Comments on: Microvascular and macrovascular complications in diabetes mellitus: Distinct or continuum?

Sir,

We read with great interest the article by Chawla et al. titled “Microvascular and macrovascular complications in diabetes mellitus: Distinct or continuum?”[1] We applaud the efforts of the authors in describing the challenges in detail. However, we would like to make important additions.

Other microvascular and macrovascular involvements are in the form of anterior ischemic optic neuropathy, diabetic papillopathy, and ocular movement disorders due to third, fourth, or sixth cranial nerve involvement, ocular ischemic syndrome, retinal vein occlusion, retinal arteriolar emboli, and retinal artery occlusion.[2] Glaucoma and glaucomatous optic neuropathy, dry eye, and diabetic keratopathy are other prominent findings due to vascular and neural involvement.[3]

Regrettably, most of the health institutes tend to focus only on the retinopathy part in an eye examination. Adequate knowledge needs to be shared on other aspects of ocular involvement.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Anubhav Chauhan, Shashi Datt Sharma

Department of Ophthalmology, Dr. Yashwant Singh Parmar Government Medical College and Hospital, Nahan, District Sirmaur, Himachal Pradesh, India

Corresponding Author: Dr. Anubhav Chauhan, Pine Castle, Near Mist Chamber, Khalini, Shimla - 171 002, Himachal Pradesh, India. E-mail: chauhan.anubhav2@gmail.com

References

1. Chawla A, Chawla R, Jaggi S. Microvascular and macrovascular complications in diabetes mellitus: Distinct or continuum? Indian J Endocrinol Metab 2016;20:546-51.

2. Jeganathan VS, Wang JJ, Wong TY. Ocular associations of diabetes other than diabetic retinopathy. Diabetes Care 2008;31:1905-12.
How prevalent are depression and anxiety symptoms in hypothyroidism?

Sir,

I read with interest the study on the prevalence of anxiety and depressive symptoms in patients with hypothyroidism by Bathla et al. [1] in the July–August issue of 2016. The study design was cross-sectional and observational. The authors have administered 17-item Hamilton depression rating scale (HAM-D) and 14-item Hamilton anxiety rating scale (HAM-A) on 100 patients aged between 18 and 45 years, diagnosed with hypothyroidism, and found depressive and anxiety symptoms in 60% and 63%, respectively. However, I would like to draw attention to some of the shortcomings in their study. The study has excluded patients having depressive disorder and anxiety disorder before the diagnosis of hypothyroidism and those having below primary education, which actually underestimated the prevalence rates of depressive and anxiety symptoms.

The authors have examined gender differences in the presence of depressive and anxiety symptoms, i.e., HAM-D and HAM-A items, although it is not clear why only 11 out of 17 HAM-D and 11 out of 14 HAM-A items are reported. Furthermore, the authors have not controlled for multiple testing, which can be done using a method such as Bonferroni correction to reduce the family-wise error rate. After correction, some of the significant differences will become nonsignificant.

It is known that HAM-D and HAM-A are loaded with somatic items, which may also be a part of clinical features of hypothyroidism. Therefore, in the presence of medical condition, an "exclusion approach" is preferred, in which the symptoms that are common to both medical and psychiatric disorder are not included. Therefore, the Hospital Anxiety and Depression Scale (HADS), which has been designed to measure both anxiety and depressive symptoms, excluding somatic symptoms, in patients with medical disorders would have been more appropriate for this study.

Furthermore, the conclusions and recommendations by the authors are not based on the study findings. For example, it is suggested that hypothyroid patients not showing adequate response with treatment should be screened for depression and anxiety symptoms, which was not explicitly examined in their study. Similarly, the suggestion that patients with depression and anxiety, when do not respond to medications need to be screened for thyroid status, is nowhere related to their study. Nevertheless, both of the statements are correct and standard practice at most centers.

The study is also limited by lack of controls, i.e., euthyroid individuals could have been screened for depressive and anxiety symptoms. Furthermore, the details of diagnosis of hypothyroid patients could have been provided, for example, thyroid-stimulating hormone levels, etiology of hypothyroidism. Also, no details of psychiatric diagnosis were provided, for example, type of anxiety disorder. In addition, the authors could have examined the factors associated with depressive and anxiety symptoms in hypothyroid patients.

Financial support of sponsorship Nil.

Conflicts of interest There are no conflicts of interest.

Samir Kumar Praharaj
Department of Psychiatry, Kasturba Medical College, Manipal, Karnataka, India

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.