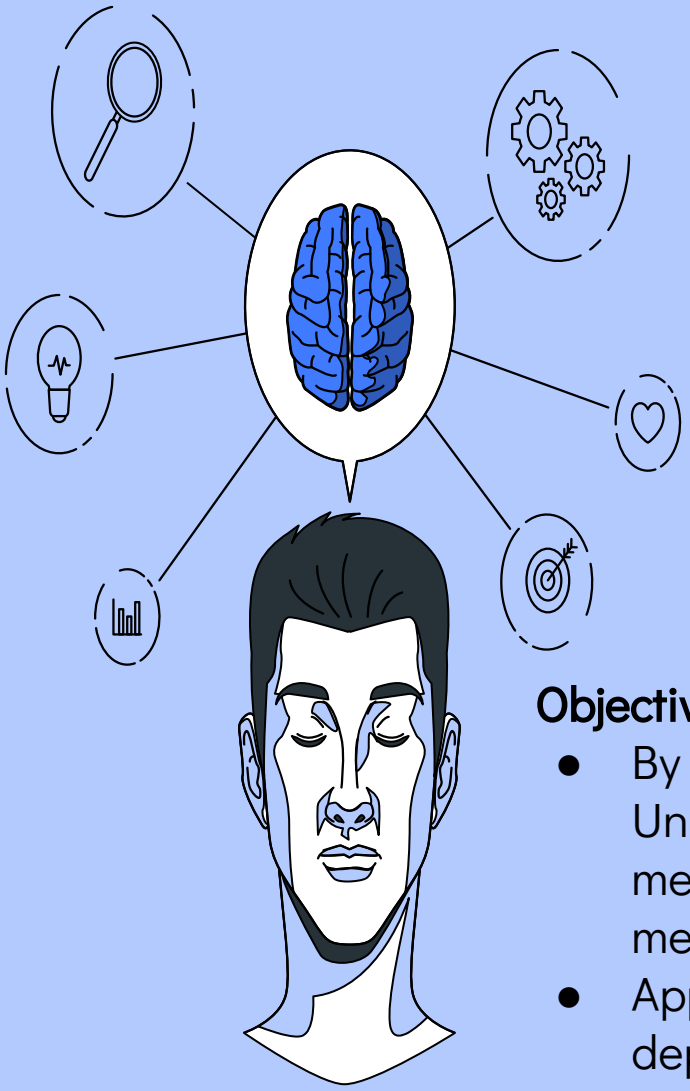


Psychosomatic medicine I & II

Objectives:

- By the end of this lecture, a student should be able to: Understand relevant concepts related to psychosomatic medicine which resides at interface of physical and mental illnesses.
- Appreciate that accurate diagnosis and treatment of depression in medically ill pts improves quality of life, enhances engagement in treatment, decreases symptom quantity and severity, and decreases cost utilization,morbidity and mortality.
- Acquire preliminary skills to evaluate and intervene adequately to manage somatic symptoms and related disorders.

Done by: Lujain Alzaid, Renad AlMogren, Rania Alessa, and Norah Alkadi

- Color index: Golden notes - Dr. notes - extra

Introduction

- Psychosomatic medicine is the subspecialty of psychiatry whose practitioners have particular expertise in the diagnosis and treatment of psychiatric disorders and difficulties in complex medically ill patients (Gitlin et al. 2004)
- Psychosomatic medicine resides at the interface of physical and mental illness.
- The clinical practice of psychosomatic medicine is sometimes called consultation-liaison psychiatry (CLP)
- Since 2001, Psychosomatic medicine has become a subspecialty recognized by the American Board of Medical Specialties
- Medical factors/illnesses may affect individual vulnerability, course, & outcome of ANY psychiatric disorder.
- Psychosocial factors/illnesses may affect individual vulnerability, course, & outcome of ANY type of disease.
- Psychological factors may operate to facilitate, sustain, or modify the course of medical disease , even though their relative weight may vary
  - from illness to illness.
  - form one individual to another.
  - between 2 different episodes of the same illness in the same individual.

Illness Vs. Disease

Illness	Disease
• The response of the individual and his/her family to symptoms • Subjective. ○ psychosocial , cultural, religious factors	• Defined by physicians and associated with pathophysiological processes and documented lesions • Objective.

Areas that the psychosomatic work on:
Pathophysiological related conditions:
1-Bidirectional (each of them increases the other)
-DM and Depression
2- Medical diseases that induce psychiatric illness:
-hypo\hyperthyroidism
-Multiple sclerosis
-Parkinson disease
3- Psychiatric illnesses that induce medical conditions:
-peptic ulcer
-anorexia nervosa= hypokalemia= arrhythmia

Pathophysiological related conditions:
1- Psychological related:
-Adjustment disorder\ reaction: Patient with query breast cancer and started to have anxiety\ depression because of it.
2- Psychiatric patient developed a medical illness:
مريض فصام جاه سرطان قولون ويقول ان الامساك الي عندي بسبب الجهاز الي حاطينه الاستخبارات بمعدتي انا ما عندي شي ولا ابغى اتعالج
3- Physical symptom not medically explained

Illness Behavior

- The manner in which individuals monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the health care system.
- Variety of factors.
- Achievement of objectives.
- Abnormal illness behavior: Inappropriate or maladaptive mode of perceiving, evaluating or acting in relation to one's own health status.

فيه دراسة على طريقة تفاعل مرضى القلب على المرض ،تأثيرها على ال prognosis
المجموعة الاولى كانوا يقولون الحمدلله ما فينا الا العافية أخذنا علاجات وماشين عليها (illness minimize)

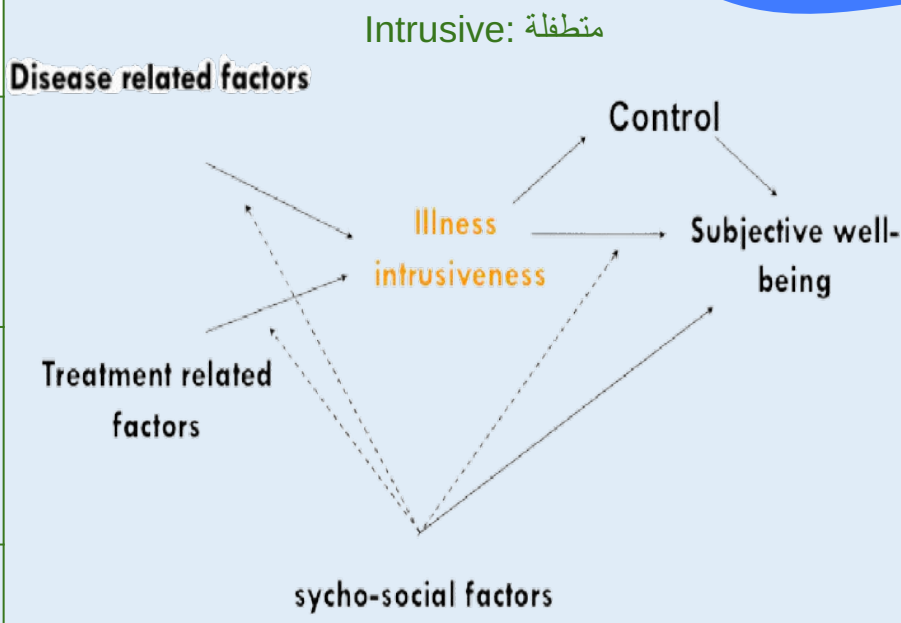
المجموعة الثانية كان عندها باكقراوند علمية وعارفين وش صار لهم بالضبط وعندهم أدوية يمشون عليها (illness affirming)

وجد أن المجموعة الاولى ال prognosis عندها افضل لأنهم المجموعة الثانية تكون قلقة أكثر والاولى مبردين الأمور

Illness affirming.....illness denying

Quality of life and illness Intrusiveness (G.Devins,1994)

	End Stage Renal Disease	Mild dyslipidemia
Disease related factors	Usually patients are alive but not living. Sx: pain, fatigue and itching	Mostly Asymptomatic
Treatment related factors	Would need dialysis, going to the hospital, and certain diet	Only meds
Psychosocial factors	Risk if anxiety and depression. Could affect marital and job life.	none

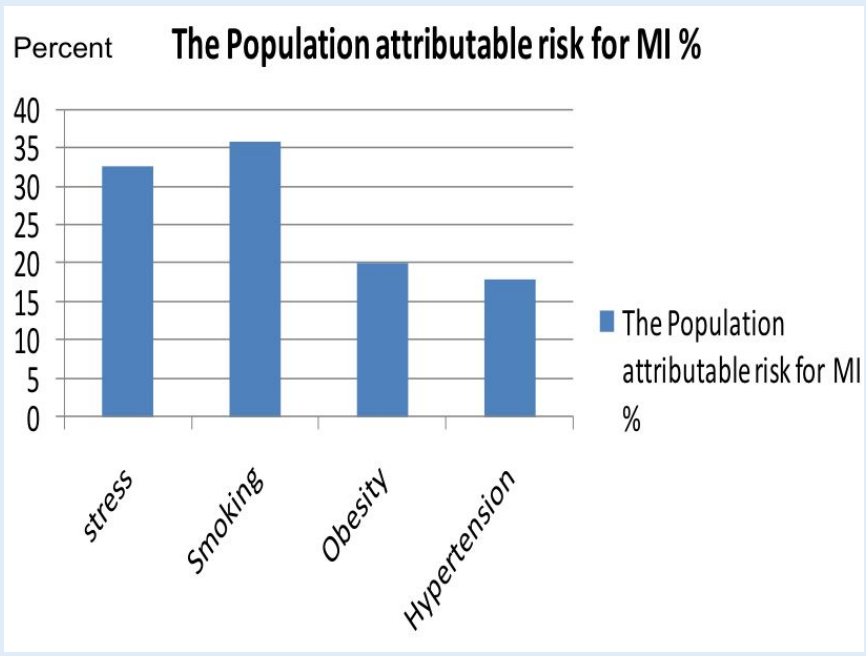


Example of psychosocial factors affecting a medical d (CHD) / stress vs CHD

According to The Interheart study, the population attributable risk factor for MI of Hypertension was 17.9% , while the psychosocial risk factors, were responsible about :

a)5%
b)10%
c)15%
d)20%
e)>30%

INTERHEART Study (EPIDEMIOLOGY, stress & CHD)



Case control study of: n > 29000 in 52 countries.

*Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study. Yusef S et al. Lancet 2004

Advantages of psychosomatic medicine (CLP) service

1. Relieve symptoms of distress & improve the quality of life of some patient with serious diseases.
2. May improve the course and prognosis of several major medical illnesses.
3. Cost-effective:
   a. Reduce the length of hospital stay.
   b. Reduce the number of unnecessary investigations (performed for physical symptoms that may actually reflect underlying psychological distress).

Approach to referral to psychosomatic medicine

How to do it (effective psych. Consultation)

1. Review patient charts, asking nurses and physician.
2. Obtain good psychiatric history (paying attention to psychological & social factors).
3. MSE & MMSE if cognitive problem is suspected and possibly neuropsychological assessment.
4. Making logical differential diagnosis among medical , neurological and psychiatric diseases (use multi-axial Dx.)
5. Investigate based on that.
6. Make treatment plan.
7. Follow up plan (as inpatient & outpatient).
8. Collaborate with both the patient and the referring team.

A 20 year old female patient with a high sky blood pressure. What will you do?
Admit the patient and think about secondary diseases due to the age it's not normal to have hypertension at this age.

