Albuminuria in adolescents with type 1 diabetes
Here’s a trial that seeks to find out if giving an angiotensin converting enzyme inhibitor together with a statin might avert deterioration of renal function in adolescents with type 1 diabetes and high albumin excretion. The primary end point chosen was the albumin-to-creatinine ratio calculated from three early morning urine samples obtained every six months over two to four years. Does this make sense? I can’t say, because nothing in nephrology really makes sense to me. If I wanted to track a person’s renal function, I would measure their cystatin C, not an inaccurate number like the estimated glomerular filtration rate or the amount of protein in their urine. Or, if I really wanted to know what happened to a group of them in real terms, I would just have to wait a long time. Based on this study, there might be no difference between those given a statin and angiotensin converting enzyme inhibitor early on, and those left alone. At least, there was no difference in albuminuria.

Type 2 diabetes: there’s no hidden iceberg in US
“With an estimated 850 000 cases of undiagnosed type 2 diabetes in the UK, around one person in every 74 has an undiagnosed case of the condition. This means that most people will have a friend or family member who has the condition but does not know it.” Diabetes UK made this claim in 2012, though I can’t find it on their website today. The idea of a hidden iceberg of diabetes persists however. But an iceberg is 90% below water, whereas according to a new population study in the US, only 10% of type 2 diabetes is hidden in the ocean, even though American primary care is much more hit-and-miss than the UK’s. “When a confirmatory definition is used, undiagnosed diabetes is a relatively small fraction of the total diabetes population; most US adults with diabetes (about 90%) have received a diagnosis of the condition.”

Sad about sertraline
Chronic disease is often accompanied by low mood, and low mood is often labelled depression. Here is a trial of antidepressant medication in people who were classed as having chronic kidney disease stage 3-5. Their entry level of estimated glomerular filtration rate was below 45, meaning many were asymptomatic from their kidney dysfunction. But given sertraline at doses up to 200 mg over three months, quite a few became symptomatic. Sertraline was chosen because it is cleared by the liver, not the kidneys, and it caused acute liver dysfunction in one patient out of 97. As for the depression, the effect of sertraline was modest, and the same as placebo. And we are not told how many patients then found it difficult to come off sertraline. My advice again: don’t go there.

Deaths from systemic lupus erythematosus
Between 1968 and 2013, just over 100 million US citizens died, and just over 50 000 of those had “systemic lupus erythematosus” on their death certificates. So, systemic lupus erythematosus is a relatively rare cause of death if these figures are to be believed. However, while all-cause mortality showed a steady downward trend over this period, there was a rise in death related to systemic lupus erythematosus between 1975 and 1999, since when it has followed the overall decline in mortality. It would be interesting to get figures from other developed countries: they shouldn’t be hard to come by. Was there something that doctors were doing over those 24 years that was actually hastening death in systemic lupus erythematosus? High dose corticosteroids?
Early psychosis for the non-specialist

Musa Basseer Sami,1 2 David Shiers,3 Saqib Latif,4 Sagnik Bhattacharyya1 5

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This is an edited version; the full version is on bmj.com.

A general practitioner may support four to eight patients with psychotic disorder and see one new presentation each year.1 2 Other non-specialist doctors will encounter patients presenting to an emergency department or complicating comorbid illness.

Psychosis often emerges for the first time in adolescence and young adulthood.1 The first two to five years of psychosis are considered a critical period for intervening to improve long term outcome.5 7

What is psychosis?
The term psychosis embraces a constellation of symptoms characterised by hallucinations, delusions, or disorganised behaviour or thought (“positive symptoms”).8 Less obvious “negative” symptoms include decreased enjoyment and motivation, social withdrawal, and neurocognitive impairments. A distinction is made between (a) psychotic symptoms, which have a wide differential (see infographic, right), (b) a psychotic episode, where symptoms manifest for a week or more, and (c) psychotic disorders, which refer to patterns of episodes. The course of psychotic disorder is difficult to predict, particularly in the early stage. It may take months before, for example, a diagnosis of schizophrenia becomes certain (see box 1).

