JAYPEE

4th Edition

Volume 2

QUICK REVIEW OF PGMEE

For Various Post Graduate Medical Entrance Examinations

Medicine, Pediatrics, Dermatology and Venereal Diseases, Radiology, Psychiatry

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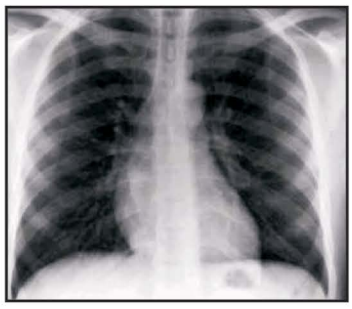
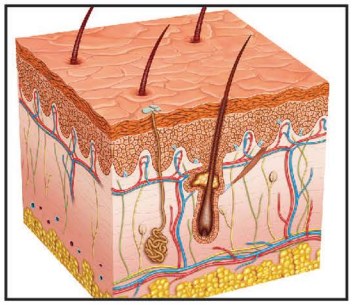


Highlights

- Over 3,500 recently asked most important original MCQs of medical sciences
- All questions with annotated answers, so that the students need not have to 'hunt' for the study material in different textbooks
- Text is lavishly illustrated with diagrams and photographs
- Explanations are written after consulting latest editions of standard textbooks of respective field
- Easy-to-learn mnemonics, which will help in remembering the mind-boggling facts without taxing the memory
- Its concise but comprehensive coverage and unique presentation makes it the 'book of choice' for PGMEE aspirants

Samiksha Publication

Contents

Psychiatry

1. **An 18-year-old boy hears voices discussing him in third person. He is suffering from:**
   A. Schizophrenia **B.** Mania
   C. Depression **D.** TLE

2. ***Not* a classical 4 'As' of Bleuler in schizophrenia:**
   A. Affective blunting **B.** Automatism
   C. Autism **D.** Ambivalence *(AI 1991)*

3. ***Not* a feature of Schizophrenia:**
   A. Anhedonia
   B. Autochthonous delusion
   C. Elated mood
   D. Hallucination

4. **Neologism is a characteristic feature of:**
   A. OCN **B.** Mania
   C. Schizophrenia **D.** All of the above

5. **Loss of insight occurs in:**
   A. Somatoform disorder
   B. OCN
   C. Schizophrenia
   D. Hysteria

6. ***Not* a first order rank symptom of schizophrenia:**
   A. Somatic passivity
   B. Primary delusion
   C. Running commentary
   D. Depersonalization *(AI 1998)*

7. **Delusions are characteristically seen in which of the following condition:**
   A. Depression **B.** Dementia
   C. Delirium **D.** Schizophrenia *(AI 1993)*

8. **A 25-year-old man who lives alone has developed suspicious behavior towards his neighbor. He also has "auditory hallucinations" and lodges a FIR which he himself was not able to prove. Symptoms are present for last two years. *Most likely* diagnosis is:**
   A. Acute psychosis **B.** Mania
   C. Schizophrenia **D.** Depression *(AIIMS 2001)*

9. **Ambivalence is associated with which of the following condition:**
   A. Schizophrenia **B.** Hysteria
   C. Depression **D.** OCN *(PGI 1999)*

10. **A 22-year-old single unmarried man is suffering from sudden onset of *3rd person hallucinations* for the past 2 weeks. He is suspicious of his family members and had decreased sleep and appetite. The diagnosis is:**
    A. Schizophrenia
    B. Acute psychosis
    C. Acute mania
    D. Delirium *(AIIMS May 2001)*

Schizophrenia has puzzled philosophers, physicians and people alike for centuries. 1% of world's population suffers from schizophrenia. In 1896 *Emil Kraepelin* classified major psychiatric diseases into two groups' viz. **dementia precox** and **manic depressive psychosis (MDP).** Under the dementia precox he put various psychiatric diseases which were earlier thought to be distinct diseases having poor outcome and recognized *delusions, hallucinations, disturbances of affect and motor disturbances.* **Eugen Bleuler (1857–1939) was a Swiss psychiatrist who renamed dementia precox as schizophrenia (mental splitting).** He further noticed that this disorder *did not always* have a poor prognosis. The **fundamental symptoms** or the **classical 4 As** described by Bleuler are as under:

Ambivalence	Severe inability to decide for or against something
Autism	Withdrawal into self
Affect disturbances	Inappropriate affect
Association disturbances	Thought disorder

Accessory symptoms *as described by Bleuler* are delusions, hallucinations, negativism, etc. The fundamental symptoms were thought to be diagnostic of schizophrenia.

