MINDS

Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

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FROM THE EDITOR'S DESK

"Medical education has been one area bearing significant brunt of the unprecedented COVID-19 pandemic. The Ministry of Health and Family Welfare released important advisories of which the recently released guidelines for medical undergraduates known as the pandemic management module, by the board of governors (BoG) in supersession of the Medical Council of India (MCI) are a much-needed step. The module covers all required areas but surprisingly falls short in psychiatry training. The significance of having psychiatry training relevant to the pandemic at undergraduate level can be better understood after going through this case scenario.

A 23-year-old married businessman was found COVID-19 positive and immediately shifted to COVID-19 designated hospital. On the 3rd day of hospitalization the man jumped from the 5th floor window and died. It was found that the man had recently begun a startup business, had severe financial losses due to the lockdown, was a sole breadwinner of the family and now diagnosed with COVID 19.

(Cont'd on Page 2)

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The overworked and exhausted hospital staff preoccupied with ensuring necessities of the protocol had no clue of the mental state of the patient. As there was no violence or aggression shown, which usually warrant a call to psychiatry, no one could anticipate the man's planning to end his life. Perhaps he waited for three days for a simple question "how do you feel?" until the thread of hope finally broken.

There is mention of training in communication skills to convey news of demise of patient to the relatives (Module 4.3; managing death during pandemic) and emotional care needed for the patient under palliative care (Module 4.6; palliative care during pandemic); however, there is no role of a psychiatrist in helping with the training in the module. Moreover, no specific hours have been allotted to psychiatry in total 80 hours of module.

In our opinion, a 4 hours training module should be added with 2 hours each to phase III part 1 and phase III, part 2. Training in soft skills, communication with patient with COVID-19 infection, dealing with COVID-19 related stigma and psychological consequences of quarantine can be included in phase III part 1 and assessment of common mental illness, violence and suicide in hospital can be included in phase III, part 2.

At the end we should remember, the medical profession is not known for programmed robots, it is known for human touch, a touch which does not spread COVID-19.

Nine – tenth of tactics are certain and are taught in books but the irrational tenth is like the kingfisher flashing across the pool
- Colonel Thomas Edward Lawrence, a British archaeologist, army-officer, diplomat, and writer

Oriental Kingfisher sketch by
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Answers to the crossword:

1. 0.1PERCENT
2. 1.5
3. PIAGET
4. COLDTURKEY
5. CLASSICAL
6. ADLER
7. TMS
9. SCHNEIDER
10. HEBEPHRENIA
11. SELYE
12. ERIKSON
13. MASLOW
14. KRAEPLIN

It was 10 years following my MBBS that I joined MD in Psychiatry at BMCRI, Bangalore after attempting Karnataka Common Entrance Test. Under the physically handicapped quota, I stood third in the merit list, scoring about 78% in the test. After I ran through all my major family obligations and coming off it almost bankrupt, I had all my hopes pinned on getting a government college seat as the fees would suit my financial standings. Some dates stick out in my memory. June 6, 2010 – organized second sister's marriage… June 10, 2020 – joined my psychiatry professional course!

Let me make a confession… In the first year, I didn't understand the subject at all. Coming from a Kannada medium background, the English of psychiatry felt difficult. "Sikkibiddidene" (trapped), I thought. I saw my teachers struggle trying to correct my ways to change my attitude, make me understand the essence of psychotherapy among other things. God sends his angels. My batch mate often reminded me of him being one. And then I got married in my second year (thought I must mention that here for all those who have half-a-thought).

I have often questioned my own capabilities as a Psychiatrist. What is my bigger purpose here? Especially after presenting dementia in a chronic alcoholic patient as chronic hypomania and defending the diagnosis in a totally biased approach during a case discussion!!!

When I completed my MD, I joined Ballari Medical College, Karnataka as an Assistant Professor in Department of Psychiatry and was requested to visit St Mary's Mental Retardation residential care facility-orphanage-home for the aged all rolled into one. Each of my visits there has changed me as a person. I had to mould myself to cater to the psychiatry, medical and surgical (except surgeries) needs of the inmates there. The type of patients would range from Tuberous sclerosis, Wilson's disease, Down's syndrome and Gestalt Geschwind syndrome apart from the routine psychiatric diagnosis.

