CHAPTER 16

PSYCHIATRIC CONDITIONS

SCHIZOPHRENIA AND ACUTE PSYCHOTIC DISORDER

Schizophrenia is a psychotic disorder, characterized by disturbances in thinking, emotions and perception and disorganized behaviour. The illness tends to be chronic. Patients may present to a physician when they develop a physical or behavioural problem.

SALIENT FEATURES

- Socially disorganized behaviour (abusive, aggressive, violent, destructive, roaming aimlessly).
- Talking irrelevantly, suspiciousness, fearfulness, thoughts of being harmed or controlled by some external agencies.
- Laughing, smiling or crying without any obvious reason.
- Muttering or talking to self or imaginary figures.
- Remaining quiet and withdrawn, neglecting personal care and disturbed sleep.
- Symptoms of schizophrenia are often present for a long time varying from a few months to many years. In acute psychotic disorder, duration varies from a few days to weeks.

Treatment

In patients already on treatment from a psychiatrist, the same may be continued. In others, the treatment as given below may be started but the patient should preferably be referred to a psychiatrist.

Nonpharmacological

- Psychological support by family
- Psychoeducation

Pharmacological

In a newly diagnosed case, treatment can be started as below:

Tab. Risperidone 1 mg/day, gradually increased to 2-4 mg/day in 2 divided doses after 2-4 days, which can be further increased depending on tolerability and clinical response (Usual therapeutic dose 4-8 mg/day, though most patients are likely to respond at 4 mg/day).

Or

Tab Olanzapine 5 mg/day as a single night-time dose; can be gradually increased up to 20 mg/day over 2-3 weeks depending on response and tolerability. Usual therapeutic dose is 10-20 mg/day

(**Caution:** Olanzapine has a potential to cause hyperlipidaemia and precipitate diabetes mellitus. Patients on olanzapine may require lipid and blood sugar monitoring every 6 months)

Or

Tab. Haloperidol 5 mg/day, which can be increased up to10 mg/day (in 2 divided doses) over 1-2 weeks.

Or

Tab. Trifluoperazine 10 mg/day, which can be increased to 15-20 mg/day (in 2- 3 divided doses) over 1-2 weeks.

Risperidone and olanzapine have been associated with weight gain when used for long period. Patients should be encouraged for lifestyle modification like regular physical exercise, diet control.

In case of acute excitement or violent behaviour, the patient may be given

Inj. Haloperidol 5-10 mg IM Stat. + Inj. Promethazine chloride 25-50 mg IM.

Or

Inj Olanzapine 10 mg IM

Or

Inj Lorazepam 2 mg IM

The injection can be repeated after 8 hours.

The antipsychotic medicine may cause mild to moderate side effects like sedation, slowness of movements, changes in facial expression and gait, rigidity, excessive salivation, dryness of mouth and constipation. Patient usually develops tolerance to these over a few weeks.

If the patient develops extrapyramidal symptoms like tremors, parkinsonian face, silorrhoea, add

Tab. Trihexyphenidyl 2 mg once in morning and once in afternoon (attempts may be made to taper it off after 3 months)

For sleep disturbance, give

Tab. Lorazepam 1-2 mg or clonazepam 0.25-1 mg at bedtime may be given in the initial period (usually for 10-15 days, to be tapered off thereafter).

Follow-up is required weekly initially. Once the symptoms stabilize, frequency of follow-ups may be gradually reduced to once in fortnight to once in 1-3 months. Improvement starts within one week. However, it may take few weeks to months for full response to come. The illness needs long-term treatment, which may go on from one to many years in schizophrenia. Treatment for acute psychotic disorder is usually required for 6-9 months.

Patient/family education

- Both the patient and the caregivers to be educated that schizophrenia is a psychiatric illness, which can be effectively treated by medicines. Family should be advised to be supportive and not to criticize the patient.
- Sensitise the patient to the common side effects. If the patient develops spasm of a part of body like neck or extremities or high grade fever or alterations in sensorium, immediately contact the treating doctor or the psychiatrist.
- Antipsychotics are often associated with weight gain. Encourage the patient for lifestyle modification like avoidance of fats and regular physical activity.
- Treatment should not be stopped abruptly without the advice of the treating psychiatrist.

References

1. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp. 9-122.
2. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 467-497.
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge 2005; pp. 56-87.
4. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. http://guidance.nice.org.uk/topic/behavioural accessed on 20.9.12.
5. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm accessed on 20.9.12.

BIPOLAR AFFECTIVE DISORDER

The illness is characterized by episodes of mania and depression or mania alone with intervening periods of normalcy. Patients may present to a physician in a new episode or when they develop a physical or behavioural problem, while on treatment with a psychiatrist.

SALIENT FEATURES

Episodes of mania are characterized by:

- Elevated, expansive or irritable mood, inflated self-esteem, or grandiosity, decreased need for sleep, overtalkativeness, overactivity, interfering behaviour, and excessive involvement in pleasurable activities that have a potential of harmful consequences (buying sprees, sexual indiscretions).
- Symptoms should be present for a minimum duration of one week for a diagnosis of mania to be made (for details about depressive episodes see section on Depression).

Treatment

Treatment is for the current episode and for prophylaxis, since the episodes tend to recur. Prophylaxis is usually indicated, if there are more than 2-3 episodes in the previous 4-5 years.

In patients of bipolar affective disorder already on treatment, the same may be continued. In others, the treatment as given below may be started and the patient should preferably be referred to a psychiatrist.

In a newly diagnosed case, treatment can be started as below:

Tab. Risperidone 1 mg/day gradually increased to 2-4 mg/day in 2 divided doses after 2-4 days, which can be further increased depending on tolerability and clinical response (Usual therapeutic dose 4-8 mg/day, though most patients are likely to respond at 4 mg/day)

Or

Tab Olanzapine 5 mg/day as a single night-time dose; can be gradually increased up to 20 mg/day over 2-3 weeks depending on response and tolerability. Usual therapeutic dose is 10-20 mg/day

(**Caution:** Olanzapine has a potential to cause hyperlipidaemia and precipitate diabetes mellitus. Patients on olanzapine may require lipid and blood sugar monitoring every 6 months.)

Or

Tab. Haloperidol 5 mg/day, which can be increased up to10 mg/day (in 2 divided doses) over 1-2 weeks.

Or

Tab. Divalproex (combination of sodium valproate and valproic acid) and lithium carbonate are other medications (mood stabilisers), also used for treatment of mania, but should be used only under strict psychiatric supervision.