Kurt Schneider described certain symptoms which, *although not specific,* are of great help in making a clinical diagnosis of schizophrenia. These are described as under:

First rank symptoms (FRS) of schizophrenia

- **Hallucinations of 3 types**: Audible thoughts or "thought echoes"; voices are heard arguing something, i.e. *2 or more hallucinatory voices discussing the subject in third person;* and voices commenting on the patient's action.
- **Delusion of 6 types**: Thought withdrawal (*thoughts stop and patient experiences them as being removed by some external force);* thought insertion *(patient experiences thoughts imposed by some external force on his passive mind)*; thought diffusion or "broadcasting" *(patient experiences that his thoughts are escaping the confines of his self and are being known to others around him)*; "made" feelings (affect), impulses or volition of acts *(patient experiences that feelings, impulses or actions are imposed by some external force and in "made" volition he thinks that his own acts are under the control of some external force and the subject is like a robot.*
- **Delusional perception**
- **Somatic passivity,** i.e. body sensation (sensory symptoms) imposed on body by external force.

Second rank symptoms (SRS) of schizophrenia

Other forms of hallucinations, affect disturbances and perplexity (to make a *person* uncertain, doubtful, or hesitant; confused; puzzled).

Clinical features: One of the most important symptoms of schizophrenia is that the thinking is governed by private and illogical rules (**autistic thinking**). The patient with *autistic thinking* may consider the two different things identical if they have identical predicates or properties (*Von Domarus law*). For example *Bill Gates has got a computer, I have also got a computer, and therefore I am Bill Gates or Amir Khan drinks coca cola, I also drink coca cola, therefore I am Amir Khan.* There is **loosening of associations,** i.e. things said in juxtaposition lack a meaningful relation with each other and this type of speech is often described as *disjointed*. If this *loosening* becomes severe speech becomes incomprehensible and is known as **incoherence.** There is a sudden interruption of speech *before the thought is completed* (**thought blocking**) although this can be seen in complex partial seizure (temporal lobe epilepsy). After *the pause* the patient *can not recall* what he meant to say. The patient *creates* new words and phrases to express a *concept* for which he has no dictionary words (**neologism**). *Sometimes* "normal" words are used in a distorted or unconventional fashion (**word approximation or paraphasias**), although the meaning can be understood; for example *describing stomach as a fuel tank*. There may be no speech production at all (**mutism**); decreases speech production (**poverty of speech**); amount of speech is adequate but it conveys *little* information (**poverty of ideation**); repetition or "echoing" of words or phrases of the psychiatrists by the patient (**echolalia**); *persistent* repetition of words beyond any relevance (**perseveration**) or senseless repetition of same word or phrases again and again (**verbigeration**). **Delusions** may be defined as *false and firm believes which is not in line with patient's socioculture and educational background.* Delusions may be of two types viz. primary and secondary. **Primary delusions are also known as autochthonous** (indigenous) **delusions and are characteristic of schizophrenia.** They are seen in *early* stages of the disorder and arise *de novo,* i.e. cannot be explained on the basis of other experiences or perceptions. **Secondary delusions are the most common delusions seen in clinical practice and are *not* diagnostic of schizophrenia.** The common secondary delusions are delusions of persecution (*being persecuted*);

delusions of reference (*being referred to by other people*); delusions of grandeur; delusions of control (*controlled by known or unknown external forces*) and hypochondrial (*abnormal anxiety over one's health, often with imaginary illnesses*) or somatic delusions. **Over-inclusion** (*inclusion of irrelevant items in speech*); **impaired abstract** (*loss of ability to generalize things*); **ambivalence** (simultaneous conflicting feelings toward a person or thing, as love and hate); **perplexity** (the condition of being perplexed; bewilderment; confusion) are other **thought and speech disorders** associated with schizophrenia. **Disorder of perception** seen in schizophrenia is hallucination which means *perception without stimulus*. **Auditory hallucination is the most common hallucination seen in schizophrenia.** *Only the third person hallucinations* (voices heard arguing) *are characteristic of schizophrenia.* Visual hallucinations can also occur along with the auditory hallucination but tactile, gustatory and olfactory hallucinations are far less common. **Disorders of affect** include emotional blunting and shallowness, apathy, anhedonia (*inability to experience pleasure*) and inappropriate emotional response. This inability of the patient to establish emotional contacts with others leads to **lack of rapport with the psychiatrist. Disorders of motor behavior** may manifest as *either* a decrease in psychomotor activity (stupor, inertia) *or* an increase (*aggression, agitation, restlessness, excitement*). Mannerisms, grimacing, stereotypes (*repetitive strange behavior*), reduced self care and poor grooming are common features. There is decreased functioning in work place, loss of ego boundaries (between self and environment), uncertainty about ones own identity and existence. **Insight into the illness is absent but there is no disturbance of consciousness, orientation, attention, memory and intelligence.**

Clinical types of schizophrenia

• **Catatonic**	• **Paranoid**	• **Hebephrenic**
• **Residual**	• **Undifferentiated**	• **Others**

Catatonic and hebephrenic schizophrenia together are known as *nuclear schizophrenia*. Catatonic schizophrenia is characterized by disturbance of motor behavior (*cata means disturbed; tonic means tone*). PFROPF SCHIZOPHRENIA occurs in presence of mental retardation (IQ < 70).

