Practice Guidelines

For Family Physicians

Volume 5

Message from His Excellency

Prof. Dr. Hatem El Gabaly

Comprehensive development and modernization is one of Egypt's priorities and pursued objectives. Out of this rule, we are committed towards improving the quality of health care services available for all Egyptians; adults, children, the poor and the well-off.

The Ministry of Health and Population has adopted, as a top priority, developing current systems to provide and finance health services in guidance and vision of the political leadership to ensure high quality in service provision and meet needs and expectations of the population as well as keeping up with top-notch developments at all levels - primary, preventive, curative, diagnostic and rehabilitation.

This vision has been translated into a promising and ambitious Five Years Plan to institutionalize the Health Sector Reform Program on the national level. The plan is focusing on implementing the Family Health Model at all primary health care facilities in the 27 Governorates.

Our dream has been realized into a competent program of Health Sector Reform aiming to provide every person with high quality health services. These include physical, psychological and social welfare, which translate into high production and progress for our cherished Country, Egypt.

I am delighted to introduce to one of the important publications for the Sector of Technical Support and Projects, representing a great team effort "**The Practice Guidelines for Family Physicians**" for the family physician at all Family Health Unites of MOHP Distributed all over the Country .

Prof. Dr. Hatem El Gabaly

Minister of Health and Population

Preface

The Ministry of Health and population is working diligently to achieve equal and available quality health services for all citizens of Egypt. Our objective is to shape national policies for the goal of advancing health care delivery in all parts of the country.

Six years ago, the Ministry has adopted new policies and strategies in order to provide basic health services of high quality for all citizens in the framework of the Family Health Model. This has led to introducing new financing mechanisms that ensure the sustainability of finance and resources, and availability of affordable services along with effectiveness and efficiency of these services.

Having made situational analysis in details, highlighting points of weaknesses and strengths and defining actual needs, strategic plans were subsequently developed putting into practice the reforming infrastructure and human resources as well as partnerships between governmental, private and national sectors.

It gives me great pleasure to present this document. This system is in continuous reform, progressing incrementally, refining the knowledge base, and modifying concepts. This document is not the end product, but rather the first step of many others.

However, I hope it will help us towards our ultimate goal of a quality, effective, efficient, evidence based service to all Egyptians irrespective of geographical or social economic barriers.

The document is a collaborative work of the Ministry of Health and Population staff, and the Sector for Technical Support and Projects on both central and peripheral levels. Work in this document is subjected to continuous assessment, operation research, many of the issues presented in this document will be updated in further version.

Dr. Emam Mossa
Undersecretary of the Sector for Technical Support and Projects

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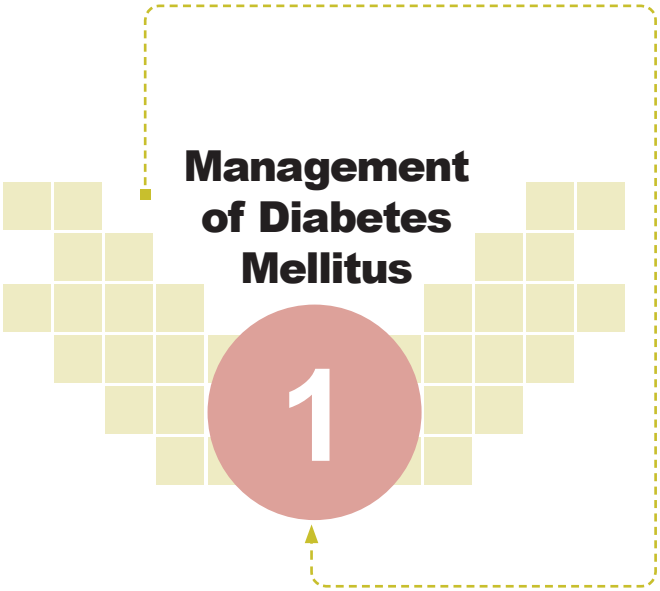
Abbreviations and Acronyms

ACEI	:Angiotensin Converting Enzyme Inhibitors
ARRBs	:Aldosteron Receptor Blockers
BB	:Beta Blockers
BMI	:Body Mass Index
BP	:Blood Pressure
CABG	:Coronary Artery Bypass Grafting
CCB	:Calcium Channels Blockers
CHD	:Coronary Heart Disease
COPD	:Chronic Obstructive Air Way Disease
CPR	:C- Reactive Protein
CVA	:Cerebro - Vascular Accidents
CVD	:Coronary Vascular Disease
DKA	:Diabetic Ketoacidosis
DM	:Diabetes Mellitus
ECG	:Electrocardiogram
FA	:Fatty Acid
FBG	:Fasting Plasma Glucose
FH	:Family History
HBA1c	:Hemoglobin A1c.
HDL	:High Density Lipoprotein
HHC	:Hyperglycemic Hyperosmolar Coma
HS	:Heart Sounds
HTN	:Hypertension
IFG	:Impaired Fasting Glucose
IGT	:Impaired Glucose Intolerance
ISH	:Isolated Systemic Hypertension
K	:Potassium
LDL	:Low Density Lipoprotein
LFT	:Liver Function Test
LVH	:Left Ventricular Hypertrophy
MI	:Myocardial Infarction
MCP	:Metacarpophalangeal
NPH	:Neutral Protein Hagedron
PCI	:Per- Cutaneous Coronary Intervention
PPG	:Prandial Plasma Glucose
PVD	:Peripheral Vascular Disease
TIA	:Transient Ischemic Attack
TOD	:Target Organ Damage
TSH	:Thyroid Stimulating Hormone


Management
of Diabetes
Mellitus
1

Management of Diabetes Mellitus

Diabetes Mellitus

- Normal and abnormal blood glucose level
- How to proceed with fasting blood sugar analysis
- Points to stress on:

1. medical history
2. clinical examination
3. investigations and diagnosis

- Prevention of diabetes:
  - o Primary prevention
  - o Metabolic syndrome
  - o Secondary prevention
  - o Tertiary
- Treatment of diabetes:
  - Type 1
  - Type 2
    - o Diet
    - o Exercise
    - o Oral hypoglycemic drugs
    - o Insulin
- Target for acceptable control
- Complications of diabetes:
  - Acute complications:
    1. Hypoglycemia
       - Etiology
       - Clinical picture
       - Therapy
       - Commonly available sources of glucose
    2. Ketoacidosis
    3. Hyperglycemic hyperosmolar coma
  - Foot care for people with diabetes
  - Follow up; at home at clinic
  - Referral
  - Diabetes with pregnancy
    - o Check list for preparing females for pregnancy
    - o Diagnosis of gestational diabetes
    - o Criteria for initiation of insulin therapy during pregnancy
    - o Diabetes mellitus in infant of a diabetic mother
    - o Diabetes mellitus & breast feeding
    - o Follow up
  - Health education

Table.1: Normal and Abnormal Blood Glucose Levels

	Normal	Glucose B	Diabetes
FPG	< 110 mg /dL	110-125 mg /dL(IFG)	> 126 mg /dL
PPPG	< 140 mg /dL	140-199 mg /dL(IGT)	> 200 mg /dL

IFG: impaired fasting glucose

IGT: impaired glucose tolerance

Diabetes Mellitus

It is a syndrome characterized by chronic hyperglycemia and relative insulin deficiency, resistance or both. Accompanied by long-term complications.

How to Proceed With Fasting Blood Sugar Analysis

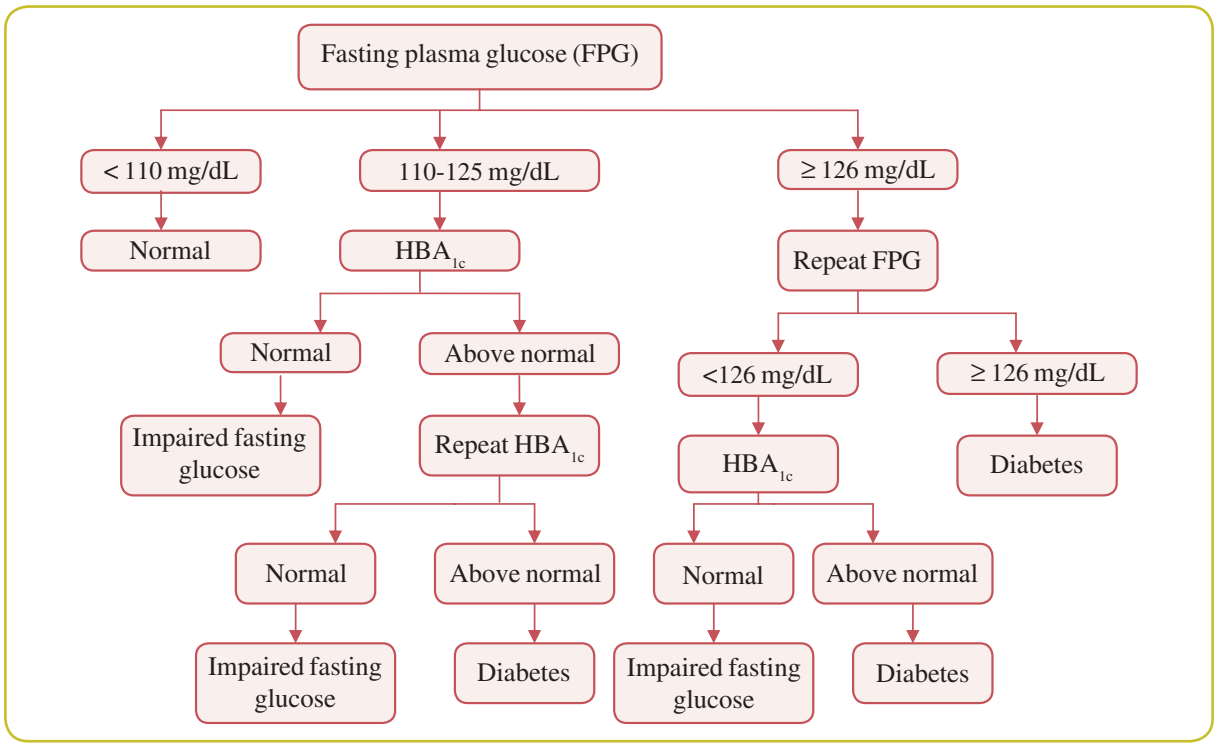


Figure "1": Flow Chart Diagram for How to Proceed With Fasting Blood Sugar Analysis

After Diagnosis of a Diabetic Patient: Points to Stress Upon in:

Medical History

Personal history
Age
Personal habits

Present history
Age at presentation
Onset at presentation
Symptoms of complications
Concomitant therapy

Family history
DM
Hypertension
Hyperlipidemia
Cardiovascular disease

Past history
BW at birth
Previous antidiabetic drugs

Clinical Examination

General
BMI
Waist circumference
BP
Peripheral pulsations
Edema
Feet examination

Cardiac
Murmurs

Abdominal
Organomegaly

Neurological
Sensations
Reflexes

Investigations at Diagnosis

Lab
F & PP bl.sugar
Urine analysis
Bl.lipids
Creatinine

Others
ECG
Fundus
Vascular Doppler

Prevention of Diabetes

Primary Prevention (Risk Factors for Type II DM)

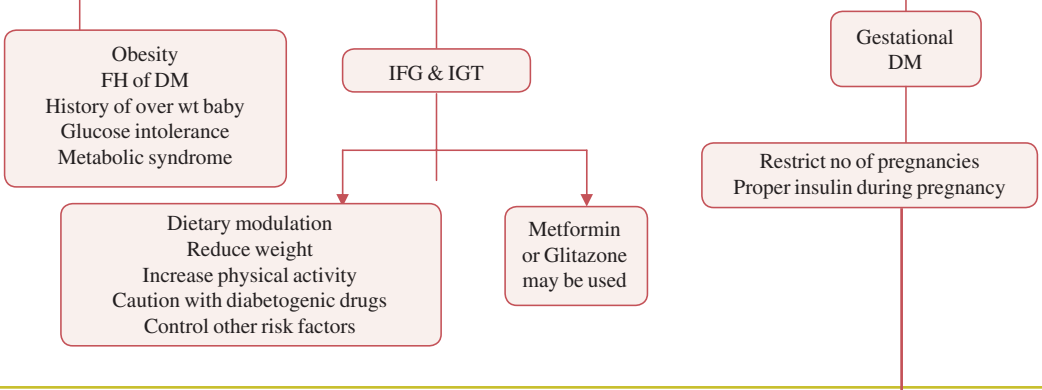


Figure "2": flow chart diagram for risk factors for type II DM

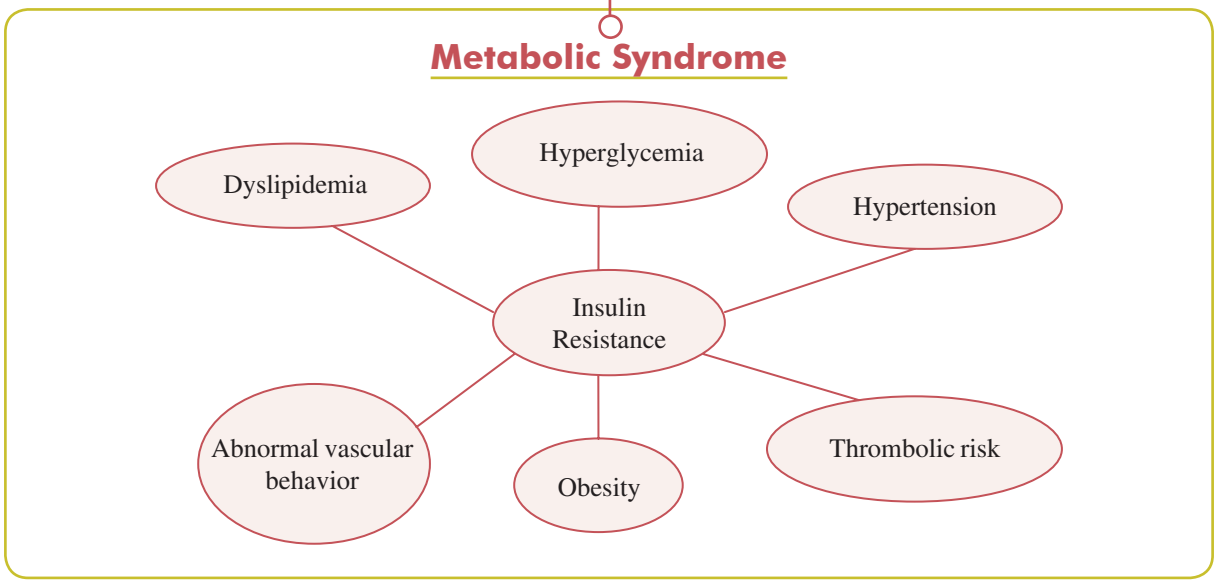


Figure "3": Flow Chart Diagram for Different Insulin Resistance Metabolic Syndrome