A 60 year old obesed patient with a family history of hypertension presented with high blood pressure?
Follow up in the clinic. (primary hypertension)

A 20 year old patient presented with recurrent seizure with a family hx of epilepsy?
Mostly it is epilepsy (primary)

A 60 year old with no family hx of epilepsy presented with seizure for the first time?
Mostly secondary cause

Primary VS secondary psychiatric disorders

Primary	Secondary
Etiology is: **Multi-factorial** e.g. schizophrenia Major depressive disorder	Etiology : one diagnosable systemic medical disease, CNS disease or substance. e.g. Depression due to SLE Psychosis due to amphetamine
In medicine: like Essential hypertension	In medicine: like secondary HTN due to renal artery stenosis.
Clues suggestive of being primary : •Normal consciousness & vital signs. •Presence of : ❑ Auditory hallucinations ❑soft neurological signs ❑Young age onset	Clues suggestive of being secondary: •Disturbance of consciousness or vital signs •Presence of : ❑ non-auditory hallucinations e.g. visual, ❑hard neurological signs ❑physical illness ❑ old age onset

Medical illnesses that can induce secondary psychiatric disorders

Endocrine	Metabolic	Infectious	Autoimmune	CNS
Thyroid disorder ➢ Hypo- ➢ Hyper- Adrenal disorder ➢ Hypo- ➢ Hyper ➢ Pheochromocytoma Parathyroid DO ➢ Hypo- ➢ Hyper Pancreatic DO ➢ Hyperglycemia ➢ Hypoglycemia ➢ Pancreatic tumor	Hepatic disorder ➢ Wilson's ➢ Encephalopathy ➢ Porphyria Vitamin def ➢ B-1 ➢ B-12 Electrolyte imbalances Hypoxia Lead toxicity	➢ Neurocystercercosis ➢ Tuberculosis (TB) ➢ PANDAS ➢ Neuroborrilosis ➢ Neurosyphilis ➢ Herpes ➢ HIV Sepsis Malaria Legionnaire disease Typhoid Diphtheria Rheumatic fever Pneumonia UTI	➢ Systemic Lupus Eryhtematosus ➢ Multiple Sclerosis ➢ Pernicious Anemia (B12 def) ➢ Addison's Disease (hypoadrenalism) ➢ Grave's Disease (hyperthyroidism) ➢ Fibromyalgia ➢ PANDAS	Seizure DO ➢ TLE ➢ Frontal LE ➢ Paraneoplastic Syndrome Dementia ➢ NPH ➢ Delirium Subdural hematoma Tumor Meningitis Encephalitis ➢ Multiple Sclerosis NMS

Medications that can induce secondary psychiatric disorders

Prescription drugs	■ Chemotherapeutic Rx's ■ Immunosuppressants (e.g., cyclosporin [Gengraf, Neoral, Sandimmune]) ■ Antiviral Rx's (e.g., interferons) ■ Antiparkinsonian Rx's ■ Cardiovascular Rx's ■ Thyroid Rx's ■ Anticholinergic Rx's ■ Corticosteroids ■ Psychostimulants ■ Sympathomimetics ■ Sedative & CNS-depressants (e.g., barbiturates, benzodiazepines) ■ Opioids

Clues Suggestive of Psychiatric disorder 2ndary to another medical condition (previously called "Organic" Mental Disorders)

History:

- Psychological symptoms occurring:
  - New onset psychiatric symptoms presenting after age 40.
  - During the course of a major medical illness which had impaired some organ function (e.g., neurological, endocrine, renal, hepatic, cardiac, pulmonary).
  - While taking medications/illicit substance, he had psychoactive effects.
- Family history of:
  - -ve for primary psychiatric illness.
  - +ve for medical disease that may present with psychiatric symptoms e.g.:
    - Degenerative or inheritable neurological disorders (e.g. Alzheimer's disease, Huntington's disease)
    - Inheritable metabolic disorders (e.g. DM,Pernicious Anemia, Porphyria)

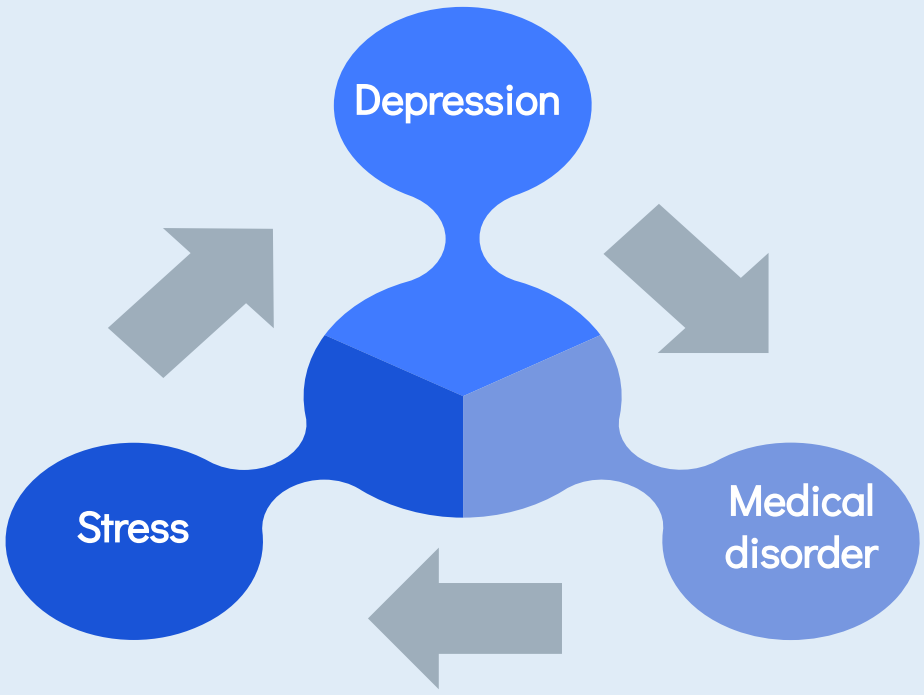
Clinical Exam

- Abnormal vital signs.
- Evidence of organ dysfunction, focal neurological deficits.
- Eye exam:
  - Pupillary changes—asymmetries
  - Nystagmus (often a sign of drug intoxication)
- Presence of altered states of mind, LOC, mental status changes, cognitive impairment; episodic, recurrent, cyclic course.
- Presence of visual, tactile or olfactory hallucinations,
- Signs of:
  - Cortical dysfunction (e.g., dysphagia, apraxia, agnosia)
  - Diffuse subcortical dysfunction (e.g. slowed speech/mentation/movement, ataxia, incoordination, tremor, chorea, asterixis, dysarthria)

Investigations to suggest secondary psychiatric disorders

Hormonal levels
CBC
Chemistry panel
Thyroid Function Test
Screening test for syphilis (VDRL or RPR)
HIV serology for high risk patients
B12 and folate
Urinalysis (with protein and glucose levels)
Toxicology screening
Urine for uroporphyrins and porphobilinogen
Serum ceruloplasmin
Chest X-ray
ECG
EEG
CT/MRI

Depression & medical illnesses

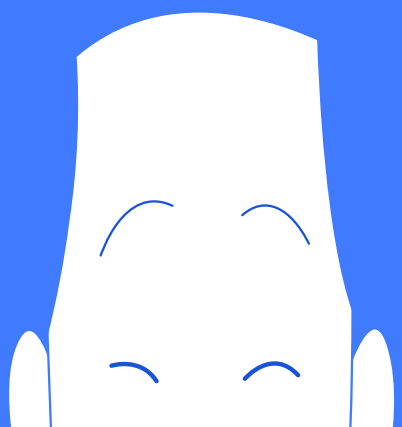


The global burden of disease, 1990–2020

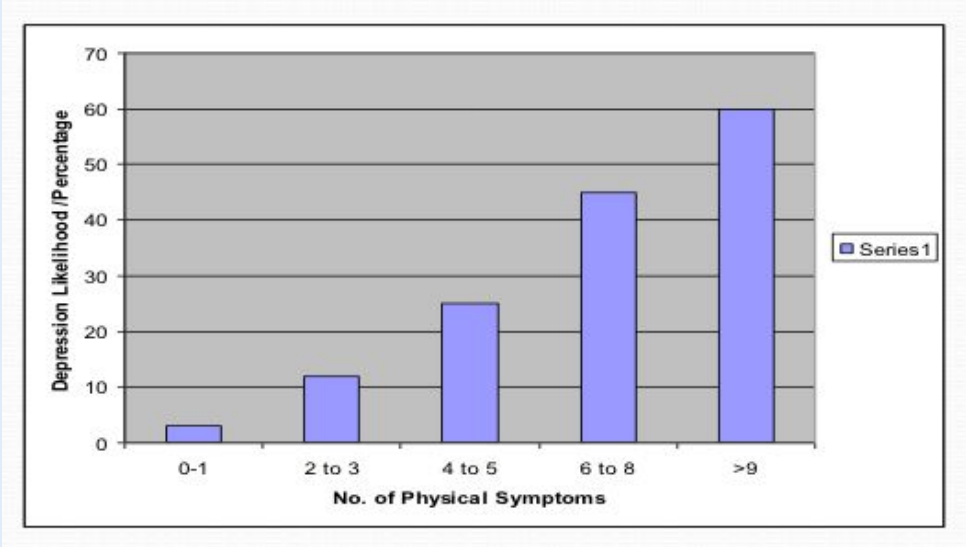
1990	2020
• Lower Respiratory Infections • Diarrheal Diseases • Perinatal conditions • Depression • Heart Diseases • Cerebrovascular D/O	• Heart Diseases • Depression • Traffic accidents • Cerebrovascular D/O • COPD • Lower Respiratory Infections
Lopez et al :Global burden of disease and risk factors, Oxford University Press, New York (2006)	

Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010 (Whiteford, the lancet, 2013)

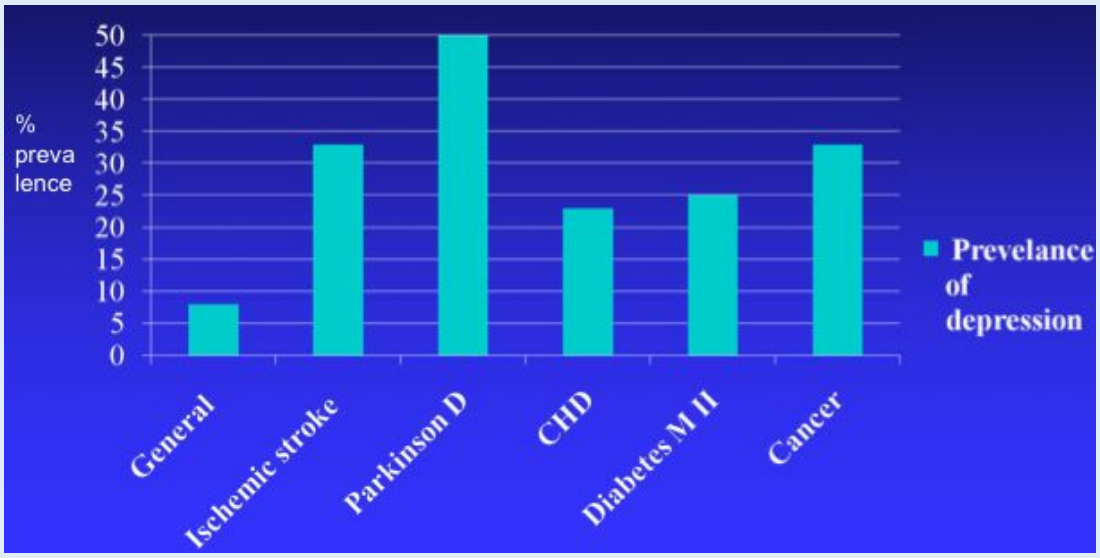
- As part of the GBD 2010, epidemiological data was collected for 20 mental and substance abuse disorders in 187 countries.
- In 2010, mental and substance use disorders accounted for 183·9 million DALYs or 7·4% of all DALYs worldwide. Mental and substance abuse disorders were the leading cause of non-fatal illness worldwide in 2010 (22.8%),
- The burden of mental and substance use disorders increased by 37·6% between 1990 and 2010.
- Depressive disorders were responsible for 40% of the burden of illness due to mental and substance abuse disorders.



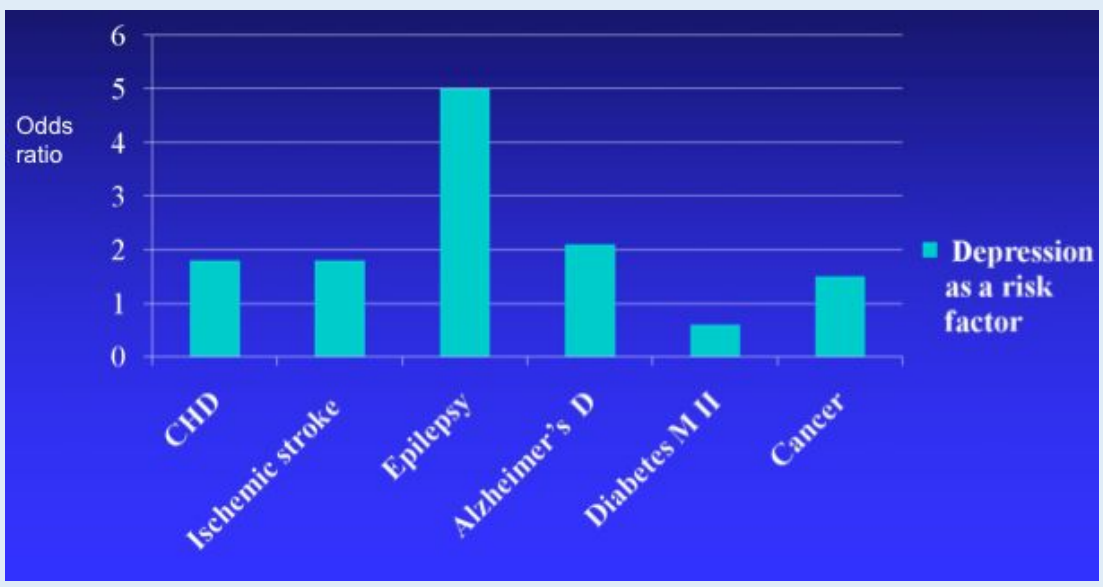
Likelihood of Depression Increases with No. of Physical Symptoms at Presentation



Epidemiology of depression in some medical illnesses



Depression as a risk factor for the development of medical illness



Depression plus Medically illness Is it serious?

- Poor outcomes of the medical illness.
- Increased mortality in cardiovascular disease, stroke, diabetes, and ?cancer.
- Chronic medical conditions and depression are interrelated and that treatment of one condition can affect the outcomes for the other.
- Worse adherence to medical regimens, tobacco smoking, sedentary lifestyle, and overeating.
- Increased functional disability, decreased self-care.
- Four to five times greater levels of morbidity, premature mortality, health services use and health care expenditures compared to non- depressed patients with no GMC.