Risperidone and olanzapine have been associated with weight gain when used for long period. Patients should be encouraged for lifestyle modification like regular physical exercise, diet control.

If the patient develops extrapyramidal symptoms like tremors, parkinsonian face, silorrhoea while on antipychotics; add,

Tab. Trihexyphenidyl 2 mg once in morning and once in afternoon (attempts may be made to taper it off after 3 months)

For sleep disturbance

Tab. Lorazepam 1-2 mg or Clonazepam 0.25-1 mg at bedtime may be given in the initial period (usually for 10-15 days, to be tapered off thereafter). In case of acute excitement or violent behaviour, the patient may be given

Inj. Haloperidol 5–10 mg IM Stat.+ Inj. Promethazine chloride 25-50 mg IM

Or

Inj Olanzapine 10 mg IM

Or

Inj Lorazepam 2 mg IM

The injection can be repeated after 8 hours.

Improvement starts within one week. The treatment may need to be given for a period of 3-6 months, usually at least for 3-4 months after the patient becomes asymptomatic. If there is no improvement in a week, the patient should be referred to a psychiatrist.

Current episode of depression

Line of treatment is similar to that as described under depression section. However, the patients of bipolar depression should also be prescribed mood stabiliser along with the antidepressant.

Prophylactic treatment

Tab. Lithium carbonate 900-1500 mg/day in 2-3 divided doses.
Or
Tab. Carbamazepine 600-1200 mg/day in 3 divided doses.
Or
Tab. Sodium valproate or divalproex 500-1500 mg/day in 2-3 divided doses.

Note: Prophylactic treatment should only be given under psychiatric supervision. Prophylaxis is required generally after 2-3 episodes. Prophylactic treatment may continue for a duration varying from 3 years to lifelong. Patients on lithium require regular blood level monitoring. Liver function test and blood cell counts should be performed at baseline and once in 6 months in patients on carbamazepine and sodium valproate.

Patient education

- General guidelines about the illness and medications similar to that for schizophrenia.
- Emphasize on recurrent course of illness and not to get too much worried on recurrences.
- Relapses can be treated as successfully as the first episode.
- When on lithium, advice to take plenty of fluids, especially during summer; not to restrict salt.
- If the patient develops fever, vomiting or diarrhoea while on lithium, reduce the dose of lithium to half and contact the physician or the psychiatrist.

References

1. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp 123-154.
2. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 527-561
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge 2005; pp. 22-55.

4. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. http://guidance.nice.org.uk/topic/behavioural accessed on 20.9.12.
5. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm accessed on 20.9.12.

DEPRESSION

Depression is one of the commonest psychiatric disorders. Patients often present to the general practitioners and the physicians. Patients of depression often present with vague somatic symptoms or aches and pains in general clinical practice, for which no physical cause is found on assessment. A careful screening for depressive symptoms (as outlined under salient features) usually elicits the diagnosis.

SALIENT FEATURES

- Sadness of mood, loss of pleasure in activities, which one enjoyed earlier, generalized lack of interest, anxiety is often associated.
- Lack of energy, slowness of thought, decreased concentration and efficiency.
- Lack of sleep, appetite and libido.
- Ideas of insufficiency, inadequacy and worthlessness, unexplained ideas of guilt, death wishes, suicidal ideas, history of suicidal attempt.
- Disruption of social and occupational functioning.
- Symptoms should be present for a minimum period of 2 weeks for a diagnosis of depression to be made.

Treatment

Nonpharmacological

- Counselling, reassurance, psychological support, encouragement.
- Cognitive therapy (to be given by a psychiatrist).

Pharmacological

Cap. Fluoxetine 20-60 mg/day as a single dose in morning with food; starting with 20 mg/day which can be increased up to 60 mg/day in increments of 20 mg after 5-6 weeks in case of non-response.

Or

Tab. Sertraline 50-200 mg/day as a single dose in morning with food; starting with 50 mg/day which can be increased up to 200 mg/day after 5-6 weeks in increments of 50 mg in case of non-response.

Or

Tab. Escitalopram 10-20 mg/day as a single dose in morning with food; starting with 5 mg/day which can be increased to 10 mg/day over a week, and further up to

20 mg/day after 5-6 weeks in case of non-response. Most patients would respond at 10 mg/day.

Or

Tab. Mirtazapine 15-45 mg/day as a single night-time dose starting with 15 mg/day which can be increased up to 45 mg/day in increments of 15 mg after 5-6 weeks in case of non-response.

Or

Tricyclic antidepressants (TCAs) like Tab. Imipramine or Tab. Amitriptyline 75-150 mg/day in 2-3 divided doses; to be started at 25 mg twice a day, and increased by 25 mg every third day till 150 mg/day.

(**Caution**: TCAs to be avoided in patients with epilepsy, heart disease, glaucoma, and benign prostatic enlargement).

Antidepressant medication begins to improve sleep, appetite and anxiety feelings within about one week. Feelings of depression may take from 2 to 4 weeks to improve. By about 12 weeks, most of the patients substantially improve. If no response to treatment seen in 5-6 weeks, confirm if the patient has been taking the medication as prescribed. If yes, increase the dose. If the dose has been adequate, one may need a change of antidepressant or augmentation to another SSRI or antidepressant from another class or use of augmentation strategies. One may need to refer to a psychiatrist at this stage.

For the first episode of depression, treatment needs to be continued for 6-9 months. Dose may be tapered off over a period of 6-8 weeks. However, if symptoms recur during this period, treatment needs to be continued for another 3-4 months. In case of multiple episodes of depression, treatment may need to be continued indefinitely.

In cases of bipolar depression, patients while on antidepressants may have a sudden switch to mania. In such cases, antidepressants should be stopped immediately.

Patient education

- Explain the nature of illness, consequences of untreated depression, suicidal risk, need for adequate doses for adequate duration, and other supportive measures.
- The therapeutic response takes time to appear but side effects may appear earlier. Common side effects of tricyclic antidepressants are dry mouth, constipation, postural hypotension (giddiness), blurred vision, sweating, palpitation, tremors, delayed micturition, sedation, etc.
- Common side effects of SSRIs are agitation, headache, nausea or heartburn, tremors, delayed ejaculation and loss of appetite.
- Mirtazapine causes sedation, giddiness and increased appetites and weight gain.
- The drug may impair mental or physical abilities initially, avoid driving or operating machinery, if patient is drowsy.
- One should avoid alcohol during treatment, as it may cause oversedation and dizziness.
- Patient should be cautioned against increasing or decreasing the dose without medical advice.