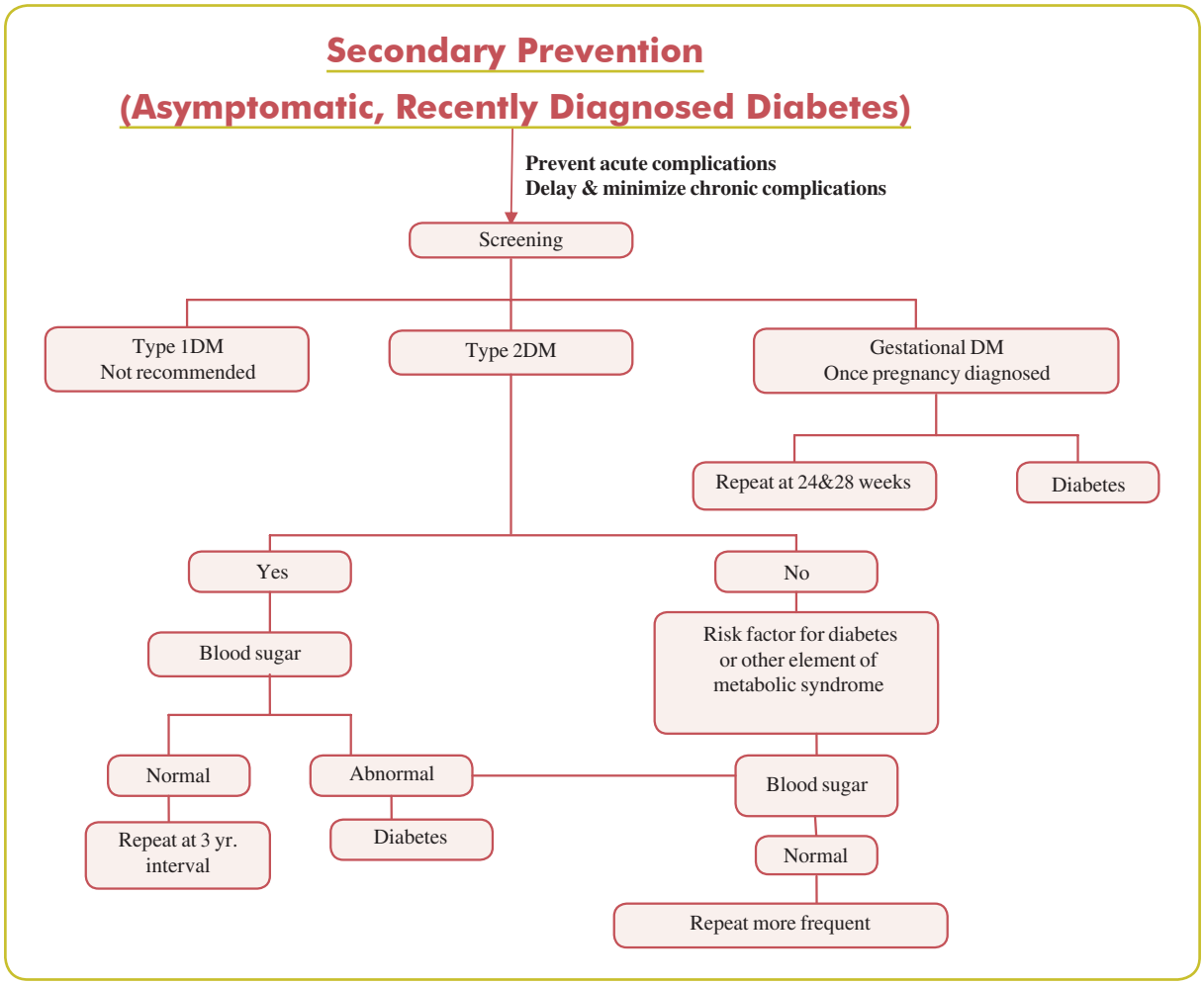


Figure "4": Flow Chart Diagram for Secondary Prevention for Asymptomatic, Recently Diagnosed Diabetes

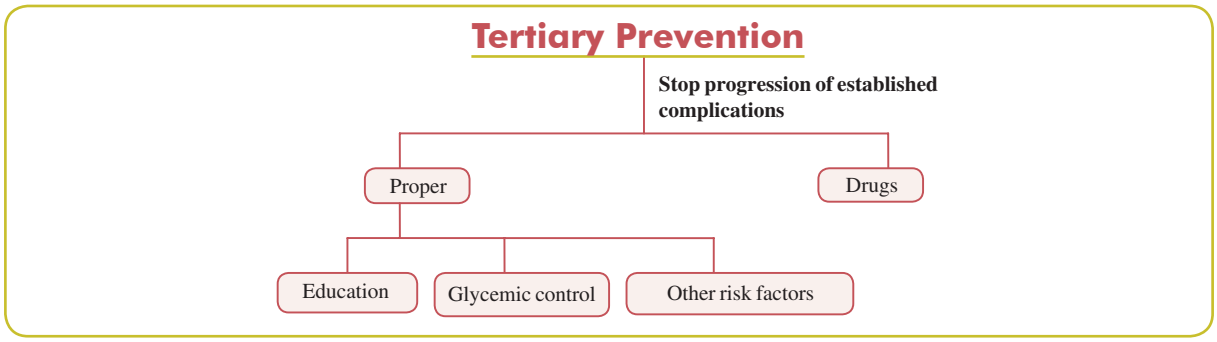


Figure "5": Flow Chart Diagram for Tertiary Prevention for DM

Treatment of Diabetes

Type 1:

Diet +Exercise +insulin + proper health education

Refer to start treatment.

Type II:

Mild or moderate (FPG< 300mg/dL):

Diet, Exercise & Proper education.

If failed start oral therapy.

Severe (FPG >300mg/dL):

Insulin for one month then shift to diet.

Exercise & oral therapy.

Elevated fasting blood sugar

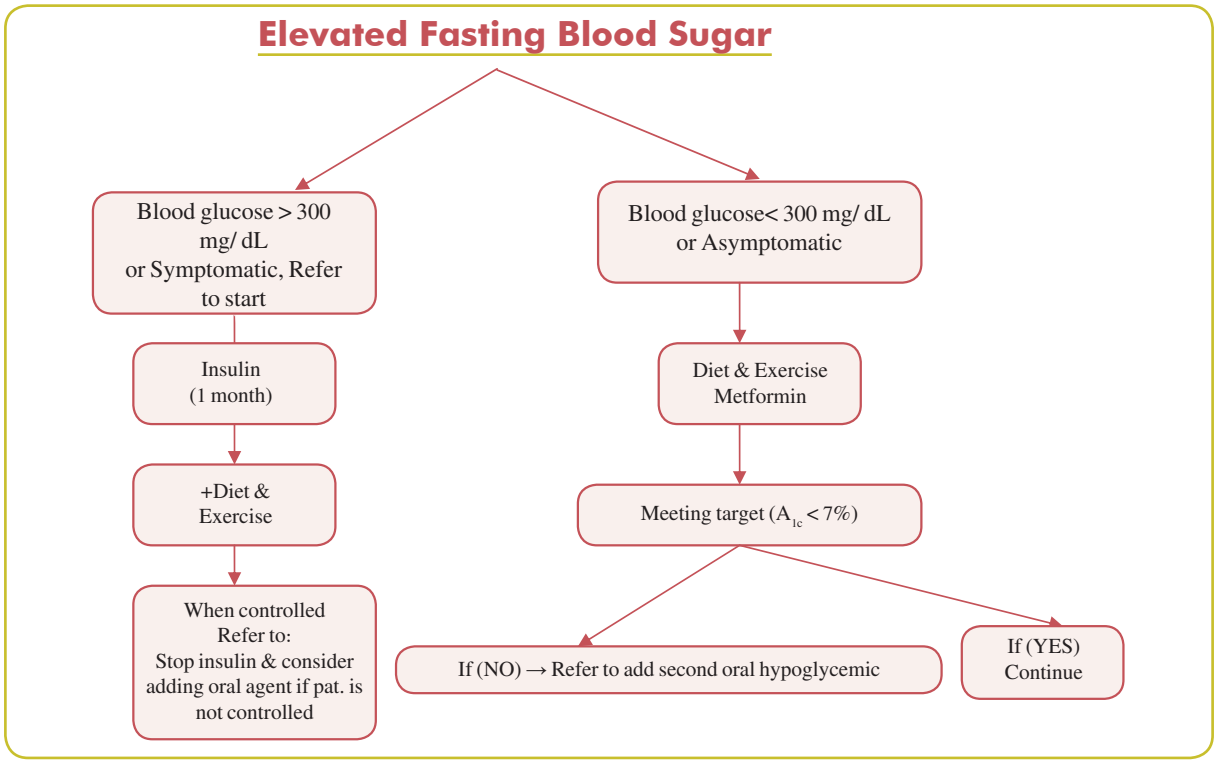
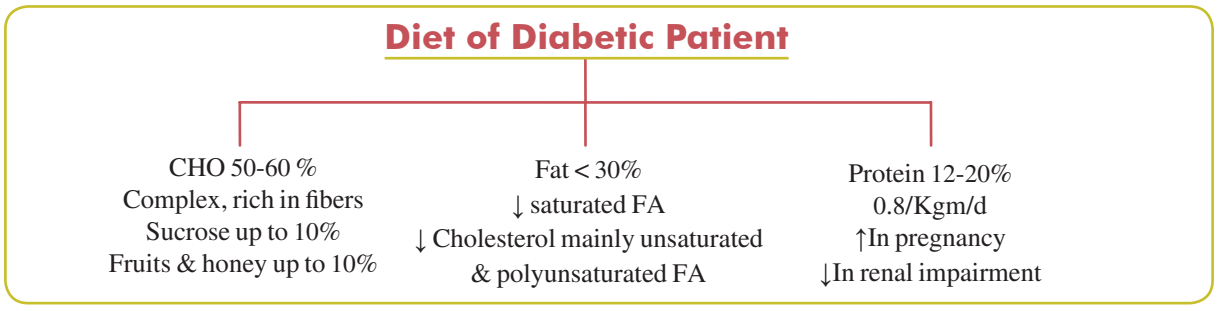


Figure "6": Flow Chart Diagram for Management of Elevated Fasting Blood Sugar

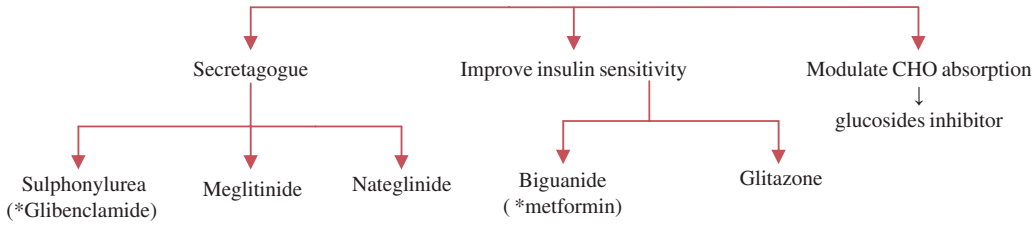


Exercise:

Points to be put in consideration before starting exercise:

- Careful cardiac, eye & feet examination.
- Gradual ↑in amount & intensity.
- 30-45 min most days of the week.
- Avoid insulin injection within one hour before exercise.

Oral Hypoglycemic Drugs



Essential drug list Cannot be used in:

- Type 1
- Liver damage
- Renal impairment
- Pregnancy
- Infection & surgery

Insulin

Indications:

1. Type I DM
2. Type II DM:
   - Secondary failure
   - During stress

Insulin in use can be kept at room temperature

Unopened insulin should be refrigerated

Syringes can be prefilled & stored in refrigerator for 3 weeks

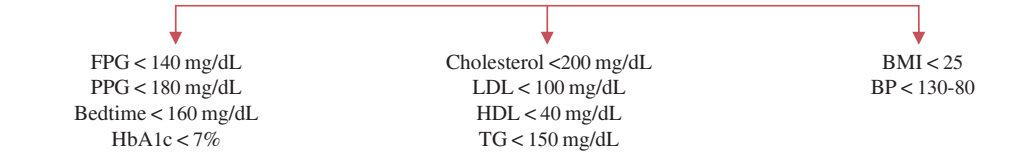
Clean needle after use & put in refrigerator

Table.2: Different Regimen of Insulin Intake for Diabetic Patients

Regimen	Before Breakfast	Before Lunch	Before Supper	Before Bedtime
A	NPH/short- or rapid-acting insulin*	_	NPH/ short-or rapid-acting insulin*	
B	NPH/short- or rapid-acting insulin*		Short-or rapid-acting insulin	NPH
C	Short-or rapid-acting insulin	Short-or rapid-acting insulin	Short-or rapid-acting insulin	Glargine
D	Daytime oral agent(s)			Glargine or NPH
E	Insulin pump therapy with rapid- acting insulin (usually, although short - acting insulin can also be used), using a basal rate(s) as well as premeal bolus of insulin.			

- Glargine should not be mixed with any other insulins.In some individuals it can be given before breakfast or split between breakfast and bedtime.
- Human insulin (Soluble, NPH, Zinc) 40 U / ml & 100 U/ml. are included in the family essential drug list (EDL).
- In type II DM, Insulin glargine can be given as basal insulin secretion + oral hypoglycemic drugs.

Target for Acceptable Control



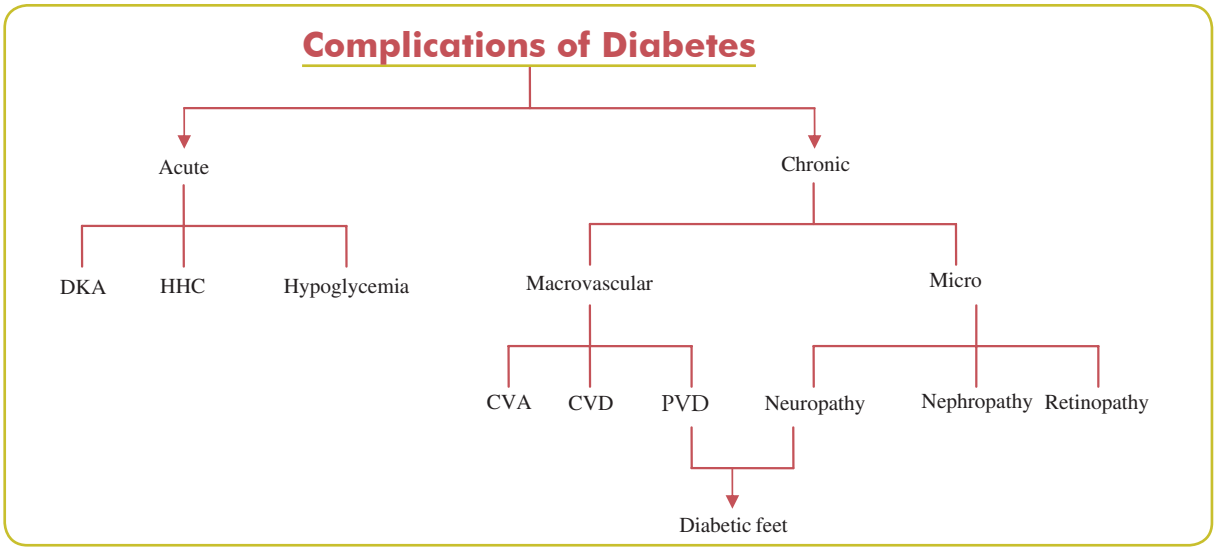


Figure "7": Flow Chart Diagram For complications of DM

Acute Complications

Hypoglycemia:

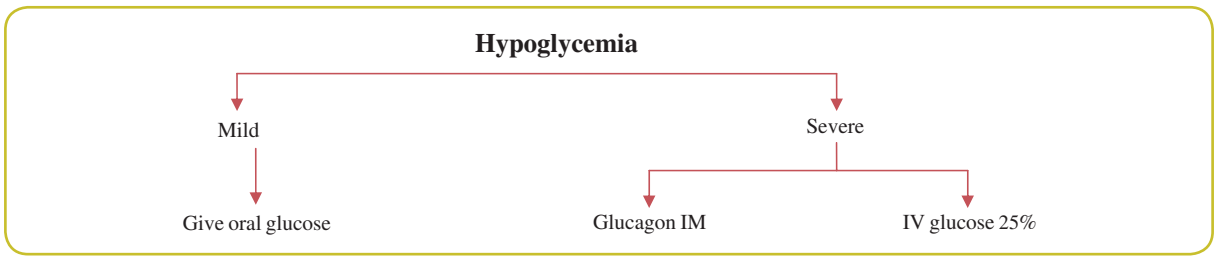
Etiology: (Predisposing factors)

a) In appropriate therapy
b) Kidney failure
c) Liver disease
d) Alcohol intake
e) Long acting oral hypoglycemic agent

Clinical picture:

Adrenergic	Cholinergic	Neuroglycopenic	Neuronal damage
Tremulousness Palpitations Anxiety Nervousness Hunger Pallor Flushing	Parasthesias Sweating	Headache Dizziness Confusion Amnesia Blurred vision Aggressiveness	Babinsky sign Transient hemiplegia Seizure

Therapy:



Commonly available sources of 10 g.of Glucose	
Orange juice Grape juice Table sugar Honey	1 cup ½ cup 4 tea spoons 3 teaspoons

1 cup =8 ounces (fluid)

1 tablespoon=3teaspoons

Ketoacidosis:

Precipitating events	Clinical manifestations	Laboratory signs
Infections Withdrawal of insulin therapy Type1 at onset Acute myocardial infarction Stroke Unknown causes	Thirst Polydipsia Nausea and vomiting Acetone in breath Dry skin Polyuria Asthenia Tachypnea and /or Kussmaul breathing Dehydration Hyporeflexia Tachycardia and hypotension Abdominal pain	↑Blood glucose rarely > 600 mg/dL Urine ketone : intense positive

Therapy:

0.9% Na Cl. IV+ regular insulin 0.4U/Kg, ½ as IV bolus&½ IM & refer to emergency unit.

Table.4: Hyperglycemic Hyperosmolar Coma, Etiology, Clinical Manifestations and Lab Signs

Etiology	Clinical manifestations	Laboratory signs
Onset of type 2 Diabetes Mellitus (Type2DM) Inappropriate treatment Type 2DM Infections Acute myocardial infarction Stroke Thrombophlebitis Drugs Exaggerated food intake Trauma	The majority of patients > 60 year old Signs and symptoms of intercurrent disease are often present The presence of a severe dehydration (10-12 liters) is the rule Elevated mortality (around 10-20%) Neurological alterations Fever	Blood glucose > 800 mg/dL No ketonuria (or mild)

Therapy:

Administer 0.9% Na Cl & regular insulin 0.15U/Kg, as IV bolus &refer to emergency unit.

