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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From The Desk of the Editor:

"Facebook".....Is it time to 'face' the consequences?

In 1971, the first email was delivered. More than 40 years on, social media has taken the world by storm. Social networking sites, such as Facebook and Twitter, are now used by 1 in 4 people worldwide. Facebook is the leading social networking site, with more than 1.2 billion global active users every month.

Social networks are undeniably convenient and practical. They facilitate our communication with friends, promote new acquaintances and facilitate the access to information scattered on the Internet by collecting it in one place. Such activity may seem harmless, but some researchers suggest social media may affect our mental health and well-being.

The downside of Facebook is sobering and worth our attention. It appears that one in every three Facebook users experience feelings of jealousy and envy after spending time on the site. Researchers at the University of Chicago found that quitting Facebook was more difficult than giving up cigarettes or alcohol and thus rekindling the hypothesis of Facebook addiction. Researchers found that people who are more anxious and socially insecure are more likely to use the social networking site. Further issues like relationship issues, online emotional bonding, online suicidal attempt, bullying, virtual empathy, virtual modeling, lack of attention span, immediate gratification, emotional suppression, inflated sense of social well being are all going to affect the mental well being of our society. It's time for the society to become technologically mature and to incorporate some 'virtual hygiene' rules for optimal utilization of this ever evolving social network.

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

Guest Column: Down The Memory Lane..... A RURAL ENCOUNTER

After my post-graduation I was working in a rural health project 'Major mental morbidity survey' at a village. I had to go on my bicycle to hamlets around for door to door survey. I had an updated list of all households in the catchment area with the name of the head of each family. Once I set on such a mission to a village. As soon as I reached the outskirts of the village I asked a man walking past for direction to a particular household. He looked keenly at me and asked me the purpose of my search. After I explained him the purpose he told me that the head of that particular family is in a hotel where I can see him. He asked me to follow him till the hotel which was housed in a hut. He asked me to wait outside and entered the hut. After few minutes he called me in. When I entered the hut I saw 8 to 10 persons sitting on a carpet on the floor in a circle. One of them, a decently clad man, motioned me to sit along in the circle where they seemed to have kept a place reserved for me. Suddenly I realized that I was up to some trouble. When I hesitated to sit the man almost ordered me to sit which made me feel scared. With a pounding heart I sat fearing what would happen next. Then the man started asking me questions to know my identity and real purpose of looking for that particular man. They did not seem to believe that I was a doctor doing such a survey in that village. By that time I feared that they may attack me suspecting me to be a policeman in disguise. The so called hotel and the persons sitting around me appeared to be involved in some illegal activities. I had no way to escape from the situation. Suddenly a young lady walked in from the inner room and asked me if I was the doctor who had treated a particular person from the neighboring village who had been suffering from epileptic fits. With my affirmative answer she explained to them that she had heard of it and that the man is free from fits after receiving my treatment. At that juncture they appeared to believe my statements. Soon the man asked me to go away and warned me not to come to their village again. With a sigh of relief, thanking silently that God sent woman who saved my life, I cleared the place.

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

Invited Article

Buprenorphine replacement program: Boon or Bane?

Substances such as heroin, opium and morphine are known as 'opioids'. Many opioids are 'psychoactive', which means they affect the way the brain works. Opioid dependence is a chronic relapsing disorder and is associated with a wide range of psycho social issues. Opioid replacement treatment has proven efficacy in reducing opioid consumption, harm reduction strategy and psychosocial, medical morbidity and social functioning in opioid addicts.

How does Buprenorphine work?

Buprenorphine is a partial mu-opioid receptor agonist and kappa antagonist with a long half-life of 24-60 hours. When the mu receptor is stimulated, it sets in motion a chain of nerve cell activities that underlies most of the familiar opioid effects, for example, pain reduction, feelings of wellbeing or pleasure, and respiratory suppression. By stimulating the receptor only partially, buprenorphine yields those same effects, but with less intensity than heroin, morphine, or methadone, all of which stimulate the receptor fully. Buprenorphine provides a positive but moderate psychoactive effect that reduces craving and helps patients comply with their medication regimens.