- Patient should be advised not to stop drug suddenly as it may result in withdrawal symptoms.

References

1. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp 155-228.
2. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 527-561
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge 2005; pp. 1-21.
4. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. http://guidance.nice.org.uk/topic/behavioural accessed on 20.9.12
5. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm accessed on 20.9.12.

DEPRESSION IN CHILDREN

Depression in children is not uncommon, though the presentation may vary. The predominant mood is often irritable. Diagnosis is made on the same criteria as in adult depression. Depression should be suspected in a child presenting with decline in school performance, withdrawal from peers, and increased conflict with peers, siblings, parents and other adults, and irritability. Children may be anxious and tearful and may also present with somatic symptoms.

Treatment should mainly be supportive. Pharmacological treatment is generally not encouraged. SSRIs can be used, if depression is severe. Fluoxetine, starting with 10 mg/day as a single morning dose can be used, which can be increased to 20 mg/day after 1-2 weeks. Other SSRIs may not be as safe as fluoxetine. Duration of treatment is as described in adult depression.

References

1. Kowatch RA, Emslie GJ, Wilkaitis J, Dingle AD. Mood disorders. In: Child and Adolescent Psychiatry. Sexson SB (ed), Blackwell Publishing: Massachusetts, 2005; pp. 132-153.
2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp 253-255.

SUICIDAL PATIENT

Patients with suicidal ideation need immediate psychiatric intervention. Suicidal ideation can occur in the background of depression, schizophrenia, adjustment disorders and alcohol and other psychoactive substance abuse.

Assessment of suicidal risk-specific questions to be asked:

- Whether the patient often feels low, sad or dejected?
- Whether he or she has lost all hopes in life?
- Thoughts that it is better to be dead than to face the constant miseries of life.

- Recurrent thoughts of death
- Thoughts of causing harm to self or wishing to die.
- History of acts of self-harm or suicidal attempt in the past
- Suicide plans.

Risk factors for predicting the risk of suicide include:

- History of suicidal attempt in past – the strongest predictor
- Male sex
- Age above 45 years in men and above 55 years in women
- Presence of psychiatric illness, especially schizophrenia and depression, substance abuse or dependence
- Recent bereavement, social isolation, family history of suicide
- Unemployment
- Physical illnesses like malignancy, chronic pain, epilepsy, AIDS
- Recent declaration of will.

Treatment

Treatment is specifically directed at the cause, if identifiable. The patient should be referred to a psychiatrist immediately after ensuring the following steps:

- Patient should not be left alone and be kept under constant observation.
- Family should be explained the seriousness of the problem and actively included in management.
- Patient should be offered psychological support and reassurance and not criticized.
- No dangerous or potentially dangerous objects such as knife, blade, sharp edged objects, rope, medication supply, etc. should be available in immediate vicinity of the patient.
- Specific treatment for depression, psychotic disorder or whatever may be the cause should immediately be started.

Patient/family education

- Family should be advised to follow a supportive approach towards the patient and should not criticize.
- Suicidal attempt is indicative of distress and needs treatment of the causative illness.

Reference

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 897-906.

MIXED ANXIETY DEPRESSION

It is one of the commonest psychiatric disorder seen in general clinical practice presenting with anxiety and depressive symptoms.

SALIENT FEATURES

- Presence of both anxiety and depressive symptoms.
- Anxiety and depressive symptoms not sufficient enough to meet criteria for anxiety or depressive disorder respectively.
- Symptoms of autonomic hyperactivity like palpitations, tremors, dry mouth, stomach churning, etc.

Treatment

Nonpharmacological

Psychological support, encouragement, relaxation exercises, yoga, and meditation.

Pharmacological

Antidepressants can be avoided unless the symptoms are severe. A short course of benzodiazepines for 2-3 weeks may suffice. If the patient does not show satisfactory improvement and needs medication for longer time, antidepressant can be started.

Tab. Diazepam 5-20 mg/day or Tab. Lorazepam 1-4 mg/day or Tab. Alprazolam 0.75-1.5 mg/day or Tab. Clonazepam 0.5-1.0 mg/day in 2-3 divided doses.

Treatment should be started at the lowest dose, which can be increased up to the maximum dose to achieve a therapeutic response, but attempt should be to keep it at the minimal possible level. Because of the abuse potential, benzodiazepines should not be given for more than 2-4 weeks.

Or

Tab. Buspirone 30-60 mg/day in 2-3 divided doses. It takes two to three weeks to show its effect.

Or

Cap. Fluoxetine 20-60 mg/day as a single dose in morning with food; starting with 20 mg/day which can be increased up to 60 mg/day in increments of 20 mg after 5-6 weeks in case of non-response.

Or

Tab. Sertraline 50-200 mg/day as a single dose in morning with food; starting with 50 mg/day which can be increased up to 200 mg/day after 5-6 weeks in increments of 50 mg in case of non-response.

Or

Tab. Escitalopram 10-20 mg/day as a single dose in morning with food; starting with 5 mg/day which can be increased to 10 mg/day over a week, and further up to 20 mg/day after 5-6 weeks in case of non-response. Most patients would respond at 10 mg/day.

Treatment may be continued up to a period of 6 months. If no response in 6 weeks, the patient should be referred to a psychiatrist.

Patient education

- It is a mild illness, though symptoms may last for long time. Lifestyle changes like stress management, regular physical exercise, avoiding over work often help in reducing symptoms.
- One should not stop treatment without consulting one's doctor.
- The drugs are quite safe and do not cause any harmful side effects even if taken for a long time.

Reference

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 571.

GENERALIZED ANXIETY DISORDER

It is one of the common psychiatric disorder in general clinical practices, more common in women than in men. Patients often present in primary care with symptoms of sympathetic overactivity or vague aches or pains, sleep disturbance, forgetfulness or worrying too much.

SALIENT FEATURES

- Persistent anxiety, present all the time.
- Tremulousness, shakiness, generalized aches, restlessness.
- Apprehension, worries of future, irritability, sleeplessness.
- Palpitations, sweating, dry mouth, increased frequency, abdominal distress.

Intensity, duration and frequency of the anxiety and worry are far out of proportion to the actual likelihood or the impact of the feared event and it interferes with the task in hand.

Treatment

Nonpharmacological

- Reassurance, psychological support, encouragement.
- Anxiety management—relaxation exercises, breathing exercises, meditation, and yoga.

