DEPARTMENT OF PSYCHIATRY GRANT GOVERNMENT MEDICAL COLLEGE AND SIR J.J.GROUP OF HOSPITALS,MUMBAI

WELCOMES YOU ALL

BPS CLINICAL MEET OCT' 2017

TOPIC-

PSYCHIATRIC FITNESS BEFORE SURGERY

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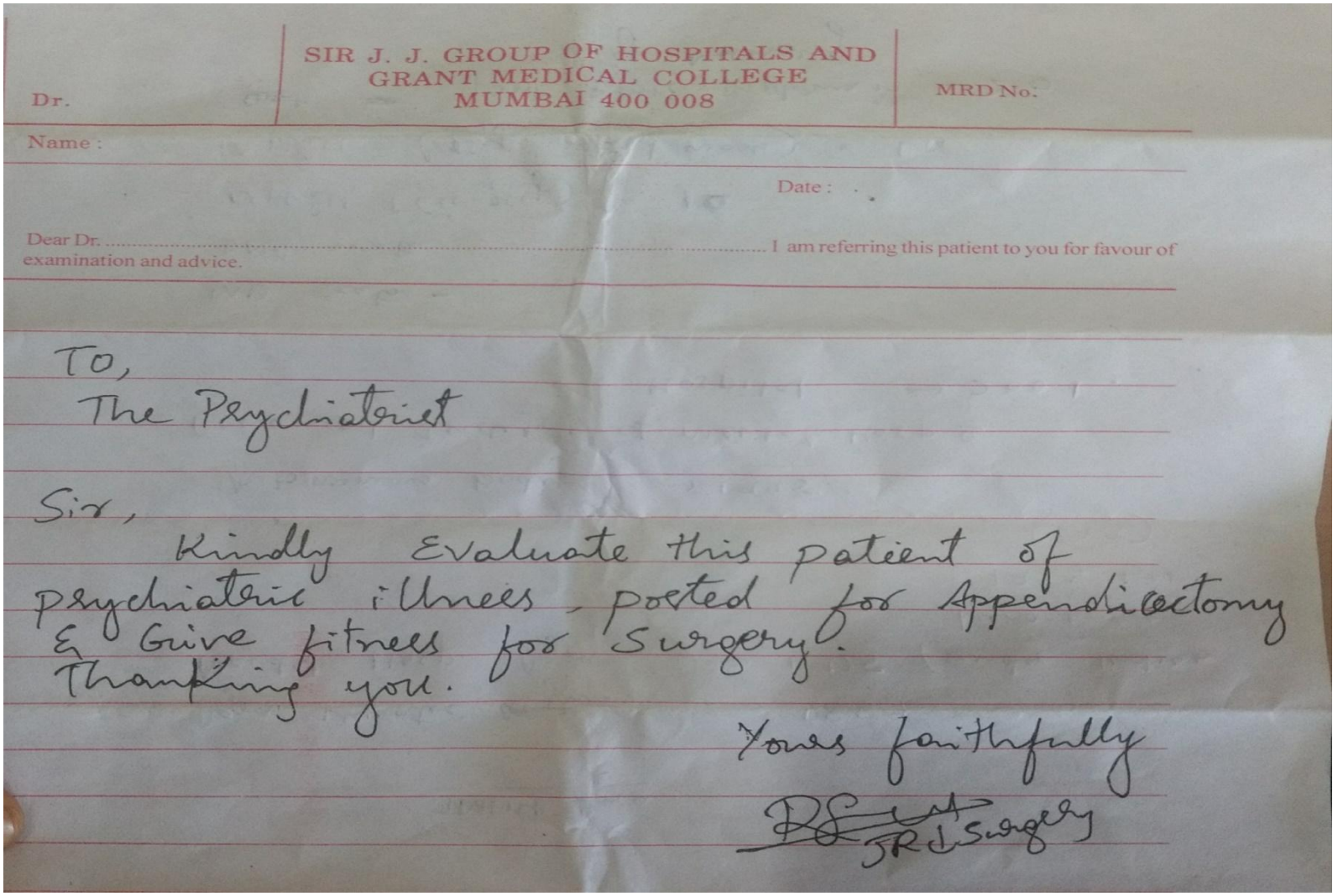
DESERT ROSE
20% to 50%
ILIAS

Psychiatric fitness before surgery

Introduction

Why this topic ???



SIR J. J. GROUP OF HOSPITALS AND
GRANT MEDICAL COLLEGE
MUMBAI 400 008

Dr.

MRD No:

Name :

Date : . .

Dear Dr. ..... I am referring this patient to you for favour of examination and advice.

To,
The Psychiatrist

Sir,
Kindly Evaluate this patient of psychiatric illness, posted for Appendicectomy & Give fitness for Surgery.
Thanking you.

Yours faithfully
JR I Surgery

Common referrals

- Any surgery in a patient who is k/c/o psychiatric illness or Metal Retardation.
- Bariatric surgeries.
- Transplant surgeries – donor and recipient.
- Sex change/ reassignment surgeries.
- Cosmetic surgeries.
- Refusal to undergo a surgery.

LATEST MEDICAL NEWS ention

Mental Health Issues Common in Bariatric Surgery Candidates

— Depression, binge eating seen at higher than average rates

CBS NEWS LIVE

Plastic surgeons often miss patients' mental disorders

JAN 18, 2017 1:08 PM EST HEALTH

BY MAUREEN SALAMON / HEALTHDAY

Your Certificate can make tomorrow's headlines

NEW YORK POST

NEWS

Man who was denied lung transplant over marijuana use dies

By Joshua Rhett Miller

April 24, 2017 | 4:18pm

Dilemma we face

- New patient – certify or refer to treating psychiatrist??!!!!
- One's own patient – under your treatment for long duration and wants fitness.
- Fitness dilemmas
- If you decide to certify- how to put it on paper.
- Possible implications.

Factors to be considered for fitness

- **Indication for surgery-** emergency/planned
- **Presence and absence of Psychiatric illness/substance use.**
- **Illness characteristics**

- Treatable/irreversible condition(MR, Dementia)

- Substance abuse

- cause impaired judgement and affect decision making??

- pros & cons of surgery,

- cooperation for examination and procedure

- capacity for aftercare.

Fitness in Intellectually Disabled Patient

- A detailed birth and developmental history has to be taken.
- Information about behavioural disturbances, psychiatric illness and Self care is important and should be mentioned.
- Clinical assessment stating IQ.
- A written informed consent for any surgical procedure has to be taken from the legal guardian or the care giver.

Use of psychotropics in perioperative period

- Continuing psychotropics –

- Interaction b/w psychotropic agents and anaesthetic agents,
- bleeding ,
- hypotension/hypertension,
- hyperthermia.

- Discontinuation –
- can cause relapse or worsening of symptoms.
- discontinuation syndromes-can confuse perioperative clinical presentation with delirium etc.

Drug Class	Considerations	Safety in Surgery	Remarks
Antipsychotic	■ Increased risk of arrhythmia with most drugs ■ α1 blockade may lead to hypotension and interfere with effects of epinephrine/ norepinephrine ■ Most drugs lower seizure threshold ■ Preoperative olanzapine reduces risk of delirium3	Considered safe. Usually continued to prevent relapse.	Pt may be shifted to parenteral antipsychotics if the Pt has to be kept NBM.

Drug Class	Considerations	Safety in Surgery	Remarks
Antidepressants - TCA	■ QT Prolongation and arrhythmia . ■ α1 blockade may lead to hypotension	Unclear, but it is advised to discontinue the drug long before the surgery.	Effects persist for several days after cessation so will need to be stopped some time before surgery

Drug Class	Considerations	Safety in Surgery	Remarks
Antidepressants - SSRI	Danger of serotonin syndrome if administered with pethidine, fentanyl, pentazocine or tramadol. Cessation may result in withdrawal syndrome ■ Increased risk of perioperative bleeding.	Probably, but avoid other serotonergic drug .	

Drug Class	Considerations	Safety in Surgery	Remarks
Benzodiazepines	Reduced requirements for induction and maintenance anaesthetics ■ Withdrawal symptoms possible	Probably; usually continued	If dependent on BZD, shift to a long acting BZD, and taper gradually.

Drug	Risk in Surgery	Comments
Lithium	Prolongs the action of muscle relaxants. ■ Surgery-related electrolyte disturbance and reduced renal function may precipitate lithium toxicity. Avoided by preventing dehydration and NSAIDs use.. ■ Possible increased risk of arrhythmia	Probably safe in minor surgery but usually discontinued before major procedures . Note to anaesthetist - Slow discontinuation is essential.

Clomipramine and Amitryptline	Increases the bleeding risk during surgery. Risk of serotonin syndrome when administered with tramadol , pethidine or pentazocin.	
Clozapine	Can delay recovery from anesthesia.	
Venlafaxine	May provoke opioid induced rigidity.	