Catatonic-type describes patients whose clinical presentation is dominated by profound changes in motor activity, negativism, and echolalia or echopraxia**.**

Paranoid-type describes patients who have a prominent preoccupation with a specific delusional system and who otherwise do not qualify as having *disorganized-type* disease, in which disorganized speech and behavior are accompanied by a superficial or silly affect.

In **residual-type** disease, negative symptomatology exists in the absence of delusions, hallucinations, or motor disturbance.

The diagnosis of **schizophreniform disorder** is reserved for patients who meet the symptom requirements but not the duration requirements for schizophrenia, and that of *schizoaffective disorder* is used for those whose symptoms of schizophrenia are independent of associated periods of mood disturbance.

Positive symptoms of schizophrenia are those symptoms which are *added* to the clinical picture, i.e. delusion, hallucination, agitation, etc**.**

Negative symptoms of schizophrenia are those symptoms which are *subtracted* from the clinical picture, i.e. social withdrawal, apathy, anhedonia, poverty of thoughts, etc**.**

11. In schizophrenia, bad prognostic factor is:
A. Presence of depression **B.** Fat patient
C. Family history **D.** Late onset *(UP 1996)*

12. Good prognostic factor for schizophrenia is:
A. Chronic course **B.** Catatonic features
C. Early onset **D.** Gradual onset *(SGPGI 1999)*

13. *Not* a bad prognostic factor of schizophrenia:
A. Early onset
B. Family history
C. Presence of precipitating factor
D. Insidious onset *(KERALA 1999)*

Prognosis of Schizophrenia

Favorable prognostic features	Poor prognostic features
Acute onset	Gradual onset
Onset after 35 years of age	Onset before 25 years of age
Short duration (less than 6 months)	Long duration (more than 2 years)
Precipitation by environmental or physical factors	Absence of precipitating factors
Good pre-disease adjustment	Poor pre-disease adjustment
Depression present	Depression absent
Fat physique	Thin physique
History of previous attacks from which recovery has occurred	Family history of schizophrenia
Catatonic or paranoid subtypes	Undifferentiated, hebephrenic or chronic catatonic subtypes

14. *Absolute* contraindication for ECT is:
A. Heart disease **B.** Raised ICT
C. Very ill patient **D.** Pregnancy *(AI 1992, UP 1997))*

15. *Most common* side effect of modified ECT is:
A. Convulsions **B.** Body aches
C. Amnesia **D.** Arrhythmia *(AI 1992)*

16. ECT causes:
A. Retrograde amnesia **B.** Anterograde amnesia
C. Both **D.** None

17. ECT is most effective in:
A. Parkinsonism **B.** OCN
C. Paranoid syndrome **D.** Neurotic depression

18. ECT is *not* indicated in:
A. Catatonic schizophrenia **B.** Acute depression
C. Obsessive compulsive neurosis **D.** Acute mania *(UP 1995)*

19. Memory disturbance of ECT recovers after:
A. Few days-few weeks **B.** They are permanent
C. Few weeks–few months **D.** Few months–few years

20. ECT is useful in treatment of all of the following *except*:
A. Acute psychosis **B.** Endogenous depression
C. Chronic schizophrenia **D.** Catatonic schizophrenia *(AI 1993)*

21. A 36-year-old girl has no interest in anything, nihilistic attitude, sad appearance with suicidal ideas and plans. She should be managed with:
A. ECT **B.** Antidepressants
C. Behavior therapy **D.** Haloperidol *(AIIMS 2001)*

22. Treatment of choice in a patient of depression with suicidal tendency:
A. ECT **B.** MAO inhibitors
C. Tricyclic antidepressant **D.** Fluoxetine *(AI 1994)*

23. A 26-year-old female diagnosed to be suffering from depression, now for the past 2 days had suicidal tendencies, thoughts and ideas. The best treatment is:
A. Amitryptiline **B.** Selegiline
C. Haloperidol + Chlorpromazine **D.** ECT *(AIIMS May 2001)*

24. Absolute contraindication for ECT is:
A. Myocardial disease **B.** Aortic aneurysm
C. Glaucoma **D.** Brain tumor

Cerletti and Bini used **electro convulsive therapy** (ECT) for the first time in 1938. In 1976 American Psychiatric Association (APA) task force on ECT declared it to be a safe and effective method of treatment by professionals trained in the technique and gave guideline for its use. **Unilateral ECT is safer than the bilateral ECT and carries much less side effects mainly those of memory impairment** *but* the bilateral ECT is superior to unilateral ECT in *effectiveness.* **Direct ECT** is given in the *absence* of muscle relaxant and GA and is only *rarely* used. **Modified ECT** is given with drug (suxamethonium) induced muscle relaxation and anesthesia (thiopentone sodium).