How safe is BUPRENORPHINE?

"SAFE CEILING" Effect

Unlike full agonists, agonist effects of buprenorphine reach a ceiling and is less likely to cause respiratory depression incase of overdose. Buprenorphine is readily absorbed through the gastrointestinal and mucosal membranes. However, due to extensive first-pass metabolism, buprenorphine has very poor oral bioavailability (10% of the intravenous route) if swallowed. Its availability is significantly increased with sublingual administration (30–50% of the intravenous route) making this a feasible route of administration for the treatment of opioid dependence.

How to administer Buprenorphine :

Initial dose

Dispense 2-4 mg only if the patient has symptoms of withdrawal

- 2 mg if at higher risk (eg, older, lower tolerance, taking benzodiazepines)
- 4 mg for lower-risk patients

Observe for 2 h, then dispense according to symptoms:

- Withdrawal symptoms resolved

Discharge after complete detoxification, with maintenance dose of 2-4 mg/day, preferably combination with Nalaxone.

Safety:

It is estimated that buprenorphine has been prescribed close to 200,000 worldwide. The most common side effects include constipation, headache, nausea, urinary retention, and sedation. Although a decrease in respiratory rate may be observed, this is generally not clinically significant. Since buprenorphine is metabolized primarily via the cytochrome p450 3A4 system, there is potential for interaction with medications that induce or inhibit this pathway.

Our experience with Buprenorphine:

We have found buprenorphine to be vastly superior to oral drugs in terms of long term recovery, harm reduction and safety profile. With buprenorphine patients have very less withdrawal symptoms during opioid replacement therapy. It has also helped the patients to reduce cravings for opioids. Buprenorphine/naloxone is safe, cost-effective, and long-term alternative to the use of methadone. Physicians prescribing buprenorphine replacement program need not receive special training for Opioid addiction is an added advantage. It can be recommended that buprenorphine be the frontline treatment for opioid dependence in primary care. Buprenorphine along with combination of naloxone has opened a new frontier of treatment for opiate addiction. We at present with our experiences with buprenorphine success feel that this can be a miracle/wonder drug for opioid addiction.

Dr. Mahesh R Gowda, Director - Spandana Health Care, Rehab Center, Bangalore.
Dr. Sampath V, Resident- Spandana Health Care

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

- ☒ Cocaine is a clean & safe drug
- ✓ Cocaine is a psychoactive substance with lot of adverse effects.
- ☒ Cocaine is only addictive if injected
- ✓ Cocaine can be addictive any way it is taken; snorted, injected, or ingested.
- ☒ Cocaine is good at improving sexual drive
- ✓ In short term can have increased sexual drive, but on long term can have adverse effects on sex.

-Compiled by Dr. Raj Kiran D.

The Role of Pharmacovigilance in Psychiatry

A 37 year old female patient was diagnosed as a case of partial epilepsy based on history, examination, investigations and clinical judgment. She was then prescribed the antiepileptic drug, Tablet Levetiracetam, 500 mg per day. Her seizure was well controlled with the drug. After 4 months of therapy, she failed to report for her monthly visit. As she was part of a clinical study, she was contacted over phone for follow up. It was found out that she started showing less interest in household chores, was socially withdrawn and felt like committing suicide. A diagnosis of Levetiracetam induced suicidal tendency was attained based on literature review and causality assessment. The drug was stopped; the patient was prescribed Tablet Carbamazepine and was referred to psychiatry department for assessment and further monitoring.

The above is a case of adverse drug reaction (ADR). This rare reaction was reported due to the vigilant attitude of the concerned practitioner. To collate, process, and analyze such pharmacovigilance data, the pharmacovigilance program of India (PvPI) was started in the year 1986. The mission of PvPI is to safeguard the health of the population by ensuring that the benefits of use of medicines outweigh the risks associated with their use. PvPI is coordinated by the Indian Pharmacopoeia Commission and conducted by the Central Drugs Standard Control Organization (CDSCO). The purpose of PvPI is to collate data, process and analyze it and use the inferences to recommend regulatory interventions, besides communicating risks to healthcare professionals and the public.