Every face had a different story to tell…one from north India , one abandoned by a family of a nearby city; one spoke Tamil, another Telugu, one Hindi, and yet another no language at all… mute since years! I used to respond to all in the language that they understood…the language of empathy. This was the place that they all called 'Home'. Ajjas (grandfathers) and ajjis (grandmothers) of the home would wish me with folded arms and a gleeful face.

The next 5 years went by. I visited the home regularly without an expectation of any remuneration but with a greedy heart to feel fulfilment. Being there for them was therapy enough…

When I was days away from joining my MD course, a physician acquaintance commented that your limb problem isn't serious enough to be called a 'disability'. It felt like he disregarded all my experiences of a different childhood in seconds. It's true that in my study period, my colleagues never brought the topic into context but they did something more. Treated me as an equal… English or not, urban or not, stylish or not, and least of all limp or not.

I'd like to tell all the young readers, likewise, that psychiatric care cannot and should not be confined to the four walls or to pages on a diagnostic book. The clinician must lower his guard, observe patients in a non-evaluative, non-provocative setting, even if it may seem unstructured. It's essential for each one of you to choose a cause that's dear to you and invest in it the moral principles of being non-judgmental and empathic.

These shall teach you lessons for life and maybe you'll find your bigger purpose!

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(Based on an interview by Dr.Yamini. D)

INVITED ARTICLE

PALLIATIVE CARE PSYCHIATRY – ROLE OF A PSYCHIATRIST IN 'END OF LIFE CARE'

Palliative care refers to providing a patient relief from suffering caused by pain and other symptoms of a terminal illness. It is an emerging discipline at the intersection of palliative medicine and psychiatry that focuses on understanding human experience to the care of dying patients and offering emotional support to their family. Palliative care is often provided in the context of cancer patients, but is also in practice for AIDS and degenerative neurological conditions.

‘Hospice care’:

In 1960’s, due to gross inequities in caring for patients with terminal illness, the ‘Hospice movement’ was initiated by Cicely Saunders, an English health nurse, social worker-cum-physician. She emphasized the importance of integrating palliative approach into standard care for terminally ill patients. Hospice care centers exclusively offer round-the-clock pain management, house visits and medical care of these patients with on-call emergency services, counseling services to patients and families. Families express more satisfaction with hospice care services when it is combined with standard treatment services. To date, more than 100 hospice care centers are involved in care for these patients.

Palliative care psychiatrist in patient care:

Towards the end-of-life, fear of dying, loss of productivity in life, being dependent on family members generates enormous stress. They are prone to a range of psychiatric problems including anxiety, depression and delirium.

Patients with anxiety often present with restlessness, tachycardia, gastro-intestinal distress, insomnia, tremors, shortness of breath. Anxiety is also known to lower pain threshold causing increased pain and distress.

Major depressive disorder is also quite common in this population with prevalence up to 58%. Diagnostic criteria such as ‘Endicott substitution criteria’ that focus on teasing out behavioral manifestations could be useful. A past history or family history of depression is significant. Antidepressants and stimulants are the mainstay of treatment along with supportive psychotherapy. Sociality can co-occur with depression. Such patients need 24 hour monitoring. In this context, the relationship with supervising nurse may have therapeutic overtones.

Delirium has an estimated prevalence of 85% in those with advanced disease. It is multifactorial in origin with higher doses of opioids given for pain control being an important cause. Symptoms such as disorientation, impaired memory and concentration, altered arousal, sleeping excessively in daytime are common.

Palliative care psychiatrist in care of the family:

Family members assume important caring responsibilities towards care of terminally ill patients and their emotional problems intensify during this endeavor. They want to protect the patient by not talking about dying; patient is tense because he is not talking about things that will upset them

Family sessions with a psychiatrist can open up these silences and offer avenues to both parties to talk about their concerns regarding treatment, family issues, etc. Death of the patient may destabilize the family structure. In such situations, psychiatrist plays a role in promoting adaptive change and reconstitution.

