MINDS

Wellbeing begins in Our MINDS

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

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Articles on Psychiatry from over 20 specialities!!

Contribution from More than 50 Authors!!

Seven Sections in every Issue

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Editor
Dr. M .Kishor *MD*
Consultant Psychiatrist
Mysore

Assistant Editor
Dr. H.R Vinay *DPM*
Consultant Psychiatrist
Bangalore

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Dr Vinay Kumar
Chief Coordinator
9964319345

From the desk of Editor

Number One Priority in Life

Recently, one of the oldest and most respected monthly digest of India 'Wisdom' carried an editorial on an important but rarely discussed topic. It was about number one priority in life, "the expansion of our awareness". Aptly this is probably the only mission one should have and this could remain relevant in all scenarios whether it is scientific, socio economic, cultural, spiritual ,Intellectual or even awareness about interpersonal issues.

Every body would have noticed as child grows it explores the environment relentlessly and expands its awareness. The positive or negative outcomes do not interfere in this venture of expansion of awareness. It is only in later stage of life that majority get fixed with assumptions which actually means an inability to learn new things or think laterally. The mission of many great lives throughout the history was to expand their awareness. This ensured that their life was enriched in all ways & was satisfied. It is time each of us make an effort to reorient our priority in life towards expansion of our awareness.

Dr.M Kishor *MD*, **Consultant Psychiatrist, Mysore**

Guest Column: Down The Memory Lane… Remembering A Life Lost

A lady from Mumbai had come to consult me. I was told that she was called by her cousin specifically for consulting me for her long standing psychiatric problem. She was accompanied by the cousin's teenage daughter. History and MSE revealed it to be a rapid cycling bipolar type II and she had long standing wish to put an end to her life. I started her on appropriate regimen on outpatient basis as she was averse to admission. She started coming for regular follow-ups along with the teenage girl. The patient started showing gradual improvement and even the suicidal thoughts had also vanished. The girl accompanying her endorsed to the fact that the patient was indeed improving. Somehow the lady failed to turn up for review for about two weeks. Then one day she turned up to tell me that she had improved considerably and expressed her wish to return to Mumbai. As I was writing her prescription I casually remarked that I was also convinced about her improvement as she had come unaccompanied for the review. I suddenly heard her sobbing. I looked up wondering what the matter is. Somehow she controlled herself and said: "Doctor, see how strange facts are! The girl who was accompanying me committed suicide the very next day of my last visit to you." I was stunned to hear the news. I had observed her to be quite a cheerful youngster and could have hardly imagined such an act from her. I remained dumbstruck for long before I could react again. This incident is firmly stuck in my memory and I am not likely to forget the impact it made on me. I keep wondering how could I miss to notice any sad note or any hint of depression in her. It is true that she did not reveal it even when the so called "savior" was within her reach. I ponder: How often do we talk to the accompanying relative/person to elicit how they feel about the patient's problem and whether they feel it stressful to be with such person? How much do we really care for the emotional burden the relatives experience in such a situation? And also "Did the patient's thoughts of killing herself uncoil the dormant "Thanatos"in the teenager?"

Dr. Shripathy M Bhat **is a senior psychiatrist and professor at KMC Manipal.**

Invited Article

Negative Symptoms in Schizophrenia

Schizophrenia is a major psychiatric disorder characterized by hallucinations, delusions, disorganized behavior etc. which are called positive symptoms. However there are another set of manifestations which is called negative symptoms comprising apathy, anhedonia, poor social interaction and poor emotional reactivity. They lack a drive or motivation to pursue goals, their inability to express emotions. There is withdrawal from friends and family resulting in aloofness. Poor emotional reactivity is seen as a lack of facial expressions, intonations in the voice and reduction in gestures while talking.

