Your Wellbeing begins here…

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

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From the desk of Editor

Patient, Doctor & Health Insurance!

Over the past decade there has been flood of health insurance schemes by numerous companies in India. Insurance companies have made profit of millions from premium and have spent a minuscule on payment for utilization by policy holders. People have realized that health care being a costly affair is more like a necessary investment than an option. Most people choose particular health insurance based on casual recommendation by someone or a scheme with least possible premium amount. Corporate sector picks up particular insurance and even changes it every year based on lowest bid it receives for its employees and hence individuals do not have a choice.

The most important aspect of all insurance schemes is that each of them has numerous exemptions! That may be related to time period since the first policy or particular illness or kind of clinical settings or type of intervention or maximum reimbursement for that category of Hospital etc. Paradoxically none of these can be understood well without input from doctors. Although most of inconvenience can be avoided in preplanned hospitalization but for many, emergency hospitalization can become a nightmare for lifetime. Sadly, most people get insured primarily for unexpected crisis. Majority of hospitals simply deny any facility even in emergency unless patient coughs up required advance amount until so called cashless insurance people approve the case! This may take couple of hours during working period of that company or whole day if admission was beyond working hours. Most important role of doctors in all insurance related issues about their patients is to have clear & open discussion with patients or relative, and also to be aware of limitations especially if the process involves planned hospitalization and in case of emergency, to do only necessary intervention until the insurance agency approves the cost. They need to be careful while filling the reimbursement form. Doctors neither can ethically neglect being aware of these neither issues nor be ignorant at the end, more so when a patient approaches doctor in complete faith.

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Guest Column: Down the Memory Lane…………How do I Understand This Case?

I am narrating here a summary of my observation concerning a unique pattern of illness manifestation in many rural patients attending the out-patient services during my service at NIMHANS. They suffered from 'somatoform disorders.' In this, somatic symptoms are the presenting features, which co-exist with both anxiety and depression. Decades ago, this syndrome was also called 'somatic- depression.'

These patients used to be given appointments for review 2-8 weeks later. But, many of them would come for review only after a few months. When enquired about the reason for not coming earlier and the status of their health during the interval, it would turn out that they would be symptom free initially for a few weeks. Later, symptoms would recur. But, they will not be able to attend review due to urgent agriculture-related work, or some important and unavoidable engagement. Despite the presence of symptoms, they would attend work whenever they can manage. If the symptoms become severe, they would rest for a day or two before getting back to work.
My experience with these patients was that, in spite of having symptoms, these patients do not have time to "fall ill," and cannot afford to "fall ill." The question that still bothers me is: "What diagnostic label to give these patients?" (i) "Symptomatically ill, but functionally healthy?" (ii) "Pathologically healthy?" (iii) Or, "Just ignorant?"
As if in response to the above experience, I have begun to recognize in my practice in the last 15 years, a small proportion of patients who suffer physical symptoms without identifiable pathology. They have no satisfying engagement during their waking hours. It is as though they suffer because they do not have anything better to do.

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

Consultation Liaison Psychiatry

Focus: Biochemistry, an Overview on Gamma Glutamyl Transferase

Gamma Glutamyl Transferase (GGT) has long been known to be helpful in Psychiatry to detect recent consumption of alcohol, as this information can be useful during motivational interview in alcohol de-addiction. However knowledge about GGT can be of help to physicians across specialities. GGT is a microsomal glycoprotein enzyme present in hepatocytes and biliary epithelial cells, renal tubules, pancreas and intestine. It is also present in cell membrane performing transfer of glutamyl residues to various peptide acceptors and involved in glutathione metabolism. Serum GGT activity mainly attributed to hepatobiliary system even though it is found in more concentration in renal tissue.

The normal level of GGT is 9 to 85 U/L.

GGT as Diagnostic tool

Elevated serum GGT activity can be found in diseases of the liver, biliary system, and pancreas. In this respect, it is similar to alkaline phosphatase (ALP) in detecting disease of the biliary tract. The main value of GGT over ALP is in verifying that ALP elevations are, in fact, due to biliary disease; ALP can also be increased in certain bone diseases, but GGT is not.

Elevated serum GGT levels of more than 10 times is observed in alcoholism. It is partly related to structural liver damage, hepatic microsomal enzyme induction or alcoholic pancreatic damage. But GGT is a poor marker when alcohol consumption needs to be screened in patients with non-alcoholic liver diseases or in hospitalised patients. Serum GGT may help to distinguish those with or without liver disease. Small increase is observed in fatty liver in alcoholics. Raised level of GGT must be interpreted in the context of other liver function tests.