Indications of ECT

1. **Major severe depression**
   - With suicidal risk **(first and most important indication for ECT)**
   - With stupor
   - With poor intake of fluids and food
   - With melancholia
   - With psychotic features
   - With unsatisfactory response to drug therapy
   - When drugs are contraindicated or have serious side effects
   - When fast recovery is needed
2. **Severe catatonia (functional)**
   - With stupor
   - With poor intake of fluids and food
   - With unsatisfactory response to drug therapy
   - When drugs are contraindicated or have serious side effects
   - When fast recovery is needed
3. **Severe psychosis (schizophrenia or mania)**
   - With risk of suicide, homicide or danger of physical assault
   - With unsatisfactory response to drug therapy
   - When drugs are contraindicated or have serious side effects
   - With very prominent depressive features
4. **Organic mental disorders**
   - Organic mood syndrome
   - Organic psychotic syndrome
   - Delirium
5. **Medical disorders**
   - Organic catatonia
   - Hypopituitarism
   - Intractable seizure disorders
   - Neuroleptic malignant syndrome
   - Parkinsonism

Contraindications of ECT

Absolute contraindications	Relative contraindications
• Raised intracranial tension	• Recent myocardial infarction • Cerebrovascular accident (CVA) • Severe hypertension • Severe lung disease • Retinal detachment • Pheochromocytoma

Adverse effects of ECT

- Death
- Memory disturbances (both anterograde and retrograde) are **very common** and **recovery occurs within 1–6 months of ECT**
- Confusion is much common with bilateral ECT
- Headache, apnea, prolonged seizures, CVS dysfunctions, mania, muscle pains and apprehension for further ECT are other side effects

∗ **ECT does not cause brain damage.**

25. *Not* seen in attention deficit hyperactivity disorder (ADHD):
A. Mental retardation **B.** Impulsivity
C. Less attention in study **D.** Hyperactivity *(UP 1997)*

26. *Not* seen in hyperkinetic child:
A. Soft neurological signs **B.** Left to right disorientation
C. Decreased attention span **D.** Aggressive out burst *(AI 1991)*

27. *Not* a feature of hyperkinetic child:
A. Amphetamine is the drug of choice **B.** Right to left dissociation
C. Low attention span **D.** Difficulty in completing tasks *(JIPMER 1991)*

28. Attention deficiency disorder is seen with which of the following drug:
A. Phenobarbitone **B.** Amphetamine
C. Low doses benzodiazepine **D.** Cocaine *(JIPMER 1991)*

29. An 11-year-old child was found to be very restless and hyperactive in the classroom making it difficult for the other students in the classroom to concentrate. He runs round the class all the day cannot sit at one place for a long time. He gets very agitated when the toy in his hand is taken away. The *most probable* diagnosis is:
A. Autism
B. Conduct disorder
C. Attention deficit hyperactivity disorder
D. Conversion *(AI 2002)*

The main symptoms of **attention deficit hyperactivity disorder (ADHD)** are short attention span, difficulty in concentration, impulsivity, distractibility, excitability and hyperactivity. *Hyperactivity* is defined as *an increase in motor activity to a level which interferes with the child's functioning at school, at home and in society.* It is important to remember that *the symptoms of ADHD may exist with or without hyperactivity.* The *Diagnostic and Statistical Manual of Mental Disorders 4th edition* (DMS–IV) divides it into 3 subtypes:

- ADHD–predominantly inattentive type;
- ADHD–predominantly hyperactive-impulsive type;
- ADHD–combined type.

Diagnostic criteria for ADHD

Inattention	Hyperactivity	Impulsivity
Lack of attention to details	Excessive talking	Answering without raising hand
Difficulty in *sustaining* attention for prolonged period	Difficulty in performing "non action" activities	Answering before the end of the question
Not listening	Difficulty in remaining in seat and sitting quietly	Difficulty with "turn taking" activities
Difficulty in completing tasks	Restlessness	Interruption or intrusion into other peoples conversations or activities.

Disorganization	Developmentally excessive activity level
Forgetfulness	
Marked distractibility	
Tendency to loose personal belongings	
Avoidance of activity that require sustained attention	
Some symptoms should be present before 7 years of age and must be causing significant functional impairment.	
Sedative and hypnotic drugs (*paradoxical effect*), depression, anxiety, head injury, serious CNS disease, constitutional hyperactivity, intolerant parent, teacher or supervisor, specific language disabilities, language disorders and Tourette syndrome can all lead to ADHD.	
Any underlying disorder should be treated and stimulant medications such as methylphenidate, dextroamphetamine and pemoline are effective. Clonidine, desipramine and bupropion are alternative effective drug in some children. Behavior modification programs, psychotherapy and environmental engineering are all beneficial.	
Due to normal developmental activity, diagnosis may be difficult in children under 5 years of age. In children at least 5 years old, "soft signs" may appear early and suggest the presence of ADHD. These soft signs of the neurological system include the following: • Coordination difficulty • Impaired motor skills • Nystagmus (i.e. constant, involuntary movement of eyes) • Visual motor problem (e.g. hand eye coordination) When observed collectively, these symptoms can suggest a diagnosis of ADHD.	