What are the risk factors?
Causes of psychotic disorders are multifactorial. Prevalent risk factors are outlined in the table (p 244). Genetic risk is evidenced from twin studies demonstrating 85% heritability.17 Cannabis use is associated with psychotic disorder, with greater risk in heavier users.16 Use of amphetamines, khat, phencyclidine, and ketamine19 are associated with psychosis. Alcohol is associated with delusional disorders.20

What is early intervention in psychosis?
Experiencing psychosis for the first time is hugely challenging for individuals and their families. They must adjust to the direct impacts of the disorder and its treatments alongside stigma and uncertainty for the future. Most psychosocial disability accrues in the early phase. Hence, the first two to five years of illness are considered to be a critical period for intervention to offset future disability.21 22 Avoiding treatment delay is preferred by patient and family and predicts better outcome.23

How to identify patients with emerging psychosis?
Presentation of psychosis can be subtle. Subthreshold psychotic-like experiences occur in around 5% of the population18 and may reflect a normal phenomenon. The generalist may identify and manage within primary care common mental disorders such as anxiety, depression, and acute intoxication. However in some cases a gathering intensity of difficulties could suggest an individual is entering a prodromal state and be at high risk of developing psychosis. In such cases it is important, even without clear evidence of psychosis, to have a low threshold for seeking specialist assessment. Mental health services consider diagnostic uncertainty appropriate grounds for offering assessment. Typical alerts include:

WHAT YOU NEED TO KNOW
- Psychosis can be frightening and bewildering for patients and families. Early intervention improves clinical outcomes, avoids hospital admissions, and is preferred by patients
- Have a low threshold for referral for specialist assessment if you suspect psychosis or prodromal illness
- People with psychosis face a mortality gap of 10–15 years, mainly from physical comorbidities. Identify and treat modifiable risks for cardiovascular disease and type 2 diabetes

"Where the Soft Winds Blow" by Bryan Charnley (1949-1991), who had schizophrenia

© THE ESTATE OF BRYAN CHARNLEY, REPRODUCED WITH PERMISSION
• Subtle subjective disturbances in thinking, perception, and mood
• Brief, self-limiting psychotic experiences for less than seven days
• Functional decline in individuals with family history of psychosis.

The key reflection for a GP considering specialist referral might be: “Would I be surprised if this turned out to be psychosis over the next six months?”

Referral to secondary care does not constitute a diagnosis. A meta-analysis of 33 follow-up studies (4227 participants) suggests that only a third of those receiving a specialist diagnosis of high risk for psychosis develop a frank disorder over the next three years. Guidelines from the European Psychiatry Association and National Institute for Health and Care Excellence (NICE) recommend psychological therapy (based on grade A evidence) but not antipsychotic medication for reducing or delaying transition to psychosis.

An approach to early psychosis

Comprehensive bio-psycho-social approach to treatment—Treatment is tailored around symptoms and effects on quality of life and function. For example, medication is not prescribed to treat the diagnosis but to reduce distressing psychotic symptoms or to prevent risk of relapse.

Care plans—Shared care models involving a collaborative approach between primary and secondary care, with a named person designated to coordinate care, are favoured by patients. The plan includes what to do in the event of a crisis or suspected relapse (see box 1, overleaf).

Specialist early intervention teams—A review of service provision across the UK showed that specialised Early Intervention in Psychosis teams are preferred by patients and their families and are cost effective. Benefits on symptoms and functioning have been shown up to three years after psychosis onset.

What treatments are available for psychosis?

Medication

Medication is effective in promoting remission and preventing relapse. Second generation antipsychotics (risperidone, olanzapine, quetiapine, aripiprazole)
Epidemiology of psychotic disorders

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point prevalence (active disease) (UK)*</td>
<td>4 per 1000</td>
</tr>
<tr>
<td>Incidence per year (UK)†</td>
<td>32 per 100,000</td>
</tr>
<tr>
<td>Lifetime prevalence‡</td>
<td>24-35 per 1000</td>
</tr>
<tr>
<td>Risk factors*</td>
<td>Odds or risk ratio (95% CI)</td>
</tr>
<tr>
<td>Parent with schizophrenia</td>
<td>RR 7.5 (6.0 to 14.1)</td>
</tr>
<tr>
<td>Black Caribbean ethnicity (UK)*</td>
<td>RR 5.4 (3.4 to 9.2)</td>
</tr>
<tr>
<td>Stressful life events‡</td>
<td>OR 3.2 (2.2 to 4.8)</td>
</tr>
<tr>
<td>Migration‡</td>
<td>RR 2.9 (2.5 to 3.4)</td>
</tr>
<tr>
<td>Childhood adversity‡</td>
<td>OR 2.8 (2.3 to 3.3)</td>
</tr>
<tr>
<td>Urban environment‡</td>
<td>OR 2.4 (2.0 to 2.8)</td>
</tr>
<tr>
<td>Cannabis use‡</td>
<td>OR 1.4 (1.2 to 1.7)</td>
</tr>
</tbody>
</table>

