Wellbeing begins in Our MINDS

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

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From the desk of Editor *In The Pursuit of Perfect Health*

Most of the doctors now practicing in urban centres are facing new challenge. Patients, in increasing numbers are seeking consultation for symptoms that arise with longevity of life and its related health issues. People in most of the countries are now able to survive well even years after a myocardial infarction, can walk with replaced knee joints when their knee capsule has worn out , survive a diagnosis of cancer, and in general, can challenge death quite often! The aging body is now equipped with more and more alien components, than before. The million dollar question is, has this necessarily transformed quality of life made living better than before? In other words, are we chasing shadows in the dark?

Paradoxically, along with the advancement in Health Sciences, there is a parallel increase in environmental health hazards, both of which are determinants of health! Ultimately, health is the responsibility of each individual, and he is indeed the master of his body. But, can humans have perfect health, and can we know all and prevent all? Should we pursue perfect health? When, where & who should draw a line?

Dr.Kishor.M, Consultant Psychiatrist, Mysore

Guest Column: Down The Memory Lane... *Illness Is Nothing, Where There Is Humanity*

Nearly 20 years ago, one night around 11.30 p.m. when the whole household was asleep, there was noise at our gate. I sleepily woke up to find a car load of people came urging me to come and see a patient urgently. With my standard annoyed response, I told them I would not be able to come now. The brother of one of my female patient suffering from Bipolar Affective Disorder, told me that his sister was getting married the next morning, had become symptomatic. The boy's family was refusing to go ahead with the marriage. To start with, I did not know that she was getting married (as usual they did not seek my advice in this matter). Feeling sorry for the family and looking at the gravity of the situation, I decided to go and see what I can do to help. By the time, I reached the Kalyana Mantap, it was past midnight and I could see people asleep. Bride was in a hypomanic state having stopped medication, a few days ago. I was taken to the prospective father-in-law, an orthodox, elderly man, who was fuming, that the bride's party had withheld the information. I then asked to see the bridegroom. I explained the situation to him and I was taken aback when he said, "this marriage is arranged by both the families and I have agreed. Good or bad, I will go through with it. I will not back out now, even if my family is not for it." I was dumbfounded. I had not obviously expected this answer and certainly not with the ease with which it came from him. There are people in the world, who value commitment and honour, no matter what the circumstances are. Illness is nothing, where we see humanity.

Post script: It is nearly twenty years since this incident took place. They are a happily family now and she is doing well with her maintenance medication. They come for follow up regularly. I constantly thank God, for giving me the opportunity to serve and also for getting to know that such Humans do exist amongst us.

Dr.S.Kalyanasundaram, Senior Consultant Psychiatrist, Bengaluru. He is the chairperson of Organizing committee of upcoming, Annual National Conference of Indian Psychiatry Society (ANCIPS) 2013

Invited Article

Premenstrual Dysphoric Disorder

Premenstrual Syndrome (PMS) is a combination of emotional, behavioral and physical symptoms that occur in the premenstrual or luteal phase of the menstrual cycle. The term "premenstrual tension" appeared in the medical literature 80yrs ago, but widely accepted diagnostic criteria for PMS do not exist. Approximately 80% of women report at least mild symptoms, 20 – 50% report moderate to severe symptoms and about 5% of women report severe symptoms for several says with impairment of role and social functioning. The 5% of women with severest form of PMS generally have symptoms that meet the diagnostic criteria for premenstrual dysphoric disorder (PMDD).

Research criteria for PMDD have been mentioned in DSM-IV-TR. Generally recognized syndrome involves mood symptoms (depressed mood, marked anxiety, lability, decreased interest in work, decreased concentration), behavioural symptoms (changes in eating patterns, interpersonal conflicts, lack of energy), and physical symptoms (breast tenderness, edema, headaches). This pattern of symptoms occurs at a specific time during the menstrual cycle, and the symptoms resolve for some period of time between menstrual cycles. These symptoms present in most menstrual cycles during past year, to be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles The hormonal changes occurring during the menstrual cycle are probably involved in producing symptoms, although the exact etiology is unknown. Evaluation includes a full psychiatric evaluation. Medical evaluation should rule out physical conditions that may cause symptoms in association with the premenstrual phase of the menstrual cycle (endometriosis, fibrocystic breast disease, migraine). Use of medications (OTC), caffeine, alcohol, and nicotine should be assessed because these may cause symptoms that mimic PMDD.

