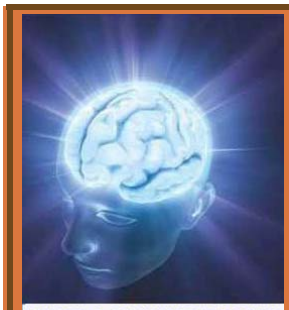

MINDS NEWSLETTER

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MINDS

Wellbeing begins in Our MINDS

MONTHLY NEWSLETTER ON PSYCHIATRY FOR DOCTORS & MEDICAL STUDENTS

Volume 3 *Issue 5* *May, 2013*

From the desk of Editor

To Acknowledge Ignorance

All holy books speak nothing but truth. Even though many valuable lessons are conveyed in the form of stories, there are immensely meaningful conversations within these stories. One of the stories on Lord Hanuman is about his great adventures during his childhood. His parents being from royal lineage invite the best of best teachers from the kingdom to teach Bal Hanuman. However the story goes on to state that none of the teachers accept him as their pupil. They humbly acknowledge that considering the adventures of Bal Hanuman only the gods can teach the child. Even though anybody could overlook this aspect of the story and move on with more adventures part, this issue has great relevance in today's world. Today, our world has numerous individuals who although are well recognized in certain areas but over the period of time assume "omnipotent role". They find it difficult to acknowledge that any field or area of knowledge could simply be beyond their competence. And this assumed belief only strengths with time; strangely it also creates a dent in their chosen field without their awareness. It is to be propagated that it is only humbleness, one has to learn to acknowledge that there are many things we do not know or cannot do.

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

Guest Column: Down The Memory Lane… Self Respect

In early 1978, when I was working at occupation therapy & rehabilitation unit, where most patients residing were deserted by their families. None had any reliable residential address. Many inmates would live together as family. One day when I was sitting in my room, two youngsters in their early twenties entered and told me that were looking for their sister who was admitted many years ago. They said that they were very young when the sister was admitted to the psychiatry hospital by father and they were keen on taking the sister home. This was an unexpected event for us and I was thrilled imagining the event of seeing the patient's reunion with her family.

I sent for their sister, Kaveri (name not real), who was working in a OT unit. She came neatly dressed, well kempt, but bearing the usual expression less face. I said with excitement "Look, your brothers have come to see you and they want to take you home." But to my amazement she looked at them casually and asked me "How do you know that these are my brothers? Ask them where were they all these years?" I could suddenly see (never seen) expression of pent up anger on her face as she turned to those youngsters and said "I have never seen you so far. I have no brothers or sisters or anyone in this world. I don't want to go anywhere from here and would stay here till I die." Now she was livid with anger and shouted "I was brought here by your father and after admitting me here he never turned up. Now why has he sent you here? Tell him I am happy here and I do not want to come home." The brothers shocked by her reaction tried to explain that they were too young at that time and it was no fault of theirs. But Kaveri did not change her stance. Tears rolled from the brothers' eyes; yet they failed to soften her stand. My attempts to alleviate her feelings and to persuade her failed. She was firm in her decision. As the whole thing had come to an impasse she got up to go back to her room. One of her brothers took out few notes of money from his pocket and offered them to her. She again became angry and said "I am paid for the work I do here" and she walked away. I looked helplessly at them. I felt sorry for them. At the same time was able to understand Kaveri's feelings. I appreciated the way she stood up for herself and took such a hard decision. Her decision reflected the self respect she had, which was hidden from us till then.

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

Invited Article

Management of Opioid Dependence

Opioids like naturally occurring opium, semi-synthetic heroine and pure synthetics such as fentanyl and methadone are a commonly abused class of substances that activate receptors like μ(mu), κ(kappa) and δ(delta) found mostly in the brain, spinal cord and gut (Goodman et al, 2001). People though initially derive pleasure and intoxication out of opioid use but soon develop craving and withdrawal symptoms. As per International Classification of Diseases (ICD-10) this cluster of physiological, behavioural and cognitive phenomena constitutes the opioid dependence syndrome (WHO, 1992). Sustained opioid dependence is associated with several negative outcomes, including early mortality, increased rates of hepatitis, human immunodeficiency virus (HIV) infection, sexually transmitted diseases, and other health problems, as well as criminal justice system involvement (Sadock, Sadock & Ruiz, 2009).