Table.5: Foot Care for People with Diabetes

For the doctor	For the patient
1. Ulcer detersion 2. Microbiologic examination 3. Metabolic control 4. Antibiotics • Fluoroquinolone • Amoxicillin-clavulanic acid • Erythromycin/ Clarithromycin • Cefoxitin • Metronidazole(anaerobes) • Imipemen-cilastatin • Aminoglycosides 5. Decrease edema 6. No weight bearing 7. Improve circulation 8. Optimize nutritional intake 9. Hyperbaric oxygen therapy 10. Surgical correction • Peripheral bypass graft • Transluminal balloon angioplasty • Minor amputation • Major amputation	1. Do not smoke 2. Inspect feet daily 3. Wash feet daily and dry carefully 4. Avoid temperature extremes 5. Do not walk barefoot 6. Do not use adhesive tapes 7. Do not soak feet 8. For dry skin, use cream 9. Wear properly fitting stockings 10. Do not cut corns and calluses 11. Shoes should be comfortable 12. Cut nails straight across 13. Notify your physician of blisters or sores on foot

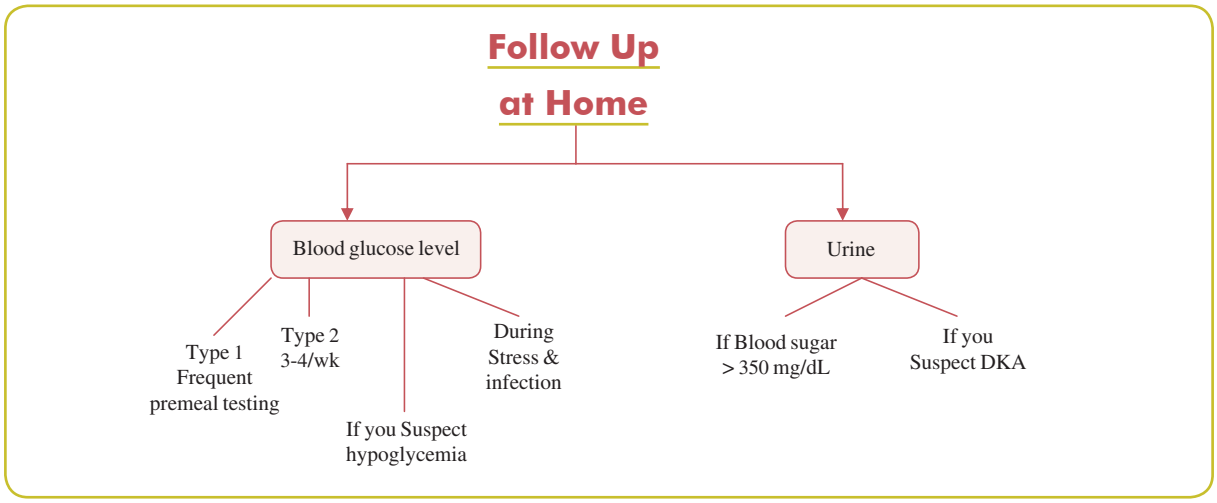


Figure "8": Flow Chart Diagram For follow up of Diabetic patient at home

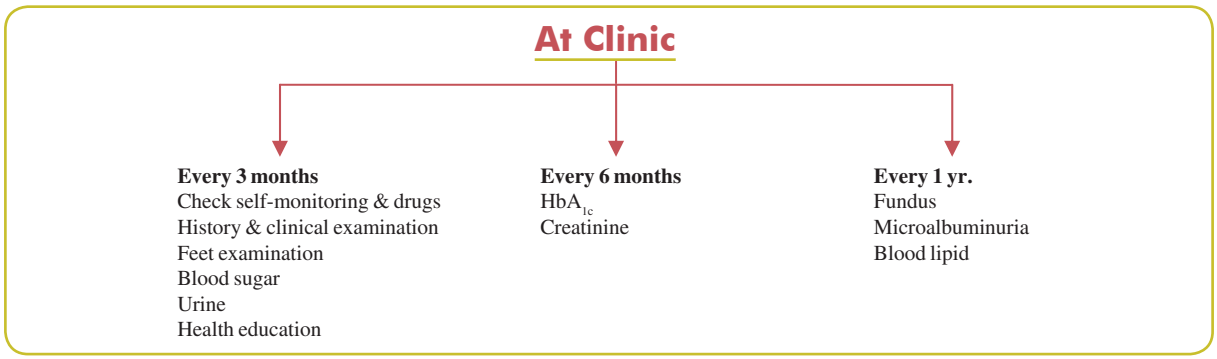


Figure "9": Flow Chart Diagram For follow up of Diabetic patient at Clinic

Referral:

- Type 1 diabetes.
- Seriously out of control
- Persistent morning hyperglycemia
- Switching from oral hypoglycemic drugs to insulin
- Foot ulcer
- Ketoacidosis or Hyperglycemic Hyperosmolar coma
- Presence of micro vascular complications:
  - o Neuropathy
  - o Nephropathy
  - o Retinopathy

Diabetes And Maternity

DM & Conception:

- DM does not cause any change in fertility.
- HbA_{1c} level should be in the normal level.
- Those on oral agents should shift to insulin.
- Patients with nephropathy and retinopathy can worsen.
- CHD causes increase in mortality during pregnancy
- ACE inhibitors, diuretics or beta-blockers in treatment of Hypertension should be changed.

Table. 6: Checklist for preparing for pregnancy

Type of Diabetes	Issue	Action
All	A1c	< 7%
Type1	Insulin	Glargine not approved in pregnancy; stabilize on the regimen that will be used in pregnancy
TypeII	Medication	Stop oral agents; switch to insulin
All	Monitoring	To monitor pre- and postprandial blood glucose values; lower targets as needed to bring A1c to <7%
All	Neural Tube Defects	Start folic acid replacement
All	Retinopathy	Dilated retinal examination prior to conception
All	Other medications	Stop or change in conjunction with health care team
All	Renal Function	Address implications if abnormal
All	Smoking , alcohol and illicit drug use	Counsel cessation

DM & Pregnancy:

- Keep blood glucose level 70-120 mg/dl
- Use intensified insulin treatment in both type 1 and type2
- Blood glucose monitoring is 5-7 times daily if possible
- HbA1c every 6-8 weeks
- Urine analysis every month.
- Fundus every 3 months, if proliferative retinopathy every month
- If microalbuminuria, creatinine clearance every 3 months.

Gestional Diabetes:

- Is usually diagnosed between 24th and 32nd week
- Insulin started for FG > 105 mg/dl and PP > 120 mg/dl.
- Blood glucose self-monitoring is necessary.

1. Medical History

The following are important data in the history that suggest the presence of diabetes mellitus:

History of Polyuria, Polydipsia or Polyphagia

2. Glucose Challenge Test

If the patient has symptoms suggestive of diabetes mellitus, order the following:

One-Hour Random Oral 50 gm Glucose Challenge Test

- The patient does not need to be fasting.
- Fifty (50) gm of glucose is dissolved in water and taken by the patient.
- The patient's blood glucose is measured after one hour.
- If the blood glucose is greater than 140 mg/dl, a three-hour oral glucose tolerance test should be performed to confirm the diagnosis of diabetes mellitus, and the patient should be referred.

Table. 7: Diagnosis of Gestational D.M using 3-Hour 100-Gm Oral Glucose Tolerance Test

Time of test	Serum glucose concentration (must exceed two or more values for diagnosis)
Fasting	> 95 mg/dL
One hour	> 180 mg/dL
Two hour	> 155 mg/ dL
Three hour	> 140 mg/ dL

American Diabetes Association Criteria Recommended for the initiation of insulin therapy in women with gestational diabetes

Fasting	1hr Postprandial	2hrPostprandial
> 95	> 140 mg/dL	> 120

Blood glucose Target levels during pregnancy in women with prepregnancy diabetes	
Time	**Target**
Fasting	60-90 mg/dL
1-hr postprandial	100-130 mg/dL
2-hr postprandial	90-120 mg/dL
Preprandial	60-105 mg/dL
02:00-06:00AM	70-120 mg/dL

During Delivary

- Maintain blood glucose 80-120 mg/dl
- At the beginning of labor use ½ insulin dose + 10% glucose infusions with short acting Insulin + monitor blood sugar every hour.
- After delivery SC insulin resumed
- CS birth: Infusion of glucose 5% and short acting insulin until patient starts eating.

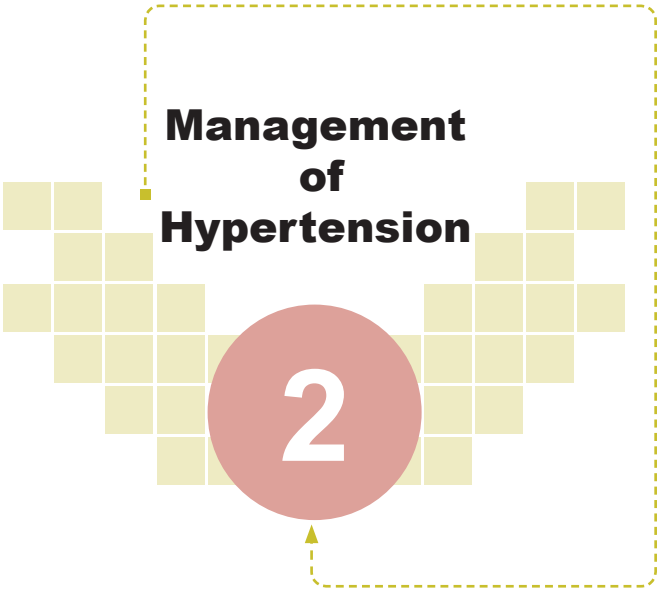
Diabetes and babies of diabetic mother:

Check babies blood sugar immediately for fear of hypoglycemia.

→ If decrease blood sugar → give glucose

DM& Breast feeding:

→ Reduce insulin dose


Management
of
Hypertension
2

Management of Hypertension

Hypertension

- Classifications according to BP level
- Diagnosis of hypertension if BP is elevated
- Causes of hypertension
- DD for the etiology of hypertension
- Points to stress in:* history: major risk factor

TOD

Symptoms suggesting 2ry

hypertension, co morbid condition

Clinical examination

Investigation in 1st. visit and annually

- **How to avoid common pitfalls in measuring BP?**

Cuff

Stethoscope

Preparing patients

Patient position

Standing BP

Right or Left

Procedure

Kortkov sounds

- Management of hypertensive patients.
- AB/CD Treatment hypertension patient
- Life style modification
- Antihypertensive drugs in essential drug list
- Preferred & Problematic drugs in special condition
- Preferred drugs in other conditions
- Management and hypertension
- Breast feeding
- Children feeding and hypertension
- Elderly and hypertension
- Black patients and hypertension
- Target in treatment hypertension
- Follow up after starting treatment for hypertension
- How to increase compliance to treatment of hypertension
- When to refer

Classification According of BP Level:

Normal <120/80

Prehypertension 120/80 - 139/89

Hypertension >140/90

Hypertension:

Stage 1: 140-159/90-99

Stage 2 :> 160/100

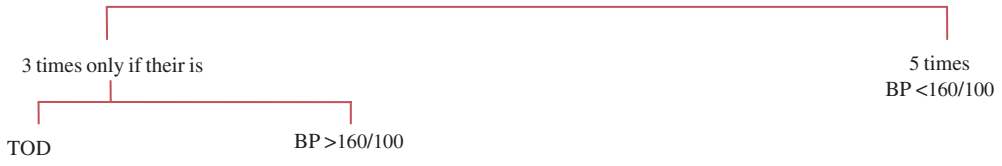
Isolated Systolic Hypertension:

Grade 1 140-145/ < 80

Grade 2 > 160/ < 80

Above 115/75 CVD risk doubles for each increment of 20/10 mmhg

Diagnosis of Hypertension if BP is Elevated



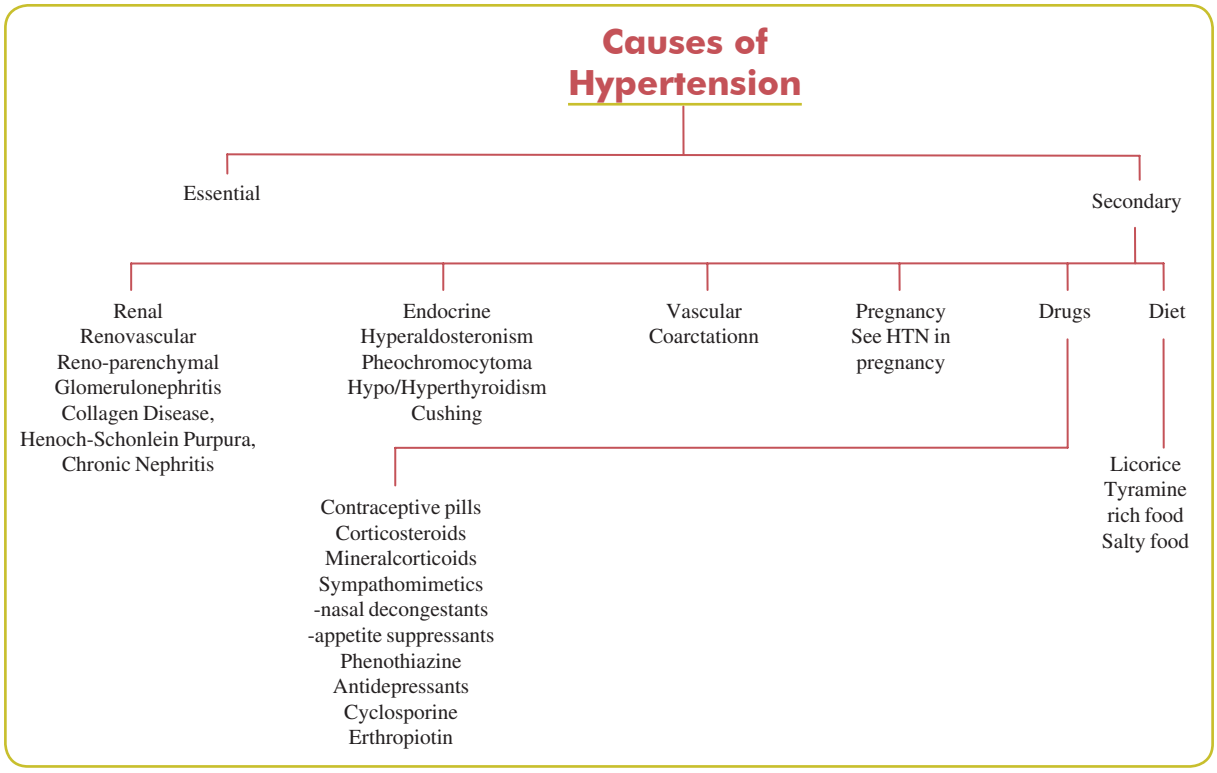


Figure "10": Flow Chart Diagram For Causes of Hypertension

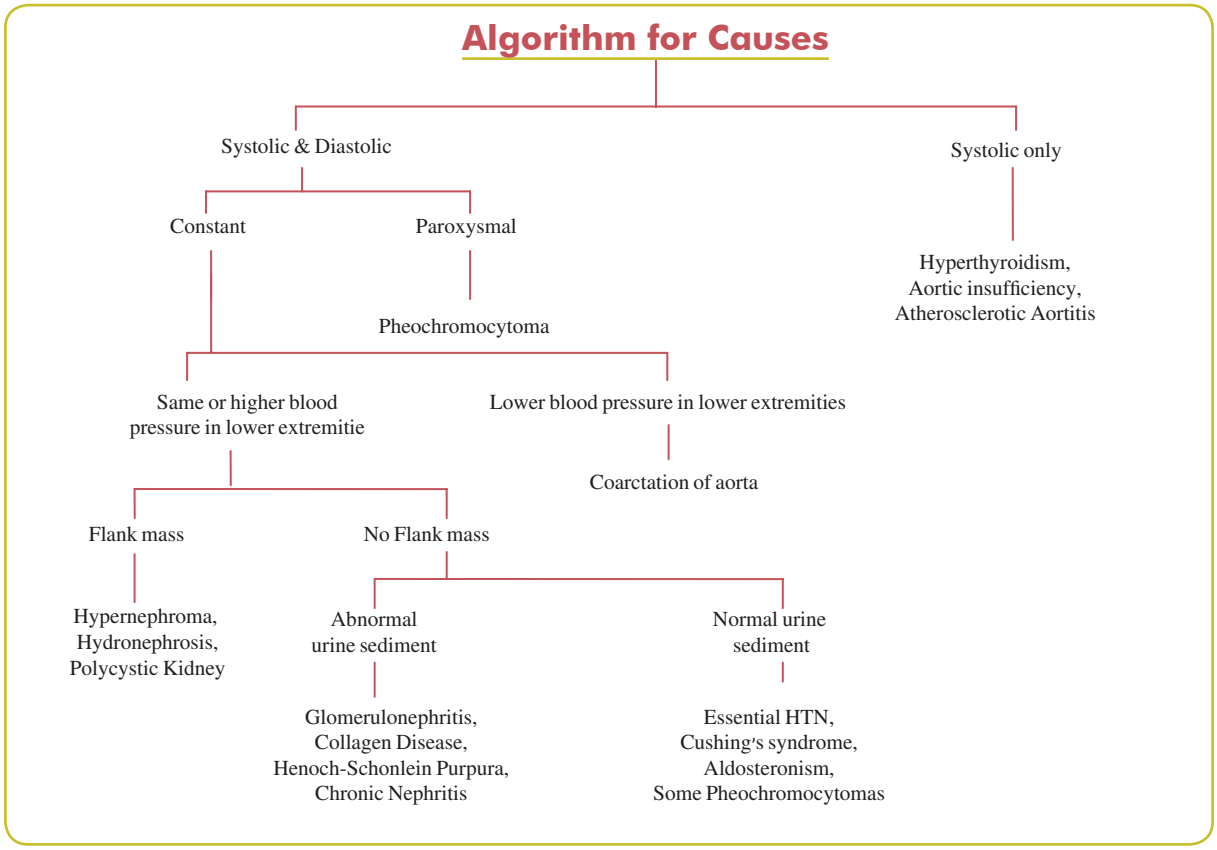


Figure "11": Flow Chart Diagram For Algorithm for Causes of Hypertension

History

Personal
- Age
- Smoking
- Alcohol

Present
- TOD
- Other risk factors
- Symptoms of 2 ry HTN
- Co-morbid conditions
- Diet
- Exercise
- Drugs