Pharmacological

Tab. Diazepam 5-20 mg/day
Or
Tab. Lorazepam 1-4 mg/day
Or
Tab. Alprazolam 0.75-1.5 mg/day in 2-3 divided doses
Or

Tab Clonazepam 0.5-1.0 mg/day in 2-3 divided doses.

Treatment should be started at the lowest dose, which can be increased up to the maximum dose to achieve a therapeutic response, but attempt should be to keep it at the minimal possible level.

Treatment with above should not be given for more than 2-4 weeks because of the abuse potential.

Or

Cap. Fluoxetine 20-60 mg/day as a single dose in morning with food; starting with 10 mg/day which can be increased to 20-60 mg/day in increments of 20 mg after 5-6 weeks in case of non-response. Most patients may not require more than 20 mg/day.

Or

Tab. Sertraline 50-200 mg/day as a single dose in morning with food; starting with 25 mg/day which can be increased up to 200 mg/day after 5-6 weeks in increments of 50 mg in case of non-response. Most patients may not require more than 50 mg/day.

Or

Tab. Escitalopram 10-20 mg/day as a single dose in morning with food; starting with 5 mg/day which can be increased up to 20 mg/day after 5-6 weeks in case of non-response. Most patients may not require more than 10 mg/day.

(**Caution**: SSRIs may exacerbate anxiety symptoms in the first few days; usually a low dose is required for anxiety disorders).

Or

Tab. Buspirone 30-60 mg/day in 2-3 divided doses. It is effective in 60 to 80% of patients especially in reducing the cognitive symptoms. It takes two to three weeks to show its effect.

Or

Tab. Propranolol 40-80 mg/day in 2 divided doses, given especially if the predominant symptoms are those of sympathetic overactivity.

(**Caution**: To be avoided in patients with history of chronic obstructive airway disease and bronchial asthma).

SSRIs to be used, if the patient needs treatment for longer period. Both SSRIs and benzodiazepines can be started together. Benzodiazepines can be withdrawn over 2-4 weeks, as the SSRIs take over the effect.

In another approach, buspirone may be combined with benzodiazepines initially as it shows its effect after two to three weeks after which benzodiazepines may be gradually withdrawn.

Patient education

- Patient should be encouraged to bring changes in lifestyle like mild exercise such as morning walk, keeping some time for leisure or entertainment.
- Patients should be informed about the abuse potential of the drug.

References

1. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp. 234-247.

2. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 622-626.
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge, 2005; pp. 88-104.
4. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. http://guidance.nice.org.uk/topic/behavioural accessed on 20.9.12.
5. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm accessed on 20.9.12.

PANIC DISORDER

Panic disorder is a common psychiatric disorder, presenting often in primary care or general medical emergency settings. The patients are likely to be misdiagnosed as having acute cardiorespiratory problem.

SALIENT FEATURES

- Discrete episodes of sudden onset of palpitations, chest pain, choking sensations, dizziness, feelings of unreality; often accompanied by fear of dying, losing control.
- Individual attacks last for minutes.
- Not associated with situational trigger and occurs out of the blue.
- Onset and remission of individual attacks spontaneous.
- Often lead to persistent fear of going alone or the situation of attack.
- Diagnosis made when several attacks have occurred in previous month.

Treatment

Nonpharmacological

- Reassurance, encouragement, psychological support.
- Muscular relaxation exercises, meditation, yoga.
- Cognitive behaviour therapy (to be given by a psychiatrist).

Pharmacological

Cap. Fluoxetine 20-60 mg/day as a single dose in morning with food; starting with 10 mg/day which can be increased to 20-60 mg/day in increments of 20 mg after 5-6 weeks in case of non-response. Most patients may not require more than 20 mg/day.

Or

Tab. Sertraline 50-200 mg/day as a single dose in morning with food; starting with 25 mg/day which can be increased up to 200 mg/day after 5-6 weeks in increments of 50 mg in case of non-response. Most patients may not require more than 50 mg/day.

Or

Tab. Escitalopram 10-20 mg/day as a single dose in morning with food; starting with 5 mg/day which can be increased up to 20 mg/day after 5-6 weeks in case of non-response. Most patients may not require more than 10 mg/day.

(**Caution**: SSRIs may exacerbate anxiety symptoms in the first few days; usually a low dose is required for anxiety disorders).

Or/and

Tab. Alprazolam 1.5-6.0 mg/day in 2-3 divided doses or Tab. Clonazepam 1-4 mg/day in two divided doses. Treatment started at dose of 0.5-0.75 mg/day and increased every 2-3 days to the minimal effective therapeutic dose.

Or

Tab. Imipramine 50 mg/day in 2 divided doses, increased slowly by 25 mg every two to three days to a maximum dose of 150-250 mg/day.

Response may take 2-3 weeks to begin and 8-12 weeks to stabilize. Treatment needs to be given for a minimal period of 8-12 months. Medicines should be tapered off thereafter slowly over a period of 6-8 weeks. If the patient does not show any response in 6 weeks, refer to a psychiatrist.

Patient education

- General reassurance about benign nature of symptoms and spontaneous recovery of individual attacks.
- Don't avoid the anxiety provoking situations; try to face them.
- Breathing exercises.

References

1. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009;. pp. 234-247.
2. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 587-596.
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge, 2005; pp. 105-120.
4. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. http://guidance.nice.org.uk/topic/behavioural accessed on 20.9.12.
5. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm accessed on 20.9.12.

SOCIAL PHOBIA OR SOCIAL ANXIETY DISORDER

Social phobias often start in adolescence and are centred around fears of scrutiny by other people in comparatively small groups rather than in crowds. It is equally common in both the sexes.

SALIENT FEATURES

- Strong and persistent fear of social or performance situations in which embarrassment or humiliation may occur and avoidance of such situations.
- Fear considered irrational by the individual.
- Anticipatory anxiety before such exposure.
- Exposure leads to panic attack.

Treatment

Nonpharmacological

- Reassurance, encouragement, psychological support.
- Muscular relaxation exercises, meditation, yoga.
- Cognitive behaviour therapy (to be given by a psychiatrist).
- Social skill training (to be given by a psychiatrist).

Pharmacological

Benzodiazepines: like Tab. Alprazolam 1.5-6.0 mg/day in 2-3 divided doses or Tab. Clonazepam 1-4 mg/day in 2 divided doses. Treatment started at dose of 0.5-0.75 mg/day and increased every 2-3 days to the minimal effective therapeutic dose.