DYSPHORIA IN GENDER IDENTITY DISORDER

- Dysphoria in GID is psychological distress due to mismatch between the individual's biological sex and their identity of gender by themselves or by others
- When this distress creates a functional impairment, it can be formally diagnosed as gender dysphoria.

- It is important to note that all transgenders are not dysphoric and thus doesnot need sex reassignment.

- Further, It is observed that transgender teens are at a higher risk for depression, anxiety, suicidality and have been shown to engage in more high-risk behaviors. (Unger, 2014; Yadegarfard, Ho, & Bahramabadian, 2013).

- And Dysphoria in GID creates functional impairments in a person's life. For many people, Gender Reassignment Surgery is the only means of reducing that dysphoria.

SEX REASSIGNMENT THERAPY

Sex reassignment therapy is modifying one's characteristics to better suit one's gender identity.

It consists of –

Hormone replacement therapy (HRT) to modify secondary sex characteristics,
and sex reassignment surgery to
alter primary sex characteristics.

NEED FOR PSYCHIATRIC EVALUATION -

- The Vancouver Coastal Transgender Health Program.
- Transitioning Regret.
- Severely distressed and suicidal even after the surgery.
- Post surgical satisfaction.

RECOMMENDATIONS

- World Professional Association of Transgender Health (WPATH) Standards of Care 72 (SOC72).
- Legal age of majority. (Milrod, 2014).
- Psychiatric assessment minimum by 2 Mental Health Professionals.
- However, there are no guidelines available for practice in India.

ASSESSMENT-

Components of a Comprehensive Assessment

Diagnosis

To affirm their identity.

Consent.

To rule out other conditions.

Pre existing Psychiatric illness.

INTEGRAL ASPECTS OF THE ASSESSMENT

- Positive long-term outcome.
- Lifelong irreversible results.
- Functionality after the surgery.
- Lag time.

First Assessment

- If the patient is in mental health treatment, and their gender experiences are well known to the assessor, the initial assessment could happen in a single session.

- The number of sessions should be more if the patient`s –
  - gender issues are not well known
  - is inadequately resourced
  - struggling with a mental health or substance use issue that may
    - confound the diagnosis or
    - complicates the consent or
    - the aftercare.

Second Assessment

- The second assessment is mainly to rectify any biased decisions based on counter transferences from the initial assessment.

- The second assessment is completed by a different Mental Health Professional.

- There should be minimum 2 sessions, atleast 1 month apart for successful completion of second assessment.

ASSESSMENT REPORT-

What Must Be in the Letter Documenting the Assessment?

- 1) It must be addressed to the surgeon or just to the surgical team if the actual surgeon is not known.
- 2) Describe your identity and designation, explain your relationship to the patient and how long and in what aspects you know the person.
- 3) The description of the patient, their current gender identity and a brief history of their gender evolution.
- 4) Any Axis I and Axis II psychiatric diagnosis and medications that patient is prescribed.

- 5) Any concerns about patient compliance.
- 6) Why the patient wants this particular surgery.
- 7) Current and past substance abuse.
- 8) Aftercare plans.
- 9) You welcome a call for further information about the patient.

CASE 1

- Miss. ABC, a 27 year old female, Hindi speaking Hindu, educated upto 9^{th} std, single, resident of Chunabhatti, working as a helper at a grocery shop came with a friend (Informant- reliable, inadequate) to Psychiatry OPD, JJH with complaints of-
- Strong desire to become a male and behave like them,
- Prefers dressing like males
- Feeling uncomfortable and distressed with her identity……since around 18 years

- According to the patient, since 11 years of age she enjoyed playing sports with both girls and boys but generally preferred the companionship of boys.
- She would prefer dressing up as a boy and would resist wearing a skirt or a dress. She claims that she would wear skirts out of compulsion as a school uniform and would change her clothes immediately after returning from school.
- After leaving school she completely changed her outlook regarding dressing sense and started wearing shirts and pants and would behave like a boy.

- She even tried to hide her breast development by wearing loose fitting tops and stooping forwards.
- When she reached menarche, she felt very embarrassing and distressing as it reminded her of her feminism which she never wanted and which was becoming increasingly distressing.
- Initially she was confused as she did not like feminine talks with female friends and would strive to be a part of group of boys, therefore gradually she started changes in her behavior in form of changing her voice, her attitude and her appearance.

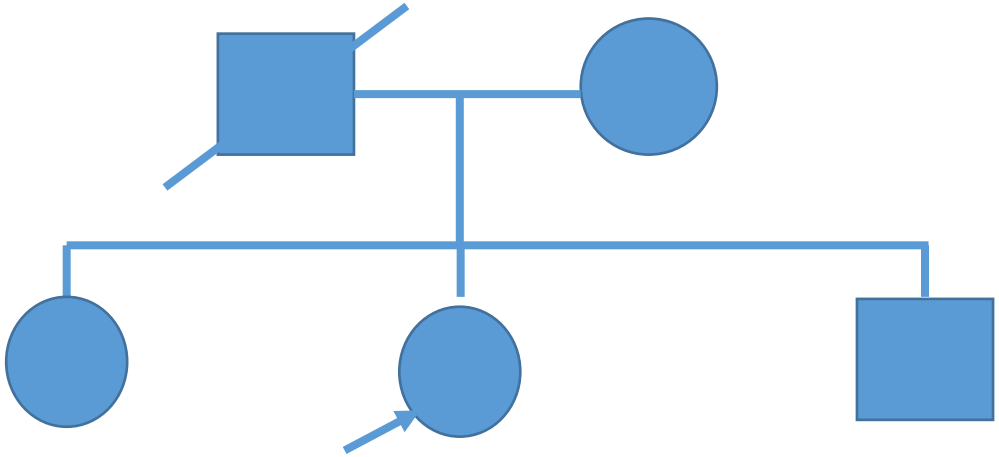
- Her mother would scold for her changed behavior, would insist her again and again to dress up like her female friends but she would refuse every time to wear them.
- She would feel uncomfortable with her female friends, finding their talks useless, preferred behaving like boys using their gestures and enjoying their talks.
- Because of her behavior, she suffered bullying at school but it did not affect her.
- As sexual attractions evolved, they were exclusively directed to female partners though she would hang out, spent most of the time with male friends of her age and felt comfortable with them.

- Gradually she started disliking her female organs and wanted to get rid of them.
- In her late teens, she describes her one such sexual encounter with a man at her workplace after which she felt very aversive.
- She also tried socializing with females of her age, but did not feel comfortable there as she felt more like a man.
- In her leisure time, she spends most of the time with her male coworkers and enjoys their company and discussing about girls or even eve teasing at times.

- She expressed her wish to undergo a sex change surgery as she feels like a man trapped in a woman’s body.
- As her feelings became increasingly pronounced and she feels she will be better accepted amongst her male friends she decided to consult a doctor and came in JJH Psychiatry OPD With her male friend.

- No h/o Muttering to self with gesticulating movements/ suspiciousness/ wandering behavior in the past, Fearfulness, thought being inserted or taken away or being known to others.
- No h/s/o body dysmorphic disorder or any paraphilic disorder
- No h/o persistent sadness of mood/ loss of interest in activities / or ideas of hopelessness, worthlessness, helplessness or suicidal ideations
- No h/o repeated hand washing or checking behavior or doing same things repeatedly.
- No h/o big talks/ increased self esteem/ spending spree in the past.
- No h/o any substance use in the past and present.
- No major medical or surgical illness in the past
- According to informant there is no present or past h/o psychiatric symptoms or behavioral problems.

Family history



- Patient is 2nd out of 3 siblings
- No family h/o any psy illness
- She claims initially she faced some issues and oppositions from family members, neighbors, relatives but it didn't affect her at all and her family accepted her condition soon.
- Since then no oppositions from family members even on having all male friends.
- After lot of discussions and coercions, family has agreed for sex change operation and is willing to support her throughout the procedure.

Personal history

- Birth/childhood history-Not available
- SCHOLASTICALLY average
- Left studies after 9th std due to poor interest in studies and also due to financial constraints
- She does all the outdoor chores like delivering grocery to different homes and working in a glass factory to earn for her family.
- She took up jobs, which was physically exhausting and those which are taken by men.

Working since then, took responsibilities at early age to support her family and at present the only earner for family.