Past
- Previous BP level
- Anti HTN drug

Family History
- Diabetes
- Coronary heart disease
- Cerebrovascular disease
- Renal disease

Table. 8: Major Risk Factors and Target Organ Damage/ Clinical CVD

Major risk factors	Target Organ Damage/ Clinical Cardiovascular Disease
1.Smoking 2.Dyslipidemia 3.Diabetes Mellitus 4.Age older than 60 5.Sex::Men and postmenopausal women 6.Family history of cardiovascular disease: Men<55 years or Women <65 years	1.Heart disease -LVH -Angina/prior myocardial infarction -Heart failure 2.Stroke or transient ischemic attacks 3.Nephropathy 4.Peripheral arterial disease 5.Retinopathy

Symptoms Suggesting Secondary HTN:

- Onset at age <25 or >60 yr.
- Sudden onset
- Change from mild to severe in < 1 yr
- Resistant or poor prognosis to treatment

Co- Morbid Conditions:

- Diabetes
- Bronchial asthma
- Gout
- Migraine
- Depression

Clinical Examination (Every Visit)

General
BP
Pulse:
Radial
Femoral (2ry)
Carotid
BMI

Cardiac
- LVH
- ↑ 2 nd HS
- 3rd.HS
- Ejection murmurs

Abd
- Renal mass (2ry)
- Bruit → (aorta) →Renal (2ry)

Chest
-COPD

Neuro
- Speech
- Motor pain
- Reflexes

How to Measure BP:

The Manometer:

The two commercially available types of manometer (mercury and aneroid) need periodic check.

The Cuff:

The cuff size must match the arm size:

- Most adults' 12 x 26 cm bladder.
- Large adults with arm circumference > 33cm - use 12 x 40cm bladder.
- Thin adults and children with arm circumference < 26cm – use 10 x 18 cm bladder.
- The width of the rubber bladder inside the fabric cuff (not the fabric itself) should be more than 40% of the circumference of the mid- upper arm.

Stethoscope:

- The tube of stethoscope should be long. The cone is better for listening but the limited field of reception limits it.

- The diaphragm should only be used in very obese arm.

Before Taking Blood Pressure The Patient Should:

- Avoid smoking, eating and coffee for at least two hours prior to measurement.
- Urine should be voided if necessary.
- Talking should be avoided five minutes before and during blood pressure measurement.
- Blood pressure should be measured in quiet room with comfortable temperature.

Patient Position:

- Blood pressure is to be measured in the supine or sitting positions.
- The abducted supinated arm should be at the heart level and supported on a pillow.
- In sitting position the back should be supported and the feet on the ground.
- The arm should be slightly flexed and supported on a desk.
- In the standing position, the arm should rest & be supported.

There is usually no difference between supine and sitting BP however standing BP should be taking in:

- First visit evaluation.
- Elderly patients above 60 years.
- Diabetic patients.
- Patients with postural symptoms.
- Patients on potent VD or large doses of diuretics.
- Standing BP should be measured 2 minutes after standing.

If the radial pulse volume is equal in both arms, the right arm BP is measured.

The Procedure:

- The cuff should be applied directly to the skin, with no clothing intervening.
- Tight sleeves should be taken off before cuff application.
- Palpate the brachial artery and center the bladder over the artery.
- Wrap the cuff tightly around the arm. The edge of the cuff should be 3 cm above elbow crease.
- Close the valve and inflate the cuff first rapidly to about 70 mmHg, then by 10 mmHg at time while the other hand feels for the radial pulse at the wrist.
- The pulse occlusion pressure (POP) is identified and then releases all pressure.
- Raise the arm above the level of head for a few seconds to prevent venous engorgement.
- Close the valve and rapidly inflate the cuff to 30 mmHg above the POP identified from the previous step. Rapid inflation is essential to minimize venous engorgement, which attenuates the korotkov sounds. The cuff is then deflated slowly (at 2 mmHg/sec) while the cone of the stethoscope is firmly applied over the brachial artery but not touching or the cuff.
- The mercury manometer should be viewed from a distance of 1 to 3 feet and the eye level should be at the mid point of the manometer. It is not essential to keep the manometer at heart level. Record the blood pressure to the nearest 2 mmHg.

The Korotkov Sounds:

Stage I:

Appearance of sound (systolic BP).

Stage IV:

Sudden reduction of sound (diastolic BP) in case of wide pulse pressure or sound continue to zero.

Stage V:

Disappearance of the sound (diastolic BP) in all other patients.

Damped Korotkov Sounds:

- Cuff has been repeatedly inflated with incomplete deflation.
- Obese arm.

Augmentation of The Korotkov Sounds:

Raise the arm above head level to enhance venous emptying. Inflate the cuff with the arm still elevated. Lower the arm to the heart level and proceed as usual.

After inflation ask the patient to open and clinch the fist several times.

Take the lower of at least two readings 1-2 minutes apart. If the difference is more than 6 mmHg, a third reading is needed.

With irregular pulse take average of four BP readings.

With very slow pulse low deflation is needed.

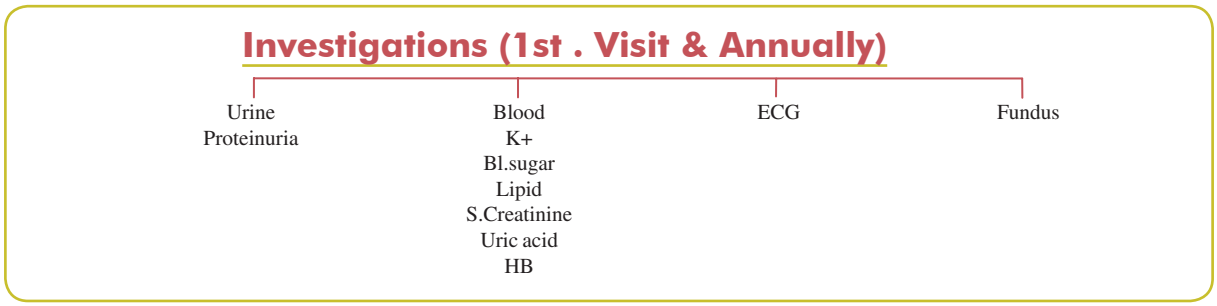


Figure "12": Flow Chart Diagram For Investigations (1st Visit & annual investigation of hypertensive patient)

Treatment

Life style modification

Stage 1: (140-159 / 90-99)

Start with thiazide or in special situations you can start

with ACEI , ARB , BB ,CCB .

Stage 2:≥ 160/100

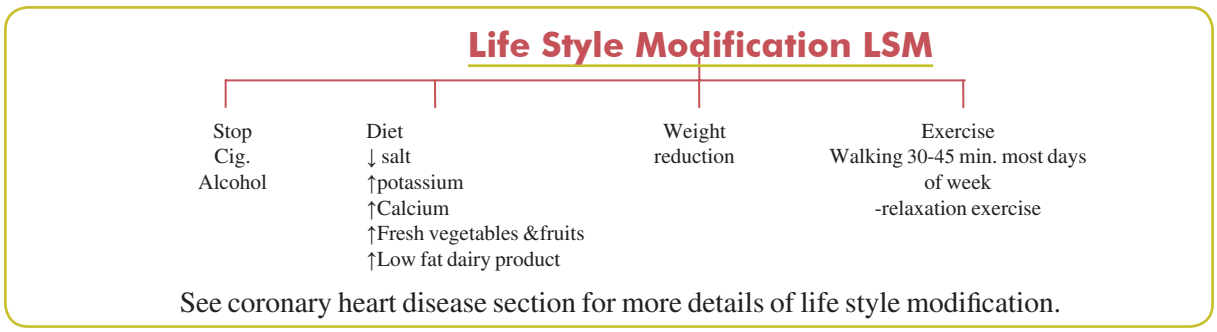
Two drugs combinations

If patient with diabetes or chronic kidney disease you start with 2 or more antihypertensive drugs to achieve goal BP

After 1 month if target BP is not reached: reach optimum doses or add additional drug

Inadequate response to antihypertensive drugs

: decrease BP < 10/5 after 15 days therapy



See coronary heart disease section for more details of life style modification.

Figure "13": Flow Chart Diagram For Life Style Modification for hypertensive patient

Anti Hypertensive Drugs (EDL)

Methyldopa: Tablet	250 mg
B-blockers: Atenolol tablets	50 mg
Proplanolol tablets	10 mg
	40 mg
Ca blockers: Nifedipine tablets	20 mg
Deltiazem tablets	60 mg
Caps	90 mg, 120mg, 180mg

ACEI : Captopril tab 25 mg

Diuretics : Thiazide hydrochlorothiazide tablets 25 mg

Loop diuretic furosemide tablets40 mg

Injection 40 mg

Potassium-sparing diuretics: spirolactone tablets 25mg.

Table. 9: Anti-Hypertensive medications , dosage, Side effects and Contraindication

Drug	Dosage Form	Side-effects	Contraindication
Hydrochlorothiazide	tablets 25 mg	**CVD**: postural hypotension **Digestive**: jaundice diarrhea, vomiting, constipation, gastric irritation, nausea, anorexia. **Hematologic**: leukopenia, hemolytic anemia, thrombocytopenia. **Hypersensitivity** **Metabolic**: Electrolyte imbalance	- Sever renal & hepatic impairment - Anuria.
Furosemide	Tablets 40 mg Injection 40mg		- Liver cirrhosis - Hypokalaemia - Anuria.
Spirolactone	tablets 25mg	**Digestive**: Gastric bleeding, gastritis, diarrhea nausea and vomiting. **Endocrine**: Gynecomastia **Hematologic**: Agranulocytosis **Hypersensitivity**	- Renal impairment - Anuria. - Hyperkalemia.
Captopril	tablets 25mg	- Cough, Rash - Renal Failure - Neutropenia - Angioedema - Taste impairment	- Bilateral renal artery stenosis - Hyperkalaemia - Neutropenia
Atenolol	tablets 50 mg	- Bradycardia - Cold Extremities - Tiredness - Impotence	- Sinus bradycardia - Heart block greater than first degree - Cardiogenic shock
Propranolol	tablets 10 mg & 40 mg		
Nifedipine	tablets 20 mg	- Flushing - Oedema - Postural hypotension - Headache	- Hypersensitivity
Deltiazem	tablets 60 mg capsules 90 mg, 120mg, 180mg	- Bradycardia/ heart block	- Heart failure, heart block - Severe hypotension (less than 90 mm Hg systolic)
Methyldopa	tablets 250 mg	- Drowsiness during the first few weeks of therapy - Fluid retention - Headache - Weakness	- Liver disease or cirrhosis - Hypersensitivity

Table. 10: Treatment in Special Situations

Conditions	Preferred drug	Problematic drugs
1.Diabetes Mellitus	ACE inhibiors,CA	B-blockers, high doses of diuretics
2.Systolic Heart Failure	ACE inhibiors,diuretics	B-blockers (except carvedilol),CA,diuretics
3.Diastolic Heart Failure	ACE inhibiors, B-blockers,CA	Diuretics
4.Angina	B-blockers, CA	Short acting dihydropyridine CA(e.g. nifedipine)
5.Myocardial Infarction	B-blockers, ACE inhibitors(with systolic dysfunction)	Short acting dihydropyridine CA(e.g. nifedipine)
6.Obstructive Lung Disease	ACE inhibitors	B-blockers, combined α &β -blockers
7.Renal Insufficiency	Diuretics, ACE inhibitors (if serum creatinine <3 mg/dl)	ACE inhibitors, A Π receptor blockers, K-sparing diuretics
8.Pregnancy	Methyl dopa,B-blockers (in late pregnancy),hydralazine	ACE inhibitors, A Π receptor blockers

ACE, angiotensin converting enzyme; CA, calcium antagonists

Preferred Drugs in Other Conditions:

- After stroke: thiazide
- Peripheral vascular disease: calcium blockers
- Hypercholesterolemia blockers, centrally acting drugs, calcium blockers, ACEI.
- Obesity: thiazide
- Benign senile prostatic hyperplasia: α blockers

- Migraine: B-blockers
- Essential tremors-blockers
- Anxiety & tachycardia-blockers

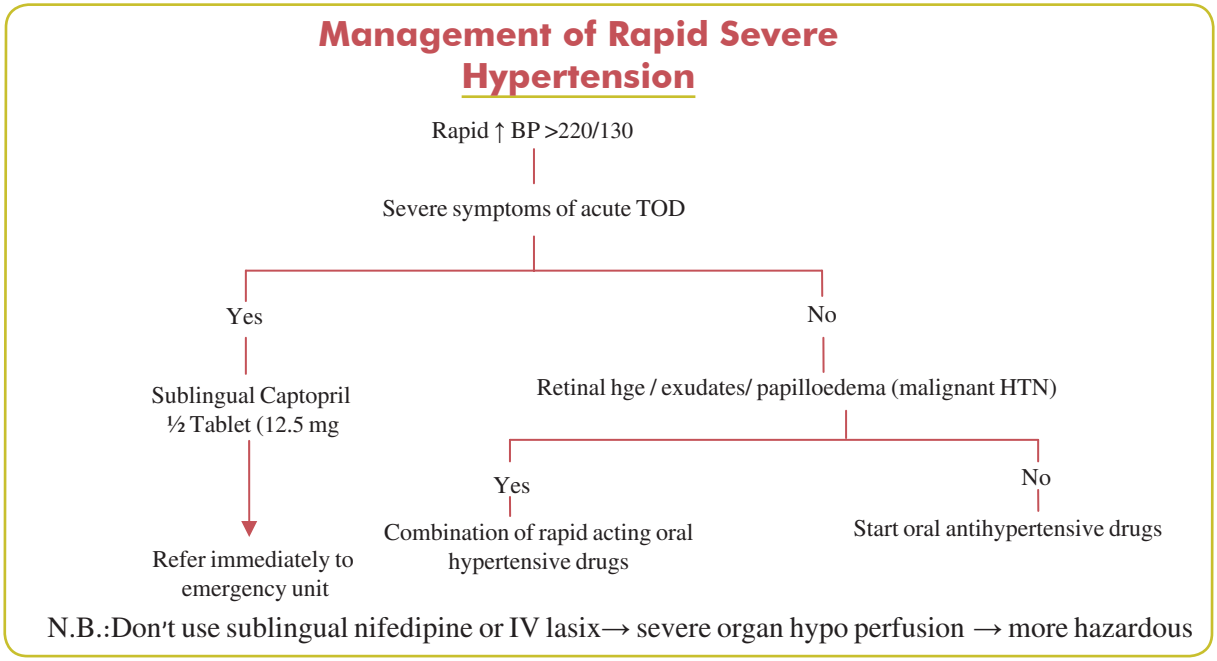


Figure "14": Flow Chart Diagram for Management of Rapid severe Hypertension

Pregnancy and Hypertension

Diagnosis:

BP>140/90 on 2 measurements at least 4 hours apart or Diastolic >110mmHg at any time during pregnancy & up to 6 wk post -partum.