Or

Tab. Propranolol 10-20 mg 1 hour before the performance. Treatment needs to be continued for about one year. If no response in 8 weeks, patient should be referred to a psychiatrist.

Or

Cap. Fluoxetine 20-60 mg/day as a single dose in morning with food; starting with 10 mg/day which can be increased to 20-60 mg/day in increments of 20 mg after 5-6 weeks in case of non-response. Most patients may not require more than 20 mg/day.

Or

Tab. Sertraline 50-200 mg/day as a single dose in morning with food; starting with 25 mg/day which can be increased up to 200 mg/day after 5-6 weeks in increments of 50 mg in case of non-response. Most patients may not require more than 50 mg/day.

Or

Tab. Escitalopram 10-20 mg/day as a single dose in morning with food; starting with 5 mg/day which can be increased up to 20 mg/day after 5-6 weeks in case of non-response. Most patients may not require more than 10 mg/day.

(**Caution**: SSRIs may exacerbate anxiety symptoms in the first few days; usually a low dose is required for anxiety disorders).

Patient education

- Don't avoid the anxiety provoking situations; try to face them.
- Take your medicines regularly as advised. Medicine helps in controlling the anxiety and building up the confidence.
- The symptoms can be treated effectively.

References

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 597-603.
2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp. 234-247.
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge, 2005; pp. 137-164.

OBSESSIVE COMPULSIVE DISORDER

Obsessive compulsive disorder is characterized by obsessions and compulsions and often tends to be chronic. Illness usually begins in adolescent or early adult life and majority of patients have a chronic waxing and waning course.

SALIENT FEATURES

- Recurrent obsessional thoughts may present in form of repetitive ideas, images or impulses (e.g. constantly thinking that the door has been left unlocked).
- Perceived as senseless by the sufferer, who feels distressed and tries to resist them unsuccessfully.
- Compulsive acts are repetitive behaviour which are not enjoyable and do not result in the completion of inherently useful tasks (e.g. constantly going back to check the door lock) and cause marked anxiety and distress in the individual.
- Significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationship.

Treatment

Nonpharmacological

- Counselling, reassurance, support
- Cognitive behaviour therapy (to be given by a psychiatrist)
- Exposure and response prevention (to be given by a psychiatrist)

Pharmacological

Cap. Fluoxetine 20-60 mg/day as a single dose in morning with food; starting with 10 mg/day which can be increased to 20-60 mg/day in increments of 20 mg after 5-6 weeks in case of non-response. Most patients may not require more than 20 mg/day.

Or

Tab. Sertraline 50-200 mg/day as a single dose in morning with food; starting with 50 mg/day which can be increased up to 200 mg/day after 5-6 weeks in increments of 50 mg in case of non-response. Most patients may not require more than 50 mg/day.

Or

Tab. Escitalopram 10-20 mg/day as a single dose in morning with food; starting with 5 mg/day which can be increased up to 20 mg/day after 5-6 weeks in case of non-response. Most patients may not require more than 10 mg/day.

Or

Tab. Fluovoxamine 50 mg twice a day to be increased to 100-200 mg twice a day in 1-2 weeks.

(**Caution**: SSRIs may exacerbate anxiety symptoms in the first few days; usually a low dose is required for anxiety disorders).

Or

Tab. Clomipramine 75-150 mg/day in single or divided doses; to be started with 25 mg twice a day, increased by 25 mg/day every third day till 150 mg/day (to be avoided in patients with epilepsy, heart diseases, glaucoma, and benign prostate hypertrophy).

In the initial 2-4 weeks of treatment, one may need to add benzodiazepines like diazepam, lorazepam or alprazolam, if anxiety symptoms are troublesome. These can be given in doses as describe under generalised anxiety disorder.

Anxiety and distress are the first symptoms to respond. Obsessive and compulsive symptoms respond later. Doses of SSRIs required are often higher than in depression and response is slower than in depression. If no response is seen within 6-8 weeks, the patient should be referred to a psychiatrist.

Patient education

- Reassure the patient that although disease is distressing and disabling, but is treatable.
- The drug takes about 2 weeks for its therapeutic response to manifest.
- Side effects may appear before the onset of therapeutic response. Common side effects of Clomipramine are dry mouth, constipation, postural hypotension (giddiness), blurred vision, and sedation. Side effects of fluoxetine include gastrointestinal distress, nausea, headache, nervousness, anorexia, restlessness and sexual side effects. Patient usually adapts to these side effects with time.
- Advise the patient that treatment may continue for a long time. He/she should not leave drugs without medical advice.
- In case of any untoward effects of drugs, he/she must immediately get in touch with his clinician.
- Patient must continue all his regular activities as far as possible.
- Yoga, meditation, physical exercises are useful measures along with drug therapy.

References

1. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp. 234-247.
2. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 604-611.
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge, 2005; pp. 165-203.
4. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. www.nice.org.uk
5. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. www.psych.org/psych_pract/

ACUTE STRESS REACTION

Acute stress reaction and disorder follow immediately a stressful event of exceptional nature and are characterized by severe anxiety symptoms accompanied by a daze. The symptoms last only for a short period varying from few hours to days.

SALIENT FEATURES

- Marked symptoms of anxiety and increased arousal.
- An initial state of daze followed by depression, anxiety, anger, despair, over activity and withdrawal.
- Clinical picture often changes rapidly with a mixture of the above mentioned symptoms.
- Symptoms appear usually within a few minutes of the impact of the stressful event and resolve rapidly, if stressor is removed, and within 1-3 days, even if it is not.
- Triggered by an overwhelming traumatic experience (e.g. natural catastrophe, accident, battle, criminal assault, rape, multiple bereavement or domestic fire, etc.)

Treatment

Nonpharmacological

- Address the individual's requirements for medical care, rest, nutrition, and control of injury-related pain and establish a safe environment.
- Detailed recollection of the traumatic event—psychological debriefing.
- General support, reassurance, and assistance with coping resources.

Pharmacological

- No significant role of medications. One may use diazepam 2.5-5 mg on as and when required basis and increased, if necessary, to 15-30 mg daily in divided doses; elderly (or debilitated) half the adult dose, if anxiety symptoms or the distress are uncontrollable. If insomnia is troublesome, 5-15 mg at bedtime.

Patient and family education

- Reassure and educate the patient and the family that the symptoms are short lasting and the patient would recover fully within a short time.