Disability adjusted life years (DALYs)
كم هذا المرض يؤدي إلى فقد سنوات من البرودكتيفيتي للانسان او ياخذ من الوقت ليقتله، مثال:
Horner disease happens to 1 person every 1 million people
Causes severe mental retardation and the child will die in few years
هل هذا المرض يستدعي ان تنفق الدولة ملايين للوقاية منه؟ لا

اثبتت الدراسات ان الامراض النفسية تشكل 7.4% من الdalys
لو حسبنا الـ lethal and non-lethal
من كل ٤ اشخاص في المجتمع واحد منهم يكون مرض نفسي = ٢٢.٨٪
والاكتئاب يجي رقم واحد

Pathophysiology : mediating factors between Depression/Stress & medical illnesses

Physiological	Behavioural
• hyperactivity of the hypothalamic-pituitary- adrenal (HPA) axis. • immune activation with release of proinflammatory cytokines. • activation of the sympathetic nervous system.	• Physical inactivity. • Smoking. • High carbohydrate & high fat diet. • Poor adherence to medications. • Social isolation.

Dsm-5 criteria for major depression

(physical & psychological symptoms)

Depressed mood and loss of interest or pleasure (pervasive for 2 weeks)

+

4 of the follow (3 with both depressed mood and loss of interest or pleasure)

Physical	Psychological
Sleep disorder	Low self-esteem/ guilt
Appetite/ weight change	Poor concentration/ indecisiveness
Psychomotor retardation/ agitation	Thoughts of death/ suicidal ideation
Fatigue	Depressed Mood
	Loss of interest/ pleasure

Diagnostic Approach in the Medically Ill:
Inclusion approach: "count" all physical symptoms as part of depression even if possibly explained by the medical illness (to give patients, the benefit of doubt, by treating serious disabling illness like depression).

It's difficult to diagnose pt w/ MDD when they have a medical illness like cancer, because both of them have fatigue and loss of appetite. We use inclusion criteria in this case to diagnose, however research relies of exclusive approach.

DIFFERENTIAL DIAGNOSIS

1. Depressive disorder due to another medical condition.
2. Substance-induced depressive disorder, iatrogenic versus other illicit substances.
3. Bipolar I/II disorder, most recent episode depressed.
4. Major depressive disorder(uni polar).
5. Persistent depressive disorder (Dysthymia).
6. Adjustment disorder with depressed mood (common in medical setting).

Examples of Depression in medically ill patients

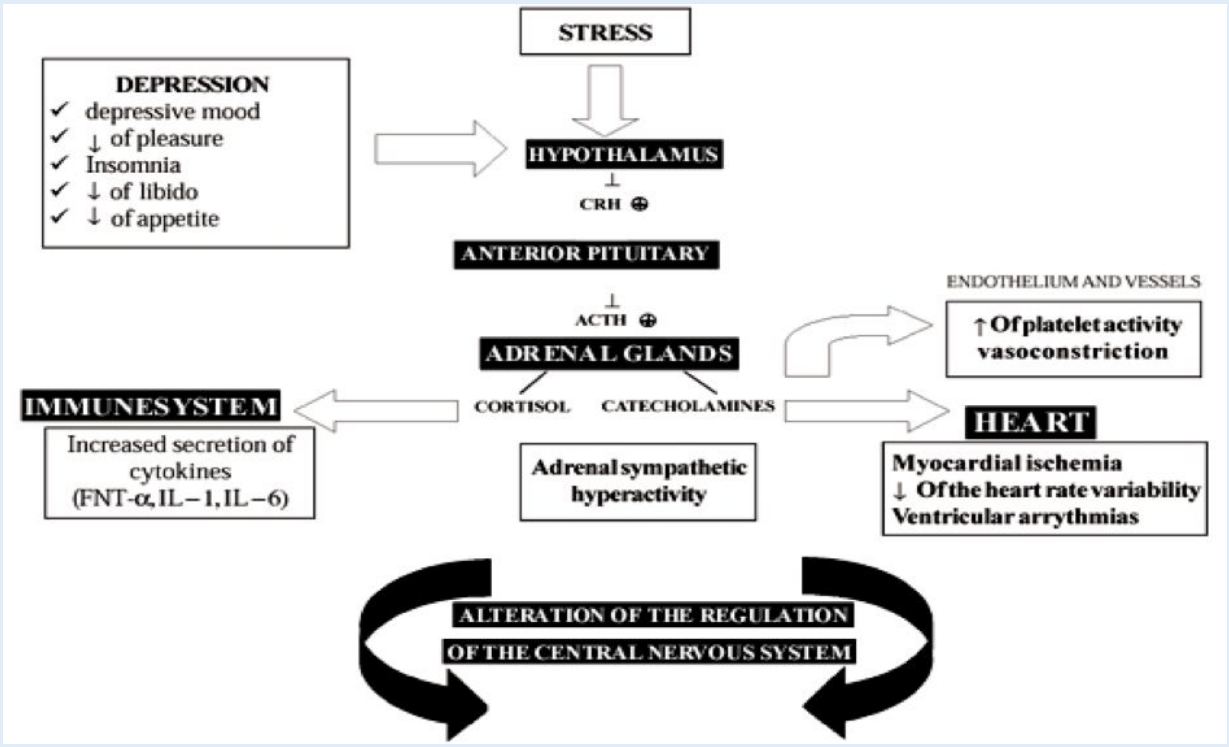
Depression & Coronary heart disease

Epidemiology

Depression has rep**eatedly been found to predict:**

- early-onset CHD.
- post-MI mortality (1.5- 5.07 times risk), esp. severe and chronic types. e.g. (HAM-Depression) scale score in first 2 weeks post CHD event predict 7 years mortality risk.
- increased CHD symptoms(chest pain, fatigue).
- noncompliance on exercise/medication/smoking .

Pathophysiology



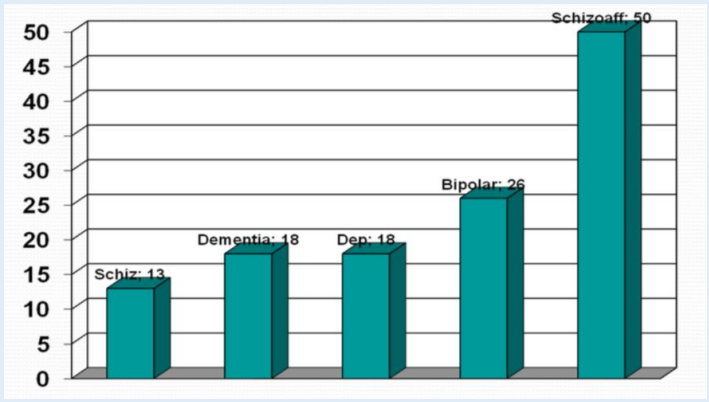
Post-stroke depression

- After stroke, 25 to 40% of patients meet criteria for Depression.
- Studies in the 80's and 90's demonstrated that post-stroke depression (PSD) was associated with left frontal brain lesions, worse physical and cognitive recovery, and increased mortality.
- These depressions were shown to be treatable with antidepressants and successful treatment led to both improved recovery and survival.
- There have now been RCTs showing PSD may be treated and prevented effectively with citalopram, nortriptyline, or reboxetine.
- Later, antidepressants (ADs) shown to improve physical and cognitive recovery over 1 year independent of dep.
- Over 7 years, antidepressants shown to decrease mortality by 50% even among non-dep pts, how? Inflammatory proteins are released both by stroke and depression and can have long lasting negative effects on brain function.
- Antidepressants have been shown to decrease these Inflammatory proteins ⟶ neurogenesis and synaptogenesis ⟶ improved recovery and decreased mortality following stroke.
- However, pts who take both NSAIDs & ADs should be monitored for intracranial hemorrhage.

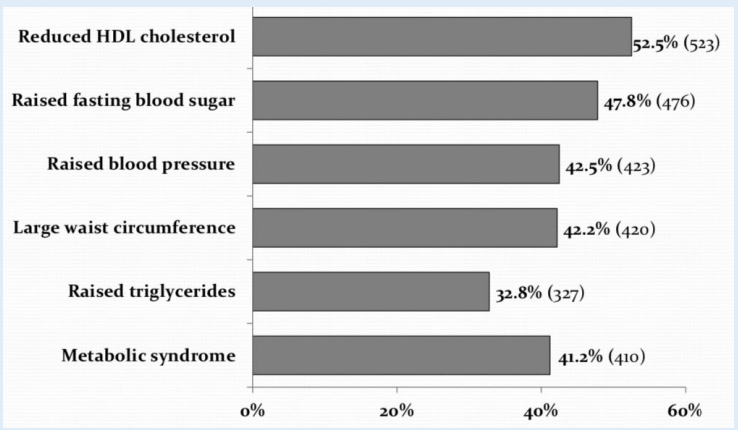
Prevention of depression by Antidepressants in stroke patients (prophylaxis):
1-Family hx of depression 2-Ischemic stroke 3-Personal hx of stroke 4-left frontal lobe stroke

Depression & Diabetes

Prevalence of Diabetes among patients with major psychiatric disorders

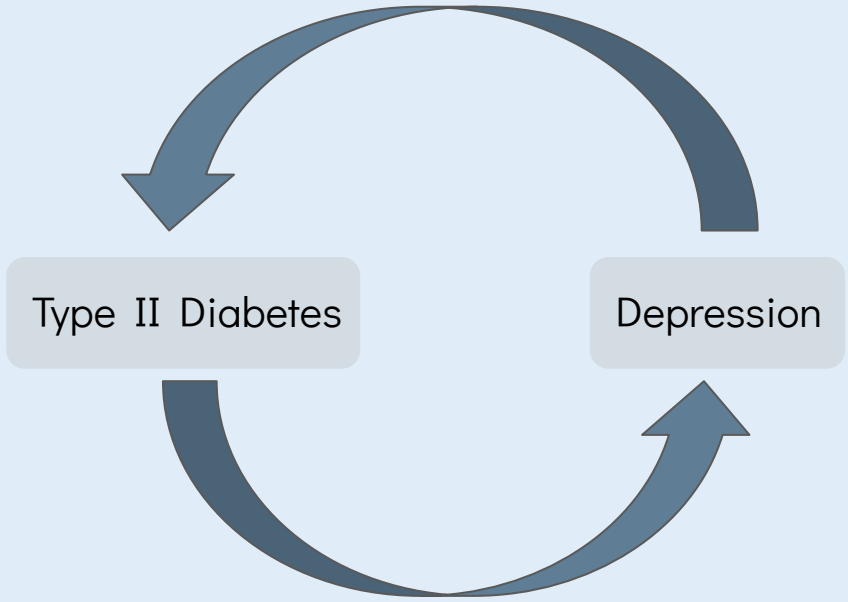


Prevalence of metabolic syndrome and its individual components among Saudi psychiatric patients (N=996) (Alosaimi FD, et al, 2016)



Bi-directional Relationship: Independent of multiple confounding factors

Depression is associated with a 60-65% increased risk to develop Type II Diabetes

