
MINDS

*Wellbeing begins in our MINDS*

**Monthly Newsletter on Psychiatry for Doctors & Medical Students**

***Volume 3*** ***Issue 12*** ***December, 2013***

**Published from 2011**

**Articles on Psychiatry from over 20 specialities!!**

**Contribution from More than 50 Authors!!**

**Seven Sections in every Issue**

**Free e-copy just by an SMS Request!!!**

**Editor**
**Dr. Kiran Kumar K.,** *MD*
***Consultant Psychiatrist***
***Bangalore***

**Assistant Editor**
**Dr. Shivanand Manohar.,**
*DPM, DNB*
***Consultant Psychiatrist***
***Mysore***

**E-mail**
editormind@gmail.com

**You can Follow us www.facebook.com /minds.newsletter**

**For free E-copy Just mail us or SMS MINDS & your Email ID to editor**

**Immediate Past Editor & Assistant Editor**

**Dr M Kishor.,** *MD*

**Dr H R Vinay.** *DPM*

## From The Desk of the Editor: Electronic Medical Record (EMR) in current day practice

Today the buzz word in the world is digitalization, with gadgets virtually controlling all our daily routine activities. Over the past decade, every major industry has invested heavily in computerization and so is in the case of health care industry. EMRs are defined as "a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports". Doctors use specialized software, which allows them to enter information electronically and makes patient's complete history available immediately. Physicians can use a desktop, laptop, tab or electronic clipboard to navigate though patients' charts and record notes.

When weighing the pros and cons of electronic medical records, there are key advantages and disadvantages. The benefits include; significantly fewer errors found within personal health records, faster care and decision making responses from assigned medical professionals, the space saving benefit of a digital records environment, reduced operational costs such as transcription services and overtime labor expenses, customizable and scalable electronic medical records, advanced e-prescribing and clinical documentation capabilities, better processing of patient billing, ease of transferring patients data to another professional and ease of mobility with the new cloud technology. Disadvantages like perceived threat to privacy, lose of human oversight, lack of standardization and cost have to be considered before its implementation.

EMR adoption must be considered one of many approaches that diversify our focus on quality improvement and cost reduction in the near future.

**Dr. Kiran Kumar K., *MD,* Consultant Psychiatrist, Bangalore.**

## Guest Column: Down The Memory Lane…… Stirring up a Hornet's nest

While doing my post-graduation, I had an interesting interaction with a person in the campus. He was an elderly man, probably in his sixties, who was running a small shop in the campus near the old psychiatry OPD, clad in khadi shirt and mundu (lungi). He was selling biscuits, cigarettes, beedies, matches etc. (those days there were no rules governing sales and use of these things). I casually asked him "How are you swamy? How is your business?" He suddenly appeared provoked and started telling me: "What do you want to know? Do you really want to know how all those well-known people of Bangalore had and have been treating me? I can give you an account of what they did to trouble me and how they have all haunted me. I will not spare any one, whatever position he is in, be a high court judge or the prime minister or even the President of India. If you hear the story you will realize how all these so called great people have tried to put me down. But I have survived all their attempts to harass me…" He went on and on without allowing me to interrupt. I remained stunned by everything he recalled and told to me within a span of about 10 minutes. It was clear that he was elaborating on his so far encapsulated delusions. Till that day I had presumed him to be a person with some personal miseries with no one to care for him and hence housed here for shelter. I had hardly imagined him to be having so much to say in response to my informal enquiry. At the end when I abruptly departed saying I have some work, I could see a contemptuous smile on his face which I remember even now.

**Dr. Shripathy M Bhat** **is a Senior Psychiatrist and Professor at KMC, Manipal.**

## Invited Article

# Somatization Disorder: SOMATIC EXPRESSION OF PSYCHOLOGICAL DISTRESS

Somatization Disorder also known as Briquet's Syndrome is a distinct, poorly understood, clinical and public health problem, was first introduced by Stekel (1911), who defined it as "a bodily disorder that arises as the expression of deep-seated neurosis". This syndrome has been classified under somatoform disorder in ICD-10 (F45.0) and renamed as Somatic Symptom Disorder (SSD) in DSM-5. The disorder usually starts before the age of 30 years and run a chronic course. It is more common in lower socio-economic, less educated, unemployed people, with an estimated life time prevalence of 0.2-2% in females and 0.2% in males. The essential features for the diagnosis are recurrent, multiple, changing distressing somatic symptoms of many years (>2) duration, that are not fully explained by physical factor, which eventually results in significant psychological distress and socio-occupational functioning impairment. Patients generally have long complicated medical history, negative investigations and often fruitless surgeries.

The exact etiology is unknown and probably multifactorial. Biopsychosocial model suggest genetic vulnerability (abnormal proprioceptive acuity, increase sensitivity to pain), early traumatic experiences (violence, abuse), faulty learning, lack of reinforcement of nonsomatic expression of distress, and cultural/social support for somatic symptoms results in somatization disorder. Psychological factors such as inability to express emotions, assumption of sick role, secondary gains along with cultural stigma of psychological suffering than physical, family modeling and reinforcement of abnormal illness behavior contribute in etiology of disorder.