Negative symptoms may be primary or secondary. They are called Primary when they occur as a part of the illness. The type of schizophrenia with primary negative symptoms is also called the 'Deficit subtype'. Secondary negative symptoms are those seen in some patients on antipsychotics who develop extrapyramidal side effects, viz, masked facies, decrease in movements, apathetic look etc. Antipsychotics cause sedation and also affect the dopamine reward system, which in turn affects the motivation of the individual. Studies on cerebral regional blood flow and SPECT show hypoperfusion in the right orbitofrontal cortex in these patients. There is a controversy as to whether the gray matter is more or less in the deficit subtype according to the results of certain studies. It is very essential to differentiate between these two types as management of each differs. SANS (Scale for Assessment of Negative Symptoms) is the scale used to assess the negative symptoms of schizophrenia. CAINS (Clinical Assessment Interview for Negative Symptoms) is another tool used to assess the same.

Patients with predominantly negative symptoms are generally less responsive to antipsychotic treatment. But there have been many studies on the usefulness of atypical antipsychotics especially clozapine. This is especially because of their action on the serotonin receptors. Drugs like risperidone, olanzapine, amisulpiride etc have been found useful. SSRIs(Selective Serotonin Reuptake Inhibitors) too have been tried. Non pharmacological treatment modalities have also been tried. A review of the studies on rTMS(repetitive transmagnetic stimulation) in the treatment of negative symptoms of schizophrenia shows that there may be promising results, but the exact potential of rTMS is not known. Along with pharmacological management, social skill training, behavioural therapy with positive reinforcement and family education in integral part of management of negative symptoms.

Dr Bindu Annageri,
Consultant Psychiatrist, JSS Medical College Hospital

FOOD FOR THOUGHT: Undergraduates /Interns/Postgraduates can write in their own words on topic "Physical Co-morbidities in Schizophrenia " 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.

REFRAME - Let Awareness Reframe Assumption: **Myths & Facts about Sexual Dysfunction In Women**

- ☒ Only Men Report with Sexual Dysfunction
- ✓ Women do report with sexual dysfunction, however most clinician's are not trained to elicit and / manage them.
- ☒ Sexual Dysfunction in women is seen only after menopausal period
- ✓ Sexual Dysfunction can be seen during any phase of life and it is not restricted to post menopausal phase.
- ☒ Sexual Dysfunction in women means severe distress.
- ✓ Sexual Dysfunction in women may not always mean severe distress. WHO describes it as lack of interest / enjoyment or failure of physiological responses necessary for effective sexual interaction or inability to have orgasm

FRONTAL LOBE TUMORS AND THEIR SURGICAL MANAGEMENT

The frontal lobe tumours by definition are intra axial arising from within the brain parenchyma (gliomas). However extrinsic tumors originating from the neighboring structures like meninges (meningiomas) would present with similar clinical features. The gliomas can be astrocytomas, oligodendrogliomas, ependymomas,with subvarieties and also mixed types. Several new tumor types have been added recently by WHO (2007). The lower grade tumors (1& 2) have longer survival compared to higher grade (3 & 4) tumors. Grade -4 tumor also known as Glioblastoma multiforme is probably the most malignant tumor known. The extra axial tumors can be varied like meningiomas or inflammatory lesions which behave like tumors eg. Tubercular, bacterial or fungal abscesses.

The clinical features may so much simulate a psychiatric disorder that they are referred to a Psychiatrist. Basal frontal lobe tumors present with pseudomania, lateral frontal with pseudodepression, medial frontal with pseudodementia. Apathy, change in personality, memory impairment, inappropriate social behavior, incontinence are all common features. Left frontal tumors cause greater loss of IQ in right handed individuals. Also speech may be affected in tumors arising in speech areas of left frontal lobe. Neighbourhood signs include anosmia, visual deterioration owing to compression on the cranial nerves. Pseudo cerebellar signs with ataxia and tremors may be seen in some of the patients. Adversive fits with head and eyes turning to opposite side may be seen in lateral frontal lobe tumors. Tumors in motor strip may cause focal or generalized seizures by irritation or may cause paralytic effects on contarlateral half or part of the body by pressure effects. Raised ICP features in later stages due to increased volume of the tumor would result in headache, vomiting, blurring of vision. Further progress would cause deterioration in consciousness progressing to coma and death.

The imaging includes mainly Contrast enhanced CT scan of the brain in suspected cases. But the MRI is essential for most of the cases prior to surgery for planning the operative approach apart from gaining information about the nature of the tumor.