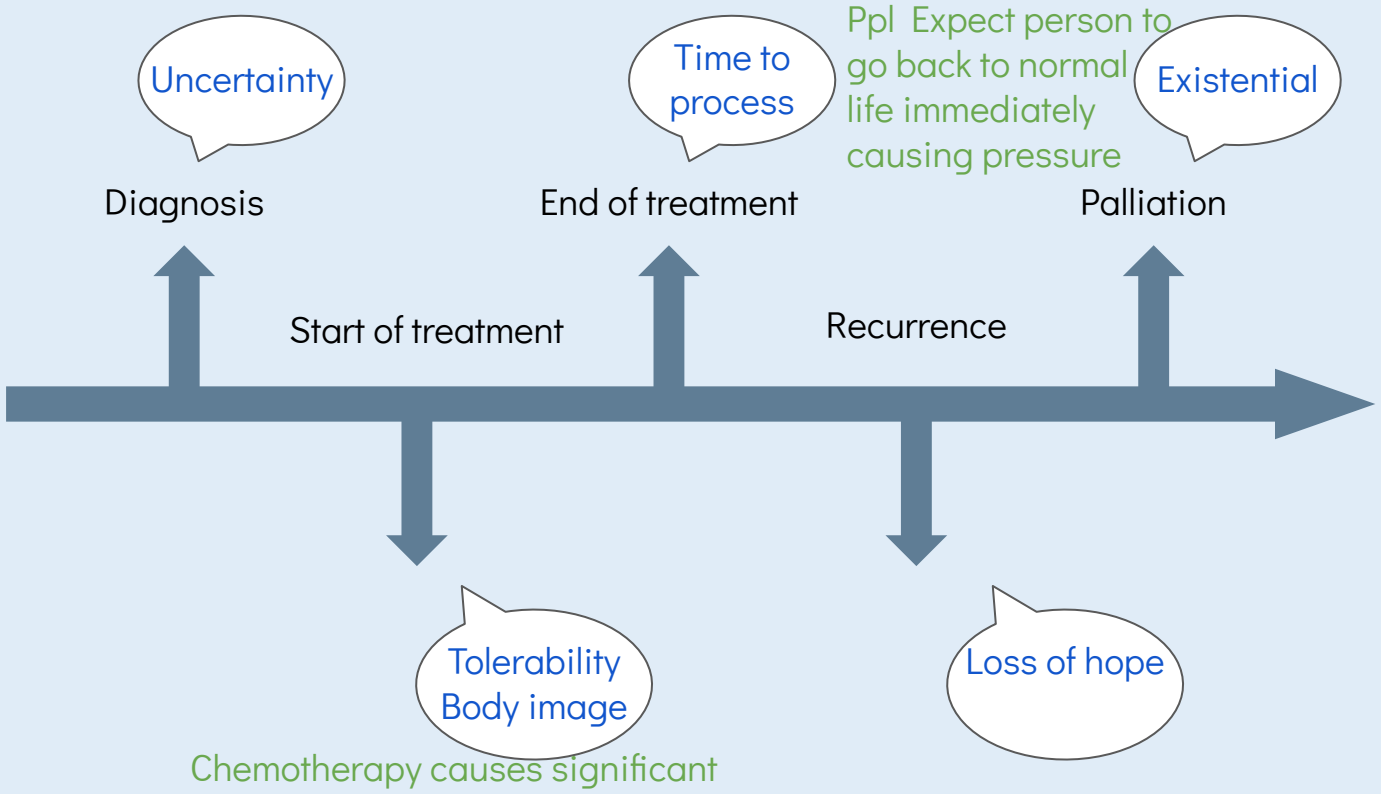


2-3x higher prevalence than in general population

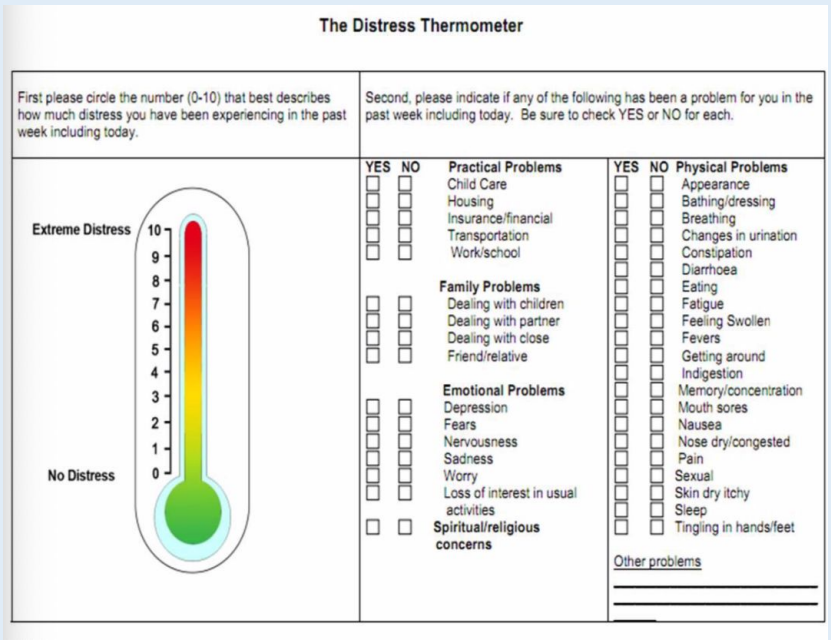
Cancer

- Many oncologists consider depression part of the illness and often conclude it therefore does not require treatment.
- Many also believe that if the cancer can be treated, then the accompanying depression will remit on its own.
- Many patients deal with the knowledge of having cancer through the expected grieving process. BUT, it may precipitates an episode of major depression in 25%.

Distress along the illness trajectory



Chemotherapy causes significant depression



The Distress Thermometer

First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

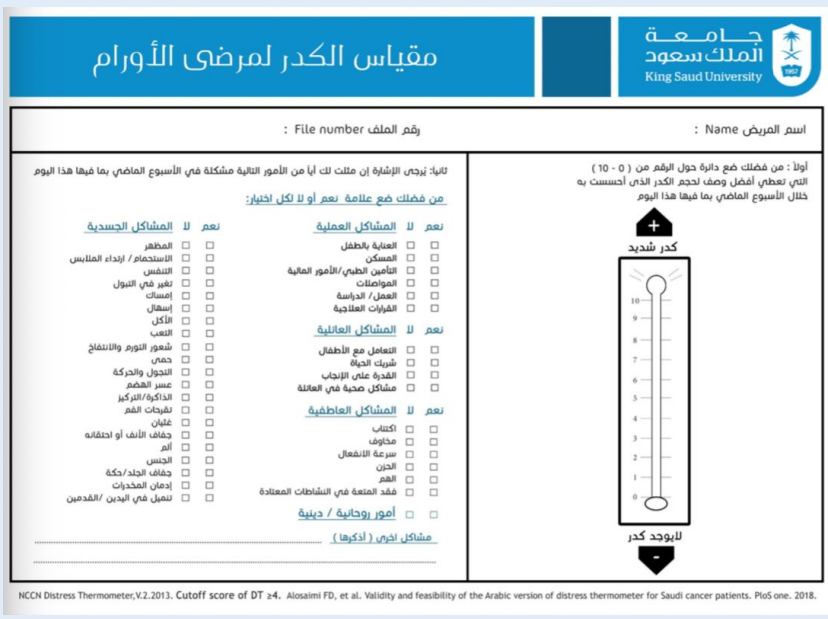
Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

Extreme Distress 10 9 8 7 6 5 4 3 2 1 0 No Distress

YES	NO	Practical Problems
☐	☐	Child Care
☐	☐	Housing
☐	☐	Insurance/financial
☐	☐	Transportation
☐	☐	Work/school
		Family Problems
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Dealing with close
☐	☐	Friend/relative
		Emotional Problems
☐	☐	Depression
☐	☐	Fears
☐	☐	Nervousness
☐	☐	Sadness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	**Spiritual/religious concerns**

YES	NO	Physical Problems
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhoea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling Swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry/congested
☐	☐	Pain
☐	☐	Sexual
☐	☐	Skin dry itchy
☐	☐	Sleep
☐	☐	Tingling in hands/feet

Other problems _____



مقياس الكدر لمرضى الأورام

جامعة الملك سعود King Saud University

اسم المريض Name : رقم الملف File number :

أولاً : من فضلك ضع دائرة حول الرقم من (0 - 10) التي تعطي أفضل وصف لحجم الكدر الذي أحسست به خلال الأسبوع الماضي بما فيها هذا اليوم

كدر شديد + 10 9 8 7 6 5 4 3 2 1 0 لايوجد كدر -

ثانياً: يُرجى الإشارة إن مثلت لك أيا من الأمور التالية مشكلة في الأسبوع الماضي بما فيها هذا اليوم

من فضلك ضع علامة نعم أو لا لكل اختيار:

نعم	لا	المشاكل العملية
☐	☐	العناية بالطفل
☐	☐	المسكن
☐	☐	التأمين الطبي/الأمور المالية
☐	☐	المواصلات
☐	☐	العمل/ الدراسة
☐	☐	القرارات العلاجية

نعم	لا	المشاكل العائلية
☐	☐	التعامل مع الأطفال
☐	☐	شريك الحياة
☐	☐	القدرة على الإنجاب
☐	☐	مشاكل صحية في العائلة

نعم	لا	المشاكل العاطفية
☐	☐	اكتئاب
☐	☐	مخاوف
☐	☐	سرعة الانفعال
☐	☐	الحزن
☐	☐	الهم
☐	☐	فقد المتعة في النشاطات المعتادة
☐	☐	أمور روحانية / دينية

مشاكل اخرى (أذكرها) .....

نعم	لا	المشاكل الجسدية
☐	☐	المظهر
☐	☐	الاستحمام / ارتداء الملابس
☐	☐	التنفس
☐	☐	تغير في البول
☐	☐	إمساك
☐	☐	إسهال
☐	☐	الأكل
☐	☐	التعب
☐	☐	شعور التورم والانتفاخ
☐	☐	حمى
☐	☐	التجول والحركة
☐	☐	عسر الهضم
☐	☐	الذاكرة/التركيز
☐	☐	تغيرات الفم
☐	☐	غثيان
☐	☐	جفاف الأنف أو احتقانه
☐	☐	ألم
☐	☐	الجنس
☐	☐	جفاف الجلد/حكة
☐	☐	إدمان المخدرات
☐	☐	تنميل في اليدين /القدمين

NCCN Distress Thermometer,V.2.2013. Cutoff score of DT ≥4. Alosaimi FD, et al. Validity and feasibility of the Arabic version of distress thermometer for Saudi cancer patients. PloS one. 2018.

Summary (Depression in medically ill)

- Historically, depression in the medically ill was often considered a natural and expected response to medical illness.
- Treatment of depression was often considered secondary to treatment of the medical illness, if the depression was even treated at all.
- Today, this perspective can no longer be accepted.

- Depression is a systemic disease.
- The effect of depression on the course of medical illness is multifaceted because there are systemic pathophysiologic implications, as well as psychological and behavioral ramifications.
- The accurate diagnosis and appropriate treatment of depression in the medically ill improves quality of life, enhances the patient's ability to be actively engaged in his or her treatment, decreases symptom quantity and severity, and decreases cost utilization.
- Most important, it decreases morbidity and mortality.

Four important messages about MEDS in ESRD

- Most psychotropic medications are fat soluble, easily pass the blood-brain barrier, are not dialyzable, are metabolized primarily by the liver, and are excreted mainly in bile.
- The majority of these drugs can be safely used with the ESRD populations.
- Dosing often involves trial and error. The majority of patients with ESRD both tolerate and require ordinary doses of most psychotropic medications.
- Toxicity is usually obvious, and we would caution more against under-medicating patients than against overmedication.

Summary of psychopharmacology for patients with liver disease

- To guide pharmacotherapy in liver disease, use Childs-Pugh scores with closer monitoring to help to increase safety and tolerability.
- When choosing psychotropic agents for patients with liver disease, consider the following:
  - **Drug interactions** e.g : NSAIDs + SSRI for GI bleed
  - **Medical Disease** e.g : Severity of liver disease, protein binding
  - **Age** e.g. : Decreased risk hepatotoxicity in adults
  - **Drug profile** e.g.: Hepatotoxicity, hyperammonemia
  - **Hepatic modifications** e.g: Bupropion vs. citalopram

Perinatal Psychiatry

Consequences of Depression in Pregnancy

Mother	Baby
• Suicide • Unhealthy practices e.g. smoking • Poor nutrition • Less compliant with prenatal care • Increased pain, nausea, stomach pain, SOB, GI symptoms, etc	• Low birth weight, smaller head circumferences, premature delivery, etc. • Poor mother-infant attachment, delayed cognitive and linguistic skills, impaired emotional development, and behavioral issues. • Emotional instability and conduct disorders, attempt suicide, and require mental health services.

Depression in Pregnant Women

- 10% to 16% of pregnant women fulfill the diagnostic criteria for MDD, and even more women experience subsyndromal depressive symptoms.
- Many of depressive symptoms overlap with the physical and mental changes experienced during pregnancy.

Treatment of Depression in Pregnant Women

- Antidepressants reduce risk for preterm birth and cesarean delivery compared with Depressed women untreated BUT has more neonatal complications, including low Apgar score (? Withdrawal syndrome). (Heli Malm, AJP, 2015).
- Sertraline, Escitalopram and Citalopram are the Safest SSRIs in Pregnancy. (Reefhuis J et al, BMJ 2015)
- SSRIs : exposure show NO consistent information to support specific morphological teratogenic risks.
- NO association between TCA use in pregnancy and structural malformations.
- Presumed associations between antidepressants and malformations may be complicated by poly-drug interactions.
- Bupropion, venlafaxine, duloxetine, nefazodone, and mirtazepine: NO statistically significant difference or higher than expected rate of congenital anomalies.
- ECT has long been regarded as a safe and effective treatment for severe depression, life threatening depression, or failure to response to antidepressant drugs.
- Psychotherapy: is considered to be an evidence-based treatment of mood disorders.
- Mild depression: interpersonal psychotherapy (IPT) or cognitive behavioral therapy (CBT), both having solid evidence-based outcomes data for the treatment of depression.
- Couples counseling.
- Mild to moderate depression = try to treat it with psychotherapy
- Moderate to severe= you have to give antidepressants
- Antidepressants don't cause teratogenicity with exceptions to some medications.
- Some antidepressants may affect the baby (20%) but it can be treated easily.

Treatment of Mania & Psychosis during Pregnancy

- Typical antipsychotics esp. high potent considered as relatively safe compared to other medications.
- Atypical antipsychotics: no major malformations were found. However, limited data so far, Metabolic syndrome is more with olanzapine and clozapine. (Gestational DM)
- Lithium is considered first line mood stabilizer during pregnancy despite rare cardiac anomaly (operable). If pt is already taking it, it's safer to just continue with it.t
- Lamotrigine is the safest anticonvulsants mood stabilizers.
- Avoid valproate & carbamazepine in child bearing women and pregnancy.

Why to avoid Valproate in child bearing women and pregnancy?

- Neural tube defects secondary to interference with folate metabolism with first trimester exposure.
- Risk = 7-16%.Valproate is usually avoided in all child-bearing women.
- Craniofacial defects: mid-face hypoplasia, short nose with anteverted nostrils, and long upper lip.
- Hypoglycemia, hepatic dysfunction, fingernail hypoplasia, cardiac defects, cleft palate, hypospadias, polydactyly.
- Neonatal toxicity possible.
- Significantly lower mean IQ and verbal IQ.

Postpartum Depression

- 10% to 20% of women who give birth.
- Undetected and commonly underdiagnosed.
- Continuum of Affective Symptoms
  - "baby blues"..... postpartum psychosis

Treatment of Postpartum Depression

- SSRIs are medications prescribed most commonly but other agents should be considered.
- ?More positive response to SSRIs and Venlafaxine, than to TCAs.
- Pharmacotherapy should continue for at least 6 months to prevent a relapse of symptoms.
- Breastfeeding: All antidepressants are secreted to some degree into the breast milk! But rarely cause any side effect.
- Recommend sertraline or Paroxetine: Infant serum levels are low to undetectable.

