



MINDS NEWSLETTER

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- Contribution from More than 50 Authors!!
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Wellbeing begins in Our MINDS

Monthly Newsletter on Psychiatry for Doctors & Medical Students

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From the desk of Editor

Greetings to everyone from the editorial team of MINDS.

We are back with yet another issue. This issue features an article on the interesting topic of phantom limb, an article on mild cognitive impairment and another article on the problems related to stigma. Apart from these, we have the regular sections on 'down the memory lane' by a senior psychiatrist, quiz and a crossword.

Hope all of you enjoy reading the latest issue of the MINDS newsletter, find it useful and send us your opinion and suggestions to improve it further.

Dr. Bindu Annigeri

Guest Column: Down The Memory Lane...

BOWING TO CULTURE!

I have mentioned elsewhere when I used to cut and throw 'the limbus' adorned by the patients, they used to come back the very next morning with 'addition of limbus', pooja being done for 'overcoming the mistake' and to prevent anything wrong happening to the doctor.

It was in 1984 and I had just started my practice in Davangere. The nearby temple and Pujari there used to have more patients than I would. When taken into confidence, he became friendly. After the rituals and poojas, he used to direct them to go on the 'main road right side' (which was where I practised) and that he had vested 'great powers' in the doctor working in that 'independent tall building' and that 'he would cure them'. Even though, initially not to my liking, it worked. I could realize the patients referred by him co-operated well in the treatment, got well much better than many others and were better compliant with the treatment. He was happy that he got his clients and that they got back to him after recovery. I was happy that I was getting a steady stream of patients and above all agreed to all the treatments, were regular and compliant and they were bringing more patients. Even though the success was attributed to God and the Pujari, it was a win – win situation for all involved.

The narration then is equally effective even today. With slight modification I have found it effective, whether in Mysore or in Mandya! It all depends on how we understand the biology and its nuances with the culture, community, religion and spirituality. Each can be rewarding if utilized properly and effectively.

Dr. T.S. Sathyanarayana Rao

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INVITED ARTICLES

PHANTOM LIMB

The phantom limb pain (PLP) is the pain perceived by the region of the body no longer present. It was first described by Ambrose Pare, a sixteenth century French military surgeon. It continues to remain a poorly understood and difficult to treat medical condition. Vascular problems, trauma, cancer, and congenital limb deficiency are among the common causes of limb loss. The incidence of PLP has been reported to range from 42.2 to 78.8% in patients requiring amputation.

Table 1. Risk factors for phantom limb pain

Female Sex
Upper extremity amputation
Presence of preamputation pain
Residual pain in remaining limb
Time after amputation

Stump pain is described as the pain in the residual portion of the amputated limb whereas phantom sensations are the nonpainful sensations experienced in the body part that no longer exists. Superadded phantom sensations are touch and pressure-like sensations felt on the phantom limb from objects such as clothing. Phantom sensations and pain have been reported following amputation of different body parts including the eyes, teeth, tongue, nose, breast, penis, bowel, and bladder but the most common occurrence is following limb amputation. The phantom pain and sensation may have its onset immediately or years after the amputation. There are reports of two peak periods of onset, the first within a month and the second a year after amputation. Tingling, throbbing, piercing, and pins and needles sensations were among the most commonly described types of pain.

PLP was once thought to be primarily a psychiatric illness. But years of research has pointed towards peripheral and central neural mechanisms Proposed mechanisms to explain phantom limb pain are shown in [Table 2](#). However, none of these theoretical constructs appears to be able to explain the phenomenon of PLP independently and many experts believe that multiple mechanism are likely to be responsible.

Table 2. Proposed theoretical mechanisms to explain phantom limb pain.

1. Pheripheral mechanism
Stump and neuroma hyperactivity
 2. Central neural mechanism
Spinal cord sensitization and changes
Cortical reorganization and cortical-motor sensory dissociation
Body schema, neuromatrix and neurosignature hypothesis
 3. Psychogenic mechanism
-

A number of different therapies relying on different principles have been proposed for the management of PLP as shown in [Table 3](#). However, specific treatment guidelines are yet to evolve and most successful measures employ multidisciplinary approaches in the management of pain and in rehabilitation.