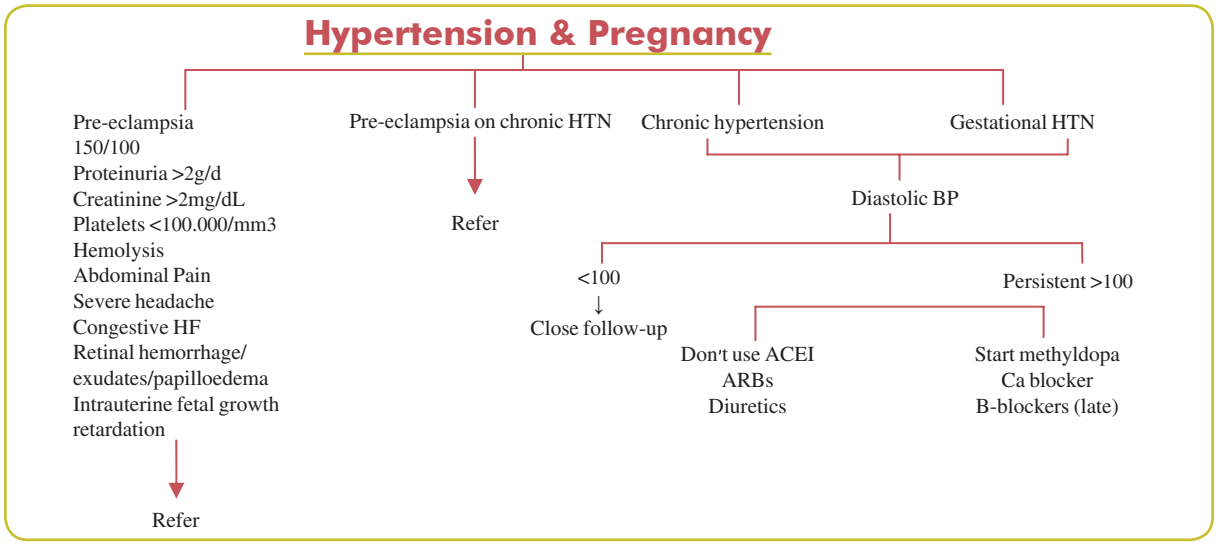


Figure "15": Flow Chart Diagram for Hypertension & Pregnancy

*** Breast feeding& hypertension:**

Methyldopa, Hydralazine, BB (propranolol / labetalol) are safe

ACEI & ARBs should be avoided

Diuretics may suppress lactation

Children & Hypertension

Age (year)	Systolic Blood Pressure	Diastolic Blood Pressure
1	105	70
6	115	76
12	125	84
18	135	90

Evaluation of Asymptomatic Hypertensive Child:

1. History

Patient

- Past or present history of events that influence blood pressure e.g. radiation to the kidney, recurrent urinary tract infection, drugs with pressor properties.
- Dietary habits: calories, sodium intake.

Family

- Essential hypertension and/or its complications.
- Obesity, hyperlipedemia.
- Genetic disorders associated with hypertension.
- Blood pressure elevation in siblings.

2. Physical Examination

- Blood pressure in both arms and legs.
- Clues to secondary causes: coarctation, Cushing's syndrome, abdominal mass or bruits.
- Target organ damage: fundoscopic and cardiac examination.

3. Laboratory

- Urine analysis.
- Hematocrit.
- Urea,creatinine,electrolytes.
- Renal ultrasound.
- Lipid levels.
- Echocardiography

Pediatric doses of antihypertensive drugs:

Captopril : Initial : 0.3 - 0.5 mg/kg/dose (every 12 h)

Maximum: 6 mg/kg/day

Propronolol: Initial: 1 - 2 mg/kg/day

Maximum: 4 mg/kg/day

Long acting nifidipine: Initial: 0.15 - 0.2 mg/kg/day

Maximum: 3 mg/kg/day (up to 120 mg/day)

Elderly:

Take care:

- Auscultatory gap
- White coat hypertension
- Isolated systolic hypertension(ISH)
- Postural hypotension
  - o After meal
  - o Drugs (central & adrenergic blocker)→ measure in supine &standing→ mg/kg/ readjust dose to the standing measure

ISH: is a stronger predictor of complications

It's lowering leads to sig. reduction in:

- Cardiovascular mortality
- Stroke
- Heart failure
- Myocardial infarction
- Dementia

Black:

Thiazide is more effective

ARBs & B-blockers are less effective

ACEI is less effective in lower doses but effective in higher doses.

Target

Low/intermediate risk	High risk	>1 g protein	Acute stroke
<140/90	DM, Kidney disease < 135/85	125/75	160/100

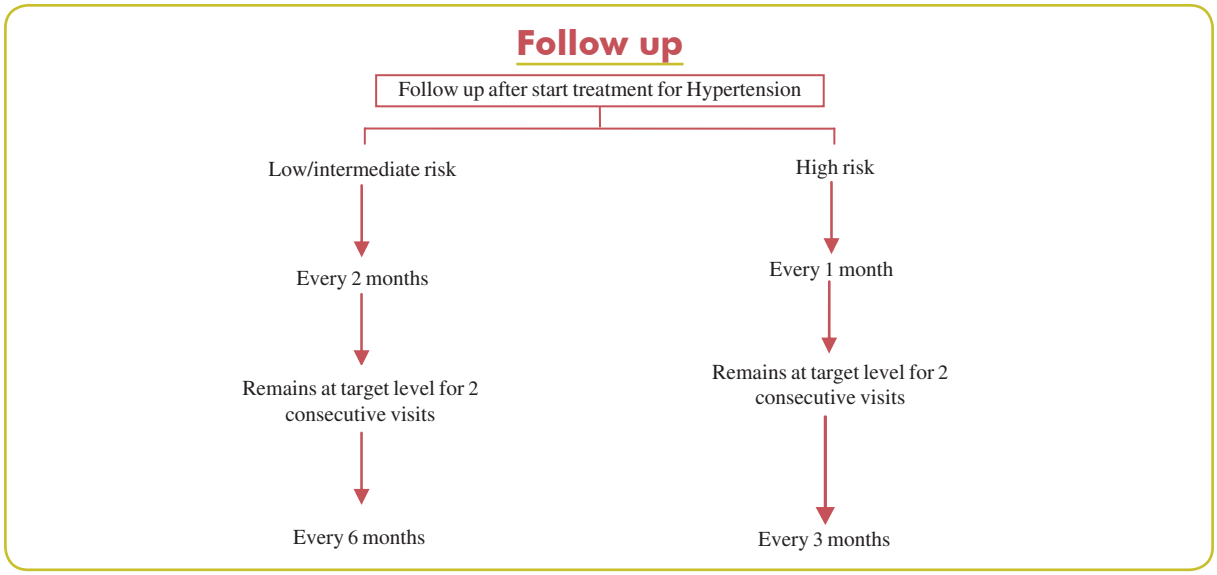


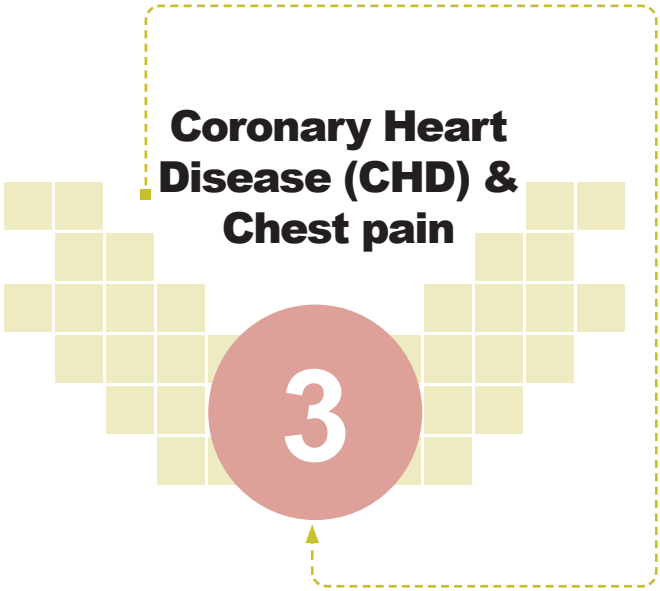
Figure "16": Flow Chart Diagram For Follow up after start treatment of Hypertension

How to Increase Compliance to Treatment of Hypertension :

- Health education
- Use less expensive drugs
- Single daily dose
- Fixed drug combination
- Continue monitoring by spouse

When to Refer?

- Suspecting 2 ry hypertension
- Complicated hypertension
- Multiple risk factors
- Difficult or resistant to treatment
- Pregnancy


Coronary Heart
Disease (CHD) &
Chest pain
3

Coronary Heart Disease (CHD) & Chest Pain

Primary Prevention

Dealing with risk factors for CHD

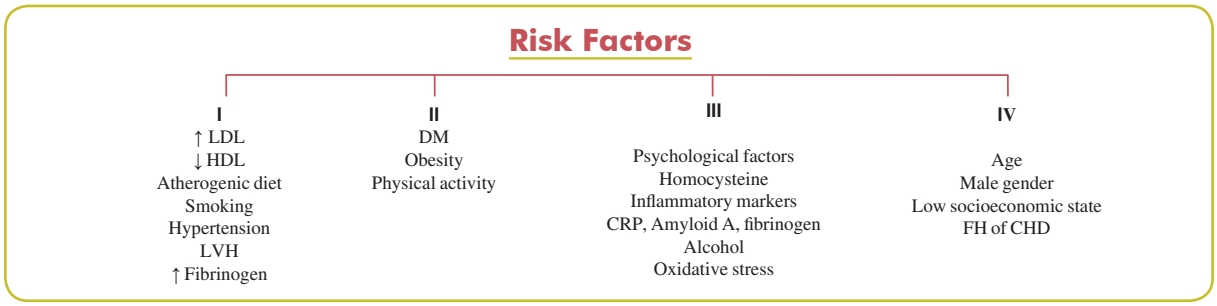


Figure "17": Flow Chart Diagram For Risk factors for CHD

I. Risk factors for which interventions have proved to lower risk of CHD

II. Risk factors for which interventions are likely to lower risk of CHD

III. Risk factors for which interventions might lower risk of CHD

IV. Risk factors which cannot be modified.

Practical Recommendations:

- **LDL:**
  - Achieve desirable BW
  - ↓ saturated FA (dairy fats, animal fats, fatty processed meat)
  - &↓cholesterol in diet (eggs, dairy food, and animal products).
  - Daily intake of 3g/d plant steroids (↓LDL by 10-15%).
  - ↑dietary fibers (↓LDL by 3-5%)
  - Use poly & monounsaturated FA

LDL Cholesterol Treatment Guidelines

Category	Diet	Drug	Goal
1. No coronary HD and <2 risk factors	> 160	> 190	< 160
2. No coronary HD and ≥ 2 risk factors	>130	> 160	< 130
3. Presence of coronary HD	> 100	> 130	< 100

- Level of serum LDL at which patient will be put on diet treatment or on diet and drug treatment.
- Goal needed to reach in serum LDL in patients with or without coronary heart disease

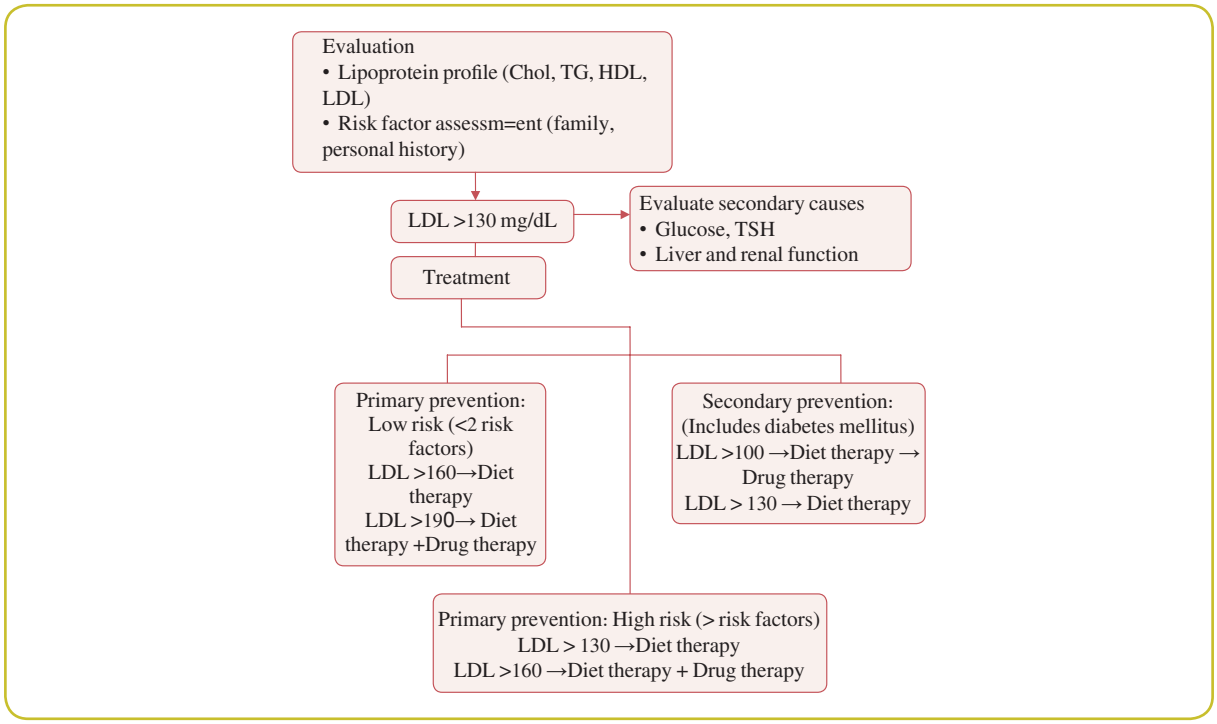


Figure "18": Flow Chart Diagram - Algorithm for Management of Hypercholesterolemia

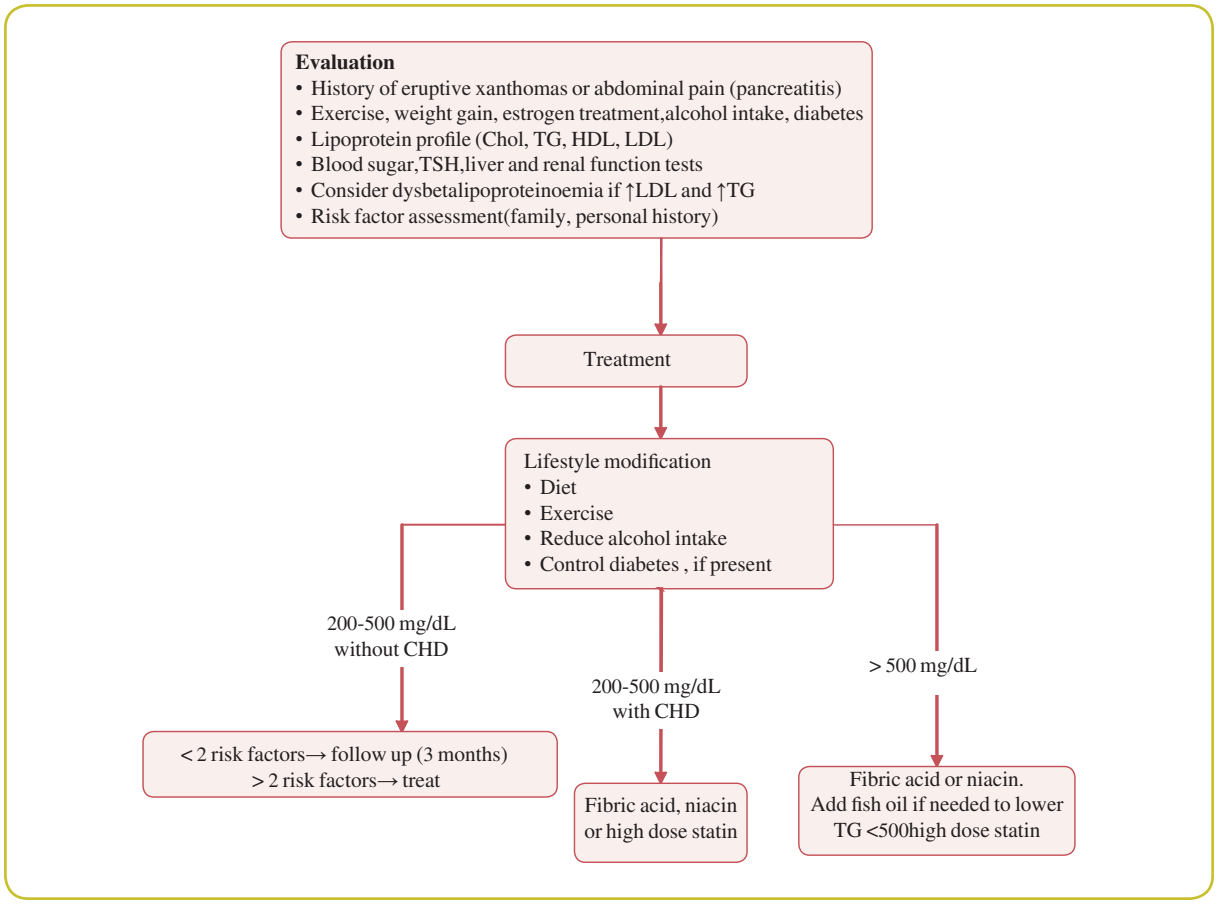


Figure "19": Flow Chart Diagram - Algorithm for Management of Hypertriglyceridaemia