Treatment is based on the severity and nature of symptoms. Patients desire to be treated continuously throughout the cycle / only on symptomatic days, and patient's views regarding the use of psychotropic versus other palliative agents needs to be considered. Mild symptoms can be treated with non-pharmacological interventions (sleep hygiene, exercise, relaxation, CBT, minimize use of caffeine, salt, alcohol, & nicotine). For those with severe PMDD pharmacological therapy is required. SSRIs (fluoxetine, sertraline, paroxetine, or citalopram) can be administered throughout month / during two premenstrual weeks. Other medications like nortriptyline, nefazodone, & clomipramine have been used. Premenstrual anxiety and irritability may be treated with buspirone & clonazepam. Calcium carbonate, pyridoxine, primrose oil, magnesium, and vitamin E have been used with some results. Other treatment options like progesterone supplementation, synthetic androgen danazol, GnRH agonist leuprolide, are rarely used. Diuretics (spironolactone, hydrochlorothiazide), analgesics (mefenamic acid, naproxen) have been used for symptomatic relief.

Conclusion: women with severe and PMDD comprise a substantial proportion of menstruating women. These women have several symptomatic days each month that lead to disrupted relationships and decreased quality of life. Identification of the disorder and appropriate intervention is of importance to reduce the agony.

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Dear Readers, In order to make all sections of Newsletter useful and interactive, the Editorial Team of MINDS Newsletter will send your questions related to psychiatry, to experts and their answers will be mailed to you. Please send your queries to editormind@gmail.com and we will reply in shortest time possible.

FOOD FOR THOUGHT: Undergraduates /Interns/Postgraduates can write in their own words on topic "Influence of Estrogen on Mood Symptoms " in not more than 500 words and mail it to editormind@gmail.com. Best write up will be posted in Facebook group of **MINDS Newsletter.**

Focus: Anaesthesia

Preoperative anxiety: detection, contributing factors and management

Normally, Patients while facing a uneasy reality, such as a surgery, develop tension levels that compromise the emotional, physiological and cognitive abilities. The perioperative anxiety is defined as an emotional state with psychological and physiological elements with diffuse apprehension feelings, uncertainties, unpleasant and discomfort sensations, of a vague and unspecified nature associated to alienation and insecurity. The reported incidence of preoperative anxiety in adults ranges from 11% to 80% and Up to 65% of all children. Surprisingly interdepartmental research in this area is sparse. Three distinct dimensions of anxiety related to operation are: 1) The fear of the unknown (fear of not knowing what occurs while unconscious during anaesthesia). 2) The fear of feeling ill (fear of perioperative pain, post operative recovery as before). 3) The fear for one's life ("Not regaining consciousness after the induction of anaesthesia," i.e., a fear of dying or remaining in a coma and fear of anaesthesia-induced physical or mental harm). The dimension of the anxiety can be measured by "Amsterdam Preoperative Anxiety Information Scale (APAIS)", "Spielberg's State-Trait Anxiety Inventory (STAI-State)", "100mm visual analogue scale (VAS)", "Multiple Affect Adjective Check List (MAACL), or Yale Preoperative Anxiety Scale for children. The STAI is used frequently. Recently, VAS is popular in evaluating preoperative anxiety & fear.

Risk factors for preoperative anxiety: Young patients, Women & Children, History of alcoholism & smoking, psychiatric disorders especially anxiety disorders like phobias, depressive symptoms, high trait-anxiety, negative future perception & patients with no previous anaesthetic experience / previous negative anaesthetic experience.

Adverse effects: Preoperative anxiety adversely influences anaesthetic induction and recovery, increased need for intra-operative sedation and anaesthetic requirements. Postoperative emergence delirium, Postoperative maladaptive behaviors, in children such as new onset enuresis, feeding difficulties, separation anxiety, apathy, withdrawal, and sleep disturbances, temper tantrums may also result from anxiety before surgery. In addition to behavioral manifestations, preoperative anxiety activates the human stress response, leading to increased serum cortisol, epinephrine, and natural killer cell activity. This is associated with alterations of immune function and susceptibility to infection.