- Mild liver disease tends to result in a ratio of alanine transaminase (ALT) to aspartate transaminase (AST) of greater than 1
- More extensive liver disease tends to result in an ALT to AST ratio of less than 1
- In a patient who is known to abuse alcohol; if the AST and ALT are normal then the GGT may provide an indicator of recent alcohol intake

Alcohol cessation and relation to GGT

- Increased activities usually return to normal if the patient abstains from alcohol with a normalization time of 2-3 weeks
- Persistently abnormal values in the absence of continuing ethanol exposure suggest liver disease.

GGT and risk of disease

GGT has long been used as a liver function test and a marker of alcohol abuse but in recent years, knowledge about the physiological function and several important associations have been expanded.

- Many epidemiological studies have proved that GGT is an independent predictor of risk of diabetes, hypertension, metabolic syndrome, coronary disease and hypertension.
- GGT is a novel predictor of chronic kidney disease.
- In Cancer- GGT, a known marker for apoptotic balance, seems to promote tumour progression, invasion and drug resistance
- GGT can also be an early marker of oxidative stress.

Dr Sumathi M.E, Asst Professor of Biochemistry,Sri Devraj Urs Medical College, Kolar
Dr Sumathi has done extensive research on GGT. She can be contacted at drsuma_bio@yahoo.co.in

REFRAME: Awareness Reframes Assumption

Medications used in AUTISM: MYTHS & FACTS

- ✘ Autism is classified under Mental Retardation (MR)
- ☑ Autism spectrum disorders are distinct group of disorders classified separately under pervasive developmental disorders and MR is usually a comorbid condition in most of the cases
- ✘ Medications are mainstay in the management of Autism
- ✓ Parental education and training is mainstay in management of children with Autism and medications are used only for comorbid conditions.
- ✘ Autism can be diagnosed by investigations like CT and MRI
- ☑ Autism is diagnosed clinically in a child with abnormal functioning in all 3 areas of social interaction, communication and language and restricted repetitive behaviors.
- ✘ Only boys are affected with autism and child can be diagnosed at birth
- ✓ Though boys are 3-4 times more affected, autism is also seen in girls. Diagnosis can be made clearly before the age of 3 years according to WHO. But parents appear to be concerned and seek help when the child is 18-24 months.

By Dr Nischith B K, Intern, AIMS

Invited Article

Alcohol Withdrawal Syndrome & Its Management, in Brief

Alcohol Withdrawal features are commonly encountered in clinical practice across specialties and most of the time the patient may not have revealed to the clinician that he consumes alcohol regularly or has problem drinking. Criteria to say person is in withdrawal state are, there should be reduction or cessation of alcohol use following which there must be two or more of the symptoms like, insomnia, hand tremor, tachycardia, sweating, nausea, vomiting, transient visual auditory or tactile hallucinations, psychomotor agitation and seizures, causing significant distress or impairment in social & occupational functioning. Withdrawal symptoms can occur in any settings for example patient admitted in medical, surgical or orthopedic ward etc. Symptoms of withdrawal relate proportionately to the amount & duration of alcohol intake, & also recent drinking habit.

The spectrum and time range for the appearance of symptoms after cessation of alcohol use are listed below.

Symptoms
Minor withdrawal symptoms: *6 to 12 hours* Insomnia, tremulousness, mild anxiety, gastrointestinal upset, headache, diaphoresis, palpitations, anorexia
Alcoholic hallucinosis: *12 to 24 hours* visual, auditory or tactile hallucinations
Withdrawal seizures: *24 to 48 hours* Generalized tonic-clonic seizures
Alcohol withdrawal delirium (delirium tremens): *48 to 72 hours* Hallucinations (predominately visual), disorientation, tachycardia, hypertension, low-grade fever, agitation, diaphoresis

Management of alcohol withdrawal

General care: Never over look physical condition. Supportive care like correction of fluid level, electrolytes or nutrition should be taken care. Multivitamins and thiamine100mg per day should be given before the glucose is administered to prevent precipitation of Wernicke's encephalopathy.

Pharmacological management: Detoxification is the medical management of withdrawal symptoms. Medications can be fixed schedule or symptom triggered regimen. Benzodiazepines have been shown to be safe & effective particularly for preventing or treating seizures and delirium. Important note that there is no antiepileptic prophylaxis is required for alcohol withdrawal seizures.
Choice of the agent should be based on pharmacokinetics.