30. ***Most common*** **complication of obsessive compulsive disorder is:**
- **A.** Mania
- **B.** Dissociation of symptoms
- **C.** Persecutory delusions
- **D.** Depression

31. ***False*** **regarding obsessive compulsive neurosis is:**
- **A.** Insight is present
- **B.** Ego syntonic
- **C.** Patient tries to resist against ego
- **D.** Ego alien

(AI 1995)

32. ***Not*** **a characteristic feature of obsessive compulsive neurosis:**
- **A.** Excessive slowness
- **B.** Sexual thoughts
- **C.** Repeated hand washing
- **D.** Elaborate checking

(PGI 1993)

33. Drug *not* used in obsessive compulsive neurosis is:
- **A.** Lithium
- **B.** Haloperidol
- **C.** Fluoxetine
- **D.** Clomipramine

(UP 2001)

34. ***Not*** **a feature of obsessive compulsive neurosis:**
- **A.** Persistence
- **B.** Resisting the idea
- **C.** Ego-syntonic
- **D.** Irrational thoughts

(AI 1993)

35. In obsessive compulsive neurosis, the *drug of choice* is:
- **A.** Lithium
- **B.** Fluphenazine
- **C.** Clomipramine
- **D.** Chlorpromazine

(UP 1994, AI 1994, 1995, 1996, 1998)

36. A woman complains that she feels like abusing god and slap a gentleman. The thoughts persist in spite of her not willing to do so. She is suffering from:
A. Conversion disorder **B.** Hypochondriasis
C. Somatization **D.** Obsessive compulsive disorder *(AI 2000)*

37. Delusions are seen in all the following *except*:
A. Obsessive compulsive disorder **B.** Depression
C. Mania **D.** Schizophrenia *(AI 2002)*

Obsessive compulsive disorder (OCD): An obsession may be defined as an "idea", "impulse", or an "image" which intrudes into the conscious awareness time and again. The idea is patient's own but is **ego alien,** i.e. foreign to the patient's personality and is **recognized as absurd and irrational by the patient** (**insight is present**) who tries to resist against it but is unable to do so. This failure to resist leads to marked distress. *In contrast* the *delusion* is ones own idea but is not "recognized" as ego alien, hence the patient never thinks it to be irrational and is never resisted. The "**obsession**" is associated with "**compulsion**" which is a form of *behavior* that *follows* the obsession. The aim of compulsion is to prevent or *neutralize* the distress or fear aroused by obsession. The behavior caused by compulsion is unrealistic and is *irrational* or *excessive*. As the insight is present the patient *also realizes the irrationality of compulsion.* In our country OCD is common in unmarried men of upper social strata with high intelligence and the average age of onset is in late twenties. *Insel* in 1985 described **4 clinical syndromes**, although "mixture" is common than pure syndromes. **The *most common* type of patients of OCD are "washers".** There is obsession of *contamination* with dirt, germs, and body secretions and, naturally, the compulsion is *washing* of hands or whole body several times in a day. As the condition progresses it "spreads" to washing of clothes, bathroom, bedroom, door knobs and even any article, although the patient tries to avoid "contamination" but is unable to do so and the washing becomes a *ritual.* The SECOND types of patients are "**checkers**" who have multiple *doubts* about lock in the door, kitchen gas knob, and counting of money. The *compulsion*, naturally, is repeated *checking* to "clear" the *doubt.* Any attempt to stop the *checking* leads to *anxiety*. The tragedy is that even before one *doubt* is *cleared* the other creeps in. The THIRD syndrome is "**pure obsession**" characterized by repeated intrusive thoughts, impulses or even images *not* associated with compulsion. The distress caused by these obsessions is *dealt* with *counter thoughts*. A variant of this syndrome is *thought rumination* in which there is **preoccupation with thoughts**. The FOURTH and relatively rare syndrome is that of *primary obsessive slowness* characterized by severe obsession and extensive compulsion *without anxiety* leading to marked slowness in daily activities. **Depression is commonly associated with obsessive compulsive disorder and at least 50% of patients have major depressive episode while the others have mild depression.**
Behavior therapy has a success rate of 80% for compulsive acts. **Anti-depressants such as clomipramine and selective serotonin reuptake inhibitors (SSRIs) are affective in OCD even in absence of co-existing depression.**