Management is by surgery. It involves total excision of benign tumors like meningiomas or epidermoids or inflammatory lesions aiming to give 'cure' for the patient. However in case of gliomas radical resection by removal of as much of the tumor from the healthy parenchyma as seen under the Operating Microscope is now the standard dictum. This gives the specimen for HPE and the reduces the central bulk of the tumor which poorly responds to Radiotherapy as the latter acts mainly on the dividing cell lines in the periphery of the tumor. The extent of the tumor resection has been shown to be directly proportional to the longevity of the survival. However it may have to be restricted at times to prevent fresh neurological deficits. Routinely patients improve after tumor resection unless they come too late with advanced raised ICP features.

The higher grade gliomas Grade 3/4 will require Radio and chemotherapy. The median survival in high grade gliomas is one year although 10-20% has been living for even 2-3 years. The survival in low grade gliomas is better with few years from 4-8 years.

Dr (Col) T. Vasan *MBBS, MS, DNB MCh*
Head of the Department of Neurosurgery ,
JSS Medical College & Hospital, Mysore

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

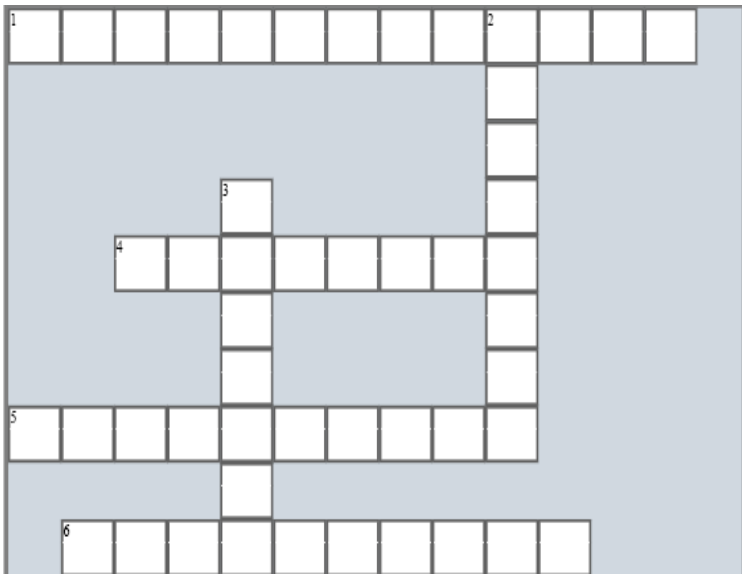
UG n PG

MINDS QUIZ

1. Sleepwalking is also called as?
   a) Bruxisim b) Nyctohermal c) Somanambulism d) Narcoplepsy
2. Which of these is the theme of World Mental Health Day 2013?
   a) Suicide b) Depression c) Anxiety d) Older age
3. According to WHO Severe Mental Retardation means IQ of
   a) 70-60 b) 50-45 c) 45-35 d) 34-20
4. Which of these is not a personality Disorder?
   a) Borderline b) Anankastic c) Schizoid d) Multiple

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

1. DOSMED is about study on this illness (13)
4. Jargon aphasia is called as_____ aphasia (8)
5. Sleep paralysis & cataplexy are seen in (10)
6. First drug approved for Restless leg syndrome (10)

Down

2. Gestaut geiswich syndrome is seen in patients with (8)
3. Delusion of doubles is called _____ Syndrome (7)

ANSWERS

MINDS QUIZ

1. Somanabulisml
2.Older age
3.34-20
4.Multiple

CROSS WORDS

ACROSS

1.Schizophrenia
3. Wernike
5.Narcoplepsy
6.Ropinirole

DOWN

2.Epilepsy
3.Fregoli

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MINDS Newsletter was launched in July 2011 as a Monthly Newsletter on Psychiatry for doctors & medical students for creating awareness and continued medical education. You can receive a free e-copy of MINDS by an e-mail request to editormind@gmail.com, or by just SMS MINDS to Editor: +91 9449347072/ Asst. Editor: +91 9886412530, or join our Facebook group @ facebook/mindsnewsletter.
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