Diazepam & Chlordiazepoxide are long acting & excellent, because of the long half life, withdrawal is smoother & rebound withdrawal symptoms are less likely to occur. Lorazepam and oxazepam are intermediate acting may be preferable in patients with liver failure and elderly.

Fixed schedule therapy: Predetermined amount of drug in divided doses over the day on day 1 dose, then gradually tapered off over 7 to 10 days.
One unit standard drink = 10 gms of ethanol requires = 10 mg of chlordiazepoxide = 5mg of diazepam = 1mg of lorazepam

One standard drink = 30ml of spirit (whiskey, rum, brandy, gin) = 60ml of wine = half bottle of beer = 1/3rd sachet of arrack

Choice of treatment setting: With mild to moderate withdrawal symptoms, outpatient detoxification is safe and effective, however severe withdrawal symptoms, history of withdrawal seizures or delirium tremens, multiple previous treatment failures, concomitant psychiatric or medical illness requires inpatient care

Management of alcohol withdrawal syndrome should be tailored in each case & should be followed by deaddiction treatment for alcohol dependence

Dr H. D. Bhagyavathi, Assistant Professor of Psychiatry,
Mandya Institute of Medical Sciences.

FOOD FOR THOUGHT: FOR UGs, INTERNS - YOU CAN WRITE ON "RELEVANCE OF BIOCHEMICAL & PATHOLOGICAL INVESTIGATION IN ALCOHOLIC LIVER DISEASE" 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, MAY 2012

UG n PG

An Exclusive Section for Undergraduates and Postgraduates

UG n PG

MIND QUIZ

by Dr.Chaitra VHM, Intern, AIMS

Answers at the bottom of page

1. Most common substance abuse in India is:
   a) Tobacco b) Cannabis c) Alcohol d) Opium

2. Diarrhoea, rhinorrhoea, sweating and lacrimation are seen in....
   a) Cocaine withdrawal b) Heroin withdrawal c) Alcohol withdrawal d) LSD withdrawal

3. Alcoholic Hallucinosis is associated with:
   a) Clear consciousness b) Delusions c) Delirium d) Intoxication

4. All of the following are done in behaviour therapy to increase a behaviour except:
   a) Punishment b) Operant conditioning c) Negative reinforcement d) Reward

Can you CROSS the CROSSWORD?? !!

Across

2. An Antidepressant approved in Nicotine addiction(9)

3. Used in Benzodiazepine overdose(10)

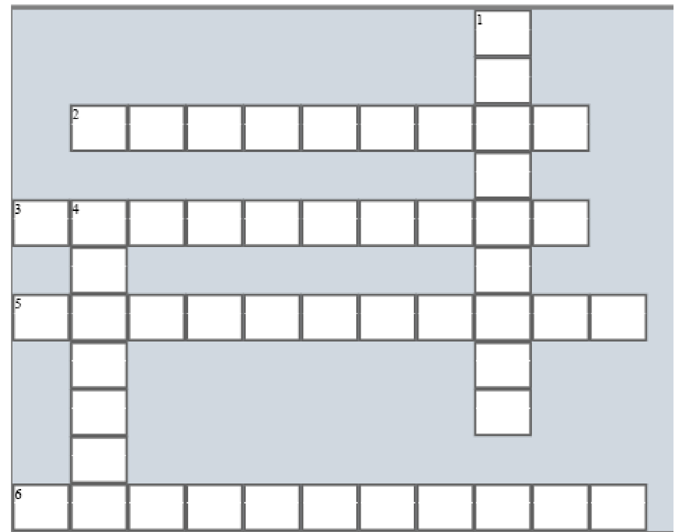
5. Used in Children with ADHD(11)

6. Atypical antipsychotic for Negative Symptoms(11)

Down

1. An antihypertensive used in ADHD (9)

4. Metal used in Mood Disorders (7)



LEVEL: NOT SO EASY

ANSWERS: GIVEN BELOW

Created by
Dr. Aashish S Nayak , *MBBS*

Answers

MIND QUIZ

1.Tobacco

2.Heroin withdrawal

3.Clear consciousness

4.Punishment

CROSS WORDS

ACROSS

2.Bupropion

4.Flumazenil

5.Atomoxetine

6.Amisulpride

DOWN

1.Clonidine

4.Lithium

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