Hence a psychiatrist’s role is salient and extends beyond the death of the patient in helping family members cope with the loss.

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TRANSCULTURAL PSYCHIATRY

A virus that has truly taken us by Storm! – A pathologist's resilience

The COVID-19 pandemic has posed great challenges to lab personnel. The high transmissibility of COVID -19 virus which may present in viable forms in various pathological specimens has led to development of anxiety and fearfulness among staffs and has indirectly reduced the size of workforce. New norms of maintaining social distancing resulted in segregation of staff, work in shifts, staggering of breaks and restructuring of workstations has become common. All samples need to be considered potentially infectious and handled with full safety precautions.

The COVID-19 virus is classified as a 'risk group 3' human pathogen. The Centers for Disease Control and Prevention suggests that all pathological samples pertaining to COVID-19 positive patients should be handled in a BSL2 laboratory.

Sample transportation is a potential area in pathology for which a strict protocol addressing proper labeling, packing of samples, wearing personal protective kit by staff should be included to ensure safety. The histopathology samples are placed in adequate amount of 10% formalin in spill free containers clearly marked with COVID-19 status (negative, suspected, confirmed, not tested) and all these specimens should be further placed in a secondary large container then tightly packed in a yellow bag with biohazard labeling. The corona virus takes about 24 hrs for fixation, so all small biopsies should be grossed after 24 hrs and large specimen should be processed after 48-72 hrs of fixation.

The increase in fixation time and decreased workforce are main factors responsible for exceeding the turnaround time of reporting. Frozen section examination facility is completely stopped till the pandemic gets over. Similarly direct immunofluorescence study in fresh tissue in skin and kidney biopsies is temporarily halted.

The Cytopathology lab handles different types of fresh samples and requires aerosol generating procedures like centrifugation, cytospin, FNAC smearing and cell block preparations. Processing of these samples require full PPE kits for residents, cytotechnician and other staffs acting as a potential limitation for handling large volume of routine samples. Owing to the high infectivity of corona virus, cytology lab is receiving samples related to cancer diagnostics and staging in COVID-19 negative patients only. Only alcohol fixed smears are accepted. ROSE examination for all the guided FNACs is not performed and cervical smear screening is also temporarily withheld. Liquid based cytology (LBC) preparations use relatively low alcohol concentrations, mostly based on methanol, hence this procedure is also not being used in most labs in the current pandemic.

In hematology and clinical pathology lab, centrifugation process is not done for any kind of sample as it is highly potent aerosol generating procedure. Since, Chhattisgarh is under endemic zone for sickle cell disease, for confirmed COVID-19 positive cases, a solubility test is preferred over sickling test for screening of sickle cell anaemia which is non-aerosol generating procedure.

Digital pathology is an important tool which is used in most advanced and resourceful labs which is safe mode not only for reporting but also for teaching.

To summarize, COVID-19 pandemic has remarkably changed the work pattern, workstation, and procedures and reporting in pathology laboratories. And we are holding on!