A proper treatment would involve detailed history, medical and psychiatric assessment particularly keeping in view the physical social, psychological, financial, familial, occupational and legal consequences. Among the psychiatric co-morbidities patients often have mood disorder, psychotic disorder and personality disorders. Often patients particularly (injection drug users, IDUs) require detailed investigations for the medical problems (Galanter & Kleber, 2008). The goals of treatment of opioid dependence can be either harm reduction or abstinence and subsequent rehabilitation. Depending upon motivational status harm reduction (e.g. needle exchange programme for hardcore IDUs) may be practiced. Those patients desirous of complete abstinence require detoxification whereby they are treated for troublesome withdrawal symptoms by less harmful opioids having significant cross-tolerance, longer half-life and higher potency. Commonly used are methadone (μ receptor agonist- not available in India) and buprenorphine (partial μ agonist and weak antagonist at k receptor which is not widely available in India). So, other less effective though commonly used are dextropropoxyphene (DPP) and tramadol. For symptomatic use ibuprofen or other NSAIDS (for analgesia), clonidine, an alpha 2 agonist (for reducing sympathetic over activity) and benzodiazepines (for sleep and reducing anxiety) can be used (Ruiz & Strain, 2011).

Since opioid dependence shares a prolonged relapsing and remitting type of course as in chronic medical illnesses like diabetes and hypertension, long term maintenance treatment is essential for abstinence. Agonist maintenance is done with methadone (Not in India) and buprenorphine (some centers in India). Antagonist maintenance with naltrexone is also a useful treatment though less effective particularly for the heavy users (Dhawan & Jhanjee, 2007).

Apart from pharmacotherapy, psycho-social interventions like motivation enhancement, and relapse prevention therapy can be useful. Patients also derive benefit from self-help groups like narcotics anonymous (NA), family and network therapy or by joining therapeutic communities (Lal, 2005). Only a holistic approach with comprehensive long-term therapy involving both pharmacological and non-pharmacological measures can effectively reduce the scourge of opioid dependence.

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FOOD FOR THOUGHT: Undergraduates /Interns/Postgraduates can write in their own words on topic "HIV and Opioid Abuse "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 Cannabis**

- ☒ Cannabis use is rare among Indian population
- ✓ Cannabis is most common illegal drug abused in India.
- ☒ Cannabis does not lead to dependence
- ✓ Cannabis is known to cause dependence and even in those who have not developed dependence, cannabis can causes adverse impact on their body & mind. Cannabis use has been closely associated with psychosis.
- ☒ Cannabis does not cause physical problems.
- ✓ Cannabis use is well known to affect respiratory system and hence all tobacco smokers & those abusing alcohol should be enquired for cannabis.
- ✓ Cannabis use in patients should not be neglected, doctors should motivate them to quit and or seek help

Systemic Lupus Erythematosus and Psychiatric co morbidities

Systemic Lupus Erythematosus (SLE) is a multisystem disease with protean manifestations and these are a result of circulating pathogenic autoantibodies, deposition of immune complexes and presence of circulating inflammatory cytokines. Psychiatric symptoms are common in SLE and the prevalence shows a great variability ranging from 17 to 75 %. Neuropsychiatric SLE (NPSLE) manifestations occur as single or multiple events even during periods of no non-nervous system disease activity. 40% of NPSLE manifestations develop before diagnosis of SLE and 63% occur within first year of diagnosis.

NPSLE syndromes in SLE may manifest in 19 different ways in the central and peripheral nervous system ranging from acute confusional state to plexopathy and polyneuropathy. What makes NPSLE so complex and heterogeneous is the multiplicity of proposed pathogenic mechanisms. Three mechanisms are currently described: autoantibodies, vascular abnormalities, and inflammatory mediators. Autoantibodies include antiribosomal P, antineuronal, antiglutamate, anti NMDA receptor and antiphospholipid antibodies

A psychiatric disturbance due to CNS lupus is a diagnosis of exclusion; all other possible causes of the observed symptoms must therefore be considered, including infection, electrolyte abnormalities, renal failure, drug effects, mass lesions, arterial emboli, and primary psychiatric disorders (such as bipolar disorder or severe stress disorder resulting from a chronic and life-threatening disease). Controversy exists concerning the factors responsible for psychiatric manifestations as the pathophysiological process may be compounded by iatrogenic effects of corticosteroids and psychosocial stressors related to chronic disease.