Cont. Treatment of Postpartum Depression

- Fluoxetine: higher rate of secretion into breast milk, long half-lives of metabolites, they can accumulate in an infant's blood, reaching detectable levels.
  - NOT considered the first-line SSRI for breastfeeding women.
- Mirtazapine: no negative effects on infants with maternal use.
- Research on long-term effects of SSRI and TCA exposure through breast milk on children shows NO alteration in IQ, language development, or behavior.
- Stopping breastfeeding should be the LAST option.
- IPT and CBT are effective.

Postpartum Psychosis

- Rare: 1 in 500-1000 deliveries.
- Typically presents within 2 weeks of delivery.
- Often is a manifestation of bipolar disorder.
- Signs/symptoms: Severe insomnia, Rapid mood swings, Anxiety, Psychomotor restlessness, Delusions (childbirth themes), hallucinations, cognitive disturbance, neglecting the infant.
- Assess for suicidal, homicidal/infanticidal ideations.
- Treatment: mostly similar to Tx of bipolar disorder, consider ECT. Hospitalization

Somatic Symptoms & Related Disorders

Medically unexplained symptoms

Suspicious symptoms or complaints

- Conscious attempt to deceive
  - Chief goal is psychological (primary gain)
    - Factitious disorder
      - هو متعمد يسوي بنفسه كذا عشان وده يلعب دور المريض عشان يعتنى به لذلك يرحب بأي فحوصات او اجراءات تسويها له
  - Chief goal is external (secondary gain)
    - **Malingering**
      - يتمارض ليحصل على شي معين كعذر طبي وغيره
      - لذلك مجرد ما تقوله بسوي لك اجراء او فحص يرفض
- NO conscious attempt to deceive
  - **Somatic symptoms and related disorders:**
    - Somatic symptoms disorder.
    - Illness anxiety disorder.
    - Conversion disorder.

DSM-5 criteria of **Somatic Symptom Disorder**

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
   a. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
   b. Persistently high level of anxiety about health or symptoms.
   c. Excessive time and energy devoted to these symptoms or health concerns.
C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

وحدة عندها الام في الظهر وعندها مشاكل عائلية وزلقت على ظهرها وطلع عندها intervertebral disc herniation. وسببت لها هالمشكلة ارق كبير وصارت تروح لاكثر من دكتور وتخاف يجيها شلل وتستخدم عصا. طريقة تعاملها مع العرض مبالغ فيها

DSM-5 criteria of **Illness Anxiety Disorder**

A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

شخص عمره ٣٠ سنة توفى أبوه بسرطان وسوى أكثر من مئات الفحوصات بالرغم من عدم وجود أعراض لكن فكرة ان ممكن يجيه المرض بسبب ابوه مسببت له قلق او يكون العكس ما يبي يفحص ابد

DSM-5 criteria of **Conversion Disorder**
(Functional Neurological Symptom Disorder)

A. One or more symptoms of altered voluntary motor or sensory function.
B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
C. The symptom or deficit is not better explained by another medical or mental disorder.
D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Specify symptom type:

- With weakness or paralysis
- With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)
- With swallowing symptoms
- With speech symptom (e.g., dysphonia, slurred speech)
- With attacks or seizures
- With anesthesia or sensory loss
- With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)
- With mixed symptoms

وحدة فتشت جوال زوجها وطلع زوجها متزوج عليها شافته قدامها ما تدري وش تسوي فيه قامت رجعت وبعدها فقدت القدرة على الكلام جت الطوارئ سووا لها سي تي كل شي طبيعي. عطوها Drug assisted interview

DSM-5 criteria of **Psychological Factors Affecting Other Medical Conditions**

A. A medical symptom or condition (other than a mental disorder) is present.

B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
   a. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
   b. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
   c. The factors constitute additional well-established health risks for the individual.
   d. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.

C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

وحدة عنده ارتفاع في ضغط الدم وياخد عليه ادوية لكن
مشكلته شخص غضوب والدكتور ما يقدر يزيده ادوية لان
راح يسبب له هبوط في الضغط

Etiology of Somatic Symptoms and Related Disorders

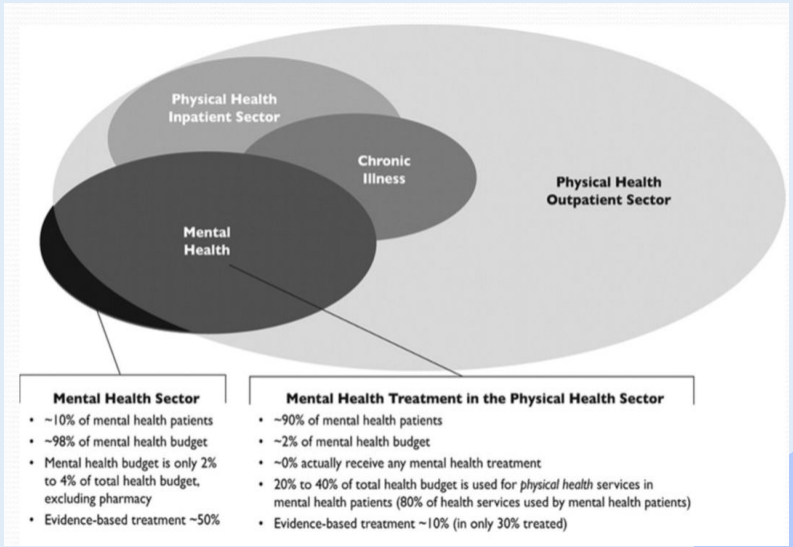
Dr. skipped

Diagnosis	Prevalence	Gender	Age of Onset	Course
Hypochondriasis (somatic symptom disorder + illness anxiety disorder)	1-5% (community) 2-7% (primary care outpatients)	M=F	Early adulthood	Chronic, waxes and wanes
Conversion Disorder	0.01-0.5% Esp. rural areas, lower SES, developing areas, and lower educational levels	F>M 2-10	Late childhood - Early adulthood	• Acute or sudden • Remit in about 2w • Recur in 25%
Pain Disorder (subtype of somatic symptom disorder)	Unknown 10-15% of U.S. adults experience chronic, disabling pain/year	M=F	Any age	Can be acute or chronic
Factitious Disorder	Unknown, 1% of hospital cases in which mental health professionals are consulted	F>M	Early adulthood	Episodic

Management of Somatic Symptoms and Related Disorders

DO	AVOID
• Allow patient role Concentrate on functions. • Frequent, short visits. • Single doctor. • Group therapy. • May individual Tx. • Drug treatment for psych co-morbidity. • SSRIs, high doses for Hypochondriasis and BDD.	• Concentrating on Symptoms. • Say (It's just in your mind,take it easy..) • Tests or Rx without Dx. • Unnecessary Referrals/ consults.

Future of Psychiatry



Psychosomatic Medicine & Consultation-Liaison Psychiatry

- Definitions Advantages
- Physical and psychiatric morbidity
- Major reasons for referral to psychiatry.
- Characteristics of an effective psychiatric
- Somatic responses to psychosocial stress

C-L Psychiatry and patients in medical specialties

- Intensive Care Units
- Cardiology
- Pulmonology
- Neurology
- Rheumatology
- Gastroenterology
- Nephrology
- Hematology
- Oncology
- Reaction to terminal illness
- Endocrinology
- Infectious Diseases
- Dermatology
- Gynecology
- Surgery

Somatic Symptom and Related Disorders

- Somatic Symptom Disorder
- Hypochondriasis
- Conversion Disorder
- Psychogenic Pain Disorder
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder/ Malingering

Dealing with physically-ill patients who have difficult personalities

A 57-year-old man had a **stroke** 2 years ago. He then showed low mood, loss of interest, crying spells, **difficulty sleeping** and death wishes.

A 48-year-old man had developed a **myocardial infarction**. In the coronary care unit, he was tearful, apprehensive, tremulous, and his chest pain symptoms worsened.

There is a unity of mind and body. Thus, psychological factors should be taken into account when considering any medical disease. It is helpful to know and differentiate between the following terms:

Disease **:** pathophysiological process recognized by physicians. It is *objective* based on biological changes in the body.

Illness: individual's understanding of disease. It is *very subjective* and varies from person to person.

Illness behavior**:** patient's behavior to adjust to his disease. This can be adaptive (e.g. consulting doctors, accepting to be referred to psychiatrist, taking medications) or non-adaptive (e.g. exaggerating symptoms, refusing medication). Personality factors play a major role in the psychological adjustment to physical diseases.

Illness-denying **attitude**: a tendency to underestimate physical symptoms and to deny physical diseases. It is a psychological defense against weakness. It may help some patients with certain serious diseases.

Illness-affirmative **attitude**: a tendency to exaggerate mild physical symptoms and to affirm physical diseases. It can lead to hypochondriasis; excessive concern & preoccupation with physical diseases see later.

Sick Role**:** socially expected/required role of ill person e.g. exemptions from some responsibilities, the right to seek care and help from others. If sick role continues after the disease is over the sick role is maladaptive.

Doctor - Patient Relationship (There are **4** main approaches / not mutually exclusive):

1.The autocratic (paternalistic) approach: the physician generally dominates the interview (as the doctor knows best) and the patient is expected to comply without questioning. It can of value in certain emergency situations.

2.The informative approach: the physician dispenses information without suggestion or interference and the choice is left to the patient. It may be appropriate for certain one-time consultations.

3.The shared decision approach: the physician is flexible, presents and discusses alternatives with the patient.

4.The deliberative approach: the physician advocates a particular course of action (e.g. how to lose weight).

Physicians as Patients**:** Physician-patients are usually poor patients, most likely because they are trained to be the masters of the patient-doctor relationship. For a physician, being a patient may mean becoming dependent, and giving up control. They may be embarrassed to ask pertinent questions for fear of appearing incompetent. The treating physician may fear criticism of his or her skills or competence.

Biopsychosocial Model (Engel 1977): It stresses an integrated systems (biological, psychological, and social) approach to human behavior and disease (etiology and management). It encourages a comprehensive understanding of disease and treatment. Each system affects, and is affected by, every other system.

Psychosomatic medicine: It is based upon observation that psychological and sociocultural factors play a role in the predisposition, onset, course and response to treatment of some physiological changes and biomedical disorders.

Liaison Psychiatry: It is the work of a psychiatrist in a general hospital, which covers the area between psychiatry and other branches of medicine where he attends medical ward rounds and other clinical meetings.

Consultation Psychiatry: Each patient, on whom an opinion is sought, is referred to the psychiatrist who may visit the ward at any time. ***Consultation-Liaison (C-L) Psychiatry***: is the study, practice, and teaching of the relation between medical and psychiatric disorders. It is associated with all the diagnostic, therapeutic, research and teaching services that psychiatrists perform in the general hospital and serves as a bridge between psychiatry and other specialties. The psychiatrist and physician meet regularly to discuss individual patients and general aspects of patient care. It is not confined solely to psychiatric disorders.

Advantages of consultation-Liaison psychiatric services:

1. Improve the quality of life and the quality of care provided to patients in non-psychiatric wards, e.g. reduce the number of unnecessary investigations performed for physical symptoms that actually reflect underlying psychological distress.
2. Reduce the length of patient's stay in the hospital and the readmission rate .Thus, reducing the cost and increasing the vacancy capacity and bed turnover.

Consultation-liaison psychiatry involves the practical application of all psychiatric knowledge, ideas, skills, and techniques where they may be helpful to non-psychiatrists in the care and understanding of their patients.

Physical and psychiatric morbidity:

There are different types of association between physical and psychiatric morbidity

1. Psychiatric *reactions to* physical disease (e.g. anxiety provoked by heart disease).
2. Psychiatric disorder *presenting with* physical symptoms (e.g. dizziness as a feature of anxiety).
3. Psychological factors *affect* the physical illness through:
   - Prolonging the course (e.g. anxiety may prolong the course of essential hypertension).
   - Maintaining unhealthy habits (e.g. psychoactive substance abuse).
   - Determining whether a person seeks helps from a doctor for a physical complaint (e.g. a person may seek medical help for backache when he feels depressed, but not when his mood is normal).
   - Affecting compliance with treatment (e.g. neglecting the oral hypoglycemic agents when depressed).
4. Psychiatric and physical illness *occurring together independently* (e.g. gallstone and depression).The physical illness may exacerbate psychiatric symptoms.
5. Physical disease *presenting with* psychiatric features (e.g. psychosis as early presentation of SLE).

The major reasons for referral to psychiatry:

1. The patient has a psychiatric disorder, on psychotropic medications, or has a past history of such.
2. The staff are under strain over the patient because of his behavior is disturbing, demanding, manipulative, or suicidal.
3. Diagnostic uncertainty with suspicion of a psychiatric problem behind the physical symptoms.
4. The patient has asked to see a psychiatrist. However, patients are usually reluctant to see psychiatrist, and families may reinforce this attitude.

Characteristics of an effective psychiatric consultation:

1. Reviewing the patient's chart.
2. Obtaining a good psychiatric history (paying attention to psychological and social factors).
3. Mental State Examination (and Mini – Mental State Examination if cognitive impairment is suspected).
4. Making a logic differential diagnosis among medical, neurological and psychiatric disorders.
5. Arriving at a diagnosis based on clinical features, laboratory investigations, and psychiatric knowledge.
6. Making reasonable treatment recommendations (medications, psychological treatment, etc.).
7. Following the patient during the entire hospitalization and after discharge.

