Psychiatric Intervention in Amputees

Dear Editor,

This is the reference to the original article titled "Effect of short term psychiatric intervention in amputees" MJAFI 2004; 60:231-4 by Kashif et al [1]. It is heartening to note that medical cadets from Armed Forces Medical College are submitting original research. This should be encouraged.

I have the following comments/suggestions on this article:

1. The role of clinical-sub clinical psychiatric morbidity in recovery from musculoskeletal disabilities is receiving increasing attention from both researchers and clinicians alike. The authors have attempted to study psychiatric morbidity in the form of depression / anxiety. However they have missed out on Post Traumatic Stress Disorder (PTSD). Literature on psychiatric morbidity in trauma is reporting a high prevalence of PTSD in cases with chronic pain in musculoskeletal injuries [2]. In a study of patients with chronic musculoskeletal pain associated with work related injury, 34.7% had symptoms consistent with a diagnosis of PTSD [2]. This brings out a drawback in the study, that the prime cause that led to amputation has not been reported / analyzed. If the demographic data is any indication, a majority of the patients may have had amputation post trauma, and understanding the incidence of PTSD in such a group would have assumed significance.
2. The authors' state that instead of high incidence of anxiety as reported in literature, they found a much higher incidence of depression [1]. This may have to do with the stage at which the patient was evaluated. It is very likely that patients may exhibit much higher levels of anxiety in the initial stages, than after having reached a stage of clinical finality. Clinical implications of such a documented observation would be in the morbidity of treatment at the two stages of the individual's illness. May be they would benefit with anxiolytics in the

initial stage followed by antidepressants later?

3. The authors have brought out the demographic characteristics of the subject population. However, no comments have been offered on any correlation between these variables and the psychiatric morbidity. It would be interesting to know whether any of those, in particular marital status and education provided protection against psychiatric morbidity in such cases.
4. The authors have not provided any justification of using the MAST test. No comparison with any other similar assessment in literature is cited. What led them to believe that alcoholism may be a problem in such patients? Moreover, a detailed explanation of their findings would be in order, rather than just an assumption that it is simply being used as a medication for depression.
5. In my opinion, the findings of the study have much wider ramifications than considered by the authors. Psychiatric co-morbidity in musculoskeletal trauma should constitute an important research area in the Armed Forces Medical Services so that appropriate measures are adopted to minimize morbidity associated with severe musculoskeletal injuries, especially those that have major trauma as the underlying cause.

References

1. Kashif AW, Walia TS, Salujha SK, Chaudhury S, et al. Effect of short-term psychiatric intervention in amputees. MJAFI 2004;60:231-4.
2. Asmundson GJG, Norton RG, Allardings MD, Norton PJ, Larsen DK. Post-traumatic stress disorder and work-related injury. J Anxiety Disord 1998;12:57-69.

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Reply

We thank the authors for reading the article with keen interest, appreciating the work and sending expert suggestions.

Comments about their observations are as under:

1. The article was based on a short-term ICMR research studentship, among the first two ever completed by medical cadets in the Department of Psychiatry, Armed Forces Medical College. Since it was a time bound pilot study a simple design was preferred. It may interest the authors to know that it is only the second study in India (the first in Armed Forces which has a Artificial Limb Center functioning for over 50 years) in which psychiatric treatment of amputees was attempted. Despite a plethora of western studies showing high prevalence of PTSD in various populations, our own experience with patients with upper and lower limb fractures [1] as also troops in counter insurgency operation areas [2] showed a rather low prevalence. However we have an open mind and another department project is also looking into this aspect in amputees.

2. We agree with the authors' contention that anxiety may have been higher in the early stages. However, as we saw the patients later no comments about their status at an earlier stage can be offered.
3. In the present study probably due to small sample size no correlations with socio-demographic characteristics was observed.
4. Alcohol related problems are very common in Armed Forces not only in India but also all over the world and is probably one of the most under-diagnosed conditions in medical setting. In earlier studies we found high scores on MAST in patients with primary hypertension [3], duodenal ulcer [4], psoriasis [5] fractures of lower limbs in eastern command [6], lower and upper limb fractures in northern command [1] and troops in counterinsurgency operations [2]. This led us to use the MAST in amputees. We agree that this aspect requires further detailed inquiry.
5. We agree with the authors' opinion that psychiatric co-morbidity