECIALITY OF MY CHOICE, WHY IS IT SO?" WAS BY GOWTHAMI ON OBG AS HER CHOICE.

CONSULTATION LIAISON PSYCHIATRY FOCUS: ORTHOPEDICS

FIBROMYALGIA

Although among patients reporting at orthopedics outpatient department are more commonly referred to psychiatrist for somatization, somatoform pain disorder and those symptoms where no organic cause could be elicited. Consultation liaison with psychiatry for management of Fibromyalgia can be beneficial to patients and clinician as well. Fibromyalgia is a nonspecific disorder characterized by many diffuse complaints, including pain, stiffness, tender muscles and joints, overwhelming fatigue, distress, and sleep disturbances. The presence of pain in fibromyalgia originates in the muscles and connective tissues of the body. The exact physiological process behind fibromyalgia has not been determined. The American College of Rheumatologists (ACR) defined fibromyalgia in 1990 as the presence of 1) body or joint pain above and below the waist, and on the right and left side of the body, 2) axial skeletal pain and 3) 11 out of 18 possible tender points. Digital palpation must elicit pain in at least 11 of possible 18 tender-point sites. These bilateral sites include occiput, lower cervical, trapezius, supraspinatus, second rib, lateral epicondyle, gluteal, greater trochanter, and knees.

Patients most often have associated fatigue, sleep disorders, irritable bowel syndrome, migraine headaches, and endocrine system disorders. When examined there is surprisingly little inflammation present and biopsy samples characteristically show no unusual patterns of disease or inflammation. About 2-5% of the general population is considered to have fibromyalgia.

The etiology and pathogenesis of fibromyalgia are unknown. Environmental factors, viruses, microbes, injury, or stress have been proposed as Neurophysiological and neuroimaging reveal changes in serotonin and increased substance P this nociceptive neurotransmitter lead to amplified pain sensations. SPECT and PET demonstrated that there is a decrease blood flow in thalamic and caudate nuclei in patients with fibromyalgia.

Diagnosis of fibromyalgia can be difficult. The most common associated symptoms are fatigue, depression, sleep disturbances, and cognitive problems. Additional features may include complaints of weakness, headaches, cold sensitivity, paresthesia or dysesthesia, swelling, Raynaud's phenomena, restless legs, exercise intolerance, and irritable bowel and bladder. Psychological abnormalities, especially depression and anxiety, often develop and aggravate the condition .Fibromyalgia should be differentiated with Musculoskeletal disorders Rheumatoid arthritis Polymyalgia rheumatica Polymyositis Metabolic-endocrine myopathies Psychiatric disturbances Dysthymic disorder Generalized anxiety disorder Somatization Chronic pain syndrome. Treatment No single medical or psychiatric intervention has been shown to be uniformly effective

The current approach combines supportive counseling, cognitive-behavioral therapy, education, physical conditioning like water aerobics, cycling, yoga, and limited pharmacological interventions. muscle relaxants ,tricyclic antidepressants useful in promoting sleep and decreasing pain. Other agents being studied include tramadol ,S-adenosyl-L-methionine,5-hydroxytryptophan,growth hormone,ondansetron ,GABA agonists, sertraline, venlafaxine benzodiazepines .

Dr.Vijay Kumar.C, MS (Ortho)
Assistant Professor of Orthopedics
Adichunchunagiri Institute of Medical Sciences

NOTE : Dept of Psychiatry, AIMS regrets that our winners of IPS Southzone UG Quiz could not attend Final Rounds in ANCIPS 2012 because of Practical Examination on the same day of Quiz. However the Dept presented 2 papers at ANCIPS 2012

ANNOUNCEMENT

Upcoming Events for Undergraduates in Medical colleges of The State
By Indian Psychiatry Society, Karnataka Branch, Dates & Details will be announced soon by organizers
More likely to be between the month of March to May 2012
1. Undergraduates and Interns across the state can compete for Written Prize Quiz in Psychiatry
2. State level Psychiatry Oral Quiz only for Undergraduates; Interns are excluded

Start the preparation now and be the Winner !

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

UG n PG

MIND QUIZ

by Dr.Chaitra VHM,Intern,AIMS

Answers at the bottom of page

1. Electroencephalogram (EEG) was introduced by :
   1. Cerletti & Bini 2. Delay & Deniker 3. Hans Berger 4. Mesmer

2. Who has been often called as the "First Psychiatrist"?
   1.Paraceisus 2. Hippocrates 3. John Weyer 4. Sigmund Freud

3. Flashback phenomenon may be seen with the following except,
   1.Cannabis 2. Cocaine 3. LSD 4. Psilocybin

4. Indian Lunacy Act was passed in____ and current Indian Mental Health Act was passed in_____
   1. 1912 & 1987 2. 1932 &1997 3.1947&1967 4.1982&1998

Can you CROSS the CROSSWORD?? !!

Across: 1) Impairment of movement despite normal motor and sensory functions (7)

6) Most Potent Hallucinogen (3)

7) Pioneer of "psychosurgery" (5)

8) Antidepressants used in nocturnal enuresis (10)

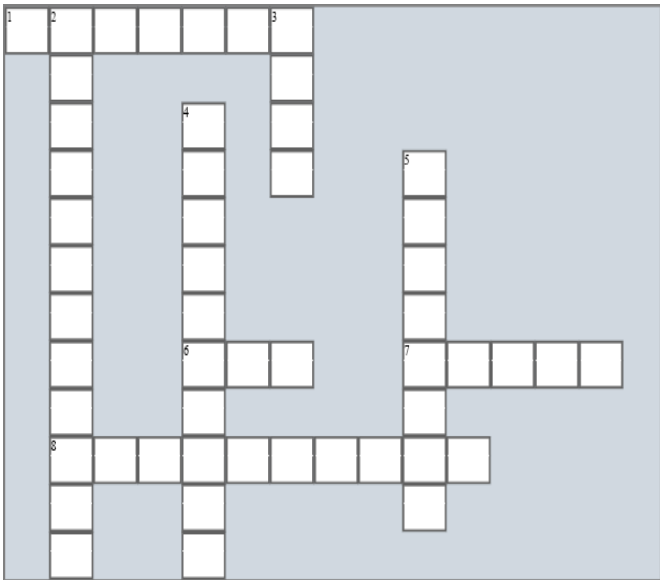
Down:

2) Group of disorders with resting tremors & bradykinesa (12)

3) Restless child, who cannot pay attention (4)

4) Sudden loss of muscle tone and with sleep, in day time (10)

5) Important neurotransmitter in schizophrenia (8)



LEVEL: NOT SO EASY ANSWERS: GIVEN BELOW

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

Answers

Mind Quiz
1.Hans Berger
2. John Weyer
3. Cocaine
4.1912 & 1987

Cross Word:
Across
1.Apraxia
6.LSD
7.Moniz
8.Imipraminel

Down:
2.Parkinsonism
3.ADHD
4.Narcolepsy
5.Dopamine

ANSWER To RGUHS Exam Final year MBBS question on Psychiatry ,**Conversion Disorders**: According to WHO ICD-10 ,Conversion or Dissociative disorders is partial or complete loss of normal integration between memories of past, awareness of identity & immediate sensations,& control of bodily movements. Types : Dissociative amnesia, fugue, stupor, trance& possession, movement& sensation, motor disorders, convulsions, anesthesia & sensory loss, mixed and ganser's syndrome, also multiple personality disorder.

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