The diagnosis of NPSLE can be made only on a case-by-case basis. Select autoantibodies, CSF analysis, neuroimaging, and neuropsychological testing may be used. If clinically indicated, echocardiograms and carotid Doppler ultrasonograms should be obtained to rule out atheroembolic disease to the brain, which is accelerated in active SLE.

The management of patients with NPSLE is multimodal and continues to be a major therapeutic challenge due to the broad spectrum of the NPSLE manifestations and limitations in diagnostic testing. Glucocorticoids are one of the primary therapeutics and other medications can range from nonsteroidal anti-inflammatory drugs for symptomatic relief, anticoagulation for thrombotic diseases, to the immunosuppressives for inflammation such as cyclophosphamide, azathioprine, mycophenolate mofetil, and methotrexate. Evidence for the efficacy of these therapies is limited to uncontrolled clinical trials and anecdotal experience. Adjunctive symptomatic treatment complements these therapies by targeting mood disorders, psychosis, cognitive impairment, seizures or headaches. Psychotropic medications (antidepressants, anxiolytics, and atypical antipsychotics) may have an important adjunctive role in SLE patients with affective disorder or psychosis. There is no standardized treatment in lupus psychosis. The treatment includes a combination psychotropic medications and glucocorticoids to control underlying disease activity. Most psychiatric episodes resolve within 2–4 weeks and only 20% of SLE patients develop a chronic psychotic disorder of lesser severity. Close liaison with psychiatry is beneficial for treating clinician in the management of SLE.

Dr. SUBRAMANIAN R, *MD PDF* (Clinical Immunology and Rheumatology)

Consultant, Department of Rheumatology, JSS Medical College, Mysore

UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

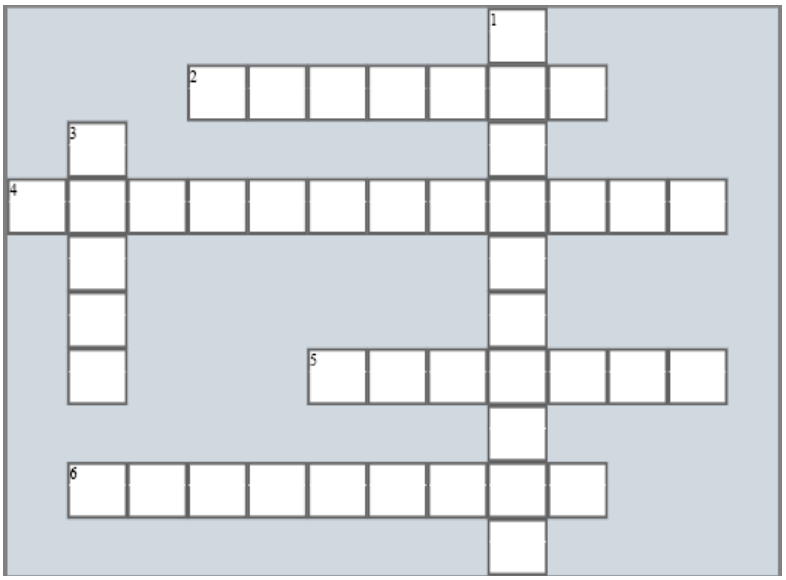
UG n PG

MINDS QUIZ

1. First Rank Symptom of Schizophrenia described by?
   a) Jasper b) Schneider c) Kasper d) Pavlov
2. Which of these is not a mature defense mechanism?
   a) Humor b) Altruism c) Suppression d) Projection
3. According to WHO Profound Mental Retardation means IQ of
   a) <50 b) <40 c) <30 d) <20
4. World Suicide Prevention Day is on ?
   a) September 10 b) April 10 c) November 10 d) October 10

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!!!



LEVEL: NOT SO EASY ANSWERS - BELOW

Across

2. Widmark formula is used for (7)

4. THERAPEUTIC Community was concept given by (12)

5. Defense mechanism used in OCD (7)

6. Drug of choice in Alzheimer's Dementia (9)

Down

1. Fear of Diseases (10)

3. Leaves of cannabis sativa are used for preparation of (5)

ANSWERS

MINDS QUIZ
1. Schenider
2.Projection
3.<20
4.September 10

CROSS WORDS
ACROSS
2.Alcohol
4.Maxwell Jones
5.Undoing
6.Donepezil
DOWN
1.Nosophobia
3.Ganja
.

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