Premorbid Personality

- According to her school friend-patient is very comfortable with boys since childhood, preferred to study and play with them.
- She liked playing games like cricket and football with her male friends.
- Dominating and aggressive by nature.
- Would frequently engage in physical fights with boys.
- Extrovert, socially well adjusted

On Mental Status Examination

- A young confident female dressed in loosely fitted shirt and pant with short hairs was seen sitting comfortably on chair.
- Patient conscious, cooperative, communicative
- Attention- aroused /sustained
- Eye to eye contact- initiated/maintained
- Oriented to time /place/person
- Rapport could be established
- Speech- Continuous/Coherent/relevant
-

- Denies delusions
- She claims she wants to undergo gender reassignment surgery and knows about all the possible complications and after discussing with family members she had finally decided to undergo sex change surgery.
- No perceptual abnormalities
- Mood-euthymic
- Affect-congruent, appropriate to surroundings
- Judgement- test, social, personal-intact
- Insight- grade 5/6

- Patient was referred to plastic surgeon and was asked to follow up with family member. The plastic surgeon informed that she will require multiple surgeries over a period of 4 years requiring a sum of around 30 thousand to1 ½ lakhs in a Government set up.
- She claims after discussing this with her family members, they decided not to opt for the surgery very soon as she belongs to lower socio-economic status having a responsibility of her family on herself.
- She wishes to financially stabilize herself and would opt for the surgery whenever she will collect adequate sum required for the surgery.

- She was evaluated by Senior resident, Assisstant professor on her first visit, diagnosis of gender dysphoria was made and was asked to follow up with family members for further assessment and decision regarding fitness

Psychiatric fitness before bariatric surgery

- Obesity has become a global epidemic.
- worldwide a multidisciplinary approach to patient assessment during the preoperative period is followed.

"Belly button enlargement is a popular alternative to other types of weight loss surgery."

INDICATIONS FOR BARIATRIC SURGERY-WHO??

(obesity and metabolic surgery society of india)

- BMI >37.5 without co-morbidities or
- BMI > 32.5 with the presence of co-morbidities
- Patients motivated to lose weight
- should have attempted conservative methods of weight loss and faile
- Ages of 18 - 65 years
- in patients more than 65 years-in the presence of severe obesity related co-morbidities / disability
- in patients < 18 years in special situations after pediatrician / endocrinology certification , but after attainment of puberty or completion of skeletal maturity

Why Psychiatric Fitness??

- Preoperative assessment
- optimize surgical results
- Increase their chances of success
- lays the groundwork-to seek help in the future
- to identify contraindications
- to better understand the patient's motivation, preparation and emotional factors.
- opportunity to perform the psychoeducation of the patient.

Factors for assessment

- The patient's understanding of the surgery and the necessary lifestyle changes.
- Expectations regarding the results.
- The ability to adhere to operatory recommendations; eating behavior (weight history, diet, exercise).
- Psychiatric comorbidities (current and previous).
- reasons to undergo the surgical procedure.
- social support.
- substance use.
- socioeconomic status.
- conjugal satisfaction.
- cognitive functioning.
- self-esteem; history of trauma/abuse; quality of life and suicidal ideation.

- *factors that can postpone or rescind the surgery are:*

1. a lack of understanding regarding the risk
2. Reluctance to adhere
3. severe mental retardation.
4. suicide attempts
5. active symptoms of obsessive-compulsive disorder and bipolar disorder.
6. life stressors.
7. nicotine use

(Psychological Assessment of the Patient Undergoing Bariatric Surgery-Allison G.Snyder et al)

- ***Resources employed during assessment***
- Clinical interviews and psychological testing.

- *What should we assess during the clinical interview??????*

- ❑Patient's behavior.
- ❑presence of psychiatric symptoms.
- ❑understanding of the surgical procedure.
- ❑ eating behavior.
- ❑stress level.

- ***Psychological testing*** shall complement subjective data collected during the clinical interview.

➢Beck Depression Inventory

➢Minnesota Multiphasic Personality Inventory

❑Enquiries regarding eating behavior, especially concerning binge eating disorder and night eating syndrome

➢The Binge Eating Scale

➢the Questionnaire of Eating and Weight Patterns

➢ the Eating Disorder Inventory

➢the Eating Disorder Examination - Questionnaire Version

Boston Interview and the ***PsyBari***:

- *Medical Psychology Service at the VA Boston Healthcare System*, is a semi-structured interview for pre-surgical gastric bypass evaluation.

- This interview contains seven major areas that are assessed:

1) weight, diet and nutritional history;

2) current eating behaviors;

3) medical history;

4) understanding of surgical procedures, risks and postoperative regime;

5) motivation and expectations regarding surgical results;

6) relationships and support system;

7) psychiatric functioning.

The PsyBari consists of 115 items, assessed according to their frequency, on a Likert scale (from 1 to 5).

- This test is divided into 11 subscales:

1) faking good/minimization/denial;

2) surgical motivation;

3) emotional eating;

4) anger;

5) binge eating;

6) obesity-related depression;

7) weight-related impairment;

8) weight-related social impairment;

9) knowledge of postsurgical eating behavior;

10) substance/alcohol abuse;

11) surgical anxiety.

The majority of items included in these scales was based on interviews with bariatric patients

PRE-SURGICAL FINDINGS

- Studies from several countries show that around 40% of all bariatric surgery patients have at least one psychiatric diagnosis.

➢3 COMMONEST PSYCHIATRIC DIAGNOSIS:-

- Depressive disorders (dysthymic disorder and major depressive disorder),
- anxiety disorders (e.g., generalized anxiety disorder)
- eating disorders (i.e., binge eating disorder) (Kalarchian MA, Marcus MD, Levine MD, et al. Psychiatric disorders among bariatric surgery candidates: relationship to obesity and functional health status. Am J Psychiatry 2007; 164:328–334quiz 74.)

PRE-SURGICAL FINDINGS…CONT.

- *<u>Apart from axis I disorders</u>*
- personality
- Neurotic personality traits
- Previous suicide attempts due to the stigma.
- Alcohol addiction

POSTSURGICAL OUTCOMES AND INTERVENTION

- Prevalence of depressive symptoms significantly decreases.
- Anxiety symptoms are not improved after surgery

(clinical interviews.*de Zwaan M, Enderle J, Wagner S, Mühlhans B, Ditzen B, Gef*Anxiety and depression in bariatric surgery patients: a prospective, follow-up study using structured *eller O, Mitchell JE, Müller A*)

- Psychiatric course of stable bipolar disorder is not altered.

(Ahmed AT, Warton EM, Schaefer CA, et al. The effect of bariatric surgery on psychiatric course among patients with bipolar disorder. Bipolar Disord 2013; 15:753–763.)

- The frequency of axis I disorders in bariatric surgery patients decreases

(Axis I disorders in adjustable gastric band patients: the relationship between psychopathology and weight loss.*Hayden MJ, Murphy KD, Brown WA, O'Brien PE.Obes Surg. 2014 Sep; 24(9):1469-75)*

- Patients with two or more psychiatric diagnoses were significantly more likely to experience weight loss cessation or weight regain after 1 year compared with those with less than two psychiatric diagnoses.(Rutledge T, Groesz LM, Savu M. Psychiatric factors and weight loss patterns following gastric bypass surgery in a veteran population. Obes Surg 2011; 21:29–35.)
- A lifetime history of mood disorder implies poor weight loss.

(Semanscin-Doerr DA, Windover A, Ashton K, Heinberg LJ. Mood disorders in laparoscopic sleeve gastrectomy patients.)

- Absence of binge-eating behavior is associated with a favorable weight loss result after surgery.(Adams ST, Salhab M, Hussain ZI, et al. Roux-en-Y gastric bypass for morbid obesity: what are the preoperative predictors of weight loss? Postgrad Med J 2013; 89:411–416)

- improved cognitive function after bariatric surgery.

(Miller LA, Crosby RD, Galioto R, et al. Bariatric surgery patients exhibit improved memory function 12 months postoperatively. Obes Surg 2013; 23:1527–1535)

- suicide rate after surgery was lower.

(Peterhansel C, Petroff D, Klinitzke G, et al. Risk of completed suicide after bariatric surgery: a systematic review.)

- Behavioural psychotherapy may improve depressive symptoms after bariatric surgery.

LACUNAE:-

- As of now, no specific guideline has been proposed for the older obese population.

[Bekheit M, Katri K, Ashour MH, et al. Gender influence on long-term weight loss after three bariatric procedures: gastric banding is less effective in males in a retrospective analysis. Surg Endosc 2014; 28:2406–2411]

KEY POINTS

- Psychiatric disorders such as depressive disorders, anxiety disorders, and binge eating disorders are prevalent among bariatric surgery candidates.
- Presurgical psychopathology may imply poor postsurgical outcomes and hence warrant thorough evaluation and aggressive treatment.
- Postsurgical weight loss is likely to improve cognitive function and psychiatric symptoms like depression, but not anxiety.
- As suicide risk is both high before and after the surgery, long-term supervision and timely intervention are suggested.

BARIATRIC SURGERY

CASE 2

- 46 years old woman , Mrs A , Marathi speaking Hindu, studied up to B.A. , married since 20 years, working as a typist in Private firm , R/O Santacruz (W) , belonging to middle socio economic status was referred from general surgery department i/v/o fitness to undergo bariatric surgery .