Table 3. Treatments for phantom limb pain.

Pharmacotherapy	Surgical/invasive procedures	Adjuvant therapy
Opioids	Stump revision	Transcutaneous nerve stimulation
Morphine	Nerve block	Mirror therapy
Tramadol	Neurectomy	Biofeedback
Tricyclic Antidepressants	Rhizotomy	Temperature biofeedback
Amitriptyline	Cordotomy	Electro myographic biofeedback
Nortriptyline	Lobectomy	Massage
Imipramine	Sympathectomy	Ultrasound
Desipramine	CNS Stimulation	Physiotherapy
AntiConvulsants	Spinal cord stimulation	Sensory discrimination training
Carbamazepine	Deep brain/thalamus stimulation	Prothesis training
Oxcarbazepine	Cortical stimulation	Cognitive behavioural pain management
Gabapentin		Electroconvulsive therapy
Pregabalin		
Sodium Channel Blockers		
Lidocaine		
Bupivacaine		
Mexiletine		
NMDA receptor antagonist		
Memantine		
Ketamine		

PLP is a relatively common and disabling entity. We have learned much about the pathophysiology and management of PLP since it was first described about five centuries ago. However, there is still no one unifying theory relative to the mechanism of PLP. Specific mechanism-based treatments are still evolving, and most treatments are based on recommendations for neuropathic pain. The evolution of the mechanistic hypothesis from body schema and neuropathic theories to the recently proposed role of mirror neurons in the mechanism of pain have added to our understanding of PLP. Further research is needed to elucidate the relationship between the different proposed mechanisms underlying PLP. A synthesized hypothesis explaining the phenomenon of PLP is necessary in the future for the evolution of more specific mechanism-based treatment recommendations.

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MILD COGNITIVE IMPAIRMENT

Overview: Mild cognitive impairment (MCI) is the stage between the expected cognitive decline of normal aging and the more serious decline of dementia. It can involve problems with memory, language, thinking and judgment that are greater than normal age-related changes. Mild cognitive impairment causes cognitive changes that are serious enough to be noticed by the individuals experiencing them or to other people, but the changes are not severe enough to interfere with daily life or independent function. Approximately 15-20% of people aged 65 or older have MCI. People with MCI, especially MCI involving memory problems, are more likely to develop Alzheimer's disease or other dementias than people without MCI. However, MCI does not always lead to dementia. In some individuals, MCI reverts to normal cognition or remains stable. In other cases, such as when a medication causes cognitive impairment, MCI is mistakenly diagnosed. It is important that people experiencing cognitive changes seek medical help to determine if the changes are normal for one's age, reversible or a symptom of Alzheimer's or another dementia.

Symptoms: Classification of MCI is based on the thinking skills affected: MCI that primarily affects memory is known as "amnesic MCI." With amnesic MCI, a person may start to forget important information that he or she would previously have recalled easily, such as appointments, conversations or recent events. MCI that affects thinking skills other than memory is known as "non-amnesic MCI." Thinking skills that may be affected by nonamnesic MCI include the ability to make sound decisions, judge the time or sequence of steps needed to complete a complex task, or visual perception. If one has MCI, one may also experience: Depression; Irritability and aggression; Anxiety; Apathy.

Causes: There's no single cause of mild cognitive impairment (MCI), just as there's no single outcome for the disorder. Symptoms of MCI may remain stable for years, progress to Alzheimer's disease or another type of dementia, or improve over time. Current evidence indicates that MCI often, but not always, develops from a lesser degree of the same types of brain changes seen in Alzheimer's disease or other forms of dementia. Some of these changes have been identified in autopsy studies of people with MCI which includes:

- ★ Abnormal clumps of beta-amyloid protein (plaques) and microscopic protein clumps of tau characteristic of Alzheimer's disease (tangles).
- ★ Lewy bodies, which are microscopic clumps of another protein associated with Parkinson's disease, dementia with Lewy bodies and some cases of Alzheimer's disease.
- ★ Small strokes or reduced blood flow through brain blood vessels.