*Not all risk factors specified. All data for risk of psychosis (including affective and non-affective) unless specified otherwise.
†Data covers risk of schizophrenia only.
‡OR=odds ratio. RR=risk ratio.

Educational therapy

NICE recommends patients with first episode psychosis be offered psychological therapy. Meta-analyses indicate that cognitive behavioural therapy for psychosis has a small to moderate effect in reducing psychotic symptoms and that family interventions significantly reduce relapse rates and improve functioning.

Social and occupational assistance

Suitable accommodation and the option of employment are important for recovery. A review of five studies showed that specialist vocational interventions such as “individual placement and support” are twice as effective as control interventions in ensuring employment and education.

What about the longer term?

Four in five patients respond to treatment in the first year. One in five patients will have no further psychotic episode within the next five years. Persisting psychotic symptoms, unresponsive to treatment at two years, have been reported in 16%. Thus some patients may experience ongoing illness with limited symptomatic or functional recovery and require rehabilitative support, such as help with activities of daily living and developing vocational skills.

What are the risks for patients with psychosis?

Early psychosis is a time of risk and vulnerability. Around one in five patients report self-harming before engaging in treatment for psychosis, and one in 10 self-harm in the early years of treatment. There is also some risk to others: a meta-analysis estimated that homicide occurs in 1 in 629 first-episode presentations. Individuals considered at particular risk of harming themselves or others (see our accompanying article) require urgent specialist assessment, often with hospital admission or crisis team input.

Psychosis, physical health, and primary care

Population registry studies in Sweden and Australia found that the life expectancy of patients with schizophrenia is reduced by 10-15 years. Disorders such as type 2 diabetes are two to three times more likely over a lifetime. Randomised controlled trials show most antipsychotic induced weight gain occurs early in the disorder, impaired glucose tolerance may be evident even before starting antipsychotic medication, while 59% of people presenting with first episode psychosis already smoke. The challenge for primary care is to work collaboratively with secondary care to identify and manage those patients at elevated risk for cardiovascular disease and diabetes from the onset of psychosis.

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Find the full version with references at http://dx.doi.org/10.1136/bmj.j4578

Individuals considered at particular risk of harming themselves or others require urgent specialist assessment

Relapse prevention plan

Document the following and make available in primary care, with patient and preferably with family or carers:

- Recognition of patient’s individualised early symptoms or markers of relapse (“relapse signature”)
- What to do when these early symptoms or markers appear
- Where to attend and who to call in a crisis
- Crisis team phone numbers and numbers for out of hours support
- What medication and strategies have worked in the past and what to consider in event of relapse
- Identification of triggers (such as substance misuse, stress) and plans to address these when well
- Consider whether other lifestyle issues may also increase risk (such as night shifts) and plans to address these.

HOW WERE PATIENTS INVOLVED IN THE CREATION OF THIS ARTICLE

MBS obtained feedback from a patient with psychosis and his mother on an initial draft. They advised on the approach to the doctor-patient consultation. The subjective experience of psychosis and the meaning of recovery has also been included online. The patient wishes to remain anonymous.

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How to approach psychotic symptoms

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Identification of psychotic symptoms in non-specialist settings is key to initiating timely pathways to care. First contact with healthcare for people with first episode psychosis is more usually through a physician than through emergency services. Prompt intervention is key to improving outcome. However, patients rarely present complaining of hallucinations or delusions. Concerns that something is not quite right may first be raised to the generalist by family members, friends, neighbours, and school teachers.

This article is aimed at generalists, primary care physicians, and hospital doctors, who play a critical role and who require a low threshold for referral for specialist assessment, sometimes before diagnosis is certain.