Clinical presentation are multiple and recurrent symptoms from various parts of body, commonly patient may present with gastrointestinal symptoms (e.g. nausea, vomiting, abdominal pain, belching, diarrhea), pain (headache, abdominal, joint, back, chest, during sexual intercourse or diffuse pain), pseudo neurological symptoms (amnesia, aphonia, pseudo seizures, paralysis, vague sensory loss, blindness, deafness , difficulty in swallowing, throat lump), cardiopulmonary symptoms (palpitation, atypical chest pain, dizziness, dyspnea, hyperventilation), reproductive organ symptom (painful sensation in genitals, irregularities in menstrual cycle) and other vague symptoms like food allergies, chronic fatigue or generalized weakness etc. The patients often describe their complaints in an exaggerated, dramatic, vague and in colorful language. Patient expends excessive time and energy for health concern and remains anxious about symptoms. Co-morbid psychiatric disorders particularly mood disorder, anxiety disorder, personality disorder especially antisocial, borderline, narcissistic, and histrionic, avoidant and dependent personality may complicate the overall picture.

Management is difficult and frustrating as there is no single superior treatment approach. Quill, smith (1985) et al proposed three steps management. The first step is rapport establishment, second step is educate the patient about various aspects of somatization disorder in a positive way and reassure that his illness has been understood, diagnosed, and will not lead to chronic mental, physical deterioration, disability or death help in relieving patient's anxiety and the third step is repeated and consistent reassurance and to link symptoms with "stress". Such discussion may help in gaining insight that stress may precipitate somatic symptoms. Patients in general responds better to a combination of Pharmacotherapy with other modalities like Cognitive behavior therapy (CBT), Eclectic supportive psychotherapy with emotional tone, exercise, yoga, relaxation and meditation. Untreated somatization disorder is chronic, fluctuating and relapsing disorder that remits rarely; awareness of this disorder among physicians and non-psychiatrist can reduce its burden and functional disability significantly from society.

**Dr. Nimisha Mishra (MD Psychiatry) Assistant Professor, Department of Psychiatry**
**Shyam Shah Medical College & Sanjay Gandhi Memorial Hospital & G.M.H. Rewa (MP)**

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

- ☒ Stammering is communicable from one person to another.
- ✓ Stammering is not communicable, but there are various causes for stammering.
- ☒ People who stammer are intellectually low.
- ✓ There is no such link between stammering and intelligence.
- ☒ Stress causes stammering.
- ✓ Stress itself is not the cause of stammering, but it can aggravate it.
- ☒ Stammering is incurable.
- ✓ Stammering can be cured with proper speech therapy.

**-Compiled by Dr. Raj Kiran D.**

## Hematology and Psychiatry

Hematology is a branch of medicine which deals with blood and blood related disorders. Hematological problems may, vary from sudden, severe and life threatening to long term chronically progressive and may lead to lifelong misery, discomfort and anxiety to the patients. Diagnosis of such severe problems can have sudden, severe and devastating effect not only on the patient, but also their family members.

Psychiatric problems are frequently encountered in hematology patients. The severity of symptoms may vary from mild anxiety to severe depression. These symptoms may be part of the disease per se, or as a consequence of patient's apprehension about the diagnosis, difficulty in understanding the treatment modalities or as a consequence of financial implications of the disease or treatment.

Hematological disorders, for example Megaloblastic anemia of vitamin B12 deficiency is associated with problems in cognition, mood, psychosis, and less commonly, anxiety. Folate deficiency primarily is associated with problems in mood. Patients who have sickle cell disease, a disease of chronic pain, experience difficulties with depression, anxiety, stigma, and are at risk for substance abuse and dependence. Iron deficiency anemia is associated irritability, depression. Disorders like haemophilia are associated with significant psychiatric manifestations. In a study, Sixty seven percent of them were anxious, 60% were depressed, 60% showed aggressive characteristics, 72% had obsessive-compulsive traits and 71% had psychiatric features while 52% showed somatization characteristics. Findings also revealed that occurrence of similar disorders among control group were three to four times lower than hemophiliac patients. Other major haematological disorders are leukemia, lymphoma and myeloma. In a study, during a six-month period, the total group of hospital inpatients suffering from leukemia, Hodgkin's disease or non-Hodgkin's lymphoma, were assessed, using a semi-structured interview. A prevalence of 30% of adjustment disorders (depression and/or anxiety) and 2% of organic mental syndromes was found employing the DSM-III-R diagnostic system. In a prospective inpatient study conducted from July 1994 to August 1997, 220 patients aged 16 to 65 years received Stem Cell Transplantation for hematologic cancer at a single institution, the study results reveal, overall psychiatric disorder prevalence was 44.1%; an adjustment disorder was diagnosed in 22.7% of patients, a mood disorder in 14.1%, an anxiety disorder in 8.2%, and delirium in 7.3%. Hematological manifestations can also occur in psychiatric patients. Anemia is the most common hematologic manifestation of psychiatric disorder, whether mania, depression, or other psychotic, or neurotic disorder.

