Comments on “Perspectives, attitude, and practice of lithium prescription among psychiatrists in India”

Sir,

An article titled “Perspectives, attitude, and practice of lithium prescription among psychiatrists in India” was published by Mandal et al.[1] It is a very interesting attempt by the authors. However, there are a few concerns that we would like to bring to the attention of this scientific forum.

The authors explicitly mention that lithium is the only U. S. Food and Drug Administration (FDA) approved treatment for the maintenance therapy of Bipolar Disorder.[2] This is scientifically misleading, as other psychotropics such as Aripiprazole, Lamotrigine, Olanzapine, Risperidone long-acting preparation (Risperdal Consta), Quetiapine, and Ziprasidone are also have been approved by the FDA specifically for maintenance therapy for Bipolar Disorder.[2,3]

The authors stated that “the majority of psychiatrists who completed the survey were of the opinion that lithium dose titrations should be done both in the acute phase and maintenance phase on a dose-dependent basis rather than the blood level-dependent basis.” One of the most important known evidence is that plasma lithium in humans does not always reflect the intracellular levels.[4] This could explain the possible scientific explanation as to why majority of psychiatrists in the survey opted for a dose-dependent titration rather than the blood level-dependent titration of Lithium to improve the symptoms.

Authors have looked to explore the barriers to lithium prescription such as adverse effects, monitoring, dose titration, experience, clinical comorbidities, the onset of action and adherence, however they missed some other important barriers like the nonavailability of medications and availability of laboratory services to monitor serum lithium and other biochemical parameters while the person is on lithium.

In the survey, authors have asked about the use of lithium over other molecules in both first episodes and multi-episode mania. The question was ambiguous as “other molecules” in the question was not explained clearly, i.e., other molecules can be interpreted as either other mood stabilizers like valproate or an antipsychotic. Furthermore, it was not clear whether the question was about lithium and other molecules being given in the acute phase or maintenance phase of mania and whether mania was associated with or without psychotic symptoms. Choosing a mood stabilizer in bipolar disorder is depends on multiple parameters like the clinical profile of patients and the patient’s choice. These were not discussed in the study. Hence, the study finding on psychiatrists with experience of >5 years preferred lithium over other molecules in both first episode and multiple-episode mania than those who had <5 years experience as psychiatrist has to be interpreted with consideration of above limitations.

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Conflicts of interest
There are no conflicts of interest.

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Sir,

The guest editorial, “Media matters in suicide – Indian guidelines on suicide reporting,” [1] made interesting reading. We are happy to note that the Press Council of India (PCI) is planning to initiate guidelines for suicide reporting. This is timely, given the known impact of media reporting on suicides. In this context, we draw the attention of readers to the position statement and guidelines on the subject issued by the Indian Psychiatric Society (IPS) and published in the Indian Journal of Psychiatry in 2014. [2]

This succinct guideline, not cited in the editorial, is the first and only national guideline on media reporting of suicide. Although the emphasis in this guideline is on print media, the recommendations can easily be extrapolated to visual and electronic media. The guideline illustrates the power of the media on suicides through both Werther and Papageno effects. With the burgeoning of technology, the widespread use of gadgets, the younger age at first gadget use, and the privacy with which the gadgets may be used, visual and electronic media may have to be targeted the most in the implementation of the guidelines. These media can particularly be of help for suicide prevention using the principles of the Papageno effect.

The guidelines by the PCI emphasize how suicide should not be reported. The IPS guidelines, in addition, give suggestions for positive reporting, such as utilizing the media to create public awareness of mental illness and to de-stigmatize suicide. The IPS guidelines also make explicit recommendations, such as not to publish suicide notes, which are often breached, perhaps to sensationalize news. The IPS guidelines may be more specific to the Indian context vis-a-vis the broad WHO guidelines based on which PCI formulated its guidelines. The IPS guidelines, therefore, complement and supplement the PCI guidelines. The joint efforts of the PCI and the IPS would, therefore, enhance the quality of media reporting of suicide.

It is also noteworthy that the Department of Psychiatry, Government Medical College, Thrissur, Kerala, had organized a workshop for journalists in collaboration with mental health professionals and had brought out a 15-item guideline for responsible media reporting of suicide in 2001. A study that was later conducted found that there were modest changes in the reporting style of the media with regard to suicides and attempted suicides, and the changes have persisted over the years. [3]

Although there are scattered efforts to create media awareness about suicide reporting under the aegis of the IPS, a consolidated nationwide approach is lacking. An active collaboration between media personnel (PCI) and psychiatrists (IPS) is urgently needed, as suggested in the editorial, to promote the responsible portrayal of suicide in media and to deter suicides, especially in young and vulnerable individuals.

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