On receiving the request for a consultation, the psychiatrist should make sure that the referring doctor has discussed the psychiatric referral with the patient. Before interviewing the patient, the psychiatrist should read the relevant medical notes and ask the nursing staff about the patient's mental state and behavior. The psychiatrist should know about treatment the patient is receiving. It may be necessary to ask further questions of the ward staff or social worker, to interview relatives and inquire about the patient's social background and any previous psychiatric history. It is often appropriate to discuss the proposed plan of management with the referring team. Nursing staff can help in the management of most brief psychiatric problems that arise in a general hospital.

Somatic responses to psychosocial stress:

Neuroendocrine responses:

Stress >> autonomic hyperarousal >> secretion of CRF from the hypothalamus >> release of ACTH >> stimulation of adrenal cortex to release glucocorticoids > > "flight or fight" response; increasing cardiovascular activity and promoting energy use.

Neuroimmune responses:

a- Stress >> glucocorticoids>>inhibition of immunity, reproduction, and growth.

b- Stress >> norepinephrine release >> immune activation > > release of cytokines (humoral immune factors) >> further release of CRF >> glucocorticoids.

C-L Psychiatry and patients in medical specialties

Intensive Care Units	Cardiology	Pulmonology	Neurology	Rheumatology
Gastroenterology	Nephrology	Hematology	Oncology	Reaction to terminal illness
Endocrinology	Infectious Diseases	Dermatology	Gynecology	Surgery

Depression is significantly associated with a wide variety of chronic physical disorders, including hypertension, cardiovascular disease, stroke, chronic respiratory disorders, diabetes, arthritis, asthma, cancer, and a variety of chronic pain conditions. Depression is a causal risk factor, it leads to an increased prevalence of these physical disorders, with all their associated impairments and increased mortality risk. In physically-ill hospitalized patients depressed mood is common. It can be primary, secondary to, or coexisting with the physical disease. Many medications can induce depression (e.g. antihypertensives, steroids, chemotherapy). Depressive disorders in psychiatric patients will be discussed later (see mood disorders).

Intensive Care Units (ICUs): Patients may experience delirium, depression, or anxiety. ICUs staff members face difficult emotional and physical circumstances e.g. deaths and medical disasters.

Cardiology:

Psychiatric patients may present to cardiology clinic because of 1. Palpitation associated with anxiety or panic attacks 2. Excessive worries about having a hidden serious cardiac disease (hypochondriasis; see later). **Patients with cardiac diseases** may present to psychiatry clinic because of depression as a side effect of medications (e.g. prolonged use of beta-blockers).

Depression is an *independent risk factor* for the development of hypertension (HTN), coronary artery diseases, (CAD) myocardial infarction (MI), & heart failure and for mortality after an acute MI. Mortality rate at 6-month follow-up in depressed post-MI patients (compared to non-depressed post-MI patients) is 4 folds. Research indicate that 15 - 25% of patients with CAD fulfill criteria for major depression.

Pathophysiology:

1.Vasospasm; due to high cortisol levels (hyperactivity of Hypothalamus-Pituitary-Adrenal Axis).
2.Atherosclerosis; Inducing inflammatory process that enhances plaque formation (inflammatory cytokines; Interleukin-6 [IL-6] and C-reactive protein[CRP]).
3. Thrombus formation; platelets activation (increase in pro-coagulant activity & level of binding of anti-ligand-induced binding site -anti-LIBS- antibody to fibrinogen-induced binding sites).
4. Depression increases the risk factors of cardiovascular diseases (DM, HTN, smoking, and obesity).

Antidepressants; reduce the risk of cardiovascular diseases in depressed patients.

1. Avoid tricyclics (serious conduction side effects, orthostatic hypotension, & drug interactions).

2. Selective Serotonin Reuptake Inhibitors (SSRIs); safe and well-tolerated but they might prolong bleeding time, and cause hyponatremia. Paroxetine has some anticholinergic activity. Citalopram 20 mg is a good choice

3. Selective Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs); Venlafaxine is well tolerated but in doses > 225 mg it may increase blood pressure (BP) in some persons.

Pulmonology:

Psychiatric patients may present to Pulmonology Clinic because of 1. Shortness of breath associated with anxiety, panic attacks, or as a side effect of beta-blockers, which are frequently prescribed to treat tremor and palpitation. Before starting beta-blockers always enquire about bronchial asthma [**BA**] (beta-2 receptors dilates bronchioles). Patients with asthma frequently suffer from anxiety symptoms. Among asthmatics, 42% reported anxiety focused on breathing, compared with 20% of **COPD** patients. Treatment of **BA** may precipitate anxiety. Obstructive sleep apnea syndrome **[OSAS]** is a common disorder in the adult population; it is often associated with significant cognitive impairments, depression, and irritability. Heroin addicts may develop respiratory depression (due heroin over dose) and pulmonary emboli from agents added to heroin (i.e., talc) or from septic emboli.

Neurology

 # Stroke:

A- Depression >>> stroke; meta-analysis studies demonstrate that depression is a significant modifiable risk factor for total stoke, fatal stroke, and ischemic stroke (see pathophysiology of depression in cardiovascular diseases). SSRIs increase bleeding tendency by inhibiting platelet aggregation and have been associated with higher risk of further strokes.

B- Stroke >>> depression; stroke may predispose, precipitate or perpetuate depressive disorders (Post-Stroke Depression [**PSD**]). Depression occurs in nearly 30 % of patients either during acute/chronic stroke period. About 80% of cases are under-diagnosed by non-psychiatric clinicians (due to lack of awareness/experience & diagnosis difficulties; aphasia, dysarthria, cognitive impairment). PSD has been associated with poor social and rehabilitation outcomes, cognitive impairment and increased mortality. About 10% PSD patients face mortality. **DDx:** vascular dementia, post-stroke apathy. **Risk Factors for PSD:** left anterior brain lesion, dysphasia and living alone. However, after 3 years post-stroke, the most important predictor for depression was cerebral atrophy. More evidence is required before recommendations can be made about the routine use of antidepressants to prevent PSD.

Treatment: pharmacologic and rehabilitation strategies are needed to treat PSD. **SSRIs** (e.g. citalopram) are effective in PSD and dramatically reduce the symptom of crying (but there is a risk of bleeding tendency due to inhibition of platelet aggregation).

 # Multiple Sclerosis: It is a central nervous system (CNS) demyelinating relapsing and remitting illness. It is chronic, disabling neurologic illness among young and middle age adults. Patients have temporary loss of vision, or dysconjugate gaze. When the spinal cord is attacked, patients typically develop paraparesis. Spinal cord involvement also leads to urinary and sexual dysfunction. Late in the illness, pseudobulbar palsy (sudden, unprovoked fits of laughing or crying) appear when large areas of frontal lobe myelin have been consumed by plaque. MRI of the brain and spinal cord typically shows lesions in affected areas. Sequelae to MS include cognitive impairment, psychosis, depression, and anxiety. Ms may be misdiagnosed as a conversion disorder (see later). Steroids can reduce neurological symptoms but may induce psychosis or affective disturbances.

 # Epilepsy: it has many comorbid psychiatric disturbances, which prompt psychiatric consultation and collaboration with neurologists, neurosurgeons, and other specialists. Partial complex seizures may present with psychosis, panic-like attacks, and delirium. Depression is common in epileptic patients (bidirectional relationship). Epilepsy increases the risk of depression and treatment of depression increases frequency of seizures.

 # Delirium, # Dementia, Amnesic Syndrome & #Head Injury.

Rheumatology:

 # Systemic lupus erythematosus (SLE): antineuronal antibodies and vasculitis in SLE can cause a range of neuropsychiatric symptoms; cognitive dysfunction, hallucinations, delusions, depression, suicidal ideation, and personality changes in ≥ 70 % of patients. Psychosis may be due to direct CNS involvement or, less frequently, to side effects of corticosteroid treatment. Mania, when present, is usually a side effect of corticosteroid therapy. Delirium becomes a more likely complication as the severity of overall SLE symptoms increases.

 # Rheumatoid arthritis (RA); is frequently characterized by psychiatric comorbidity (mostly depression or anxiety). Direct CNS involvement is rare in RA. Tricyclic antidepressants (e.g. amitriptyline 25-50mg) are prescribed to treat depressive, anxiety, and pain symptoms in RA patients.

Gastroenterology:

 # Peptic Ulcer (PU); psychological distress may induce and exacerbate PU. Psychological treatment is advised.

 # Irritable Bowel Syndrome (IBS): It is very common in G. I. Clinics. Features include fluctuating nonspecific abdominal discomfort, distention, and alteration of bowel habits; constipation or diarrhea (with occasional mucous in the stool but no blood). SSRIs and psychological treatment can improve the symptoms and quality of life.

 # Inflammatory Bowel diseases (IBD): early inflammatory processes in the gut might lead to psychiatric illness (depression, anxiety, or irritability) or vice versa, or a third factor might lead to both.

 # Interferon therapy in hepatitis C patients has psychiatric side effects (e.g. severe depression, suicidal ideation). SSRIs can be given safely to reduce depressive symptoms in such patients.

 # Hepatic Encephalopathy: broad range of neuropsychiatric manifestations (impairment of cognition, consciousness, the sleep-wake cycle, and personality changes.

Nephrology:

Patients with chronic renal failure are prone to have delirium because of uremia and electrolytes disturbances. Prolonged hemodialysis attributed to aluminum intoxication, which can lead to **dialysis encephalopathy** (dysarthria /dysphasia/myoclonus/ataxia/seizures/dementia). Some Psychiatric patients may develop renal problems due to side effects of psychotropic medications either directly (e.g. lithium), or indirectly (e.g. antipsychotics >> neuroleptic malignant syndrome >> severe prolonged muscle rigidity >> muscle destruction >> excessive amounts of myoglobin in the blood >> acute renal failure).

Hematology: Heroin addicts may present with vein thrombosis **>>>** pulmonary embolism. Patients with severe pain due to sickle cell hemolytic crises may become addict on medical narcotics (e.g. pethidine).

Oncology:

A. Depression >>> cancer: Whether depression can induce certain types of cancer remains a subject for research.

B. Cancer >>> depression (due to several biopsychosocial factors including chemotherapy). However, depression is more challenging to diagnose in patients with cancer because illness produces many neurovegetative symptoms: psychomotor retardation, fatigue, apathy, and poor concentration, appetite reduction, weight loss, and sleep disturbances. Clinical depression is prevalent among cancer patients with rates ranging between 13 and 40%. Many oncologists consider depression part of the illness and wrongly believe that if the cancer can be treated, then the accompanying depression will remit on its own. Meta-analysis research presented evidence that depression predicts mortality, but not progression, in cancer patients. Quality of life was shown to commonly predict survival perhaps even better than performance status. Most oncology divisions now have a psycho-oncology unit that provides psychosocial education, enhances the development of therapeutic communication skills for oncology staff, and seeks to study psychological and behavioral variables that may play role in cancer risk and survival. Studies that assessed depression years before cancer diagnosis found more associations with mortality than studies that assessed depression following cancer diagnosis psychological variables might have a stronger effect on disease progression and mortality in early stages of cancer. Psychological treatments (e.g. guided imagery, mindfulness based stress reduction [MBSR]) can enhance immunity, reduce fear of recurrence, and improve physical functioning in some patients. Psycho-neuro-immunity: Negative emotions are involved in the initiation or progression of cancer, and autoimmune disorders.

Psychological reactions to terminal illness & impending death.

The following psychological stages (proposed by Elizabeth Kubler-Ross) are widely encountered .These stages begin when the patient is first aware of a terminal illness. Not everyone goes through each stage and the order may be different for each person.

1. Denial/Disbelief: "This can't be happening, not to me, I feel fine". It is a temporary shock defensive response to the psychological trauma of bad news. Some persons never pass beyond this stage and may keep going from doctor to doctor searching for one who supports their position.

2.Anger –"How can this happen to me?"; *"Who is to blame?"* "Why me? It's not fair!""Others are more deserving". Anger arises once the subconscious accepts the reality of the bad news and denial cannot continue. Patient becomes frustrated, irritable, and angry. Anger towards doctors, nurses, medical agencies, relatives, fate, self, and even God/Allah (Why me and now?!). Anger may be associated with envy of healthy people. Therefore, at this stage the person may become very difficult to care for due to misplaced feelings of rage and envy. It is essential for doctors not to take this anger personally. It represents patient's desire for controlling what he feels out of control.

3.Bargaining –"I will give/ do anything for a few more years." It is a negotiation for an extended life, made with a higher power in exchange for a reformed lifestyle. Bargaining arises when the subconscious recognizes that anger does not help. Psychologically, the subconscious is saying, "anger did not work maybe being good will work, I understand I will die, but if I could just have more time...". It involves the hope that the individual can somehow postpone or delay death.

4.Depression – "Nothing worked, death is certain; I'm going to die, no way ". Depression arises when the subconscious realizes that nothing has worked to prevent or delay the coming death so that despair and hopelessness prevail. Depressive features appear; low mood, low interest, , weeping, poor appetite, disturbed sleep and isolation, negative thoughts (dependence on others, loss of financial support ...). It is not recommended to attempt to cheer up an individual who is in this stage. It is an important stage for grieving that must be processed.