- Patient is a case of morbid obesity with weight being 102 kg and height 158 cm with BMI = 41. Patient was previously advised diet plan, exercises and medications, but despite full efforts she did not achieve the required weight and hence was referred to bariatric surgery department for bariatric surgical procedure as a option for weight loss.

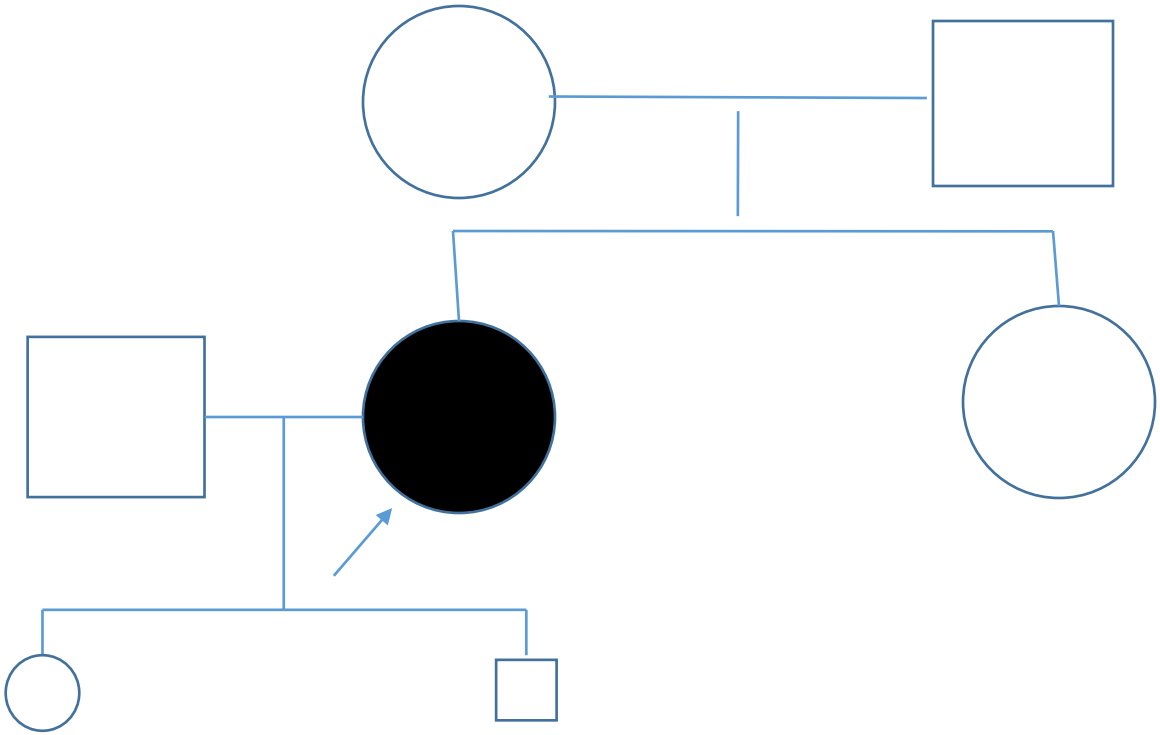
- Patient is a k/c/o Major Depressive Disorder since 1 year and is on tablet Sertraline 100 mg once a day and maintained on it.
- The illness started with the symptoms of sadness of mood , easy fatigability and decreased interest in routine activities .
- Hence she consulted a private psychiatrist and was started on tablet Sertraline 100 mg once a day and shown improvement in symptoms and reached PMP after continuing treatment for 6 months.

- The life style modifications and changes in dietary habits after bariatric surgery as well as the side effects of the surgery like nausea and gastric dumping syndrome were discussed with the patient.

- No h/o hallucinatory behaviour / catatonic features .
- No h/o irresistible urges, repetitive hand washing / checking behaviour.
- No h/o elated mood /overfamiliarity / spending spree.
- No h/o ghabrahat/ restlessness / palpitations / feeling of impending doom.

- Pt is a k/c/o diabetes mellitus and hypertension and is on T. Telmisartan 40 mg 1-0-0 and T. Metformin 500 mg 1-1-1 since 10 years.
- Patient has undergone hysterectomy 5 years back .
- No h/o head injury / seizure episodes in the past
- no h/o any substance use in the past

- ***1st out of 2 siblings***



- h/o DM in mother and is on treatment.
- no h/o psychiatric illness among family members

Personal history :-

- Birth and perinatal history- details not available.
- studied up to B. A
- Started working as a typist in a Private firm.
- Married having 2 children.

Premorbid personlity:-

- Socially well adjusted
- Extrovert in nature
- has many friends.

General examination :-

- afebrile
- Pulse- 78/min
- BP– 130 /90 mm hg
- No P/I/C/C/L/E

s/e:-

- CVS – S1 S2 – normal, no murmur
- RS – AEBE , no foreign sound heard
- CNS – conscious / oriented
- PA- soft /non tender
- No organomegaly.

Mental state examination:-

- Conscious / co operative / communicative
- Attention – aroused / sustained
- ETEC- initiated / maintained
- oriented to time, place, person
- rapport – established
- Speech- continuous / coherent / relevant

- Thought – denies delusions
- Denies ideas of h/h/w
- Patient understands the consequences of bariatric surgery and she understands that lifestyle modifications and dietary changes has to be done after the procedure , and willing to undergo bariatric surgery.
- Denies pa
- mood – euthymic
- affect – congruent to mood
- insight – gr 5/6
- Concept – both simple and abstract – intact
- Judgement – intact

- **Impression**:- major depressive disorder in full remission
- **Conclusion**:- patient is fit to undergo bariatric surgery and advised to continue t. sertraline pre and post surgery.

PSYCHIATRIC FITNESS IN GENERAL SURGERY

CASE 3

30 years old man Mr X , Marathi speaking hindu , Unmarried , studied up to 10 th std working as a tea vendor R/O Chembur , Mumbai of low socioeconomic status was referred from General Surgery Department i/v/o fitness for appendicectomy surgery. Patient had presented in general surgery opd with his elder brother as an informant (complete and reliable) with chief c/o

- Pain in the right side of abdomen ,vomiting and low grade fever since 3 days.
- Patient started having these complaints 3 days back. The pain was acute in onset and colicky in nature. It initially started in periumbilical region and then shifted to right iliac fossa.
- Patient was evaluated by surgery dept. and was advised blood investigations and USG (A+P) which was s/o acute appendicitis.

- No h/o any major medical /surgical illness in the past
- Sleep and appetite was normal.
- Bowel and bladder habits normal.

- Past history :-
- Patient is a k/c/o schizophrenia since 5 years
- Patient was apparently alright 5 years back when after a financial stressor, he started having suspiciousness towards his family members, reduced sleep , irritability and anger outbursts on minimal provocation.
- Patient consulted a private psychiatrist for these symptoms and was diagnosed as a case of schizophrenia.

- He was started on tablet Olanzapine 5 mg twice a day .
- Patient showed improvement and reached PMP in a span of around 6 months and again started working as a tea vendor.
- After around 2 years, he discontinued the medications himself thinking that since he had been totally improved from the illness, there is no need of the treatment.

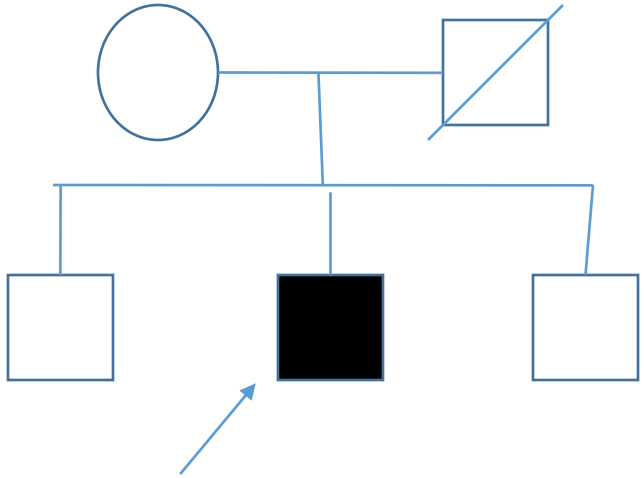
- But after around 4 months he again started having irritability on trivial issues, decreased sleep and suspiciousness . He even stopped working due to these symptoms. Hence was again taken to a private psychiatrist and was restarted on tablet Olanzapine 5 mg twice a day.
- He was advised to take medications regularly and since then he is compliant on treatment.

- No h/o hallucinatory behaviour / catatonic features
- No h/o pervasive sadness of mood, loss of interest, ideas of helplessness/ hopelessness/worthlessness / suicidal ideations
- No h/o irresistible urges, repetitive hand washing / checking behaviour
- No h/o elated mood /overfamiliarity / spending spree
- No h/o ghabrahat/ restlessness / palpitations / feeling of impending doom.

