Correspondence

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Success of community care?

There is debate regarding the success or otherwise of community care. The evidence deriving from the closure of Friern Hospital on which the Team for the Assessment of Psychiatric Services project is based, discussed by Leff (2001), cannot be generalised because, in contrast to typical hospital closures, in the region of £100 million was allocated to ensure the ‘success’ of the project. Despite this expenditure, the following points should be considered.

At the time of the closure of Friern Hospital an internal audit found that only 14 long-stay patients were there by compulsion and 11 of those were under court orders (Weller, 1989).

After closure, high wire netting was erected and 24-hour guard-dog patrols were instituted because of attempted returns by patients to the hospital.

Many of the patients offered ‘a home for life’ were subsequently moved.

Many have become ‘revolving-door’ patients.

The hospital building, of listed architectural merit (but which drew inexplicable opprobrium at the time), and spacious grounds are now luxury flats, and a £400 million deal has been struck for many more on other hospital sites (The Times, 12 September 2002: p. 3).

Twenty patients committed suicide in the first year after closure (further details available from the author upon request). This figure stands in contrast to the findings of Powell et al (2000), who showed that even within the high-risk group of inpatients, 100 patients would need to be detained unnecessarily in order to prevent one suicide.

De Leo et al’s (2002) study confirmed that a TeleHelp–TeleCheck service reduced suicides among elderly service users in northern Italy. The authors comment that the highest suicide rates in almost every country (including Hong Kong and China) are among those aged more than 75 years. The literature suggests that considerable numbers of suicides among the elderly are due to depression. Conwell (1996) reported that 60–75% of those who committed suicide had a diagnosis of depression among patients aged ≥75 years. This is particularly relevant in elderly people with chronic physical conditions such as stroke and Parkinson’s disease. My colleagues and I (Tsang et al, 2002) recently hypothesised, after a comprehensive literature review, that depression in elderly people with chronic physical illnesses results from disability and a reduction in psychosocial resources. If depression is left untreated, suicide may be a consequence.

In view of the high prevalence rates and seriousness of the consequences of the co-occurrence of depression and physical illnesses in later life, various approaches have been developed to counteract the effect of depressed mood. De Leo et al’s study reports one such approach, using a telephone helpline and emergency response service. We (Tsang et al, 2002) proposed qigong as a psychosocial intervention to help elderly people with depression and chronic physical illnesses. Qigong has a long history with diverse schools in China. It can be seen as a method to regulate the body, breathing and mind. In China, health and longevity are believed to be determined by strength, balance and cultivation of the three treasures: jing (essence),

Qigong and suicide prevention

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qi (energy) and shen (spirit). Qigong focuses on these three treasures to represent a holistic view of the human being. ‘Eight-section brocades’ is one of the many forms of health-promoting Chinese qigong. A pilot study (Tsang et al, 2002) using a group of eight out-patients (two males and six females) suffering from chronic physical illnesses was conducted in Hong Kong. The mean age of the participants was 68 years (s.d.=10.7). Rating on the Geriatric Depression Scale showed that the participants had a certain degree of depressed mood, even though they did not carry a clinical diagnosis of depression. The participants received 1h practice of qigong, twice a week, under the supervision of a qualified practitioner. As all participants had satisfactory standing balance, the standing-style eight-section brocades were used as the intervention protocol. The participants were asked to practice it daily (under the supervision of their relatives, who were also trained by the practitioner) for at least 30min (in addition to the twice-weekly supervised practice in the hospital). The feedback from the participants showed that six of them (75%) felt better in terms of their psychosocial functioning after the 12-week programme. Before 6 weeks of practice, only three (37.5%), however, reported improvement. At an early stage, the feedback centred around physical function such as movement of the limbs and activities of daily living. At a later stage, the feedback then shifted more to psychological aspects. The improvement included feeling more relaxed, less discomfort, better sleep and being more optimistic. All of these reported improvements in psychosocial functioning are indicative of less depressed mood and improved quality of life. This preliminary report showed that qigong is promising as an alternative intervention for elderly people with depression and with chronic physical illness to improve their biopsychosocial health and possibly reduce their suicide rate. More systematic evaluation with larger samples and a longer period of intervention is now underway in Hong Kong.


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Olanzapine toxicity in unconjugated hyperbilirubinaemia (Gilbert’s syndrome)

We have recently observed symptoms of toxicity caused by olanzapine at therapeutic dosages. Olanzapine metabolism was hampered because the patient had idio-pathic unconjugated hyperbilirubinaemia (Gilbert’s syndrome). As this is a frequent disorder in the general population (occurring in 10% of the European population), we feel that it is important to consider the possibility of Gilbert’s syndrome before prescribing olanzapine.