Brain-imaging studies show that the following changes may be associated with MCI:

- ★ Shrinkage of the hippocampus, a brain region important for memory.
- ★ Enlargement of the brain's fluid-filled spaces (ventricles).
- ★ Reduced use of glucose, the primary source of energy for cells, in key brain regions.

Risk factors: The strongest risk factors for MCI are: Increasing age, Diabetes, Smoking, High blood pressure, Elevated cholesterol, Obesity, Depression, Lack of physical exercise, Low education level, Infrequent participation in mentally or socially stimulating activities.

Treatment and outcomes: No medications are currently approved by the U.S. Food and Drug Administration (FDA) to treat mild cognitive impairment. Drugs approved to treat symptoms of Alzheimer's disease have not shown any lasting benefit in delaying or preventing progression of MCI to dementia. The following coping strategies may be helpful for those with MCI: Exercise on a regular basis to benefit your heart and blood vessels, including those that nourish your brain, Control cardiovascular risk factors to protect your heart and blood vessels, including those that support brain function, Participate in mentally stimulating and socially engaging activities, which may help sustain brain function. Experts recommend that a person diagnosed with MCI be re-evaluated every six months to determine if symptoms are staying the same, improving or growing worse.

Dr. Vinay Kumar, Director and chief consultant psychiatrist, Manasvi hospital, Raichur

DENOUNCING LABELS TO COMBAT STIGMA: PATHWAYS TO IMPROVED HELP SEEKING IN MENTAL HEALTHCARE

The concept of stigma has developed from Goffman's pioneering work, as a complex social process of labelling, othering, devaluation and discrimination encompassing an interplay of cognitive, emotional and behavioural components. Stigmatization occurs at multiple levels simultaneously - intrapersonal (eg. self-stigma), interpersonal (eg. relations with others), and structural (eg. discriminatory and/or exclusionary policies, laws and systems). It is also keenly recognized that only powerful social groups can stigmatize. Such an understanding is helpful for appreciating how stigmatization occurs at multiple levels including structural (eg. investment of resources for care, quality of care standards, organizational culture), interpersonal (eg. social interactions, discriminatory behaviours, negative attitudes) and intra individual (eg. self-stigma, patient's reluctance to seek care, provider reluctance to disclose a mental illness and/or seek care).

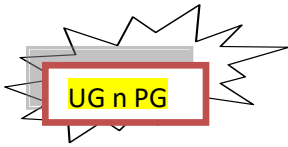
Recent research on 'help seeking' for mental health centres on the knowledge and awareness of people in order to appropriately identify signs of mental illness in themselves or in their peers (aka 'mental health literacy') and associated stigma to people with mental illness, as possible factors impacting help-seeking or help-avoidance. Studies on the sort of words used by teenagers to characterize individuals suffering from mental illness (as a measure of stigma) was conducted in middle schools across England and a total of 250 words and 20 phrases were collected. Five themes were discovered across the 250 words, with the labels used for these themes mirroring the fiercely negative connotations used by teenagers to characterize people with mental health problems. Accounting for approximately half the data (116 items) examined was the first theme, which was termed 'popular derogatory terms' and they are in effect 'slang' like "nuts, psycho, loony, crazy, mental, freak". Considering the distinction between denotative and connotative implications, these terms seem not to be specific to any emotional state (61 items) but form an assortment of negative associations and judgements in and of themselves. The second theme was found to occur around 50% times compared to the first and is described as 'negative'; most common words being "disturbed" and "confused". The third theme illustrates confusion between physical disabilities, learning difficulties and mental health problems (38 items). Fourth Theme included psychiatric terms/diagnosis like "depressed, schizophrenic" (15 items) and the fifth theme included violence (9 items). The authors concluded that, what was disturbing was the vast range and emotional power of the words chosen (n = 250) exhibiting both callousness (encroaching upon the vulgar) and a lack of accuracy in how students voiced themselves when speaking about people with mental illness.

Recent times in India has seen the use of words associated with mental illness as jibes or taunts amongst political leaders during debates on national platforms, which was called out by the Indian Psychiatry Society, who emphasized with the Electoral Committee the immediate need to discourage such connotations. A similar incident occurred wherein an upcoming Hindi movie titled "Mental hai kya?" goes against the very essence of Human rights that is invoked by the Mental Healthcare Act 2017. The IPS is currently active in seeking correction for such lapses.