- No h/o head injury / seizure episodes
- No h/o any substance use in the past

Family history

- 2nd out of 3 siblings



- No h/s/o psychiatric illness among family members
- no h/o any major medical / surgical illness among family members.

Personal history :-

- Full term normal hospital delivery
- Cried immediately after birth
- achieved developmental milestones normally.
- studied upto 10 th std , stopped studying further due to financial difficulties and poor interest
- started his tea shop
- Unmarried

Pre morbid personality :-

- Well adjusted socially
- Was responsible as a person
- extrovert in nature and had many friends
- Likes to listen music and watch movies

General examination :-

- afebrile
- p- 70/min
- bp – 110 /70 mm hg
- No p/i/c/c/l/e

s/e:-

- CVS – s1 s2 – normal
- no murmur
- RS – AEBE , no foreign sound heard
- CNS – conscious / oriented
- PA - tenderness + in rif , rigidity + over abdomen

Mental status examination :-

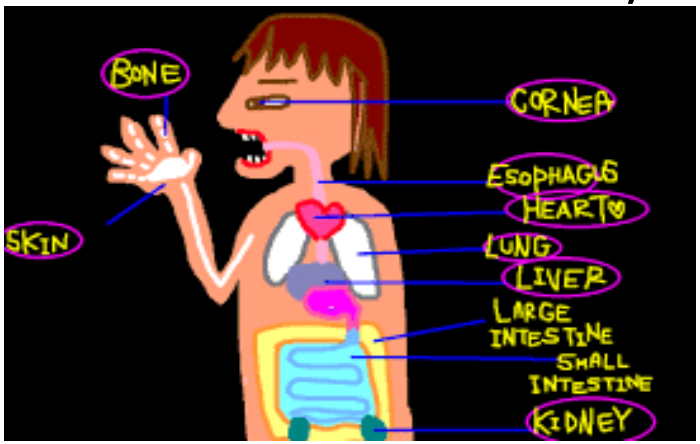
- Patient sitting in chair , appears to be apprehensive due to pain.
- Conscious, cooperative, communicating
- Attention – aroused and sustained
- ETEC – initiated /maintained
- Oriented to time, place and person
- Rapport – established
- Speech – continuous / coherent / relevant

- Thought – denies delusion
- Patient understands the need and nature of operative procedure and known consequences of surgery and is willing to undergo the surgery
- Denies perceptional abnormality
- mood – euthymic
- affect – congruent to mood
- concept – intact
- memory – intact
- insight – gr 5/6
- Judgement – intact

- **Conclusion** :- schizophrenia in full remission and patient is fit to undergo surgical procedure and advised to continue t. olanzapine 5 mg twice a day pre and post surgery.

PSYCHIATRIC FITNESS FOR ORGAN TRANSPLANTION

- Organ transplantation has emerged as the saving grace for those who are suffering from end organ disease.
- Advent of modern surgical procedures and immunosuppressants further decrease morbidity and mortality.



IMPORTANCE OF PSYCHIATRIC FITNESS

- selecting the candidate
- to tackle post-operation psychological issues
- Assessing risky health behaviours.
- treatment adherence for immunosuppressants .
- Prescribing various psychotropics
- As per the, The Transplant of Human Organs Act(THOA) AMMENDMENT 2014 -Psychiatrist's clearance in is deemed mandatory to certify the donor's mental condition, awareness, absence of any overt or latent psychiatric disease, and ability to give free consent.

Areas that need special attention-

- Depression and anxiety
- Currently, there is no general consensus on how to select/reject cases
- Psychiatric disorders predict poor outcome both pre- and post-OT.
- Caregivers burden.

- A psychiatrist as a member of the OT team can be of help for better outcome of OT.

- **PRE-TRANSPLANT ASSESSMENT-The main goal**

➢to identify any psychiatric comorbidity

➢potential risk factors

➢to decide the plan of action.

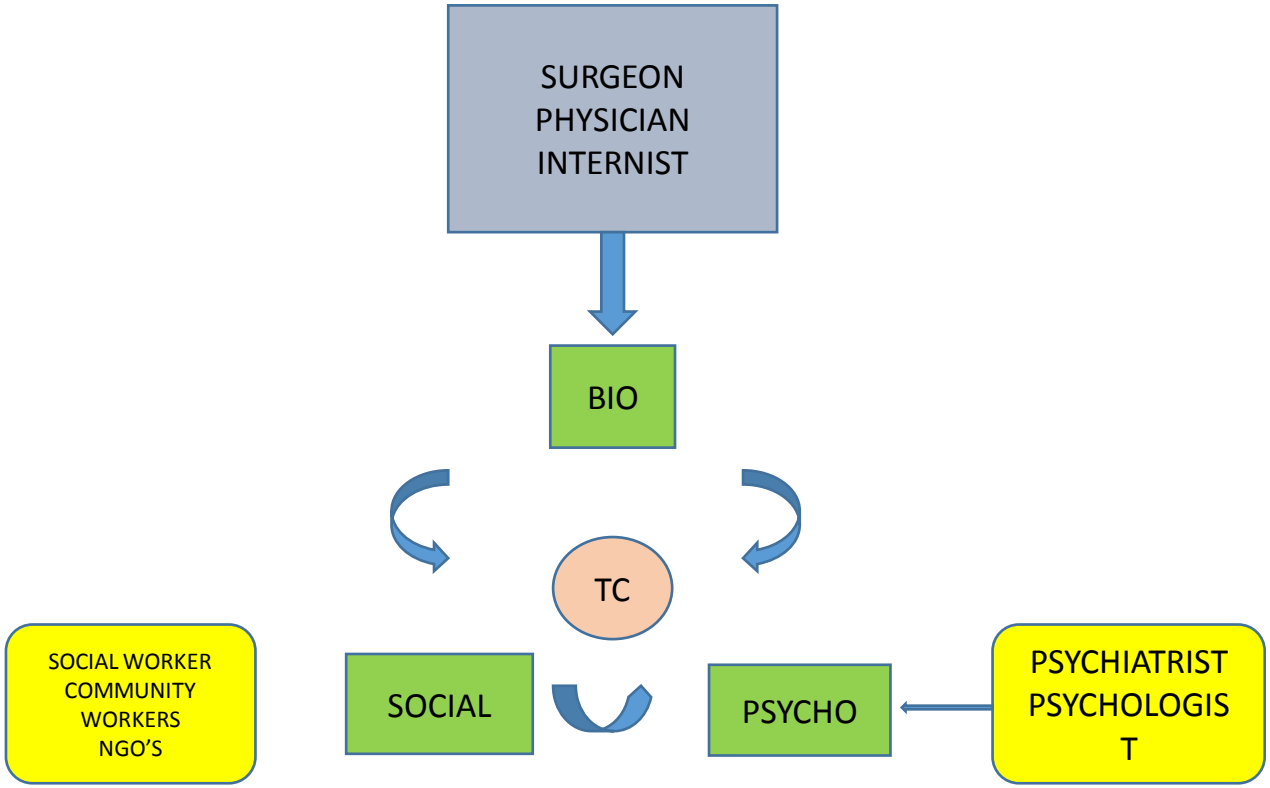
- Wherever feasible***, a bio-psycho-social approach*** in the assessment is advisable.

- **Various screening instruments such as the :**

➢Transplant Evaluation Rating Scale (TERS)

➢the Psychosocial Assessment of Candidates for Transplant (PACT)

➢Structured Interview for Renal Transplantation (SIRT).



- TC-TRANSPLANT COORDINATOR
- BIO-PSYCHO-SOCIAL ASSESSMENT OF THE PATIENT

- **<u>The various aspects of psychiatric Pre transplant assessment-</u>**

Psychosocial Assessment
Past psychiatric history
Current psychiatric symptoms/illness
Psychotropic use
Substance use history
Social support
Cognitive evaluation
Understanding & knowledge

•What else needs to be ensured:DONORS

- live donors should be informed of the probable risks, benefits and consequences
- They should be legally competent and capable of weighing the information.
- They should be acting willingly, free of any undue influence or coercion.

Important aspects of organ transplant which demand a psychiatrist's expertise

- ***Treatment adherence***

➢it is very essential to identify candidates with ambivalence about treatment and prior history of non-adherence, substance abuse, poor social support, and poor organisational skills.

- ***Risky health behaviours***

➢These include substance abuse, poor eating habits and sedentary lifestyle leading to obesity.

- ***Cognitive disorders***
- cognitive impairment results in potential negative impact on treatment compliance.
- ***Substance abuse***
- The major concern is post-OT substance abuse relapse resulting in direct damage to transplanted organ.

• ***Mental retardation (MR)***

- In USA,25.6 % considered IQ 70-90 and 74.4 per cent considered IQ <70, as an absolute contraindication for transplantation.