Table.12: Medications, Dosage, side effects and Contraindication of Hyperlipidemia

	Drugs	Dosage form	Side effects	Contraindications
Fibrates	Gemfibrozil	Tab (100-200-300 mg)	- Stomach upset, nausea, vomiting. - Abdominal pain - Risk of gallstones	- Hepatic or severe renal dysfunction - Preexisting gallbladder disease - Hypersensitivity - Peptic ulcers
	Fenofibrate	Tab/ Cap (300 - 600mg)	- Stomach upset - Risk of gallstones - Rash - Hepatitis - Myositis	
	Niacin Nicotinic acid & derivatives	Vit.B3	- Skin flushing - Headache -Postural hypotension - Hepatic dysfunction - Gout	- Peptic ulcer (risk of ulcer exacerbation)
Statins	Fluvastatin	Cap (10-20 mg)	- Abdominal pain - Constipation - Headache	- Active liver disease - Persistent elevations in serum transaminases - Hypersensitivity
	Simvastatin	Tab (5-10-20-40 mg)		

- **Non Atherogenic Diet:**
  - o Diet to maintain ideal BW.
  - o Fat < 30%.
  - o If vascular disease: saturated FA <7%.
  - o Cholesterol < 200 mg/dL
  - o Use monounsaturated and omega 3 FA (fish).

Summary of dietary guidelines				
Population goals				
	Overall healthy eating pattern	Appropriate body weight	Desirable cholesterol profile	Desirable blood pressure
Major guidelines	Include a variety of fruit, vegetables, grains, low - fat, or non-fat dairy products, fish, legumes, poultry, lean meals	Match energy intake to energy needs, with appropriate changes to achieve weight loss when indicated	Limit foods high in saturated fat and cholesterol, substitute with unsaturated fat from vegetables, fish legumes, nuts	Limit salt and alcohol; maintain a healthy body weight and a diet with emphasis on vegetables, fruit and low-fat or non-dairy products

•Smoking cessation

- o 50% reduction in cardiovascular events within 2-4yrs.
- o Up to 20 years to regain base line risk.

•LVH:

- o Use ACEI, Ca antagonists, B-blockers and /or diuretics.

•Fibrinogen:

- o Smoking cessation.
- o Physical activity.
- o Weight reduction.
- o Fibrate.
- o Aspirin & ACEI.

• DM:

- o Weight reduction.
- o Exercise.
- o Avoid sugar and saturated FA.
- o Aggressive lipid lowering → LDL<100 mg/dL.
- o Near normal fasting glucose &HbA1c < 6.5-7%.

•Physical Inactivity:

- Exercise 30 minutes most days of week (brisk walking).

Table. 13: Exercise Prescription According To Patient Characteristics

Characteristic	Training regimen	Int-ensity	Type of exercise	Frequency of sessions (no/week)	Duration of each session (minutes)
Age <65 years, not overweight	High-intensity aerobic	75-85%of maximal heart rate	Walking, jogging, cycling, rowing	3 or 4	30-45 (continuous or interval)
Age > 65 years	Low-intensity aerobic and resistance	65-75 % of maximal heart rate	Walking, cycling, rowing	3 or 4	30(may be intermittent)
Overweight	Aerobic high calorie expenditure	65-80 % of maximal heart rate	Walking,	5 or 6	45-60
Age >65 years and disabled, engaged in physical work or overweight	Resistance	50-75% of single-repetition maximal lift	Weight machine & dumb-bells, with the focus on upper legs, shoulders & arms	2 or 3	10-20(10 repetitions of each of 5-7 exercises)

•Obesity:

- o ↓ Wt 10% from baseline in 6 m.

•Psychological Factors:

- o Identify & treat depression & anxiety.

•Oxidative Stress:

- o Diet rich in fruits & vegetables.

•Postmenopausal Status:

- o Primary prevention: do not start if TG > 400 mg, if < it depends on other health risk.
- o Secondary prevention: do not start.

•Family History of CHD:

- o Powerful screening of risk factors.

CHD History

Personal	Present	FH
Smoking	Chest pain	CHD
Alcohol	Peripheral	DM
Social status	vascular disease	HTN
Employment	DM	Hyperlipidemia
Education	Hypertension	
	Hyperlipidemia	
	Physical activity	

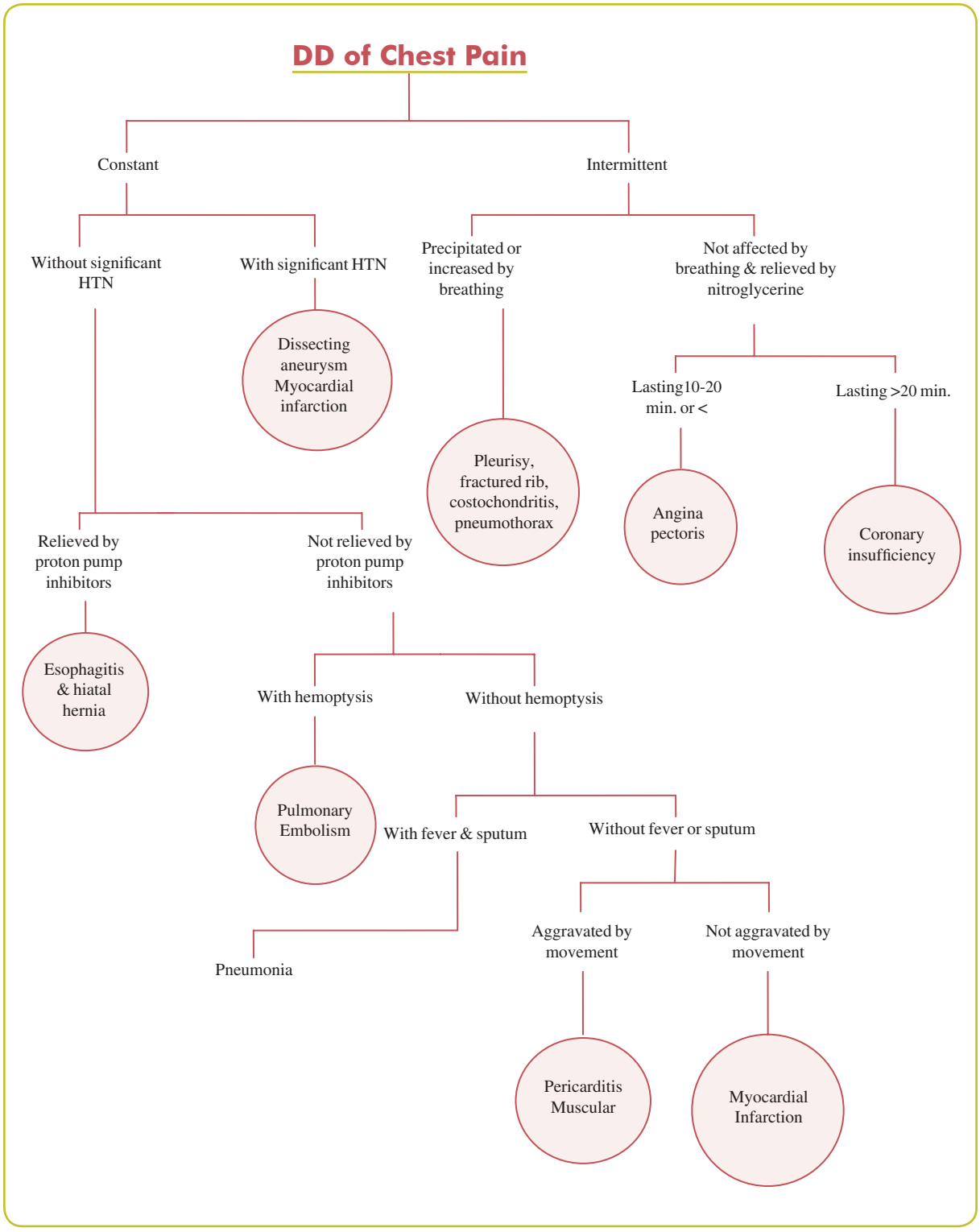


Figure "20": Flow Chart Diagram, DD of Chest Pain

Pain of Angina:

Site: retrosternal

Radiation: Left arm & left shoulder

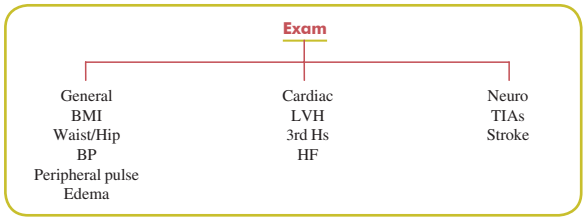
Character: compressing

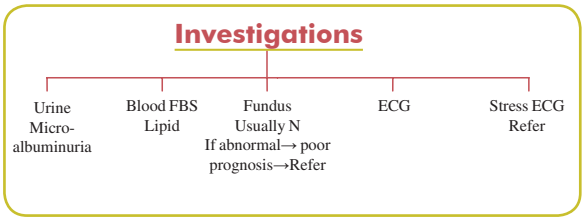
Precipitated by: effort, meal, emotions, cold exposure

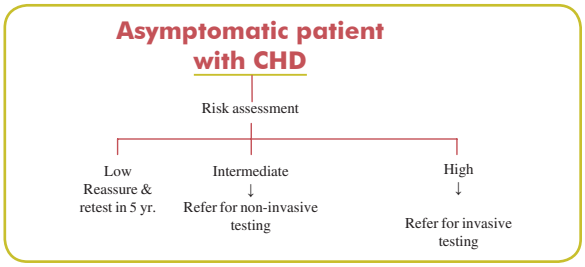
Relief: rest or sublingual nitroglycerine

Duration: 10-15 min.

Angina equivalent: Exertional dyspnea or exertional f atigue.







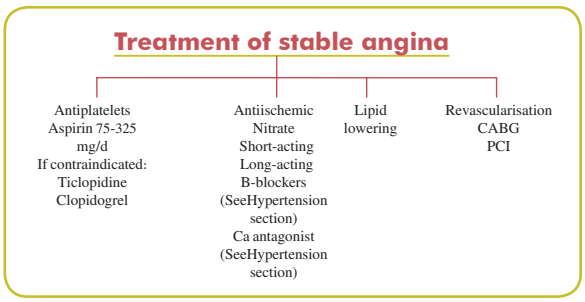


Figure "21": Flow Chart Diagram For Treatment of stable angina

CABG: Coronary Artery Bypass Grafting
PCI: Percutaneous Coronary Intervention

Table. 14: Medications, dosage , side effect and Contraindication for treatment of CHD

Drugs	Dosage form	Side effects	Contraindications
Aspirin	tablets (75mg)	Doses > 1000mg show gastrointestinal symptoms & bleeding	- Hypersensitivity - History of GI bleeding - Bleeding disorders (as. hemophilia).
Ticlopidine	tablets (250mg)	- Diarrhea, nausea and vomiting - GI pain - Rash - Neutropenia	- Hematopoietic disorders (as neutropenia) - Presence of a hemostatic disorder or active pathological bleeding (such as bleeding peptic ulcer or intracranial bleeding) - Severe liver impairment - Hypersensitivity
Clopidogrel	tablets (75mg)	- Red or purple spots on skin (varying in size) - Chest pain and cough	- Active pathological bleeding (as peptic ulcer or intracranial hemorrhage) - Hypersensitivity
Nitrates	Look below*	- Flushing & throbbing headache - Postural hypotension & dizziness - Tachycardia, palpitationand worsening of angina - Tolerance and dependence (chronic exposure) Methemoglobinemia rarely occurs after chronic high doses.	- Anemia (severe) - Glaucoma (worsened by nitrates) Precautions: - Tolerance (with chronic use) - Avoid sudden stopping (withdrawal symptoms)

For isosorbide dinitrate

For short-acting oral dosage forms (capsules or tablets):

Adults–5 to 40 mg 4 times/day

For long-acting oral dosage forms (SR capsules or tablets):

Adults–20 to 80 mg every 8-12 hours.

For isosorbide mononitrate

For short-acting oral dosage form (tablets):

Adults–20 mg 2 times/day (7 hours apart)

For long-acting oral dosage forms (SR tablets):

Adults–30 to 240 mg once a day

For nitroglycerin

For long-acting oral dosage forms (capsules or tablets):

Adults– 2.5 to 9.0 mg every 8-12 hours.

Follow up

3 m	6m	1 yr.	3 yr.
S.lipids LFTs Till target of S.lipids is reached	History &exam S.lipids LFT ECG	HA1c (if diabetic) Stress test for high risk pt.	FBS (if not diabetic) Stress for mod. risk

Referral

- Uncertain diagnosis
- For stress test
- Symptoms not controlled by maximal medical treatment
- Angina associated with AS esp. in elderly individuals
- Unstable angina
- Post infarction angina

Unstable Angina:

New onset, severe, worsening or post infarction angina

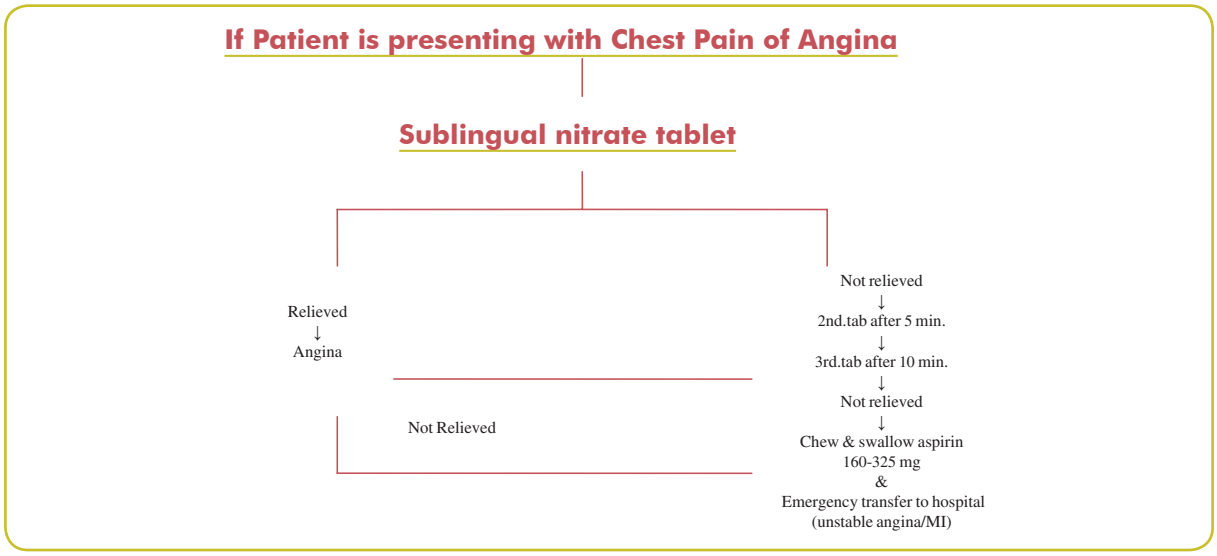


Figure "22": Flow Chart Diagram For Treatment of Unstable angina

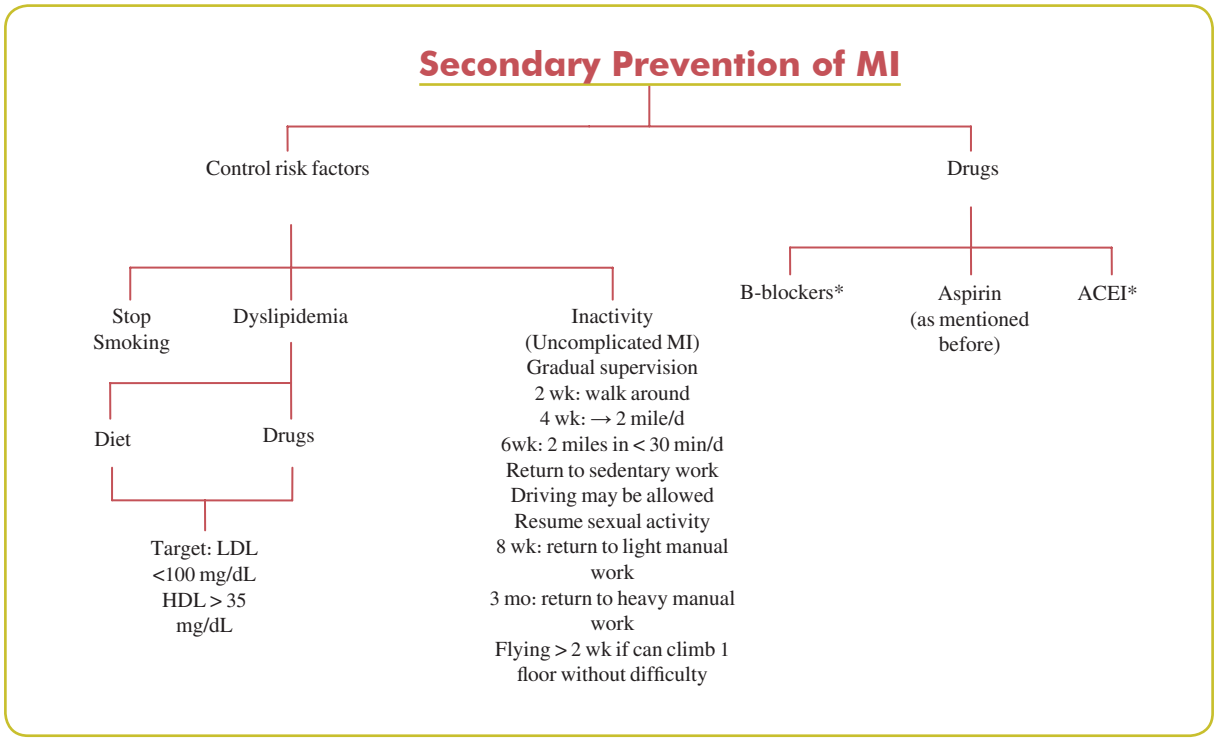
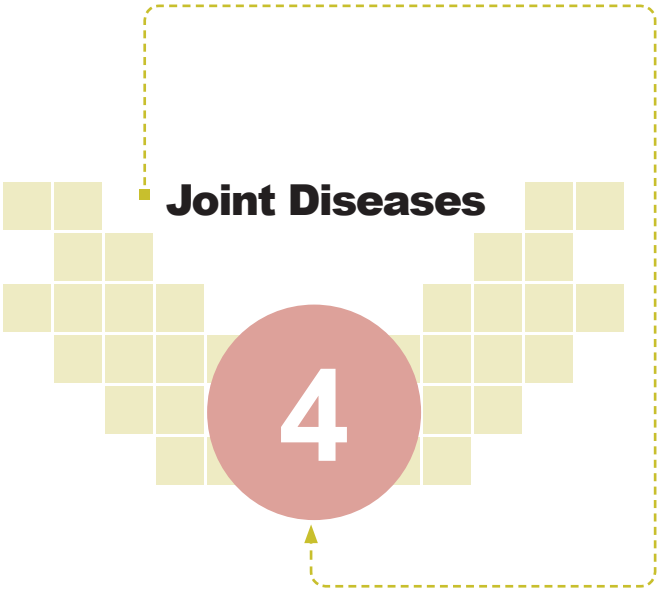


Figure "23": Flow Chart Diagram For Secondary Prevention of MI

Follow up: every 6 month life long.

See Hypertension section


Joint Diseases
4

Joint Diseases

- Joint pain
- Joint swelling
- Knee pain
- Knee swelling
- Shoulder pain
- Neck pain
- Neck stiffness
- Low back pain

Taking Amusculoskeletal History:

Stress on the following points

I.Personal History:

• Gender:

Male: gout, reactive arthritis and ankylosing spondylitis.

Female: Rheumatoid, SLE & other autoimmune connective tissue disease.

• Age:

Young: juvenile, rheumatoid arthritis.

Middle: rheumatoid arthritis.

Elderly: osteoarthritis.

II. Present history:

- **Pain:**

site: distal interphalangeal joint in osteoarthritis
Sparing interphalangeal joint in rheumatoid arthritis

It is arising from joint, muscle or bone

Radiation: joint pain usually localized

- **Stiffness:** localized or generalized

If more than 15 min each morning →inflammatory

- **Swelling:** mono or polyarticular

Symmetrical or asymmetrical

Peripheral or proximal

- **Systemic illness:** SLE & rheumatoid arthritis
- **Associated medical conditions:**

Psoriasis → psoriatic arthropathy

IBS → asymmetrical arthritis

Diabetes → Charcot's joint

Sickle cell anaemia → joint pain

• Extent of disability:

- **Impairment:** any loss or abnormality of psychological or anatomical structure or function
- **Disability:** any restriction or lack of ability to perform an activity in the manner or within the range
- **Handicap:** an impairment or disability that limits or prevents an action which is normal for that individual

III. Past History:

Similar episodes → gout

IV. Family history:

Similar condition in the family

Osteoarthritis

It is a disease of synovial joints characterized by cartilage loss with an accompanying periarticular bone response

Symptoms:	Joint pain
	Stiffness and pain after immobility
	Joint instability
	Loss of function
Signs:	Crepitus on movement
	Joint tenderness
	Limitation of range of movement
	±Joint effusion
Treatment:	Weight loss

Exercise for strength & stability

Local heat, massage, local NSAIDs

Short courses of simple analgesics

NSAIDs used intermittently

Chondroitin sulphate& glycosaminoglycan

If no improvement refer for:

Intra-articular corticosteroid injection produces short term improvement Surgery

Rheumatoid Arthritis (RA):

It is chronic symmetrical polyarthritis associated with non-articular features.

Clinical picture:

• Articular:

Bilateral, symmetrical affection of small joints of the hands & feet (sparing distal interphalangeal joints), other joints are commonly affected.

Morning stiffness

Joint deformity

• Extra- Articular:

Subcutaneous nodules

Pericarditis, endocarditis & myocarditis

Neuropathies

Scleritis sicca syndrome

Amyloidosis

Felty's syndrome: splenomegaly, LN, neutropenia + RA

Osteomalacia

Clinical Picture:

Defective mineralization of new formed bone (in

adults) usually due to Calcium deficiency

Mainly occur in females with repeated pregnancy and prolonged lactation.

Increase susceptibility to fractures with minor trauma and bone deformities

Treatment:

- Calcium salts:

(oscal tab - calcivit tab 1 tab 3 times/day)

- Vit D3 (devarol S 600,000 u amp /week or fortnight)

- One alpha (0.25 - 1 ug cap)

Osteoprosis

Clinical Picture:

Reduction of amount of calcified bone matrix per unit volume of skeletal tissue. Most common in menopausal women and old age.

Congenital, associated with hypogonadism , cushing , hyperparathyroidism

Risk factors include smoking and leading a sedentary life.

Diagnosis: X-ray show osteopenia - bone densitometry

Treatment:

- Stop smoking & regular exercise
- Oral calcium: (1.5 g/day + one alpha 0.25, 1 ug cap)
- Calcitonin: (400 u vial sc or IM /day or every other day)
- Biphosphate "Alendronate": (10 mg/day)
- Growth hormone: (4 u vial 1-2 times /week)

Estrogen replacement therapy for post menopausal women

Ankylosing Spondylitis (AS):

It is an inflammatory disorder of back & sacroiliac joints affecting young adults.

Clinical Picture:

Back pain and stiffness not relieved by lying inflammation at insertions of tendons and ligaments associated with limited mobility

Extraarticular: uveitis - aortitis - fever

Treatment:

Attention a good posture at work and sleep firm mattress and one pillow

Extension exercise of the spine where swimming is highly recommended

Drugs:

-Analgesics anti-inflammatory:

indomethacin (25 mg tab : 1 tab / 3-4 /day)

sulphasalazine (2-3 g/day may be used)

Referral to orthopedic surgeons if deformities for wedge osteotomy.

Carpal tunnel syndrome

Clinical Picture:

Compression of median nerve leads to tingling and pain in hands

Advanced cases: weakness and wasting of thenar muscles

Treatment:

- Avoid manual work
- Wrist splint
- Local injection of corticosteroids for temporary relief
- Drugs: NSAID tab or suppository at bed time or when necessary.
- Care with GIT symptoms
- Refer to expert for advice for surgery if no improvement

Tendonit is

"Tennis elbow"

Inflammation of the tendon.

Clinical Picture:

Pain on movement and when lifting objects

Treatment:

- Rest of forearm firm elastic bandage
- Analgesics: Salicylates / diclophenac (75 or 100 mg tab : 1-2 tab)
- Intraarticular injection of hydrocortisone acetate
- Add xylocaine 5% amp (2ml) at trigger points
- Physiotherapy and local heat - passive movements
- Refer to surgery in sever cases

Psoriatic Arthritis:

It is an arthritis seen in patients with psoriasis

Reactive Arthritis:

It is a sterile synovitis occurring after infection

Management: refer

Gout

It is inflammatory arthritis associated with hyperuricemia

Clinical picture:

Acute gout:

- Middle aged male
- sudden onset of pain , swelling, redness of 1st.

MCP joint

- may be precipitated by food or alcohol, dehydration or diuretics

Treatment:

Acute Attacks:

- NSAIDs in high doses for 48 hours then reduce dose
- Colchicine 1000 mg immediately then 500 mg every 6-12 hrs

In between attacks:

- Dietary:↓ total calories , cholesterol ,shell fish & spinach
- Allopurinol 300 mg/d
- Uricosuric agent: probencid 0.5 g/12 hours
- **Systemic lupus erythrematosus**

It is an inflammatory, multisystem disorder

Clinical picture:

- Female: male 9:1
- Age: 20-40 yrs
- Fever: 50% of cases
- Joints: arthritis or arthralgia leaves no deformity
- Skin: butterfly rash, vasculitis, alopecia, Raynaud's phenomenon
- Lung: pleurisy, pleural effusion, pneumonitis and atelectasis
- Heart: pericardirtis, myocarditis and endocarditis (mitral valve)
- Kidneys: hypertension, nephritic, nephrotic syndrome, RF
- Nervous system: depression, epilepsy, polyneuropathy, cranial nerve affection
- Eyes: retinal vasculitis, conjunctivitis, optic neuritis and Sjogren's syndrome
- GIT: mouth ulcers, mesenteric vasculitis, hepatomegaly.

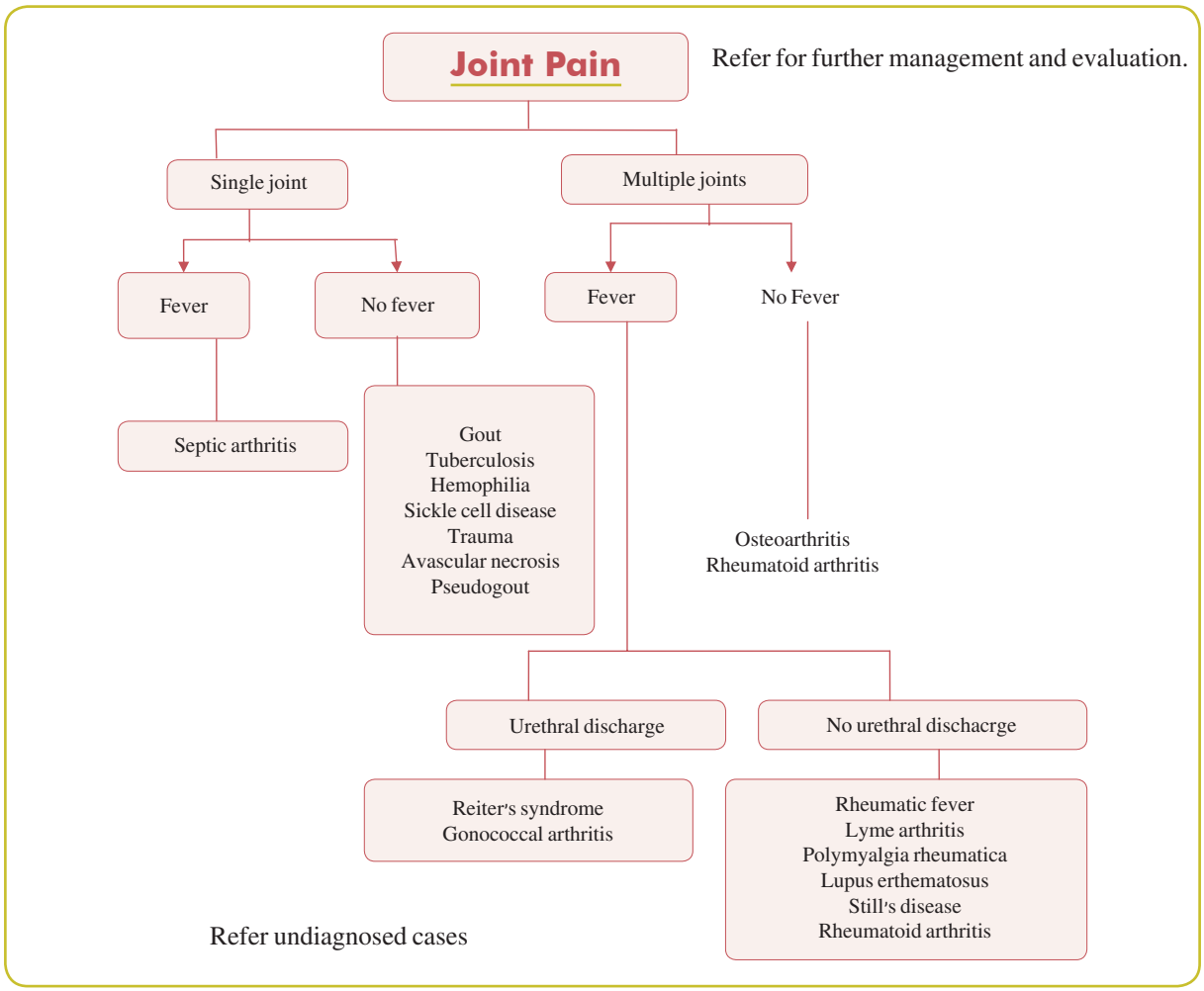


Figure "24": Flow Chart Diagram For DD of Joint Pain

Joint Pain

• Septic Arthritis:

The most common cause is Staph aureus.

Joint is hot, red, swollen & muscle spasm in previously fit person.

Refer for aspiration & proper management.

• Hemophilia:

Hereditary deficiency of factor VⅢ (hemophilia A) or factor IX (hemophilia B).

Clinical: Bleeding.
Hemarthrosis.

Management: Carrier detection & antenatal diagnosis.

Refer for proper management.

• Sickle Cell Disease:

Structural abnormality of Hb that result in sickling which leads to shortened red cell survival and obstruction of small vessels.

• Pseudo gout:

Calcium pyrophosphate deposits associated with hemochromatosis, hyperparathyroidism, Wilson's disease.

• Reiter's syndrome:

Seronegative rheumatoid arthritis. It is a triad of non specific urethritis, conjunctivitis and arthritis that follows bacterial dysentery or exposure to sexually transmitted infection.

• Gonococcal Arthritis:

Polyarthritis

Treatment: Respond rapidly to antibiotics: oral penicillin, ciprofloxacin or doxycycline for 2 weeks & joint rest.

• Lyme Arthritis:

Zoonosis by spirochete

Fever, headache, erythematous rash, periarticular arthritis

Treatment: antibiotics; amoxicillin or doxycycline

• Polymyalgia Rheumatica:

Sudden onset of severe pain and stiffness of the shoulder and neck & back, worse at morning > 30 min

Treatment: NSAIDs

Prednisolone: 10-15 mg single dose in the morning.

• **Still's Disease** (Juvenile Idiopathic Arthritis):

This arthritis is most common between 1 and 5 years.