References

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 612-621.
2. Harrison-Read P, Tyrer P, Sharpe M. Neurotic, stress related and somatoform disorders. In: Companion to Psychiatric Studies. Johnstone EC, Cunningham Owens DG, Lawrie SM, Sharpe M and Freeman CPL, (eds), 7th Edition. Churchill Livingstone: Edinburgh 2004; pp. 470-471.

3 American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. http://www.psych.org/psych_pract/treatg/pg/prac guide.cfm

POST-TRAUMATIC STRESS DISORDER (PTSD)

It is a relatively recent diagnostic category in the field of psychiatry and is being recognized as a common problem following traumatic events of catastrophic nature. Initially it was reported after the Vietnam War, but later similar syndrome has been seen in the victims of natural disasters and major accidents and personal injuries like rape or mugging. Prevalence of PTSD may be as high as 50-80% following the traumatic event.

SALIENT FEATURES

- Symptoms follow a major traumatic event of threatening or catastrophic nature (natural or manmade disasters) after a delay.
- Symptoms occur within 6 months of the event.
- Repeated reliving of trauma in the form of flashbacks, nightmares, intrusive recollections of the event.
- Emotional numbness, unresponsiveness and detachment from other people.
- Autonomic hyperarousal and hypervigilance on exposure.

Treatment

Nonpharmacological

- Emotional support, reassurance
- Behaviour therapy with focus on exposure and desensitisation
- Cognitive behaviour therapy

Pharmacological

SSRIs like fluoxetine, sertraline or escitalopram are effective in controlling the symptoms. Dosage is similar as in anxiety disorders and depression. Duration of treatment may vary from 6 months to a year depending on the response.

Patient education

- Post-traumatic stress disorder is seen after traumatic events of catastrophic nature and usually seen after a period of few months.
- The patient often relives the trauma in the form of nightmares, flashbacks or recollection of the event.
- One should contact one's doctor, if he or she develops such symptoms after a major traumatic event.

References

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 612-621.
2. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge, 2005; pp. 121-136.
3. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. http://guidance.nice.org.uk/topic/behavioural
4. American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006. APPI: Arlington. http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

INSOMNIA

Insomnia is one of the commonest complaints in psychiatric, medical and general clinical practice. Common causes include a recent stress, psychiatric illnesses like depression and anxiety disorders, pain in any body part or substance abuse.

SALIENT FEATURES

- Difficulty in initiating sleep, frequent awakenings from sleep, early morning insomnia or non-restorative sleep. In the elderly, the physiological reduction in number of hours of sleep does not amount to insomnia. If the patient is distressed by decreased sleep, treatment may be given to increase the duration of sleep.
- Stressful situation leading to insomnia or the symptoms of the causative illness can be elicited on careful enquiry. Duration of symptoms may vary from few days to many months or years depending on the cause.

Treatment

Treat the underlying cause. In both primary insomnia (where no cause is identifiable) and insomnia due to other causes, management includes introducing good sleep hygiene and medications for short period, if required.

Sleep hygiene

- Set a schedule: Go to bed at a set time each night and get up at the same time each morning. Avoid day time naps. Limit daily inbedtime to the usual amount present before the sleep disturbance.
- Avoid large meals near bedtime; eat at regular times daily. No stimulant medication or food beverages (caffeine, nicotine, alcohol, etc.) especially in the evenings.
- Mild to moderate physical exercise in the morning.
- Relax before going to bed: a warm bath, reading, or another relaxing routine can make it easier to fall sleep. Avoid evening stimulation: substitute television by radio.
- Don't lie in bed awake: If you can't get to sleep, don't just lie in bed. Do something else, like reading, watching television, or listening to music, until you feel tired.

- Practice evening relaxation routines, such as progressive muscular relaxation or meditation.
- Maintain comfortable sleeping conditions: avoid extreme temperatures.

Pharmacological

Tab. Diazepam 5-10 mg or Tab. Lorazepam 1-2 mg, or Clonazepam 0.25-0.5 mg at bedtime.
Or
Tab. Zolpidem 5-10 mg at bedtime.

Precautions

- Medication to be given ½-1 hour before the usual time of going to bed.
- Medications should be prescribed at the lower dose for a period of 5-7 days.
- Benzodiazepines have risk of abuse potential if taken for more than 4-5 weeks.
- Zolpidem has also dependence potential and, therefore, long-term use should be discouraged.

Patient education

- Stress on basic principles of sleep hygiene as above.
- Patient to avoid exceeding the prescribed dose and should not take medicines beyond the prescribed period.
- Sometimes these drugs can lead to sedation during daytime. In such case, reduce the dose to half and contact the doctor.
- Diazepam and nitrazepam carry risk of dependence.

References

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 753-759.
2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp. 248-251.

ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Attention deficit/hyperactivity disorder is one of the commonest psychiatric disorders in children, seen more often in boys.

SALIENT FEATURES

- Persistent pattern of hyperactivity or inattention (more frequent and severe than typical of children at a similar level of development).
- Onset usually before 7 years of age.
- Difficulty in sustaining attention in tasks or play activities.
- Distracted easily by extraneous stimuli.
- Irritability, temper tantrums, impulsivity, does not wait for his turn.

Treatment (to be treated by a psychiatrist)

Pharmacological

Tab. Methylphenidate 2.5-5 mg twice a day after meals at 8 AM and 12 noon; can be increased up to 10-15 mg/day (0.3-2.0 mg/kg/day). Maximum dose 60 mg/day, to be given under strict psychiatric supervision.

Or

Tab. Atomoxetine started with 0.5 mg/kg/day and increased after a minimum of 3 days to 1.2 mg/kg/day, given as a single or two divided doses (morning and afternoon).

(**Caution**: Common side effects include headache, insomnia, nausea, vomiting, decreased appetite and pain abdomen).

Parent education

- Parental counselling; learning to anticipate the situations that allow behavioural problems to appear and plan ahead so as to minimize disruption.
- Encouraging parents to screen the peer relationships of the child so as to protect the vulnerable child.
- Recognizing the attention difficulties of the child and tailoring the work expectations by reducing the length and complexity of assignments.
- A coordinated effort both at home and school.
- Side effects include anorexia, headache, insomnia, weight loss, tachycardia, and growth suppression.