(Levenson J, Olbrisch ME. Psychosocial screening and selection of candidates for organ transplantation. *In: Trzepacz PT, DiMartini AF, editors. The transplant patient. Cambridge, England: Cambridge University Press; 2000. pp. 21–41*.)

- A review of cases with MR and renal OT showed post-OT survival rates of 100 per cent at one year and 90 per cent at three years.
- Adequate support from family and other caregivers rather than the recipient's IQ level predict post-OT medication compliance.

(Panocchia N, Bossola M, Vivanti G. Transplantation and mental retardation: what is the meaning of a discrimination? Am J Transplant 2010; 10 : 727-30)

Mood and anxiety disorders

- Anxiety or depressive disorders are experienced by 25 per cent of lung, 40 per cent of liver and 50 per cent of heart pre-OT cases.

(*Trumper A, Appleby L. Psychiatric morbidity in patients undergoing heart, heart and lung, or lung transplantation. J Psychosom Res. 2001;50:103–5.*)

- In post-OT cases during the first several years, major depression was experienced by 20 per cent of kidney, 30 per cent of liver, and 63 per cent of heart cases.
- In view of higher morbidity and mortality, 45 per cent of OT centres in the USA consider current affective disorders as an absolute contraindication for OT.

(Levenson J, Olbrisch ME. Psychosocial screening and selection of candidates for organ transplantation. In: Trzepacz PT, DiMartini AF, editors. The transplant patient. Cambridge, England: Cambridge University Press; 2000. pp. 21–41.)

- ***Psychotic disorders***
- There is a need for aggressive pre-OT treatment as psychotic symptoms have a negative impact on OT outcome.
- it remains debatable as to how fair it is to deny organ to a psychotic patient;
- in the USA, 92.3 per cent OT centres consider active schizophrenia as an absolute contraindication for OT.

(Levenson J, Olbrisch ME. Psychosocial screening and selection of candidates for organ transplantation. In: Trzepacz PT, DiMartini AF, editors. The transplant patient. Cambridge, England: Cambridge University Press; 2000. pp. 21–41.)

- ***Personality disorders***
- A survey of all active OT programmes in the USA showed that 14.1 per cent of heart, 8.7 per cent of liver, 5.2 per cent of kidney OT programmes viewed personality disorder as an absolute contraindication to OT.
- Another study showed that borderline personality disorder carries highest risk for post-OT non-compliance, less stable social support and strained working relation with OT team.
- (Bunzel B, Laederach-Hofmann K. Solid organ transplantation: are there predictors for posttransplant noncompliance? A literature overview. Transplantation. 2000;70:711–6)

INDIAN SCENERIO

- limited research from India on psychiatric issues related to OT.
- common emotions among recipients and donor

- Cognitive profile and depression were studied in 30 renal transplant patients which showed depression rate of 87 and 57 per cent one month before and three month after transplantation and mean IQ increased from 88.5 to 101 following transplantation especially with respect to concentration and visual organization.

(Pawar AA, Rathod J, Chaudhury S, Saxena SK, Saldanha D, Ryali VSSR, et al. Cognitive and emotional effects of renal transplantation. Indian J Psychiatry 2006)

- In a six month to six year follow up of 50 male kidney recipients psychiatric illness was noted in 46 per cent of patients and it was more common among unmarried, high education group and high socio-economic status.

(Chaturvedi SK, Pant VLN. Psychiatric aspects of renal transplantation. Indian J Psyciatry 1985;)

Key points:

- Psychiatric evaluations-rule out any acute psychopathology such as acute psychosis, acute mania or depression, active suicidal ideations, and active substance use
- May use various projective tests like Rorschach-to detect any underlying subtle psychopatholy.
- Minnesota Multiphasic Personality Inventory (MMPI)-to know the personality profile of the patient.
- Proper documentation of the clinical findings on mental state examination (MSE) including the test findings is important.
- A baseline mental state examination followed by serial MSEs .

- Patients may have high levels of anxiety related to the surgical procedure which may fade away after the surgery.

CASE 4

- A 45 year old male, Mr. XYZ, a Hindi speaking Muslim, educated upto B.Com., working as a clerk in a Govt college, married since 22 years, having 3 children, resident of Aurangabad, referred from GMC Aurangabad through Organ transplant board for psychiatric evaluation in view of RENAL TRANSPLANT as a DONOR.
- Informant being wife, mother- complete and reliable
- At the time of presentation, patient denied any complaints s/o psychiatric illness

- Patient was apparently alright 20 years back when without any stressor, he developed irritability with anger outbursts on trivial issues.
- Subsequently, he started talking to self with gesticulating movements, when asked about his behavior, he would say that he is hearing voices of his friends and distant relatives asking about his well being.
- His sleep was disturbed, would be seen pacing around at home disturbing his family members by putting the lights on and off repeatedly.

- He would refuse food offered by his family members, sometimes throwing it on floor in the fit of anger and claiming that the food is being poisoned and having it later according to his wish.
- He would feel fearful at times claiming that some people are plotting against him and that they are coming to kill him.
- He stopped going to his workplace claiming that people are talking about him, staring , laughing , making some gestures pointing him whenever he passes by them.

- According to wife, the patient would wander away in the locality and coming back home after 7-8 hours. In one such incidence, he left home and was found by the police in a nearby village after a day in a disheveled state.
- At home he became unmanageable, extremely aggressive and abusive towards family members.
- Family members claimed these symptoms increased in a span of 15 days

- He was taken to a private psychiatrist and received indoor management in Aurangabad.
- According to the informant, he was treated with oral and injectable medications, improved in a span of 7-10 days, reached near Premorbid levels of functioning, discharged after 15 days and was prescribed oral medications on discharge and was advised to continue treatment and regular follow up after every 15 days.
- He was given Tab. Olanzapine and Tab. Haloperidol as per the documents available.

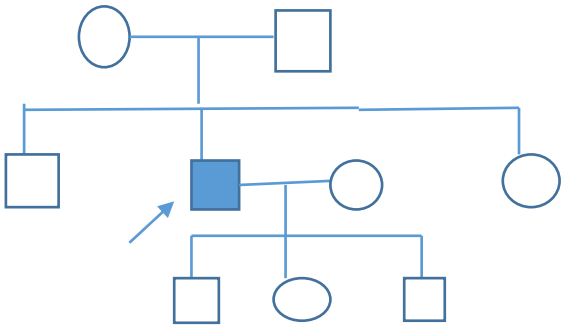
- According to the patient and the informant, he took medication on a regular basis for about 1 ½ years, and gradually tapered off his medications without the doctor's advise and finally stopped taking the medications around 2 years after his symptoms.
- There is no history of similar or any other psychiatric symptoms or behavioral disturbances in the past 18 years despite being off medications.

- Mr. XYZ’s elder son ,diagnosed as a CHRONIC KIDNEY DISEASE, currently on Dialysis , was advised to undergo RENAL TRANSPLANTATION.
- Treating doctor advised the family members to undergo investigations for compatible kidney and after investigations it was found that Mr XYZ was a perfect match as a donor for renal transplant.

- Then Mr. XYZ decided to donate his kidney voluntarily as a life-saving measure for his Son.
- Mr. XYZ the underwent a battery of blood tests and other investigations and was asked to follow up with all the past medical and surgical treatment documents.

- H/o occasional tobacco consumption, 1 pudi in 3-4 days.
- No h/o persistent sadness of mood/ loss of interest in activities / or ideas of hopelessness, worthlessness, helplessness or suicidal ideations
- No h/o repeated hand washing/ checking behavior/ doing same things repeatedly.
- No h/o big talks/ increased self esteem/ spending spree in the past.
- No past h/o any major medical or surgical illness
- No h/o head injury/ seizure disorder.

FAMILY HISTORY



- 2nd out of three children, has an elder brother and a younger sister.
- H / S / O psychiatric illness in paternal uncle(repeated aggressive, assaultive, wandering behavior) on treatment since last 35 years.

PERSONAL HISTORY

- PERSONAL HISTORY-
- Birth and Developmental History-
- FTND, CIAB, Normal developmental milestones.
- Educated upto B.Com.
- Good scholastic performance.
- Working as a clerk since the age of 20.
- Supports family well
- Only earning member in the family at present.

PREMORBID PERSONALITY

- According to the mother, as a child he was cheerful and jovial by nature, would enjoy playing with friends and siblings.
- Had many friends.
- Punctual at work.
- Was responsible and had adequate coping skills
- Loving and Caring towards family.
- Always supportive towards family financially as well as emotionally.
- Extrovert.
- Socially well adjusted.