• **Ego-syntonic means something that is consistent with the individual's self-image.**

38. Best use of lithium is in:
A. Treatment of schizophrenia
B. Treatment of recurrent depression
C. Treatment of first depressive episode
D. Prophylaxis of bipolar mood disorders *(SGPGI 1999)*

39. In bipolar manic disorder, the drug used is:
A. Amitriptyline **B.** Pimozide
C. Phenytoin **D.** Lithium *(UP 1996)*

40. In manic depressive psychosis, prophylaxis is:
A. Haloperidol **B.** Sodium valproate
C. Chlorpromazine **D.** Lithium carbonate *(AI 1996)*

Lithium is indicated as the **primary drug in the treatment of acute manic and hypomanic episodes in bipolar disorder**, and for *maintenance therapy* to help reduce the intensity and frequency of subsequent manic episodes in patients with a history of mania.

41. A woman has a car accident in which she suffered minor injuries but the driver of the car died on spot. Six months after this accident she still feels afraid of cars and avoids traveling in cars. She is suffering from:
A. Schizophrenia
B. Delusion
C. Traveling phobia
D. Post-traumatic stress disorder *(AI 2000)*

42. Post traumatic stress syndrome is because of:
A. Vascular accident
B. Major life threatening events
C. Minor stress
D. Head injury *(AI 1998)*

43. A 40-year-old woman had an accident while traveling in a bus. She has a fracture of pelvis and remained in the hospital for a long time. Now she refuses to sit in a bus. Diagnosis is:
A. Phobia
B. Conversion disorder
C. Post-traumatic stress disorder
D. Anxiety neurosis *(AI 2001)*

Post-traumatic stress disorder (PTSD) is seen after a catastrophic event in a person's or a close friend or relative's life which is usually life threatening or potentially fatal (war, robbery, accident, earthquake, riot, etc.). It is essential for diagnosing the PTSD that symptoms must be of more than one month duration. 50% patients recover completely within 3 months while others may have symptoms for years. Features of PTSD are as under:

Avoidance	**Intrusion**	**Hyperarousal**
Detachment	Recurrent distressing dreams	Irritability
Survivor's guilt	"Flash backs"	Insomnia
Low interest in activities	Difficulty in recalling stressful events at will	Persistent anxiety
Inability to feel emotions		Poor coordination
Avoidance of reminder of events		

44. In delirium tremens, the *drug of choice* is:
A. Diazepam **B.** Morphine
C. Disulfiram **D.** Chlordiazepoxide *(AI 1993, 1995)*

45. *Not* a feature of alcohol withdrawal:
A. Hallucination **B.** Restlessness
C. Epileptic seizure **D.** Hypersomnolence *(AI 1998)*

46. A 42-year-old alcoholic man has an accident. After that he suddenly stops drinking. 24 hours after this he developed tremors, irritability, poor attention span and inability to identify his family members. Most likely diagnosis is:
A. Acute psychosis **B.** Alcohol intoxication
C. Delirium tremens **D.** Wernicke's encephalopathy *(AIIMS 2001)*

47. A known alcoholic stops taking alcohol for 2 days. After which he develops insomnia, altered sensorium, restlessness. The diagnosis is most likely to be:
A. Delirium tremens
B. Korsakoff's psychosis
C. Conversion
D. Schizophrenia *(AI 2002)*

Sudden decrease in alcohol intake may cause symptoms of withdrawal from the central nervous system depressant effects. Clinical features include a tremor of the hands (*shakes or jitters*); autonomic nervous system abnormalities such as tachycardia, tachypnoea, and fever; insomnia, may be accompanied by bad dreams; feelings of generalized anxiety or panic attacks; and GI upset. Symptoms start within 5 to 10 hours of decreasing ethanol intake, peak in intensity on day 2 or 3, and improve by day 4 or 5. Anxiety, insomnia, and mild levels of autonomic dysfunction may persist for even 6 months or more as a **protracted abstinence syndrome**, which may result in the tendency to return to drinking. A small number of alcoholics also demonstrate one or two generalized seizures ("**rum fits**"), usually within 48 hours of stopping drinking. About 5 % or less of alcoholics in withdrawal show severe symptoms such as **delirium tremens** which is **a state of confusion sometimes accompanied by visual, tactile, or auditory hallucinations.** The **benzodiazepines** (diazepam) have the highest margin of safety and are, therefore, the preferred class of drugs in the treatment of alcohol withdrawal.