When to consider emerging psychosis

In very early stages, perceptual abnormalities and thought disorder may not be apparent, nor delusions well formed. Psychosis may be preceded by subtle changes in functioning and gathering intensity of distress. Features may include:

- Sleep disturbance
- Anxiety, irritability, or depressive features
- Social withdrawal
- Unexplained decline in academic or vocational performance
- Incoherent or unusual speech
- New or unusual preoccupation with mystical or religious themes
- Concerns with hacking through internet or smartphones

Hallmark features are increasing distress and decline in functioning.

How to approach psychotic symptoms:

Symptoms of anxiety or depression may precede psychosis and should not be assumed as the definitive diagnosis without prompting further exploration for psychotic symptoms. Positive symptoms may not be volunteered. Be prepared actively to seek out symptoms (see box 1). Sometimes these may only be inferred from behaviour.

Be wary of dismissing unclear presentations as teenage angst or drug misuse. In the midst of diagnostic uncertainty, primary care providers can build rapport through repeat consultations.

Key features to elicit

- Seek evidence of positive symptoms:
  - Hallucinations—Identify modality (commonly auditory) and content. Which features differentiate the hallucination from reality (for example, do others share the experience; are the voices attributed to people living at a distance)? Sometimes hallucinations may be suspected by observing the patient in conversation or gesturing or responding emotionally. Ask the patient what they are experiencing.

WHAT YOU NEED TO KNOW

- Frank psychotic symptoms (positive or negative) may not be apparent initially—be alert to sub-threshold symptoms such as problems with mood or sleep; alteration in personality, and functional decline
- Take family concerns seriously and actively seek from them relevant information (or from school or university, as appropriate)
- Accompaniment by family or carers at appointments can be particularly helpful, but ask your patient whether they also want to be seen alone
– **Delusions**—Ask the patient about their belief and the basis for it. Is it shared by others or in keeping with cultural and religious norms? Does the patient consider alternative explanations? Are there paranoid, grandiose, or bizarre qualities? Does the patient believe that their thinking or actions are controlled by someone else (passivity)?

– **Thought disturbance**—Does conversation with the patient maintain coherence? Does the patient jump from topic to topic (tangential) or veer off course gradually (circumstantial)?

• Seek evidence of negative symptoms:
  – **Alogia (poverty of speech)**—Consider whether the conversation flows and whether the patient elaborates on their answers
  – **Anhedonia (lack of pleasure in activities)**—“Have you lost interest in activities that you used to enjoy before?”
  – **Flattened affect (lack of spontaneity or reactivity of mood)**—Does the patient’s facial expressions and communication during the interview feel forced or stilted?
  – **Avolition (lack of drive)**—“How do you spend your time?”
  – **Social withdrawal**—“Have you found yourself turning down any opportunities to go out with your friends? Do you prefer to be with others or on your own?”

• Consider functional impairments affecting work, home, school, and relationships. Note the social network and history suggesting withdrawal from family and friends.

• **Risk factors:**
  – Ask about family history of mental illness
  – Have adverse experiences occurred in earlier life?
  – Ask about use of alcohol, nicotine, and other drugs. In particular ask about cannabis, given its association with psychosis onset and poor outcome.
  – Are there current stresses?
  – Consider whether pregnancy or recent delivery is contributory (“post-partum psychosis”—for a review, see Florio et al)
  – Is sleeplessness contributing?
  – A medication history is important—for example, corticosteroids can precipitate psychosis.

• Assessing insight is important. Good insight mediates engagement with treatment and self management, whereas poor insight increases risk of relapse.

**Risk assessment**

• **Risk to self**—Around 5% of patients with schizophrenia die from suicide. Greatest risk is around initial presentation and shortly after discharge from hospital. Ask about suicidal ideation, previous attempts and plans, and self harm. Consider accidental and non-accidental injury. Inquiring about self harm or suicidal ideation does not increase the likelihood of self harm.

• **Risk to others**—Be particularly concerned if the patient voices delusional ideation regarding others. Ask about confrontation with others and forensic history. If needed, act promptly to ensure the safety of vulnerable individuals such as children or dependents, considering safeguarding arrangements as appropriate.

• **Command hallucinations**—The presence of command hallucinations should raise concerns.