- Patient reported to Psychiatry Department at JJ Hospital.
- History was taken from the patient as well as the informants and corroborated

- On Psychological testing ROR-
- No psychotic, depressive features
- No contaminated/ confabulated responses
- No conflicts seen
- Good ties with reality
- No hollow feelings

On mental status examination

- An averagely built adult male, sitting comfortably on chair.
- Patient is Conscious/ Cooperative/ Communicative/ Well kempt.
- Attention- aroused/ sustained
- Eye to eye contact- Initiated/ maintained
- Rapport-Established
- Oriented to time /place/person

- Speech- Continuous/coherent/relevant
- Denies any delusions
- Patient claims he is well motivated for the procedure, understands the possible consequences. He claims he was unable to bear his son’s sufferings, hence decided to take this step to save his son s life. His decision as a donor was taken voluntarily with complete awareness of all the possible complications as explained by a treating doctor.
- No perceptual disturbances elicited.
- Memory- immediate, recent and remote intact

- Intelligence- average
- Concepts- simple and abstract intact
- Mood- euthymic
- Affect- congruent, appropriate to surroundings
- Insight- present.
- Judgement- test, social and personal intact

- Case was reviewed by Senior Resident, Lecturer, Associate Professor and HOD and was advised an observation period of 5 days on OPD basis and serial MSEs were taken.
- On the 5th day of observation, he was given psychiatric fitness as a donor for the renal transplant surgery.
- NIL ACTIVE PSYCHIATRY

CASE-5

- A 36 year old male patient, Mr. ABC, a Marathi speaking Hindu, educated upto B.Ed, working as a teacher in a private school, married since 10 years, having 2 children, resident of Kolhapur, a known case of chronic kidney disease was referred to JJ Hospital through organ donation board for psychiatric fitness to undergo RENAL TRANSPLANT as a recipient.

- Informant being Mother- complete and reliable informant.

- At the time of presentation, patient denied any complaints s/o any psychiatric illness.

The patient is on dialysis on a regular basis, case of Chronic Kidney Disease(CKD).

Patient was a diagnosed hypertensive since 8 years and was on regular medications but which gradually progressed to uncontrolled Hypertension. He gives h/o multiple admissions in the past for accelerated Hypertension.

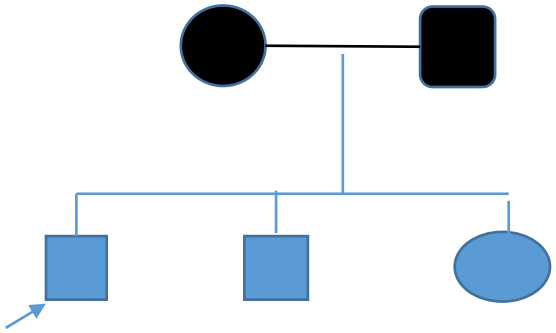
Despite repeated failed attempts to control HTN, it could not be controlled and ultimately led to Renal insult in the form of persistent deranged creatinine levels, pedal edema, decreased urine output and other renal failure signs and symptoms.

- No h/o Muttering to self with gesticulating movements/ suspiciousness/ wandering behavior in the past, Fearfulness, thought being inserted or taken away or being known to others
- No h/o persistent sadness of mood/ loss of interest in activities / or ideas of hopelessness, worthlessness, helplessness or suicidal ideations
- No h/o repeated hand washing or other activities/ checking behavior.
- No h/o big talks/ increased self esteem/ spending spree in the past.
- No h/o any substance use in the past and present.
- No h/o Past and surgical illness in past
- According to informant there is no any present or past h/o psychiatric symptoms or behavioural problems.

- Patient was well aware of the procedure that was to be undergone.
- He was been explained about the procedure, risks and consequences that may follow including failure of the renal graft or rejection after the transplant or even death of either of them by his treating Doctors and he understands the same.

FAMILY HISTORY

- Eldest of three children, has an younger brother and a younger sister.
- Patient is the only earning member of his family.
- No family history of any psychiatric illness.
- Patient has good family / social support.



Personal history

- Birth and Developmental history-
- Full term normal delivery,
- Cried immediately after birth
- No h/o NICU admission.
- Normal developmental milestones- scholastically good
- Educated upto B.Ed, was working as a teacher.

Premorbid personality

- Had many friends.
- Cheerful and jovial by nature.
- Caring towards family members
- Responsible with adequate coping skills.
- Introvert.
- Maintained cordial relations with family and friends.
- Socially well adjusted

MENTAL STATUS EXAMINATION

- Patient sitting comfortably on chair, is well aware of psychiatric evaluation to be undergone.
- Conscious/ cooperative/ communicating
- Attention- aroused/ sustained
- Eye to eye contact- initiated/ maintained
- Oriented to time, place and person
- Rapport-established easily

- Speech- continuous/ coherent/ relevant
- Patient claims he is well motivated for the procedure, understands the possible consequences.No thought or perceptual disturbances elicited.
- Memory- immediate, recent and remote intact
- MMSE-28/30
- Intelligence- average
- Concepts- simple and abstract intact
- Mood- euthymic
- Affect-congruent, appropriate to surroundings
- Insight- present.
- Judgement- test, social and personal intact

- Patient was evaluated for 2 days by senior resident, Lecturer, Associate Professor and HOD and was given fitness to undergo Renal Transplant as a recipient from psychiatric point of view.
- Patient is Nil Active Psychiatry at present.

SUMMARY

CASES

- 1) Gender Identity Disorder
- 2) Bariatric surgery
- 3) Appendicitis
- 4) Renal transplant donor
- 5) Renal transplant recipient

CASE1

27 Year old female working as a helper of grocery shop came to psychiatry OPD with complaints of :

- Feeling uncomfortable with her feminine body characteristics
- Feeling like a man trapped in a female body
- Strong desire to be a man and to have sexual characteristics of the same.

Detailed history was noted, Mental Status Examination was done and patient was assessed by faculty and a diagnosis of Gender Identity Disorder was made.

She wanted to undergo Gender Reassignment Surgery and was thereby advised to consult a plastic surgeon and follow up in psychiatric OPD with a reliable informant for further assessment.

Patient consulted a plastic surgeon. She understood the nature of the surgery, its risks and consequences and was willing to undergo the same. However, after knowing about the cost of the surgery and the total time required for the treatment , she decided to delay her procedure till she becomes financially stable.

Plan of action-

In this case, we have already done the first assessment and diagnosed the patient as having GID.

If the patient follows up, further assessment will be done by another psychiatrist. Detailed history will be corroborated from the informant to re-establish the diagnosis, motivation for surgery, to ensure that the patient has all the required information and psychological support needed to make the best decision for herself and have the best outcome.

Case 2

46 yr old Hindu married woman of middle socio economic status, working as a typist, k/c/o morbid obesity with BMI 41 and was referred from surgical department i/v/o fitness for bariatric surgery.

History revealed that patient had sadness of mood, restlessness, decreased interest in all activities since more than 1 year for which she consulted a private psychiatrist and was diagnosed as a case of MDD and started on Sertraline. She improved- reached almost PMP in approximately 6 months. She is currently Sertraline 100mg.

She is k/c/o DM, hypertension and had no history of any substance use.

- On MSE, patient had no delusions or perceptional abnormality, no depressive cognition, was euthymic and her concepts and judgement were intact.
- She understood the pros and cons of the surgery, the lifestyle modifications and dietary habits expected of her even after the surgery as well as its possible side effects. She was willing to undergo to the surgery.
- She was examined by two psychiatrists and diagnosed as major depressive disorder in remission and given fitness for the surgery. She was advised to continue medications until the day of surgery and after surgery as well.

CASE 3

30 year old unmarried man of low socioeconomic status presented in General Surgery department with complaints suggestive of acute abdomen since 3 days .

On examination and investigations, he was found to have acute appendicitis.

Although he had no history of significant medical illness or any substance use, he had f/s/o schizophrenia and was on treatment since 5 years. He had stopped medicines 3 years back but due to relapse after 6 months, again started treatment and is compliant ever since. He is currently maintained on Olanzapine 10 mg.

He was thereby referred to psychiatry for fitness for appendicectomy surgery.

Detailed history was noted which showed that patient was asymptomatic from psychiatry since last 2 years.

On MSE, there were no psychotic features. Patient understood the nature, need and consequences of surgery.

He was assessed by two psychiatrists, diagnosed as having schizophrenia in remission and given fitness for the surgery. He was also advised to continue the medications till the previous day of surgery and restart after surgery and to follow up regularly after surgery.

CASE 4

45 Year old man, posted as a donor of the renal transplant for his son, came for psychiatric fitness. Patient had no complaints s/o psychiatric illness. However past history suggested Brief Psychotic Episode 20 years back for which he took treatment for a year and was asymptomatic since then. Patient had no major medical or surgical illness in the Past.

On examination, patient had no thought or perceptual disturbances. Psychological testing revealed good ties with reality. Patient had taken the decision of donating his kidney in full awareness and voluntarily. He understood the procedure and the possible consequences of the same. Thereby after assessment from two mental health professionals, he was declared nil active from psychiatry side and was given fitness for surgery.