48. *Not* a feature of morphine withdrawal:
A. Increased nasal secretion **B.** Constipation
C. Insomnia **D.** Piloerection

49. *Not* a feature of opioid withdrawal:
A. Miosis **B.** Rhinorrhea
C. Lacrimation **D.** Diarrhea *(AI 1993)*

Symptoms of Opioid Withdrawal

- **Lacrimation**
- Sweating
- Tachycardia
- Fever
- Severe anxiety
- **Rhinorrhea**
- **Diarrhea**
- Mild hypertension
- Muscle cramps
- **Piloerection**
- **Pupillary dilatation**
- Yawning
- **Insomnia** and anorexia
- Generalized body ache
- Nausea and vomiting

50. Epileptic fits are distinguished from hysterical fits by:
A. Amnesia **B.** Sleep convulsion
C. Incontinence **D.** Injury *(UP 1996)*

Difference Between Generalized Seizure and Hysterical Fits

	Generalize seizure	**Hysterical fit**
Pattern of attack	Known clinical patterns	No pattern
Place of event	Any where	Outdoors or safe places
Warning sign	Aura may be present	Variable
Time	Anytime	**Never during sleep**
Tongue bite	Present	Absent
Urinary and fecal incontinence	Can occur	Very rare
Injury	Can occur	Very rare
Speech	Not present	May be present
Duration	Usually short	Prolonged
Neurological sign	Present	Absent
Amnesia	Complete	Partial
Post ictal confusion	Present	Absent
Stress	Seen in 25% cases	Much more common
Head turning	Unilateral	Side to side
Eye gaze	Staring	Avoidant gaze

51. Mini mental scale is:

A. Method to investigate common psychiatric problem
B. 30 questions for cognitive function
C. To evaluate schizophrenia
D. Instrument to measure delirium *(JIPMER 2002)*

I. **Indications of minimental scale**
   A. Cognitive Function Assessment
   B. Documentation of subsequent cognitive function decline
II. **Questions (Total of 30 points)**
   A. Orientation (10 points)
      1. Year, Season, Date, Day of week, and Month
      2. State, County, Town or City
      3. Hospital or clinic, Floor
   B. Registration (3 points)
      1. Name three objects: Apple, Table, Penny
      2. Each one spoken distinctly and with brief pause
      3. Patient repeats all three (one point for each)
      4. Repeat process until all three objects learned
      5. Record number of trials needed to learn all 3 objects
   C. Attention and Calculation (5 points)
      1. Spell WORLD backwards: DLROW
      2. Points given up to first misplaced letter
      3. Example: DLORW scored as 2 points only
   D. Recall (3 points)
      1. Recite the 3 objects memorized in Registration above
   E. Language (9 points)
      1. Patient names two objects when they are displayed
         a. Example: Pencil and Watch (1 point each)
      2. Repeat a sentence: 'No ifs ands or buts'
      3. Follow three stage command
         a. Take a paper in your right hand
         b. Fold it in half
         c. Put it on the floor
      4. Read and obey the following
         a. Close your eyes
         b. Write a sentence
         c. Copy the design (picture of 2 overlapped pentagons)
III. **Interpretation of Mini-mental State Score (Maximum: 30)**
   A. Normal score: 24 or higher
   B. Educational and Age Norms
      1. Fourth Grade Education
         a. Ages 18 to 69: Median MMSE Score 22-25
         b. Ages 70 to 79: Median MMSE Score 21-22
         c. Age over 79: Median MMSE Score 19-20
      2. Eighth Grade Education
         a. Ages 18 to 69: Median MMSE Score 26-27
         b. Ages 70 to 79: Median MMSE Score 25
         c. Age over 79: Median MMSE Score 23-25
      3. High School Education
         a. Ages 18 to 69: Median MMSE Score 28-29
         b. Ages 70 to 79: Median MMSE Score 27
         c. Age over 79: Median MMSE Score 25-26
      4. College Education
         a. Ages 18 to 69: Median MMSE Score 29
         b. Ages 70 to 79: Median MMSE Score 28
         c. Age over 79: Median MMSE Score 27

52. All are *false* regarding schizophrenia *except*:

A. Seen in affluent society **B.** Seen in old people
C. Seen in primitive society **D.** Common in low socioeconomic strata *(PGI 2000)*

Schizophrenia is more common in lower socioeconomic status. CT scan of brain demonstrates enlarged ventricles in chronic schizophrenia probably due to functional increase in dopamine at the post synaptic receptor.

53. Psychoanalysis was founded by which of the following scientist:

A. Eysenck **B.** Freud
C. Jung **D.** Adler *(KARNATAKA 2000)*

Psychoanalysis is a specific method of investigating unconscious mental processes and is a form of psychotherapy. The term also refers to the systematic structure of psychoanalytic theory, which is based on the relation of conscious and unconscious psychological processes. The technique of psychoanalysis and much of the psychoanalytic theory based on its application was developed by **Sigmund Freud**.