A 19-year-old male with paranoid features and schizophrenic symptoms was treated with 2.5 mg olanzapine for 2 days, which increased to 5 mg on the third day. On the fourth day, being pre-suicide attempt and extreme agitation, the patient was admitted to a psychiatric centre. He was given oral doses of 10 mg olanzapine and 5 mg lorazepam. The patient was conscious on the sixth day but did not respond to verbal stimuli and his symptoms of mutism persisted over the next few days. Communication was possible by monosyllables on day eight. On day ten he was bradypsychic, oriented and capable of articulating short sentences with great effort. Speech returned to normal on day twelve. The patient described his experience as a sensation of not being able to find the words in his head. He had not previously displayed speech alterations, nor did they appear later.

Gilbert’s syndrome and Crigler–Najjar syndromes type 1 and 2 are familial unconjugated hyperbilirubinemia caused by genetic lesions involving a single complex locus encoding bilirubin uridine diphosphate – (UDP)-glucuronosyltransferase, which is involved in the detoxification of bilirubin by conjugation with glucuronic acid.

Over the past few years a number of different mutations affecting this gene have been characterised, in which a greater frequency of schizophrenia has been described (Miyakoa et al, 2000). Olanzapine is metabolised in the liver through direct glucuronoridation reactions. Polymorphisms in glucuronosyltransferases, which often result in a decreased capacity for bilirubin glucuronoridation, may have a significant impact on our capacity to detoxify and eliminate drugs and toxins (Mackenzie et al, 2000). Drug-mediated toxicity caused by genetic deficiency of UDP-glucuronosyltransferases is known (Burchell et al, 2000), as in the case of the administration of phenothiazine antipsychotics or tricyclic antidepressants. Mutism with olanzapine use has been reported in cases of overdose (Hanel et al, 1998; Cohen, 1999).

The use of therapeutic dosages of olanzapine can cause toxic symptoms if a lack of bilirubin UDP-glucuronosyltransferase is present. We should keep in mind idio-pathic unconjugated hyperbilirubinemia when prescribing olanzapine.


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The treatment of hypochondriasis by hypnosis

The therapeutic value of hypnosis in the treatment of so-called “functional” nervous and mental affections is still debated, though its usefulness in certain cases of hypochondriasis and dipsomania has been strongly insisted on by certain authors. Dr. Ira van Gieson has recently reported a remarkable case of hypochondriasis and depressive delusions treated by systematic and skilful hypnosis, an account of which is published in the Journal of Nervous and Mental Diseases [sic] for November last.

The patient was a Russian, aged 26 years, and had a good family history. In February, 1900, he began to suffer from insomnia, headache, and loss of appetite, and he became despondent. The general health rapidly deteriorated and a local practitioner stated that his trouble was largely “indigestion” and that there were “lumps” in the bowel. Thenceforth the patient developed a delusion that these “lumps” were “worked upon” by worms in the intestine and broken into smaller lumps which were disseminated through his body. “The patient believed that he was rescued from dire distress by three agencies – viz., the spleen, the soul, and the veins, the spleen being the scavenger and the soul the director.” When the attention of the soul was distracted this work was not well done. These delusions engrossed his thoughts and he could speak of little else. There were no sensory disturbances, no hallucinations, and no tendency to suicide, while his ideas regarding his environment were clear and correct. On putting him into a hypnotic trance a striking change occurred, the state of exaltation giving way to one of great depression. Despite this the delusion referred to still persisted, thus showing, adds Dr. van Gieson, that the state of depression was secondary to the delusion and that when the former vanished, as during hypnosis, the latter still persisted. On one occasion during deeper hypnosis than usual the state of exaltation gave way to one of quiet composure which was approximately the patient’s normal demeanour. There were thus three states in which the patient lived – a waking state of melancholic depression, a slight hypnotic state of exaltation, and a deep hypnotic state of composure. These states also alternated or varied spontaneously, but throughout them all the central delusion remained unshaken. The great assimilating power of this delusion was wonderful. Various suggestions were made to the patient during hypnosis “with the object of breaking up the nucleus of the delusion, but they were turned about by the patient and fed into the systematised delusion”. It was necessary to employ indirect hypnotic suggestion in order to strengthen the effect in dissipating the delusion, as direct suggestion during deep hypnosis was found to be only temporary in this effect. During hypnosis dreams were suggested to the patient to the effect that his father told him that the “lumps” from which he suffered would go away. These dreams duly followed and impressed him deeply though slowly. When the influence of these suggested dreams had eventually become apparent and dominant the “spleen” and the “soul” ceased to be regarded as agencies in the sense in which they had formed part of his delusion. The galvanic current was now substituted therapeutically with great benefit, and it succeeded very effectually in impressing the patient with its potency. “Small spots” were next substituted during hypnotic states for the large “lumps” and these spots were gradually restricted to certain definite areas by suggestion instead of being vaguely disseminated as the patient had entertained in his delusion. The patient’s melancholia finally disappeared completely and he was able to resume his occupation. The case, concluded Dr. van Gieson, was a triumph for the hypnotic method of treatment as systematically and skilfully used. Such a case was not an isolated one but was regarded as a type of similar cases in State hospitals for the insane and in Dr. van Gieson’s opinion the treatment employed in the case might be usefully applied to others of like nature.

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