Case 5

A 36 Year old male , k/c/o Chronic Kidney Disorder was referred by nephrologist for psychiatric fitness for Renal Transplant. Patient is a k/c/o hypertension and on dialysis.

Signs and symptoms of Renal Failure were present but there were no features suggestive of any psychiatric illness in the past. **There was no history of any substance use.**

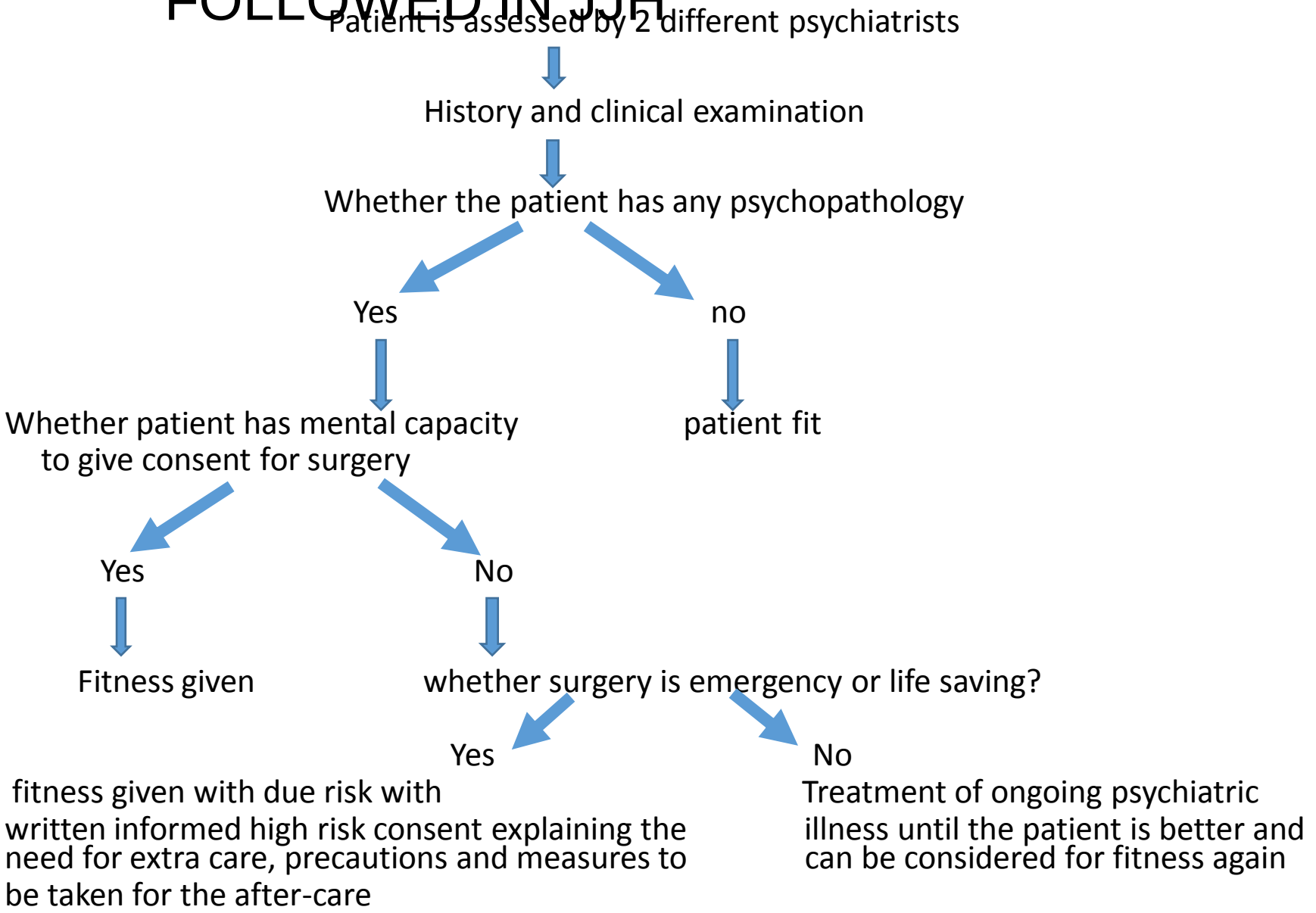
Patient was well aware about the nature of procedure, risks, possible consequences and the need for adherence to medicines post surgery.

MSE-WNL
Cognition-intact
MMSE-28

Patient has been evaluated for 2 days by the faculty.

Fitness was given.

GENERAL PROTOCOL FOLLOWED IN JJH

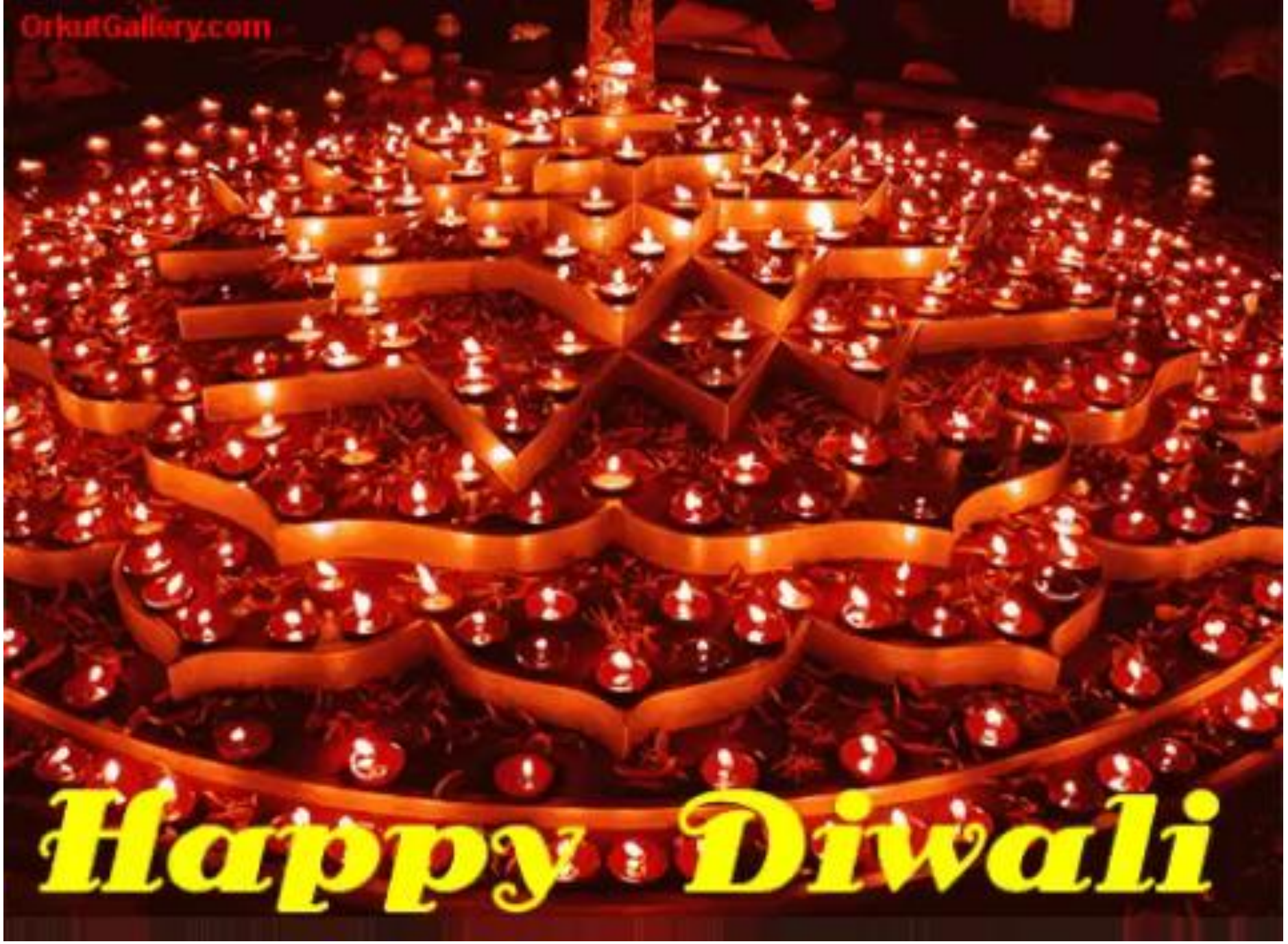


In India, there is a dearth of specific protocol to be followed in cases of fitness for surgery.

Whenever a patient is referred for psychiatric fitness,

- a comprehensive assessment is needed.
- detailed history should be taken from the informant
- psychological testing should be done whenever required
- in case of mental illness, administration of regular appropriate medications should be ensured

thank you!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