**Be wary of dismissing unclear presentations as teenage angst or drug misuse**
Box 1 | Specific questions to elicit psychotic symptoms and history

Starting the conversation
- “It seems that there is quite a lot that is on your mind; I’d like to ask you a bit more about that and in particular about any worrying thoughts you might be having. Is that OK?”

Eliciting psychotic symptoms
- Have you been feeling that people are talking about you, watching you, or giving you a hard time for no reason?
- Have you been feeling, seeing, or hearing things that others cannot?
- Have you been spending more time alone?

Establishing context
- Have stressful or traumatic experiences affected you recently or in the past?
- Is there any history in yourself or your family of mental health concerns?
- Have you used any alcohol or other drugs recently?

Box 2 | Baseline investigations

Assessment for organic causes will be guided by the nature of the presentation and usually includes the following:

- Blood tests:
  - Full blood count
  - Urea and electrolytes
  - Liver and thyroid function tests
  - Urine sampling to rule out illicit drug use
  - If organic differential suspected or neurological features (such as focal neurology or seizures), test for HIV, syphilis (VDRL test), vitamin B₁₂, anti-NMDA receptor antibodies
- Consider neuroimaging (computed tomography of head or magnetic resonance imaging) particularly if neurological features (somnolence, seizures, recent head trauma) or abnormalities on neurological exam are present
- Baseline assessments before starting antipsychotic medication:
  - Body weight and body mass index
  - Waist size
  - Serum cholesterol concentration
  - Fasting plasma glucose concentration
- Offer a baseline electrocardiogram if the patient:
  - Has a history of cardiac risk
  - Is admitted to hospital
  - Starts certain medications (see Summaries of Product Characteristics of individual drugs*)

Box 3 | How to approach the consultation—What patients and families tell us

- Adopt a non-judgmental approach through what is said and not said. Listen and understand the patient’s version of reality, however bizarre it may appear, in order to discover more about what is going on in their world
- Ask focused questions if psychosis is suspected and do not too readily dismiss symptoms as the results of depression, anxiety, or substance misuse
- Avoid arguing with the patient—for example, by saying, “Of course there aren’t devils under the bed.” It works better to say, “I understand that this is how it appears to you, but this is how it appears to me”
- Be true to the person as they were when well. Remember hostilility can be a symptom of the illness
- Avoid diagnostic labels at too early a stage; instead, focus the discussion around the patient’s symptoms and experiences
- Avoid using stigmatising language. For example, some patients prefer “a person who experiences schizophrenia” rather than “schizophrenic”

What is being commanded? Is the patient able to not act on the hallucination?
- Risk of self neglect—This includes nutritional risk (malnutrition, dehydration, Wernicke’s encephalopathy); poor personal hygiene (risk of infections, worsening of chronic medical conditions); and fire risks (does the patient smoke or live in a chaotic home environment?).

What if the patient does not attend?
Patients may not directly present, and your first clue may come from others, sensing something may be wrong while often struggling to convince their relative to seek help. If your patient does not attend appointments, consider undertaking a home visit.

It is good practice to obtain the patient’s consent when discussing the situation with carers. However, professional confidentiality is not broken by receiving information.

If your patient does agree, try to engage carers. In one large cohort study (n=549), the 10 year risk of unnatural death (including accidents and suicide) was decreased 90% in those with full family involvement at first contact.¹⁸

When to refer
Refer all cases of suspected psychotic disorder to specialist services.²⁻⁴ Frank psychotic symptoms accompanied by high levels of risk demand urgent action in conjunction with secondary care. Consider whether assessment by the crisis response team or hospital admission is required.

Tests and investigations
If possible undertake initial physical investigations (see box 2). However, no standard battery of baseline tests exists, nor any consensus on whether they should be undertaken in primary or secondary care.²¹

What to tell the patient and carers
Involve patients and seek their views (box 3). Adopt a positive approach. Explain your thinking and acknowledge if their view differs. When referring a patient, explain its purpose and who they are likely to see and when.

We thank James Chamley for permission to reproduce the artwork.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare the following: DS is an expert adviser for the NICE Centre for Guidelines. The views presented in this article are those of the authors and not those of NICE. There are no other competing interests.