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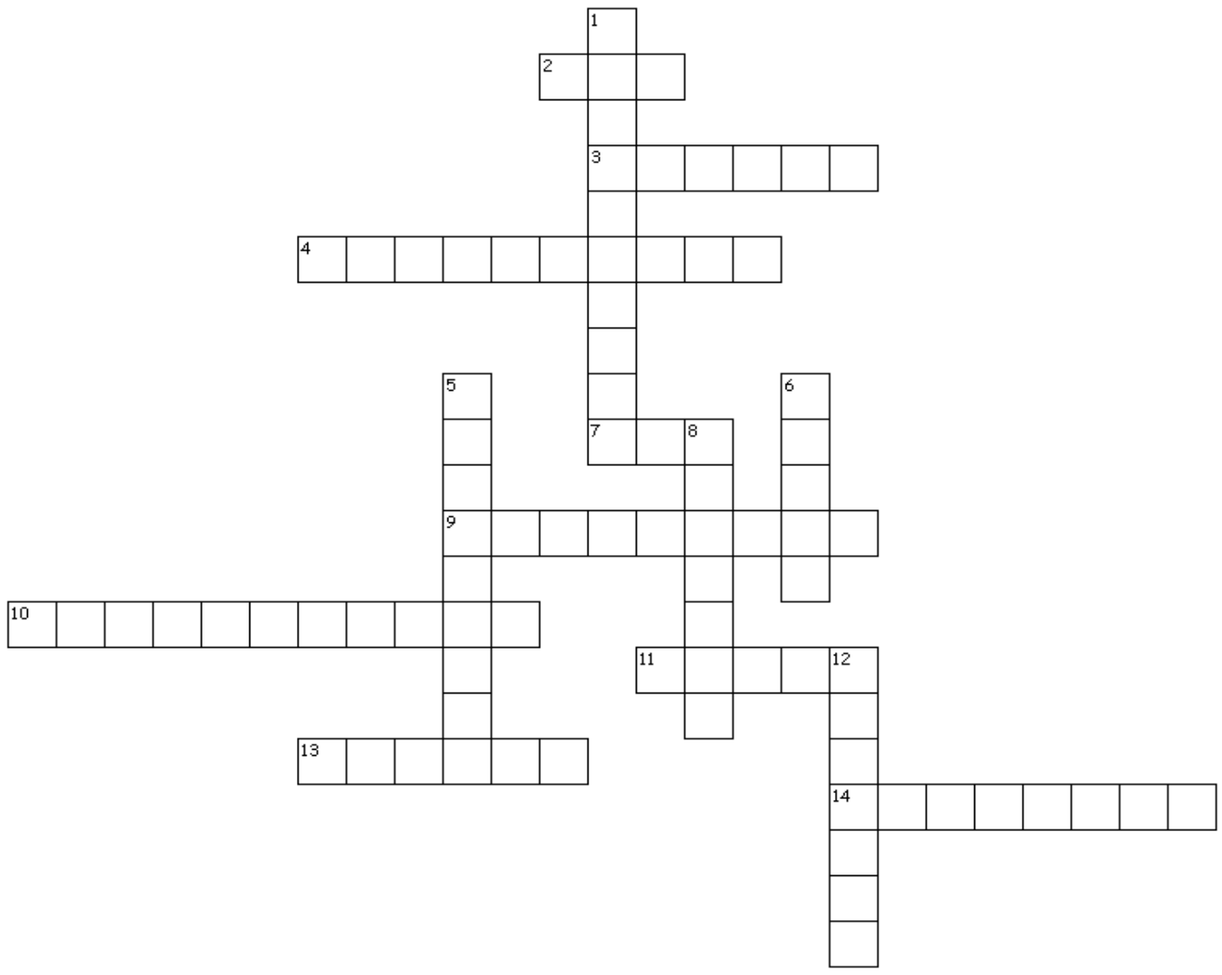

SOLVE THE CROSSWORD

Contributed by
Dr. Ramaswamy Sundararajan

ACROSS

2. meq/l of blood level of lithium which is toxic

3. contributed to the theory of cognitive development

4. the physical dependence that develops in heroin users manifests as a predictable withdrawal syndrome, often referred to as going

7. non-invasive neuronal stimulation by eddy currents used for treatment for major depressive disorder

9. first rank symptoms of schizophrenia were discovered by him

10. disorganised schizophrenia coined by hacker

11. discovered and spoke about general adaptation syndrome with respect to stress and anxiety

13. hierarchy of needs was described by him

14. coined the term dementia precox

DOWN

1. blood alcohol level causing motor actions to become clumsy

5. type of conditioning discovered by ivan pavlov

6. inferiority complex was coined by this man

8. operant conditioning was discovered and coined by this man

12.theory of psychosocial development was developed by this man

Your suggestions are important to us, kindly send them to: editormind@gmail.com

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