References

1. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp 263-268.
2. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 1206-1217.
3. Stein D, Lerer B, Stahl S. Evidence Based Psychopharmacology. Cambridge University Press: Cambridge, 2005; pp. 255-289.
4. National Institute for Clinical Excellence (NICE) Guidelines for Treatment of Mental Disorders. http://guidance.nice.org.uk/topic/behavioural
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ALCOHOL DEPENDENCE SYNDROME

Persisting with drinking despite clean evidence of overtly harmful consequences and withdrawal state.

SALIENT FEATURES

- Craving, compulsion to drink, difficulties in controlling alcohol consumption
- Tolerance (increasing amount required to achieve the same effect)
- Progressive neglect of alternative pleasures or interests
- Withdrawal symptoms are—tremor, tachycardia, anxiety, sleep disturbance, nausea, vomiting, hallucination, generalised seizure and delirium in severe cases.

Treatment

I. Detoxification (treatment of the withdrawal state and associated problems).

Detoxification can be done in an outpatient or inpatient settings. Outpatient treatment is preferred when the withdrawal state is uncomplicated.

1. Inj. Thiamine 100 mg IM.
   Or
   Tab. Thiamine orally along with oral multivitamins and Tab. Folate 1 mg.
2. Tab. Chlordiazepoxide 10-40 mg 4 times a day, depending on severity of dependence.
   Or
   Tab. Diazepam 5-20 mg 4 times a day.

Once the patient is well sedated and stable, the dosage should be decreased 20% per day over a maximum period of two weeks. The patient should be monitored over this period for the appearance of the signs of delirium.

For elderly patients or in presence of significant liver disease, Tab. Oxazepam 15 mg or Tab. Lorazepam 2-4 mg every 6 hour should be started.

Inpatient treatment is advised when withdrawal state is associated with seizures, delirium or emesis, fluid and electrolyte disturbance, medical conditions like pneumonia or surgical problem (e.g. head trauma), hallucinatory behaviour, suicidal risk and previous history of delirium tremens.

The vital signs and withdrawal symptoms should be monitored 2-4 hourly. Once the patient is stable, the dose should be gradually tapered off (20% per day) over a period of 7-10 days.

Treatment of dependence with complications:

Basic treatment will be as described above, but the patient needs to be hospitalised. Guidelines are as below:

1. **Fluid and electrolyte disturbance** should be corrected, especially, if there is vomiting or fever.
2. **Seizures—**Rum fits (appearing within 24 hours of abstinence) can be treated with Inj. Diazepam 10 mg or Inj. Lorazepam 2 mg IV stat especially when seizures are repeated. Prophylactic treatment is not recommended for true alcohol withdrawal fits.

3. **Delirium tremens—**The patient should be preferably treated in an intensive care unit.
   a. An intravenous line should be started immediately and Inj. Thiamine 100 mg administered IV, or IM. Thiamine along with multivitamin should be continued parenterally till normal diet is resumed. Later oral thiamine should be continued for at least 3-4 months.
   b. Dextrose and saline IV should be given at a rate adequate to replace fluid losses and maintain blood pressure.
   c. Hyperthermia should be managed with cold sponge.
      Tab. Paracetamol 500 mg PO 4 times a day may be used in absence of any hepatic dysfunction.
   d. Inj. Diazepam 10 mg should be given slowly IV and should be repeated every 15-20 minutes till sedation is achieved.
   e. Physical restraint may be necessary, if the patient is combative.
   f. Associated medical and surgical problems should be simultaneously investigated and treated appropriately.

II. Long-term treatment (to be treated by a psychiatrist)

The goal of this treatment is to help the patient maintain long-term abstinence.

Nonpharmacological

Individual counselling and family support should be planned along with pharmacotherapy. After remission, the patient should be encouraged to join self-help groups like Alcoholic Anonymous (AA).

Pharmacological

Long-term treatment should only be under strict supervision of a psychiatrist

Deterrents like disulfiram or anticraving agents like naltrexone or acamprosate are used for long-term treatment of alcohol dependence.

Tab. Disulfiram 250 mg a day may be used, if the patient desires enforced sobriety and who have remained alcohol free for at least 7-10 days.

Patients taking disulfiram develop an extremely unpleasant reaction on intake of even small amounts (e.g. 7 ml) of alcohol. The reaction occurs due to accumulation of acetaldehyde and includes flushing, headache, throbbing in head, dyspnoea, hyperventilation, tachycardia, hypotension, sweating and confusion.

In the event of disulfiram-ethanol reaction (DER), fall in BP should be controlled on priority basis. If DER is mild, assurance and oral fluids suffice. In case of moderate or severe DER, IV fluids are required and some patients may even need dopamine infusion.

Generally, DER does not occur in the first week of disulfiram use and if alcohol is consumed after 5-7 days of stopping disulfiram, but can occur 2 weeks after stopping disulfiram.

Disulfiram should be continued for several months to establish a long-term pattern of sobriety.

Or

Tab. Naltrexone 50 mg orally once daily.

(**Caution**: Baseline hepatic functions should be assessed, and monitored once a month while on naltrexone treatment. The drug is usually continued for a period of 6 months. However, it may have to be withdrawn in presence of significant liver disease (i.e. several fold increase in the serum levels of transaminases).

Or

Tab Acamprosate (333 mg) 2 g/day in 3 divided doses.

Patient education

Patient should be told about nature of illness, course and treatment modalities available through individual sessions.

References

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 390-406.
2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp. 286-298.
3. Lal R (Ed). Substance Use Disorder: Manual for Physicians. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi, 2005; pp. 65-76.

OPIOID DEPENDENCE SYNDROME

SALIENT FEATURES

- Compulsive need to take the drug
- Tolerance (increasing amount required to achieve the same effect)
- Progressive neglect of alternative pleasures or interests
- Persisting with drinking despite clear evidence of overtly harmful consequences and a withdrawal state (aches and pains, lacrimation, rhinorrhoea, yawning, tachycardia, piloerection, vomiting, loose motions, sleep disturbance and spontaneous ejaculation).

Treatment

Pharmacological

Buprenorphine or dextroproxyphene can be used for detoxification. The starting dose is decided according to the amount of opioid used by the patient in 24 hours. Subsequent doses need to be adjusted according to the severity of withdrawal symptoms, which usually peak during 3rd – 7th day of withdrawal.

Tab. Buprenorphine 1.2-4.0 mg/day orally in 4-6 divided doses.

Or

Cap. Dextroproxyphene (65 mg) 2-4 capsules thrice a day.