54. In which of the following disorder 'La belle indifférence' is seen:

A. Depersonalization disorder **B.** Obsessive compulsive disorder
C. Phobia **D.** Conversion disorder

55. *False* regarding conversion reaction is:

A. Symbolic relationship with stress **B.** Patient does not consciously produce sign, symptom
C. Onset is late **D.** Secondary gain

In **conversion disorder** there is unconscious *conversion* of a psychological conflict into a loss of physical function *suggesting* a neurological or other disease. The symptom is *temporary* and related to a psychological *stressor*. An additional psychiatric diagnosis such as adjustment disorder, schizophrenia or personality disorder can be made in 50% of patients. Conversion disorders are also seen in patients with *real* physical diseases. **'La belle indifférence'** in which the patient shows *little* concern for the symptoms is sometimes present. However, 'La belle indifférence' alone is not a reliable sign of conversion because a patient with a physical illness may be unmoved about his condition. **Modeling,** in which the patient unconsciously imitates the symptoms observed in *important* individuals in their life is common. Although most of the times it is a *transient* disorder sometimes it can have a chronic course resulting in significant disability. The symptoms are *inconsistent* with known diseases and patient classically presents with **an acute loss of function** suggesting a neurological disease. The symptoms are bizarre but the common symptoms are given below:

- Anesthesias and paresthesias
- "Paralysis"
- Aphonia
- Fainting
- Gait disturbances
- Unconsciousness and "seizures"
- Vomiting
- Blindness and tunnel vision

Conversion disorder is more common in low socioeconomic classes and the *usual* age group is around adolescence *but* it can occur at any age. It commonly occurs in girls although boys are sometimes also affected. It is purely a psychological disorder and two mechanisms have been described to explain the **"gains"** experienced by the patients. The **primary gain** is that the internal conflict is kept from consciousness and the **secondary gain** is reinforcement from the environment (*avoiding unpleasant duties due to "symptoms"*). Other "advantage" is that the less powerful individual (patient) gains "control" over her environment by the *display* of "symptoms". The symptoms are **learned** and then **reinforced** by the **reaction of the caretakers and parents.** A good prognosis is associated with an acute onset after an *obvious* stressful precipitant and good pre morbid functioning.

Treatment: The stressful events in the patient's life should be *evaluated* followed by appropriate *intervention* (psychotherapy or family therapy). Any associated psychiatric illness (such as depression), *if present*, should be treated by drugs or psychotherapy. Telling the patient that the symptoms are psychological is *not* helpful. *Some* patients understand the symbolic aspect of the symptom and gain conscious mastery of the conflict but *most* of them are receptive to the explanation that *the disorder is a reaction to stress* and the reassurance that *the condition will resolve over time*. These interventions allow the patient to let go off symptoms without losing face.

56. Déjà vu is seen in:
- **A.** Temporal lobe epilepsy
- **B.** Normal person
- **C.** Psychosis
- **D.** All of the above *(KERALA 1994)*

57. Unfamiliarity of familiar things is seen in:
- **A.** Déjà vu
- **B.** Jamais vu
- **C.** Déjà entendu
- **D.** Déjà pence *(KERALA 1999, JIPMER 2002)*

- **Déjà vu feelings are defined as those in which unfamiliar situations feel 'strangely' familiar.** It may occur as a normal phenomenon and is also associated with several forms of epilepsy and schizophrenia.
- **Jamais vu** are those feelings in which the familiar situations are perceived unfamiliar. Apart from schizophrenia it also occurs in epilepsy.
- **Déjà entendu** is the illusion that what one is hearing was heard previously.

58. Methadone is indicated in:
- **A.** Opioid overdose
- **B.** Opioid dependence
- **C.** Opioid withdrawal
- **D.** Alcohol withdrawal *(UP 1999)*

59. *False* regarding opiate withdrawal syndrome:
- **A.** Characterized by body pain
- **B.** Characterized by dilatation of pupils
- **C.** Treated with naltrexone
- **D.** Treated with methadone *(SGPGI 1999)*

Detoxification is the **mode of treatment of opioid withdrawal** in which the addicted person is *taken off* opioids by abrupt withdrawal and use of **substitution drugs** like **methadone.**

60. *True* regarding confabulation is:
- **A.** Making stories to fill up gaps in memory loss
- **B.** Perception in the absence of stimuli
- **C.** Misinterpretation of stimulus
- **D.** Conversion with imaginary person *(AI 1991)*

61. Confabulation is a defect of:
- **A.** Concentration
- **B.** Attention
- **C.** Intelligence
- **D.** Memory

Confabulation is a behavioral reaction to **memory loss** in which the patient fills in memory "gaps" with inappropriate words.

62. All are the features of Korsakoff psychosis *except*:
- **A.** Confabulation of memory
- **B.** Loss of immediate memory
- **C.** Loss of recent memory
- **D.** Normal sensorium

63. In Korsakoff psychosis, the site of lesion is:
- **A.** Cingulate gyrus
- **B.** Corpus striatum
- **C.** Mammillary bodies
- **D.** Frontal lobe

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