Management: Most important role of surgeon or anaesthesiologist is to empathetically educate & reassure the patient before surgery and after recovering. Referral to psychiatry, if anxiety is difficult to handle or patient has phobia or past history of psychiatric illness. Referral may be important when history of alcohol use is present because withdrawal symptoms may complicate recovery. Normally, intervention to reduce preoperative anxiety includes pharmacological anxiolytics with Benzodiazepines like Alprazolam (Caution about continued use & dependence) and Pregabalin has also been recently tried. Preoperative education program, provision of information, distraction, attention focusing and relaxation (music, humour and guided imagery) procedures, acknowledging and reassuring parental anxiety are the important keys in children.

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

- ☒ Delusions and hallucinations are one and same
- ✓ Delusions are disorders of thought and Hallucinations are disorders of perception. Delusion is a false, firm and fixed belief that a person holds on to even when proved otherwise, contrary to his social, educational and cultural upbringing. Hallucinations are perception without external stimuli.
- ☒ Delusions can be treated by proving that he / she is wrong or the belief they hold is impossible
- ✓ Delusions may be strengthened by such efforts. Delusions are classified under psychotic symptoms because the person has no or less insight about his illness.
- ☒ Delusions cannot be treated
- ✓ Delusions can be managed with antipsychotic medications and CBT (cognitive behavioural therapy). In CBT, empathetically other possible explanations for his belief are explored and the associated emotions, behaviors are modified during the therapeutic sessions.

Compiled By **Dr Neha Kulkarni**, Intern, Raichur Institute of Medical Sciences

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

1. Mr R, aged 74 yrs being treated for Hypertension, insists that he can see his mother who is dead!! This is
   (a) Illusion (b) Delusion (c) Hallucination (d) Overvalued Idea
2. Pyromania is a disorder of compulsive
   (a) Buying (b) Cellular Phone Use (c) Setting fire (d) Self mutilation
3. Historically, the neurotransmitters implicated in Schizophrenia
   (a) GABA (b) Acetylcholine (c) Serotonin (d) Dopamine
4. Not a feature of Normal Pressure Hydrocephalous
   (a) Ataxia (b) Dementia (c) Hydrocephalous (d) Ophthalmoplegia

Answers at the bottom of page

Compiled by **Dr Vinay Kumar, PG Resident, JSS Medical College**

NOTE : You can now request for any explanations to MINDS QUIZ answers by just an email to editormind@gmail.com

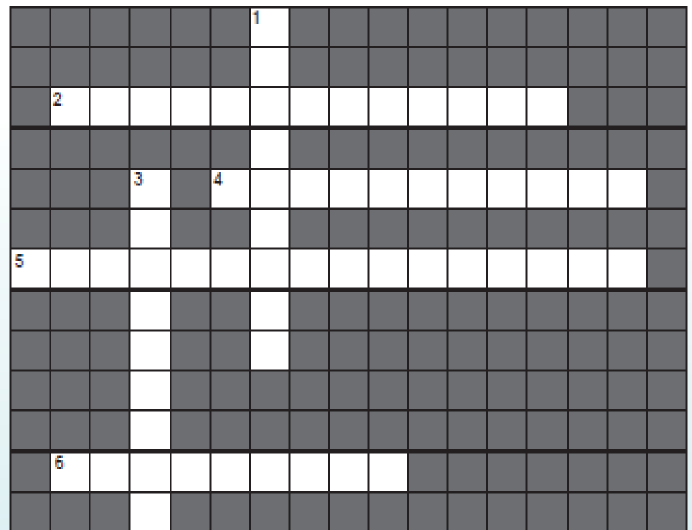
Can you CROSS the CROSSWORDS??!!

Across

2. Eugen Bleuler introduced this term (13)
4. A partial nicotine agonist used in Deaddiction of Tobacc Smoking (11)
5. Drug of choice for Alcohol Withdrawal Symptoms (16)
6. Worsening of delirium especially in night (10)

Down

1. Drug of choice in treatment resistant Schizophrenia(9)
3. Non opioid used in opioid Detoxification (9)



LEVEL: NOT SO EASY ANSWERS: GIVEN BELOW

ANSWERS

MIND QUIZ

1. Hallucination
2. Setting Fire
3. Dopamine
4. Ophtalmoplegia

CROSS WORDS

ACROSS

2. Schizophrenia
4. Varenicline
5. Chlordiazepoxide
6. SSundowning

DOWN

1.Clozapine
3.Clonidine

Created by: Dr. Vinay Kumar PG Resident, JSS Medical college

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