5.Acceptance – "death is inevitable, I can't fight it, I better give up resisting and prepare for it." The subconscious begins to come to terms with mortality. This is not a "happy" stage; it is usually void of feelings. It takes a while to reach this stage and a person who fights until the end will not reach it.

These steps do not necessarily come in the order noted above, nor are all steps experienced by all patients. Any patient could experience the stages in a different order, or could experience emotions not even mentioned in the stage theory.. Research has found that those who felt they understood their purpose in life, or found special meaning, faced less fear and despair in the final weeks of their lives than those who had not.

الأثر النفسي للاحتضار

أ د محمد الصغيّر

يتفاوت حسب الجبلة والمعتقدات والتنشئة والظروف المحيطة

١- المحتضر

أ- خوف على ذاته:

- خروج الروح (+ ألم سكرات الموت).
- الحساب.
- المصير.

ب- خوف على غيره.

أولاد / شريك حياة /..

ج- حزن:

- فراق من وما يحب.

رفع الرجاء والتذكير برحمة الله

٢- أقاربه / مرافقيه

أ- الصدمة الأولى:

- صعق الشعور فوق تحمله المعتاد/ هول المصيبة.

الشعور: خدر كالتنميل لا حزن ولا غضب.

الإدراك: خلل في التوفيق بين الحقيقة والأمل؛ نفي الحدث داخل النفس- لعله حلم أو كذب .

السلوك: تشبث ببقاء المفقود (أنعشوه سيعود للحياة.)+ مساومة (بالنذر أو الصدقة المشروطة)

 # الجسد: عدة أعراض متنوعة.

ب - إدراك الحقيقة بألمها:

الجزع؛غضب للفقد (على من ؟/ ...).

ج – الحزن والأسى (صحيّة نفسيا).

مهارات إيصال الخبر المرير + الانتباه لاحتمال العدوانية تجاه الذات أو الغير (الطاقم الطبي).

القتل في المشاجرة ؟! < القصاص

٣- الطاقم الطبي

آثار نفسية طبيعية:

مشاعر مختلطة: خوف سكرات الموت والحساب والمصير وحزن و أعراض جسدية(محدودة الشدة والمدة).

آثار نفسية مرضيّة:

- رعب و شعور بحلول الموت.

- ***تكرر المشهد في الذهن يقظة ومناما مع انزعاج وعجز عن التخلص منه.***
- ***قلق وتجنب ما يتعلق بالمشهد.***
- ***أعراض جسدية متنوعة.***

التهيئة المسبقة وتدريبات خفض القلق / + -

Dermatology:

Psycho-dermatologic disorders (e.g. psoriasis, vitiligo, alopecia, pruritis …) are conditions involving an interaction between the mind and the skin. The skin is an interface, attacked by external factors, as well as expressing psychic conflicts. Many dermatological diseases have a direct or indirect link with psychiatric pathology. Many skin diseases are cosmetically disfiguring and adversely affecting quality of life. They can be treated with psychotherapeutic techniques and psychotropic drugs.

Gynecology

 # Premenstrual Syndrome (PMS): A group of physical and psychological features beginning a few days before and ending shortly after the onset of menstrual period. **Psychological features**: tension, anxiety, irritability, nervousness and low mood. **Physical features**: abdominal distension and pain as well as breast tenderness. The condition may lead to social, academic or marital dysfunctioning. No specific cause has been found. Treatment: Support, identify and treat familial and social stresses, cognitive-behavior therapy (CBT). Many drugs have been tried (hormones, psychotropic drugs..) with varying degrees of response.

 # Amenorrhea due to antipsychotics: females with psychotic disorders treated with antipsychotics are prone to develop amenorrhea because of high prolactin levels (prolactin secretion is usually inhibited by dopamine and most antipsychotics have antidopaminergic effect notably risperidone). Some gynecologists prescribe dopaminergic medications (e.g. bromocriptine) to reverse amenorrhea in psychotic females, which may aggravate their psychosis. Quetiapine (a second-generation antipsychotic) has no effect on prolactin, thus it is a good choice in such cases.

 # Pregnancy: Minor psychological symptoms are common during pregnancy, especially in the first and third trimesters (anxiety, irritability and minor lability of mood). Risk increases in case of unwanted pregnancy, marital conflicts, and previous history of abortion or depression and in adolescent mothers. Management consists of: counseling, increased support by medical services as well as family and marital therapies. Medications are rarely used and should be avoided in the first trimester.

Lithium may cause congenital cardiac anomalies. Valproate may cause neural tube defects (e.g.spina bifida). Tricyclics may be indicated in second and third trimester.

 # Abortion: Depressive mood is an expected reaction especially if there is a previous history of abortion, a past psychiatric history or poor marital adjustment. Counseling, reassurance and supportive therapy are indicated.

 # Maternity Blues: Brief emotional disturbance (tearfulness, irritability, crying, lability of mood, insomnia and poor concentration) starts 2-3 days after delivery, remains for few days. Very common (about 50 %), more common in primiparous and those who complain of PMS. May be related to hormonal changes. No specific treatment. General measures are enough; reassurance, support … etc.

 # The Menopause: Menopausal women often complain of multiple physical symptoms including sweating, dizziness, flushing, headache. No strong evidence that depressive symptoms are more common in menopausal women than in non-menopausal. Psychiatric symptoms at menopause could have several causes: altered perception of the self, altered relationship with husband, children leave home (empty nest syndrome), Parents become ill or die. Oestrogen deficiency has been suggested but the results of oestrogen replacement were much debated. Depression and anxiety in a menopausal women can best be treated with the usual methods that have been shown to be effective for these disorders at any other time of life.

 # Infertility: It can be complicated by feelings of depression, guilt, and inadequacy frequently accompanied the perception of being infertile**.** Psychotherapy gives good results.

 # Post-Partum Depression (see mood disorders). **# Post-Partum Psychosis:** (see psychotic disorders).

Surgery

Mrs. Fatima is a 34- year- old woman hospitalized for cholecystectomy. She became excessively worried about the operation procedures and complications. She refused to sign consent for the operation.

Surgical wards often have psychiatric patients who may disrupt the smooth functioning necessary for a surgical unit and can result in danger to the patient or others (e.g., staff, visitors, other patients).

Common psychiatric consultations in surgical ward:
There is a linear relationship between anxiety before and after surgery. Those who show more general ability to cope with stress suffer fewer post-operative psychiatric problems. Psychological preparations for surgery can reduce post-operative distress and problems.

Psychiatrists are sometimes asked to advise on the capacity to consent (see below) and management of patients with pain.

Delirium is common after major surgery especially in the elderly (see epidemiology of delirium).
Adjustment disorders are common following mastectomy and after surgery that has not lead to the expected benefit.
Phantom limb sensations follow limb amputation.
Organ transplantation is associated with certain psychosocial stresses that may cause anxiety or depression. Problems of transplant rejection are frequently associated with anger and low mood. Psychological symptoms may also occur as side effects of immunosuppressive drugs, steroids in high doses and antihypertensive drugs.

Clinical-legal issues

Does a mental illness imply a loss of autonomy & capacity to consent?
No, not all mental illnesses imply that. Only when a mental illness (e.g., dementia) results in a permanent impairment of understanding, judgment, and competence for decision-making. The physician then should consider alternative ways for decision-making, through official court proceedings such as guardianship, or proxy.

Durable Power of Attorney: It permits persons to make provisions for their own anticipated loss of decision-making capacity. The document permits the advance selection of a substitute decision maker who can act without the necessity of court proceedings when the signatory becomes incompetent through progressive dementia.

***Respect for autonomy*:**
Autonomy requires that a person acts intentionally after being given sufficient information and time to understand the purpose, benefits, risks, and costs of all reasonable options and decisions about his/her wealth, family, heath (e.g. providing or withdrawing consent).

Capacity to consent; ability to: 1- Understand information & options relevant to his condition. 2- Appreciate his own clinical situation (insight into the need for treatment). 3- Form a sound decision about his condition.
4- Provide a consistent choice.

Valid informed consent:
1-Person: has capacity to consent.
2-Explanation of sufficient information about the purpose, benefits, risks, and costs of all reasonable options and decisions concerning the matter in hand.
3-Time to understand and decide. ***4-No coercion or deceit.*** **5-The right to withdraw consent.**

Somatic Symptom and Related Disorders

Mr. Ziad is a 39- year-old man referred to outpatient psychiatry clinic by a cardiologist with several months' history of intense worries about serious heart disease and fear of sudden death. He kept asking the cardiologist to repeat ECG & echocardiogram despite the normal findings.

These are a group of disorders in which physical symptoms are the main complaints and cannot be explained fully by a medical condition, a direct effect of a substance or a mental disorder. Psychological factors are judged to be behind the somatic symptoms and complaints. They usually lead to distress and / or functional impairment in social, occupational or academic aspects.

Somatic Symptom and Related Disorders (DSM -5)

- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Conversion Disorder (Functional Neurological Symptom Disorder)
- Psychological Factors Affecting Other Medical Conditions
- Factitious Disorder

Somatic Symptom and Related Disorders

In DSM-5, somatoform disorders are now referred to as somatic symptom and related disorders. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed.

Somatic Symptom Disorder

Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

Hypochondriasis (Illness Anxiety Disorder)

Hypochondriasis has been eliminated as a disorder, in part because the name was perceived as pejorative and not conducive to an effective therapeutic relationship. Most individuals who would previously have been diagnosed with hypochondriasis have significant somatic symptoms in addition to their high health anxiety, and would now receive a DSM-5 diagnosis of somatic symptom disorder. In DSM-5, individuals with high health anxiety without somatic symptoms would receive a diagnosis of illness anxiety disorder (unless their health anxiety was better explained by a primary anxiety disorder, such as generalized anxiety disorder).

Conversion Disorder (Functional Neurological Symptom Disorder)

Criteria for conversion disorder (functional neurological symptom disorder) are modified to emphasize the essential importance of the neurological examination, and in recognition that relevant psychological factors may not be demonstrable at the time of diagnosis. Medically unexplained symptoms do remain a key feature in conversion disorder.

Pain Disorder

Most individuals with chronic pain attribute their pain to a combination of factors, including somatic, psychological, and environmental influences. In DSM-5, some individuals with chronic pain would be appropriately diagnosed as having somatic symptom disorder, with predominant pain. For others, psychological factors affecting other medical conditions or an adjustment disorder would be more appropriate.

Psychological Factors Affecting Other Medical Conditions and Factitious Disorder

This disorder and factitious disorder are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings.

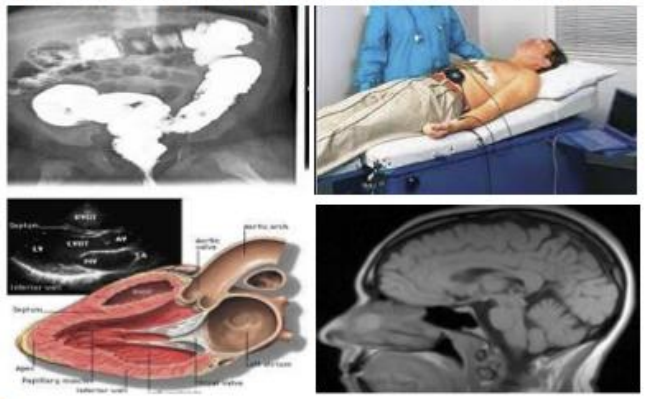
Somatoform disorders :(for further details; >>Basic Psychiatry chapter 14)

1-Somatic Symptom Disorder

Because the distinction between somatization disorder and undifferentiated somatoform disorder was arbitrary, they are merged in DSM-5 under somatic symptom disorder, and no specific number of somatic symptoms is required.

2- Illness Anxiety Disorder (Hypochondriasis)

Excessive worries about having a hidden serious physical disease (e.g. cancer, organ failure, AIDS).



3- Functional Neurological Symptom Disorder (Conversion Disorder)

A subconscious conversion of a psychological conflict into an acute loss of physical functioning, which suggests a neurologic disease; motor (e.g. paralysis) or sensory (e.g. anesthesia) deficit. The symptom is temporarily related to a psychological stressor.

4-Psychogenic Pain Disorder

Pain with no adequate physical findings. It is not intentionally produced and not due to another psychiatric disorder (e.g. anxiety). It is inconsistent with anatomical distribution of the nervous system.

5- Psychological Factors Affecting Other Medical Conditions and Factitious Disorder

This disorder and factitious disorder are placed among the somatic symptom and related disorders because somatic symptoms are predominant in both disorders, and both are most often encountered in medical settings.

1- Somatic Symptom Disorder

Features: Multiple somatic symptoms (affecting multiple organ system) that cannot be explained adequately based on physical examination and laboratory investigations. The symptoms are not intentionally produced. The disorder is chronic . It is a associated with excessive medical help-seeking behavior. It leads to significant distress and functional impairment (social, occupational...). **Epidemiology**: Women > men 5 – 10 : 1. The lifetime prevalence in the general population is about 2%. More common in patients who bottle up their emotions and are less assertive. **Etiology:** Faulty perception and assessment of somato-sensory inputs due to characteristic attention impairment. Displacement of unpleasant emotions into a physical symptom. Alleviation of guilt through suffering. To obtain attention or sympathy. **DDx**: 1.Medical diseases (e.g. SLE, endocrinopathies, chronic infections). 2.Depression (multiple somatic complaints are associated with low mood and / or loss of interest). 3.Anxiety (many physical manifestations of anxiety e.g. headache, low back pain are accompanied with excessive worries and apprehension). 4.Hypochondriasis (the emphasis is on over-concern with a serious disease). 5.Psychogenic pain disorder (limited to one or two pain symptoms). Course and Prognosis: Chronic fluctuating course with risk of multiple unnecessary operations and possible complications. **Management:** The number of medical staff involved is better limited (a single identified physician as the primary care taker) because opportunity of the patient to express somatic complaints increases when more than one physician is involved. Arrange brief regularly scheduled appointments, e.g. every month. Repeat physical examination. Avoid additional diagnostic procedures. Shift the patient's awareness to psychological factors, and support her/him. Minimize the use of psychotropic drugs (patients tend to use drugs unreliably and erratically). Encourage graded return to normal activities. Antidepressants are useful when secondary depression develops.