Tapering off of the medication can be started from the 3rd day onwards, depending on the response. Usually detoxification medicines are required for 2-3 weeks. Withdrawal symptoms may need to be treated symptomatically as under:

- Hypnotics (e.g. zolpidem, long-acting benzodiazepines) for sleep disturbance
- NSAIDs for aches and pains
- Antidiarrhoeals for loose motions
- Antiemetics for nausea and vomiting
- Fluid and electrolyte balance for electrolyte imbalance
- Manage associated physical and mental disorders simultaneously.

Certain withdrawal symptoms like insomnia, restlessness and mild body aches persist even after 3 weeks, and can be managed symptomatically as above and by non-pharmacological interventions like relaxation therapy.

Long-term treatment

Nonpharmacological

Individual counselling, family support and encouraging the patient to join the self-help groups are also important to help him maintain long-term abstinence. However, opiate dependence is a highly relapsing disorder and prolonged inpatient stay in settings that also provide rehabilitative inputs may be required in some cases.

Pharmacological (to be treated by a psychiatrist)

Tab. Naltrexone 50 mg/day orally is used to reduce craving and thereby to help patient maintain long-term abstinence (who have remained opioid free) for at least 7-10 days.

A combination of Buprenorphine 2 mg and Naloxane 0.5 mg is also used for long-term treatment. The drug is dispensed only through the Oral Substitution Treatment (OST) Centres accredited by National AIDS Control Organisation (NACO) or the designated Deaddiction Centres

(Caution: Baseline hepatic functions should be assessed, and to be monitored once a month while on naltrexone treatment. The drug is usually continued for a period of 6 months. However, it may have to be withdrawn in presence of significant liver disease (i.e. several fold increase in the serum levels of transaminases).

Patient education

- Patient should be told about nature of illness, course and treatment modalities available through individual sessions.

References

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 443-449.
2. Taylor D, Paton C, Kapur S. The Maudsley Prescribing Guidelines, 10th Edition. Informa Healthcare: London 2009; pp 299-320.
3. Lal R (Ed). Substance Use Disorder: Manual for Physicians. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi, 2005; pp. 65-76.

NICOTINE DEPENDENCE

Nicotine dependence is a major public health problem. Nicotine is abused in the form of tobacco, smoked in bidis, cigarettes and hooka, and chewed as such or in pan masala.

SALIENT FEATURES

- Most tobacco users smoke or use smokeless tobacco on a daily basis.
- Indicators of dependence include the time from waking to first use. About 15% of the dependent smokers light up within 5 minutes of waking, while almost half of smoke within the first half hour of the day.
- Typical physical symptoms following cessation or reduction of nicotine intake include craving for nicotine, irritability, anxiety, difficulty concentrating, restlessness, sleep disturbances, decreased heart rate, and increased appetite or weight gain.

Treatment

Nonpharmacological

- Progressively lowering the number of cigarettes smoked or tobacco sachets used daily.
- Using past quit experience.
- Setting a quit date.
- Throwing away items such as ashtrays, etc. the night before the quit day dawns, preferably as a ceremonial gesture.
- Advise the patient that starting from the quit date, total abstinence is essential.
- Help the patient identify each of the environmental conditions that most likely lead to tobacco use and then develop a course of behaviour that avoids those conditions or prevents them from occurring.
- Suggest that the patient develop an alternate plan to having a cigarette during the morning toilet, smoking after a meal, and smoking to manage stress at work or in traffic, being in an argument, and so on.
- The five Ds to handle urges:
  - Delay until the urge passes. It usually takes 3-5 minutes
  - Distract yourself. Call a friend or go for a walk.
  - Drink a glass of water
  - Deep breaths—Relax! Close your eyes and take 10 slow, deep breaths
  - Discuss your feelings with someone close to you.

Pharmacological

Nicotine gum, one piece of 2 mg gum/hour for light smokers, and 4 mg gum for highly nicotine-dependent smokers.

One piece of gum to be chewed slowly at one time until a peppery taste or tingling of gums occurs. Chewing can be stopped here and the gum is kept between the gums and cheek. The process is repeated over 30 minutes.

One should not eat or drink anything 15 minutes prior to and during the use of the gum. Absorption of nicotine in the buccal mucosa is decreased by an acidic environment. Therefore, patients should not use beverages (e.g. coffee, soda, juice) immediately before, during, or after nicotine gum.

Duration of treatment is 4-6 weeks. The gum is weaned off subsequently by tapering the frequency and strength of the gum over 2-3 months or less.

Or

Tab. Bupropion treatment is begun 1-2 weeks before the quit date. Usual dose is 300 mg/day given in two divided doses. It is started as 150 mg as a single daily dose in morning and increased to 150 mg twice a day on the 4th day. This is continued for 7-12 weeks after the quit date and maintenance therapy may go on for 6 months.

(Caution: It is important that patients continue to receive counselling and support throughout treatment with bupropion, and for a period of time thereafter.)

Adverse effects include feelings of agitation or restlessness that decreases in 1-2 weeks after starting medication. Insomnia, gastrointestinal upset, appetite suppression and weight loss, headache and lowering of seizure threshold also have been reported.

Patient Education

- The patient should be sensitized to the ill effects of tobacco use.

References

1. Sadock BJ, Sadock VA. Kaplan and Sadock's Synopsis of Psychiatry, 10th Edition, Lippincott Wlilliams and Wilkins: Philadelphia 2007; pp. 438-442.
2. Lal R (Ed). Substance Use Disorder: Manual for Physicians. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi, 2005; pp. 104-120.

MANAGEMENT OF WANDERING MENTALLY ILL PATIENT OR A MENTALLY ILL PATIENT WITH NO FAMILY MEMBER OR ATTENDANT

Mental Health Act, 1987 has provision for hospitalization of the mentally ill patients in mental hospitals. If one happens to come across a psychiatric patient wandering aimlessly or indulging in socially disorganized behaviour in a public place, one can approach the local police station. The incharge of the local police station under whose jurisdiction the place lies, has a duty under the Act to take the patient to the concerned Metropolitan Magistrate in Delhi (in metropolitan cities) or the Subdivisional Judicial Magistrate or Chief Judicial Magistrate or any Magistrate of first class (in other cities). The Magistrate can issue a reception order for admission of the patient to a mental hospital after getting him examined by a medical officer. Admission to mental hospital can also be made on the request of the patient, if the patient is willing to consent (voluntary admission) or on the request of family members, if they so desire (admission under special circumstances). Immediate medical management is as of an excited psychotic patient as given under schizophrenia (see section on Schizophrenia).