A cognizance of both factual unawareness and the extent of emotionally-charged prejudice by people against people with mental illness is essential while formulating interventions intended to improve help-seeking. Media is a powerful tool of mass education and can serve as a means of mental health education. Hence responsible portrayals of mental health issues, handling the matter sensitively, building awareness, emphasizing need for timely treatment would go a long way in battling stigma. The primary point nevertheless, that battling labels is not just the task of the select few, but the society at large is yet to manifest itself in people's conscience. However, we hope the work of the few will eventually translate into the many.

Dr. Keya Das, Assistant Professor, Department of Psychiatry, PESIMSR.

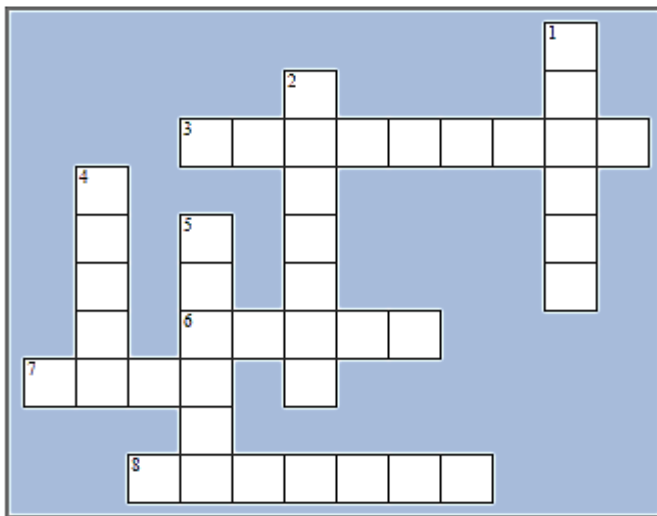
**AN EXCLUSIVE SECTION FOR
UNDERGRADUATES AND
POSTGRADUATES**



MINDS QUIZ

1. A middle aged woman is presented with a history of being repeatedly injured by husband during his sleep where he has been shouting violently moving his limbs as though enacting a dream, lasting for few minutes. He is unable to be easily woken up during such episodes. What is the likely diagnosis in husband?
 - a. Sleep terror
 - b. Sleep apnea Syndrome
 - c. REM Behavioral Disorder
 - d. Nocturnal Seizures
2. Which one of these does not belong to Obsessive-compulsive Spectrum Disorder?
 - a. OCD
 - b. Trichotillomania
 - c. Body Dysmorphic Disorder
 - d. Panic Disorder
3. All of these are characteristic symptoms of substance dependence syndrome except
 - a. Craving
 - b. Withdrawal Symptoms
 - c. Tolerance
 - d. Depression
4. What is the pathophysiology of Dopamine type-2 receptors in causation of Tardive dyskinesia?
 - a. Supersensitivity
 - b. Immune mediated
 - c. Desensitization
 - d. Hyperplasia
5. Hallucination occurring outside the limits of sensory field is called as?
 - a. Reflex hallucination
 - b. Extracampine hallucination
 - c. Pseudo-hallucination
 - d. Functional Hallucination

Can you cross the crosswords!



ACROSS

3. Compulsive buying disorder is also called as (9)
6. Infective agent causing Creutzfeldt Jacob Disease is (5)
7. This syndrome is a triad of infantile spasms, hypsarrhythmia and developmental regression (4)
8. Degree of personal awareness and understanding of illness (7)

DOWN

1. Lack of the ability to make gestures or to comprehend those made by others (6)
2. Unusually vivid or exact mental image of objects previously seen or imagined (7)
4. Rare dissociative disorders characterized by a loss of awareness of one's identity (5)
5. This is called as satiety hormone (6)

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

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

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ANSWERS

MINDS QUIZ

1. c
2. d
3. d
4. a
5. b

CROSS WORDS

ACROSS

3. Oniomania
6. Prion
7. West
8. Insight

DOWN

1. Amimia
2. Eidetic
4. Fugue
5. Leptin