2- Illness Anxiety Disorder (Hypochondriasis)

Features: Intense prolonged over-concern and preoccupation with physical health and/or excessive worry about having a serious physical disease (e.g. cancer, organ failure, AIDS, etc). The preoccupation persists in spite of medical reassurance. It is not delusional in intensity. It causes social or occupational dysfunctioning. Associated Features:
Doctor – shopping and deterioration in doctor-patient relationships, with frustration and anger on both sides.
The patient often believes that he is not getting a proper medical care and may resist referral to psychiatry. Physical complications may result from repeated diagnostic procedures. Family and social relationships may become disturbed because the patient expects special consideration. Associated Psychiatric Disorders: major depression, dysthymic disorder, generalized anxiety disorder or adjustment disorders. Most of such patients have obsessional and anxiety personality traits. **Epidemiology**: Age: it can begin at any age. However, onset is thought to be most common between 25 – 45 years. It is thought to be more common in men, and those closely associated with the disease (e.g. relatives of a patient with cancer). The true prevalence is uncertain, but it is common amongst patients attending general medical clinics. **Etiology**: No specific cause has been detected; however, there are some etiological theories: 1.The patient amplifies his normal somatic sensations due to unrealistic interpretation of physical complaints, and misattributes pathological meaning (e.g., minor usual muscular chest pain is interpreted as a sign of cardiac disease). Most of such patients have obsessional and anxiety personality traits. **DDx**: 1. Physical diseases (e.g. endocrinopathy). 2.Somatization disorder (the focus is on the symptoms and not on the over-concern with a disease). 3.Underlying other psychiatric disorders (depression – anxiety). **Course and Prognosis**: Usually chronic course with waxing and waning symptoms. Complete recovery occurs in some cases specially if there is underlying depressed or anxious mood. Presence of secondary gain (e.g. sick role) and personality problems are unfavorable prognostic factors. **Management**: 1. Exclude a possible organic pathology. 2. Search for and treat any underlying depression or anxiety. (Hypochondriasis often improves when these conditions are treated; SSRIs can give good results). A cognitive-educational approach: provide a more realistic interpretation of complaints (e.g. hyperarousal of the autonomic nervous system associated with exaggeration and misinterpretation of the consequences) explain the role of psychological factors in symptoms origin and fluctuation.

youtube.com/watch?v=0EnDW9ljO6U

3- Functional Neurological Symptom Disorder (Conversion Disorder)

Symptoms are related to the neurological system. **Sensory:** paraesthesia/partial blindness/deafness/...
Motor: paralysis/paresis/aphonia/... **Pseudoseizures and fainting**: Pseudoseizures usually lack a number of features of the true epileptic seizures e.g. aura, cyanosis, physical consequences of seizure (tongue bite, trauma, incontinence) and do not occur in sleep. EEG findings are normal. Prolactin level usually increases within 3 hours of a true seizure but not a pseudoseizure. Patient may be unconcerned about his symptoms (denial of affect) this is called "La belle indifference" or may also present in a dramatic or histrionic fashion. **Primary gain:** the reduction of inner tension and intrapsychic conflict after developing the physical disability through conversion. **Secondary gain:** the advantage that the patient gains, e.g. avoiding unpleasant duties. Conversion disorder occurs mainly in young females. It is more common among little educated persons, those with low intelligence and in low socioeconomic groups. Common associated disorders include anxiety and depressive disorders. **DDx:** 1.Neurological diseases e.g. multiple sclerosis, stroke, optic neuritis, etc. (about 30 % of patients followed up later were discovered to have neurologic diseases). 2.Acute dystonic reaction (a side effect of antipsychotics). 3. Factitious disorders (Munchausen's syndrome: intentionally produced symptoms and sign to assume the sick role without external incentives. 4.Malingering: faked symptoms motivated by an external incentive e.g. to evade the police. Patient stops the symptoms when they are no longer useful. **Course**: symptoms usually remit in a short time (hours, days).Recurrence is common. **Treatment**: Sympathetic approach with reassurance that the condition is a reaction to stress and will resolve overtime. This helps the patient let go of symptoms without confrontation. Avoid confrontation. Abreaction (drug-aided interview): using amytal or diazepam with suggestion can result in a dramatic resolution. Stressful events in the patient's life should be evaluated and appropriate intervention made: individual, marital or family therapy. Underlying psychiatric illness, such as depression, should be recognized and properly treated. **Prognosis**: Good prognosis is associated with acute onset, an obvious stressful precipitant, good premorbid personality, above average intelligence, a short interval between onset and treatment.

Comparison between conversion, factitious, and malingering disorders.

Diagnosis / Distinction	Conversion Disorder	Factitious Disorders	Malingering
Intentions	No	Yes	Yes
Goal & motivation	Subconscious Secondary gain	Partially aware. To assume the sick role	Fully aware. Motivated by external incentives (e.g. to evade the police, avoid work, or secure financial compensation). They always have some apparent end of their behavior.
Suggestibility	Yes	No	No
Course	Short & Recurrent	Intermittent or chronic	Varies depending on the goal.

Dealing with physically-ill patients who have difficult personalities (see details of personality disorders later):

	Personality	Traits /Attitude	Patient concern/worries	Approach
A	**1.Paranoid**	Mistrustful, guarded and hypervigilant.	Exploitation and betrayal.	Acknowledge complaints without arguing and honestly explain medical illness.
	2.Schizoid	Enjoys to be alone	Violations of privacy	Accept his unsociability and need for privacy. Reduce the patient's isolation as tolerated
	3.Schizotypal	Odd feelings, perception, &beliefs.	Exploration of oddities.	Empathize with the patient's oddities without confrontation.
B	**1.Antisocial**	Dishonest, deceptive, and exploiting.	Exploitation and loss of self-esteem	Verify symptoms & discover malingering. Control wish to punish patient. Explain that deception results in patient poor care.
	2.Histrionic	Excessively seeking attention and admiration.	Loss of love.	Set limits and avoid being too warm. Use logic thinking to counteract an emotional style of relationship.
	3.Borderline	Fluctuating emotions, extreme views, impulsivity, self-harm, and unstable relationships.	Abandonment & loss of support.	Empathize and set limits. Use logic thinking to counteract an emotional style of relationship.
	4.Narcissistic	Sense of superiority and priority	Devaluation and loss of prestige, or self-esteem	Do not confront self-inflation. Do not devalue the patient. If the patient devalues you, you may offer a referral as an option, not as punishment.
C	**1.Avoidant**	Shy, oversensitive to criticism, embarrassment and humiliation.	Exploration of low self-esteem, inadequacy shame, and rejection.	Empathize, support self-esteem, and encourage assertiveness.
	2.Dependent	Over-dependant seeks constant support and reassurance.	Independence	Explore why independence is so frightening and encourage independence and assertiveness.
	3.Obsessive-compulsive	Perfection seeker, over-meticulous, rigid, and self-blaming.	Imperfection and guilt.	Tolerate the patient's critical judgments and unnecessary details. Beware of his controlling behavior.

Questions:

1- A young lady come to primary care clinic b/c she recently feels anxious always want to refer her to psychiatrist what is important to ask her before referral?

A. Hx of headache B. Mood change C. Increase in weight D. Weather intolerance

Answer: D

2- which of following patients will not respond to ECT or will get worse ?

A. conversion disorder B. severe depression C. postpartum affective disorder D. severe schizophrenia

Answer: A

3-A 57 years old man hypertensive with 7 months history of CVA has low mood, lack of interest and death wishes. Which one of the following medications is effective and safe for his symptoms?

A. Amitriptyline B. Escitalopram C. Mirtazapine D. Venlafaxine

Answer: B

4- Which of the following is a bad prognostic factor about illness anxiety disorder?

A. Absence of insomnia B. Absence of hallucination C. Presence of panic attack D. Presence of secondary gain

Answer: D

5- Which one of the following is a good prognostic factor for conversion syndrome?

A. Acute onset B. No obvious stress C. Bad premorbid personality D. Low intelligence

Answer: A

6- Which of the following is a poor prognostic factor in conversion disorder?

A. Presence of a secondary gain B. Short duration C. Stressful stimulus D. Below average intelligence

Answer: D

7- 47-year-old lady came to the Psychiatry clinic complaining of low mood, anhedonia & weight gain,Order investigations for her. What are the result that is expected to be seen in her labs?

A. High Acetylcholine. B. High TSH. C. High prolactin. D. High T4.

Answer: B

8- A 29-year-old woman delivered 2 days ago noticed to be lethargic, sad and tearful. Which mental condition she is likely to be passing through?

A. postpartum psychosis B. postpartum depression C. postpartum blues D. postpartum adjustment disorder

Answer: C.

9- Pregnant lady on her 3rd trimester complaining of seizures, which one of the following is safe for her condition?

A. Sodium valproate. B. ECT C. Carbamazepine D. Lithium

10-Patient with type 2 DM and depression , what is the best drug that has benefits in peripheral neuropathy ?
A. fluoxetine B. Olanzapine C. risperidone D. duloxetine
Answer: D

11-Patient Who is Dishonest, deceptive, and exploiting.how do you approach this Patient .?
A. Verify symptoms & discover malingering. Control wish to punish patient. Explain that deception results in patient poor care. B. Acknowledge complaints without arguing and honestly explain medical illness.
C. Empathize and set limits. Use logic thinking to counteract an emotional style of relationship.
D. Accept his unsociability and need for privacy. Reduce the patient's isolation as tolerated
Answer: A

12- A 29 year old woman came to the primary care clinic asking for investigation... abdominal distention, shoulder pain, headache and numbness over her left arm, nausea and discomfort in her pelvis for 8 months. What is the most important first management step?
A. Hospitalization B. Request brain MRI C. Explore psychosocial stressors D. Request liver function test
Answer: C

13- Patient done multiple tests because he is concerned to have physical disease, dx?
A. OCD B. Illness Anxiety disorder C. OCPD D. Somatic symptoms Disorder
Answer: B

14-33.year.old woman hospitalized for assessment for repeated hematuria and vomiting. Her workup revealed no physical symptoms. The nurse in charge noticed that the patient is inducing vomiting intentionally. What would be the most likely diagnosis?
A. Dissociative disorder B. Factitious disorder C. Malingering D. Schizophrenia
Answer: B

15- 17 years old female was admitted to the psychiatry ward because of multiple nonspecific symptoms, when nursing staff want to give her medications she refuses and then exaggerates her symptoms. What is the most likely diagnosis?
A. Sick role B. Malingering C. Maladaptive illness behavior D. Illness.denying behavior
Answer: B

16-: A patient present with olfactory hallucination before the episode of psychotic disease , happens with which one of the following?
A. Brief psychosis B. Complex parietal seizure C. Schizophrenia D. Delirium tremens
Answer: B

17-: Patient went to GI specialist and was checked for liver cirrhosis and he was normal. But he insists that he has vague abdominal pain. What does he have?
A- Somatic disorder B- Illness anxiety
Ans: A

19- A 33 year old patient presented with pain in the back. Which of these would you check to confirm the diagnosis of pain disorder?

A. Factitious B. Consistency with anatomical distribution C. Malingering D. Multiple somatic symptoms
Answer: B

20- A hypertensive patient on Medications and he developed depression what is the drug that could cause his condition
A. Digoxin B. Propranolol C. Salbutamol D. Albuterol
Answer: B

21- What is the most important predictor for depression in a post stroke Patient ?
A. left anterior brain lesion B. cerebral atrophy C. dysphasia D. living alone
Answer: B

Questions:

22- Patient Diagnosed with a terminal illness. He reacted with anger to the doctor, which stage is more likely to come after anger?

A. Bargaining B. Depression C. Denial D. Acceptance

Answer: A

23-: mother just has her baby days ago have auditory hallucination and wants to kill her baby. which of the following she will end up with?

A. Schizophrenia B. bipolar C. Schizoaffective D. Major Depressive Disorder

Ans: A

الحالة الثالثة:

مريض جاي العيادة يقول أحس فيني مرض .. وذهب لأطباء كثير يقولون أنت طبيعي .. وهو يقول ما اقتنعت بكلامهم لازلت أحس إني تعبان ويدي توجعني ..

What is the most likely diagnosis?

Illness anxiety disorder (hypochondriasis)

What DDx?

1- GAD

2- Depression

3- Somatic symptom disorder

What would you like to ask about your DDx ?

- Is it more than 6 months? And is it about specific reason or many reasons? (rule out GAD)
- Ask about depression symptoms to rule out depression.
- If there is any somatic symptoms? (to Rule out somatic symptoms)
- Family Hx of serious disease? (Criteria of diagnosing illness anxiety disorder)