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Find the full version with references at http://dx.doi.org/10.1136/bmj.j4752

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MBS obtained feedback from a patient with psychosis and his mother on an initial draft. They advised on the approach to the doctor-patient consultation. The subjective experience of psychosis and the meaning of recovery has also been included in the online version. The patient wishes to remain anonymous.
Maternal mental health: Handle with care
A mother describes how opportunities were missed to identify her postpartum psychosis

Have you tried getting out more?” the health visitor asked. I explained that stairs had been impossible since my emergency caesarean section a month ago. “I manage, and I have osteoarthritis,” she replied. “You really should try.” It felt like a slap. The lack of empathy for my physical pain meant I felt unable to share my more serious worries, such as my suspicion that my baby daughter had been swapped at birth. That was the first missed opportunity to identify my postpartum psychosis.

What if she thinks I’m crazy?
The next came two weeks later. My mother and husband became concerned by my anxious pacing and rapid speech, which I now know are common symptoms of postpartum psychosis, and made an appointment for me with a GP. Leaving the house had become terrifying, and the thought of letting someone in a position of power into my head was horrifying. What if she thinks I’m crazy? What if she takes my baby? I sat down fearfully in the consulting room and burst into tears. Another clue. The GP at first listened empathetically. I shared my thoughts in stages, holding back those I felt were most shameful or disturbing. Unfortunately, I didn’t get far. When I mentioned that I’d found my health visitor unhelpful she immediately started explaining the merits of the multidisciplinary team. This created two sides, the clinical team versus me.

What if she takes my baby?
She said my unwillingness to engage with the health visitor was a “red flag.” With that single phrase my fragile engagement was shattered. I had been scouring her syllables for the faintest hint that she would take my baby, and assumed the term meant I was an unfit mother. I panicked, shut down, and exited the consultation. I went home and spent the next few days sobbing.

Missed opportunity
The GP had noticed the consultation had gone wrong, and sent me a letter later saying that she’d noticed I’d cancelled our next appointment. With my condition rapidly spiralling, it was too late.

I needed the change in my demeanour to have been dealt with at the time. It would have been helpful to hear, “you seem upset, have I said something that’s worried you?”
I wish she’d told me that I could get help without losing my child.
I endured five months of untreated, worsening mental illness. Much of this time remains a blur, but at some point a different health visitor arrived to find me unwell, speaking rapidly, and unable to stop pacing. She reported back to the GP, who quickly arranged for me to be voluntarily admitted to a wonderful mother and baby unit.

When I arrived I was very sick; terrified first that my baby was going to be replaced by a robot, then that we were going to be torn apart by hyenas hiding behind the nurses’ station.

Over six weeks, a remarkable team of nurses and an empathetic psychiatrist saved me. Medication, loving support, and charting my recovery, with photographs and by keeping a journal, all helped. I only wish I could have had help earlier.

Competing interests: The author has declared a competing interest, which is held by the journal.
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A 20 year old man presented to the emergency department with palpitations lasting half an hour. He was also feeling dizzy and felt close to fainting. He denied any chest pain. He had no known cardiac history. Examination revealed blood pressure of 70/50 mm Hg. Oxygen saturation was 91% on air. There was no murmur on auscultation of the chest. The man underwent electrocardiography (ECG) (figure). What rhythm does the ECG show?

Submitted by Debjit Chatterjee
Patient consent obtained
Cite this as: BMJ 2017;359:j4846

SPOT DIAGNOSIS
A young man with palpitations and pre-syncope

A 28 year old man was brought to hospital after a road traffic incident. He described hearing a “pop” as his right knee impacted against the dashboard at the time of collision, and he subsequently experienced extreme pain. On examination in the emergency department, his knee was swollen and tender, and range of movement was severely limited. After initial management in the emergency department, he was admitted under the orthopaedic team. Once the swelling was resolved, his knee was re-examined, and was found to be grossly unstable (fig 1).

1 What sign is shown in the clinical photograph?
2 How would you manage this patient in the emergency department?
3 What is the longer term management for this injury?
Submitted by Fidel Peat, Michael Barrett, and Stephen M McDonnell
Patient consent obtained.
Cite this as: BMJ 2017;359:j4693

CASE REVIEW
An unstable knee

A 28 year old man was brought to hospital after a road traffic incident. He described hearing a “pop” as his right knee impacted against the dashboard at the time of collision, and he subsequently experienced extreme pain. On examination in the emergency department, his knee was swollen and tender, and range of movement was severely limited. After initial management in the emergency department, he was admitted under the orthopaedic team. Once the swelling was resolved, his knee was re-examined, and was found to be grossly unstable (fig 1).