In psychiatry practice, it is very important to be aware of and report ADRs as 1.5% of severe ADRs in hospital settings are due to psychotropic drugs. Also, like the above case, many other drugs are known to produce psychiatric adverse reactions. This has a huge impact due to challenge in diagnosis as the patients may not recollect about their medication history. The other impacts are due to extended hospitalization and increase in health care cost. A physician has to remember a few points before arriving at diagnosis of ADR. These are absence of other causes, temporal relationship, pharmacological mechanism of the drug, response to de-challenge, re-challenge and likelihood of reaction. Sometimes physicians fail to detect and report ADRs due to lack of awareness about ADR, failure to follow up with patients, busy practice schedule, and a negative attitude due to fear of medico-legal implications.

Recently PvPI has started a pharmacovigilance helpline. The number is: 1800-180-3024.

For more information and reporting ADR, one should visit the website: http://www.cdsco.nic.in/writereaddata/ADR%20form%20PvPI.pdf

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UG n PG

AN EXCLUSIVE SECTION FOR UNDERGRADUATES AND POSTGRADUATES

UG n PG

MINDS QUIZ

1. **'Cold Turkey' is a slang name for**

   a. Opiate withdrawal b. Cocaine withdrawal c. Benzodiazepine withdrawal d. Cannabis withdrawal

2. **What is Hypnopompic Hallucination**

   a. Experienced while falling asleep b. Experienced while awakening c. After head trauma d. After convulsion.

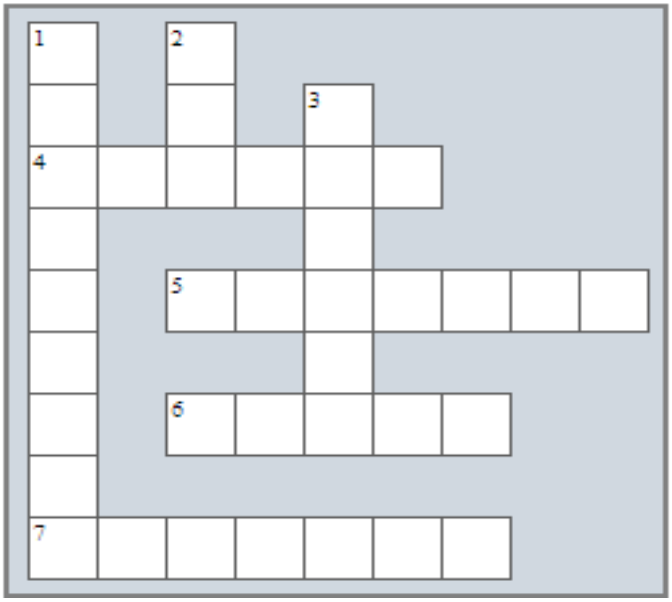
3. **La belle indifference is seen in**

   a. Schizophrenia b. Conversion Reaction c. Mania d. Depression

4. **Agoraphobia is**

   a. Fear of animals b. Fear of heights c. Caught in places from where escape would be difficult d. Fear of closed spaces

Can you cross the crosswords!!!



Across:

4. Random and involuntary quick, jerky, purposeless movements
5. .....Rorschach devised the Rorschach test
6. A rating scale used for schizophrenia
7. Patient's degree of awareness and understanding about being ill

Down:

1. One among the first to administer ECT
2. Mediates the degradation of recycled biogenic amine neuro transmitters
3. Nerve cell

Compiled by Dr. Smitha Tarachandra.

Quick Response Code for the Website

ANSWERS:

MINDS QUIZ
1. a
2. b
3. b
4. c

CROSS WORDS

ACROSS
4. CHOREA
5. HERMANN
6. PANSS
7. INSIGHT

DOWN
1. LUCIOBINI
2. MAO
3. NEURON

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