In addition, almost all classes of psychotropic agents have been reported to cause blood dyscrasias. Mechanisms include direct toxic effects upon the bone marrow, the formation of antibodies against haematopoietic precursors or involve peripheral destruction of cells. Agranulocytosis is probably the most important drug-related blood dyscrasia. The mortality from drug-induced agranulocytosis is 5-10% in Western countries. The manifestations of agranulocytosis are secondary to infection. Aggressive treatment with intravenous broad-spectrum antimicrobials and bone marrow stimulants may be required. Of drugs encountered in psychiatry, antipsychotics including clozapine (risk of agranulocytosis approximately 0.8%, predominantly in the first year of treatment) and phenothiazines (chlorpromazine agranulocytosis risk approximately 0.13%), and antiepileptics (notably carbamazepine, neutropenia risk approximately 0.5%) are the most common causes of drug-related neutropenia/agranulocytosis. Drugs known to cause neutropenia should not be used concomitantly with other drugs known to cause this problem. High temperature and other indicators of possible infection should be looked for routinely during treatment. Clozapine is well known as a drug that can cause blood dyscrasias, but olanzapine and other atypicals may also cause similar problems. In addition to genetic factors, there are likely to be dose-related and immunological components to these phenomena. Important lessons have been learnt from the haematological monitoring that is necessary with clozapine and the monitoring has been very successful in preventing deaths related to clozapine-induced agranulocytosis. Continuing research into the mechanisms of drug-induced neutropenia and agranulocytosis may serve to further enhance the safe use not only of clozapine, but also of other agents.

The summary of various studies suggest psychiatric manifestations are common, more frequent than expected in haematological disorders. In psychiatric patients, haematological problems are also common, either as a part of the disease or as a result of therapy.

**Dr. Arun V, MD, DM, Consultant Hematologist & Hemato-oncologist**

**J S S hospital, Mysore.**

UG n PG

## AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

# MINDS QUIZ

1. The term *dementia praecox* was coined by
   a. Emil Krapelin b. Sigmund Freud c. Eugen Bleuler d. Kurt Schneider

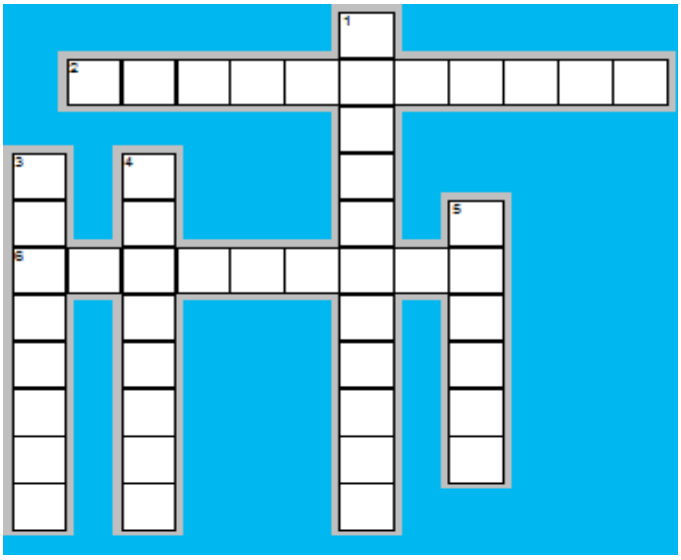
2. All are mature defense mechanisms except
   a. Altruism b. Anticipation c. Sexualization d. Sublimation

3. Serotonin norepinephrine reuptake inhibitors include
   a. Venlafaxine b. Duloxetine c. Milnacipran d. All of the above

4. Sexual gratification produced by pain that is inflicted by others or by oneself is called
   a. Sexual Masochism b. Sexual Sadism c. Transvestic Fetishism d. None of the above

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.** Neal Miller demonstrated this

**6.** Purposeful setting of fires

### Down:

**1.** An enduring pattern of inner experience and behavior

**3.** Greek word which means sleep

**4.** Social and Cultural influences on suicide

**5.** Approximate answers

**Quick Response Code for the Website**

**ANSWERS:**

MINDS QUIZ

1.a. Emil Krapelin
2. c. Sexualization
3. d. All of the above
4. a. Sexual Masochism

CROSS WORD

**ACROSS**

2. Biofeedback
6. Pyromania

**DOWN**

1. Personality
3. Hypnosis
4. Durkheim
5. Ganser

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 9886496528/ Asst. Editor: +91 9481819637, or join us www.facebook.com/minds.newsletter
All archives are available in our exclusive website www.mindsnewsletter.com or www.psychiatry4u.com
Enjoy a new way of learning!!!!

**Your suggestions are important to us, kindly mail them to editormind@gmail.com & Please pass on the newsletter**