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Submitted by Fidel Peat, Michael Barrett, and Stephen M McDonnell
Patient consent obtained.
Cite this as: BMJ 2017;359:j4693
Prayer sign due to diabetic cheiroarthropathy

A 52 year old man with type 2 diabetes for 15 years developed stiffness and limited joint movements in both hands (right). He had background diabetic retinopathy. His recent glycosylated haemoglobin was 92 mmol/mol (10.6%). Examination revealed limited movements in both flexion and extension of proximal interphalangeal, and metacarpophalangeal joints of both hands. There was no clinical evidence of Dupuytren’s contracture. The skin was waxy and tight over the joints. Diabetic cheiroarthropathy was diagnosed, following a positive prayer sign. The prevalence of diabetic cheiroarthropathy is around 30% in the diabetic population. The condition has been associated with microvascular complications. Treatment includes tight glycaemic control with stretching exercises.

Katie Yoganathan (Katie.Yoganathan@nhs.net), CT2, Alexander Stevenson, FY2, Marcus Martineau, consultant, West Middlesex University Hospital, UK

Patient consent obtained.

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Inkblots

Hermann Rorschach created his famous test in 1921 and it’s still widely used in some parts of the world. Responses to the 10 inkblots are supposed to provide information about cognition and personality. It’s not what you see that matters most, but the way in which you see it. For example, subjects who see images in motion are judged to be creative, while those who focus on details are considered pedantic and unimaginative. Psychologists still argue about whether the test is valid or reliable (https://www.lrb.co.uk/v39/n21/deborah-friedell/bat-or-tiny-king).

Benefits of bariatric surgery

Bariatric surgery is an effective intervention for obese people, but whether weight loss translates into useful benefits for future health is another matter. Follow-up of more than 3000 patients who received a Roux-en-Y gastric bypass found that all-cause mortality was reduced, compared with non-surgical controls matched by age, body mass index, and sex, but only for people with existing diabetes at the time of surgery (Diabetes Care doi:10.2337/dc17-0519). In this group, there were substantially fewer deaths from cardiovascular and respiratory disease, and from diabetes itself.

Gender similarities

Men are supposed to be reluctant users of health services, avoiding contact with doctors whenever possible. Women, on the other hand, are believed to seek medical help more readily, and for less serious complaints. A qualitative study of men and women in Scotland challenges these stereotypes, finding that men’s and women’s accounts of how they reacted to symptoms that later led to a diagnosis of cancer were strikingly similar (Soc Sci Med doi:10.1016/j.socscimed.2017.09.015).

Mitrail regurgitation

When mitral regurgitation occurs in people without previous cardiac disease, it’s usually thought of as a degenerative condition. A large database study from the UK suggests that elevated blood pressure might have something to do with it (PLoS Med doi:10.1371/journal.pmed.1002404). Among 5.5 million patients, nearly 29 000 diagnoses of mitral regurgitation were made during a 10 year observation period. Each 20 mmHg increment in systolic blood pressure was associated with a 26% higher risk of mitral regurgitation. Similar relations were found for diastolic and pulse pressures.

Marrow fat

Although Minerva knew that trabecular bone was filled with marrow fat, she had never thought to ask what its function was. According to an article in Rheumatology, it provides a mechanism to distribute the high loads that occur in the subchondral bone of weight bearing joints (Rheumatology doi:10.1093/rheumatology/kex274). This hypothesis might explain the discrepancy between in vitro testing, which shows that subchondral bone begins to fail at pressures of 2MPa, and in vivo measurements, where loads as high as 18 MPa are recorded during everyday activities such as descending a staircase.

Migraine and stroke

Although numerous studies have linked migraine to a raised risk of stroke, an investigation in twins in Sweden suggests that any increase is small (Brain doi:10.1093/brain/awx223). Among more than 50 000 twins there was no overall association between migraine and stroke. In the subgroup of people who had migraine with aura there was a 27% increased stroke risk, but the risk diminished after adjustment for gender, smoking, obesity, hypertension, and other cardiovascular risk factors. A within-pair analysis found no statistically significant association between migraine with aura and stroke.

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