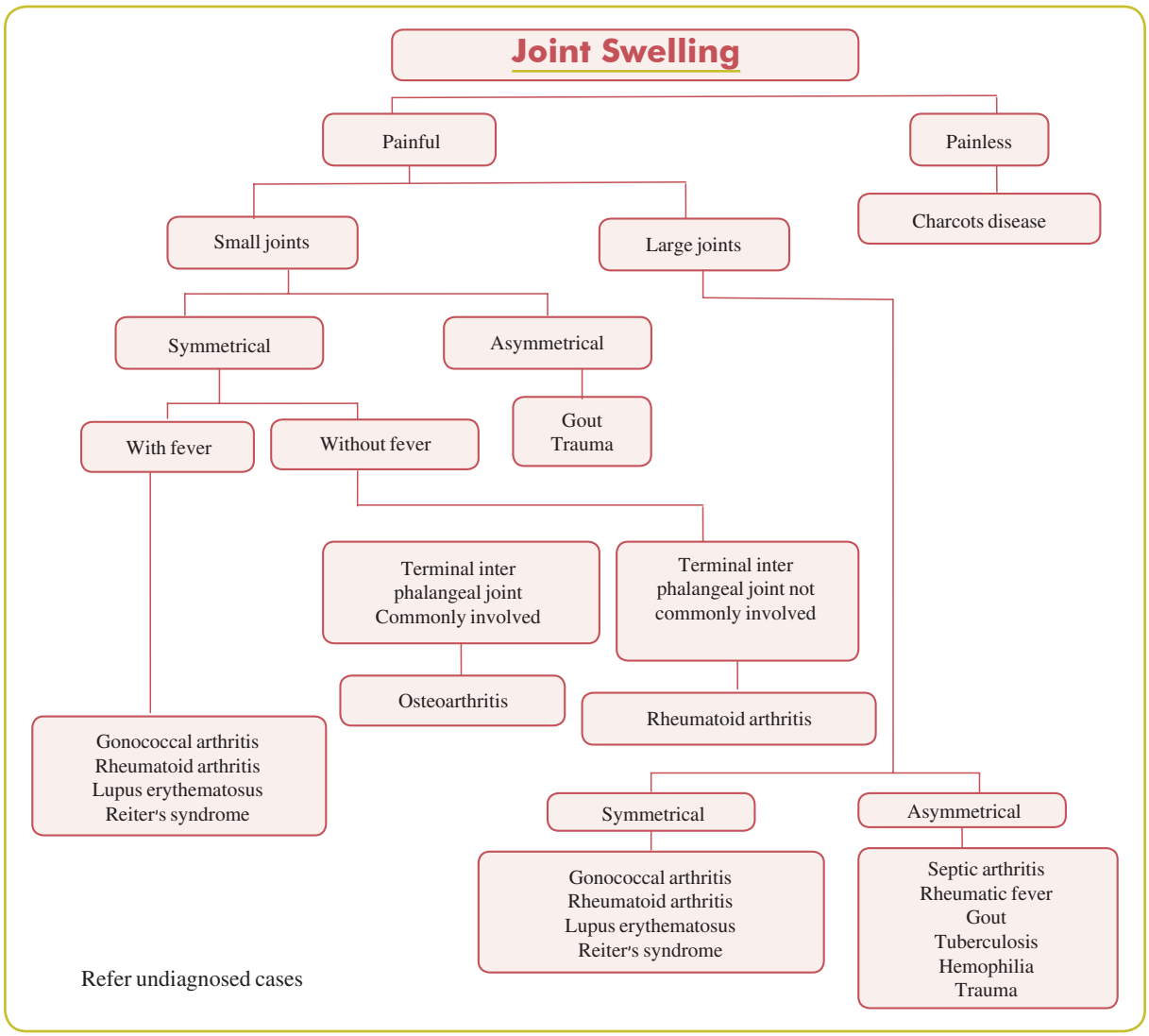


Figure "25": Flow Chart Diagram For DD of Joint Swelling

Joint Swelling

• Charcot's Diease (Neuropathic Joints):

In tabes dorsalis→ knee, ankles

Diabetes→ joints of the tarsus

Syringomyelia→ shoulder is involved

Treatment: symptomatic, in advanced cases refer to surgery

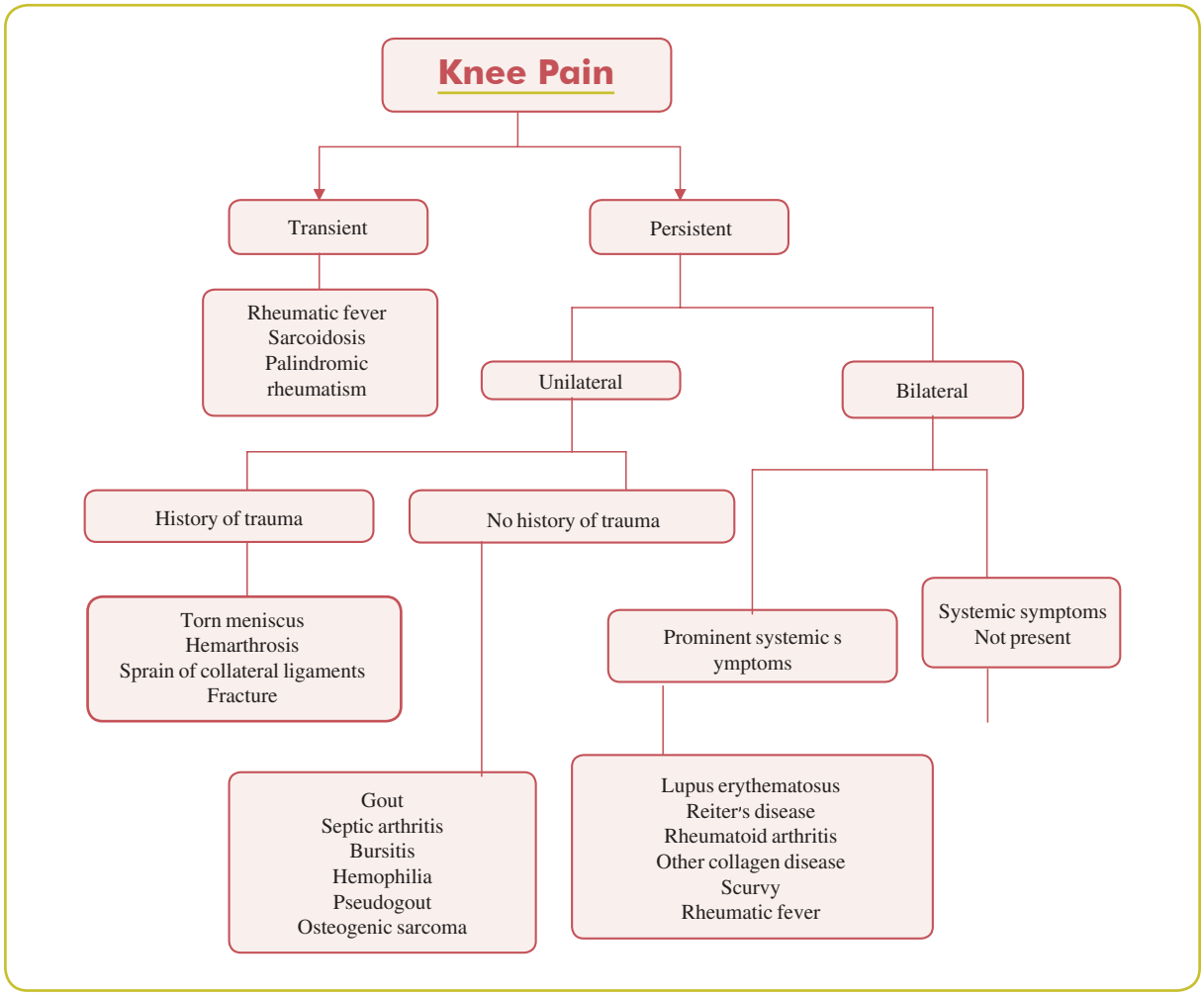


Figure "26": Flow Chart Diagram For DD of Knee Pain

Knee Pain

• Sarcoidosis:

Multisystem graulomatous disorder, affecting young adults

Bilateral hilar adenopathy

Pulmonary infiltration

Skin & eye lesions

Arthralgia, arthritis

Refer

• Palindromic Rheumatism:

May be prodroma before rheumatoid arthritis

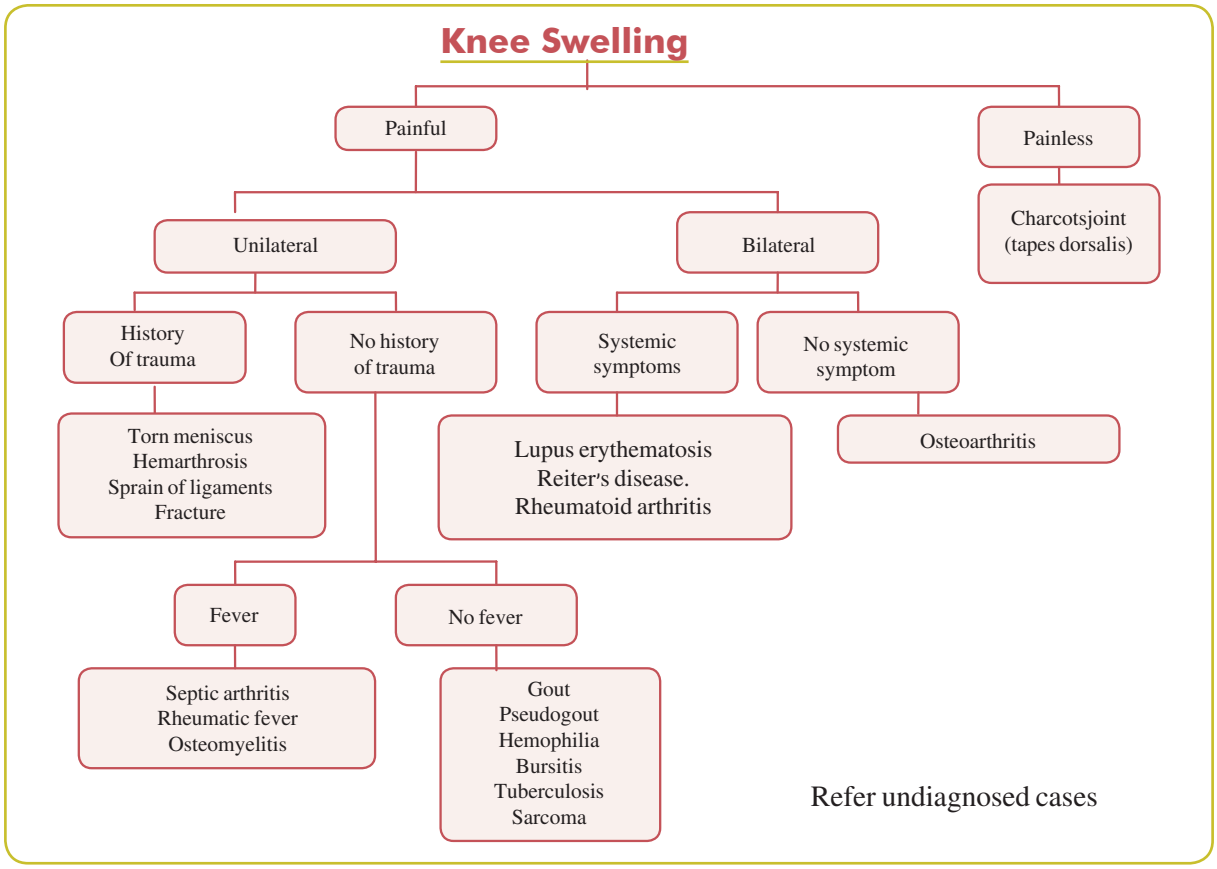


Figure "27": Flow Chart Diagram For DD of Knee Swelling

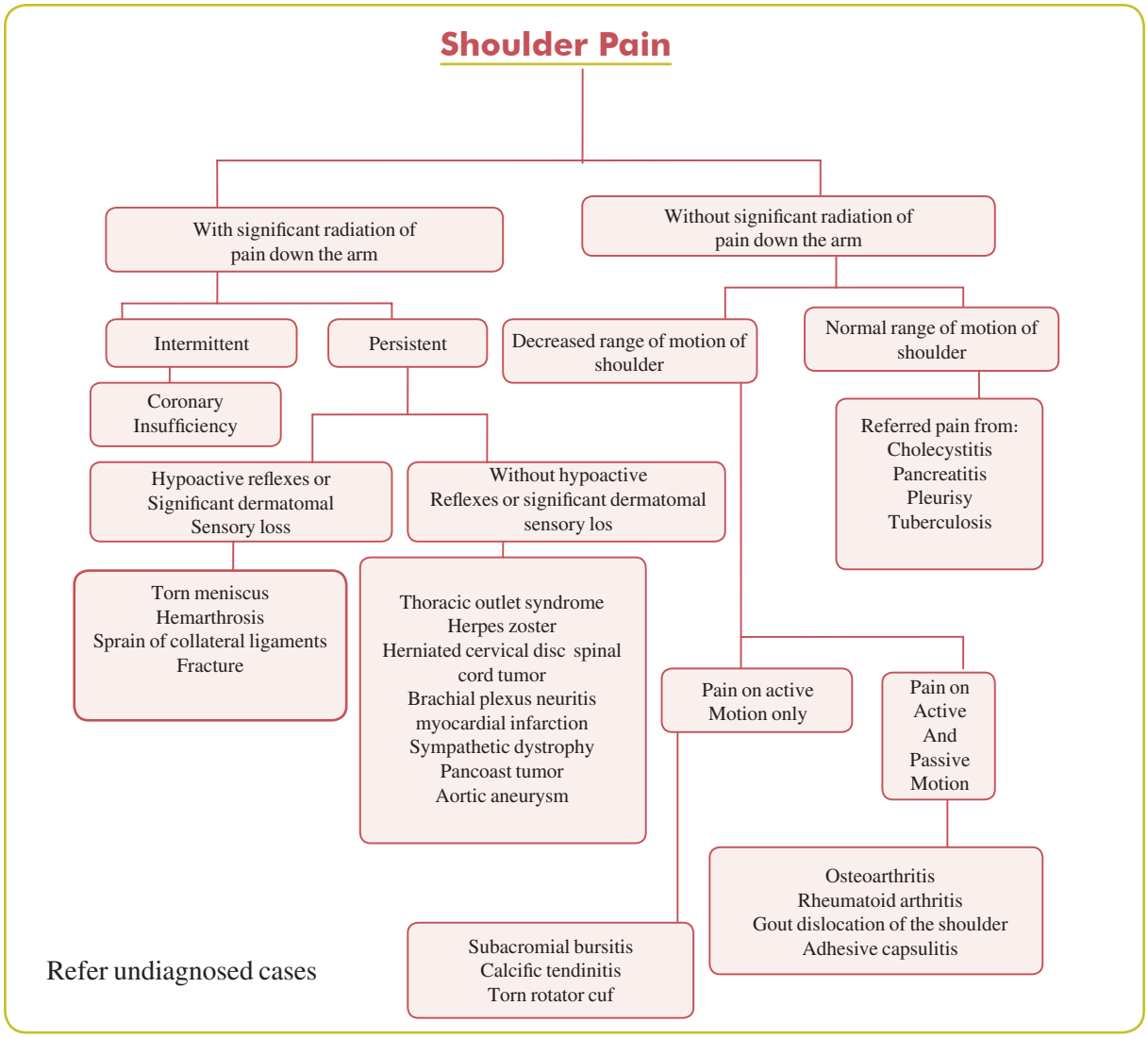


Figure "28": Flow Chart Diagram For DD of Shoulder Pain

Shoulder Pain

• Thoracic Outlet Syndrome:

Fibrous band or cervical rib

• Cervical Spondylosis:

Degenerative changes within vertebrae and in intervertebral discs due to aging or secondary to trauma or rheumatoid arthritis

• Subacromial Bursitis:

It follows trauma. Pain radiates to upper arm & worsens by arm abduction & elevation

Treatment: analgesics or NSAIDs

Severe cases → refer for local injection

• Calcific Tendinitis:

Calcium pyrophosphate deposits in the tendon

• Torn Rotator Cuff:

Caused by trauma. It prevents active abduction of the arm.

• Adhesive Capsulitis (Frozen Shoulder):

Severe shoulder pain associated with loss of all shoulder movements

Treatment: high doses of NSAIDs

Refer for intra-articular injection of corticosteroids& manipulate under anesthesia.

• Subarachnoid Haemorrhage:

Bleeding into subarachnoid space leading to devastating headache,neck pain is followed by vomiting & disturbed level of consciousness.

On examoination ,there is neck stiffness &

positive Kerng's sign.

Refer

- **Sympathetic dystrophy**

- **Torticollis:**

Dystonic spasms→ head turns

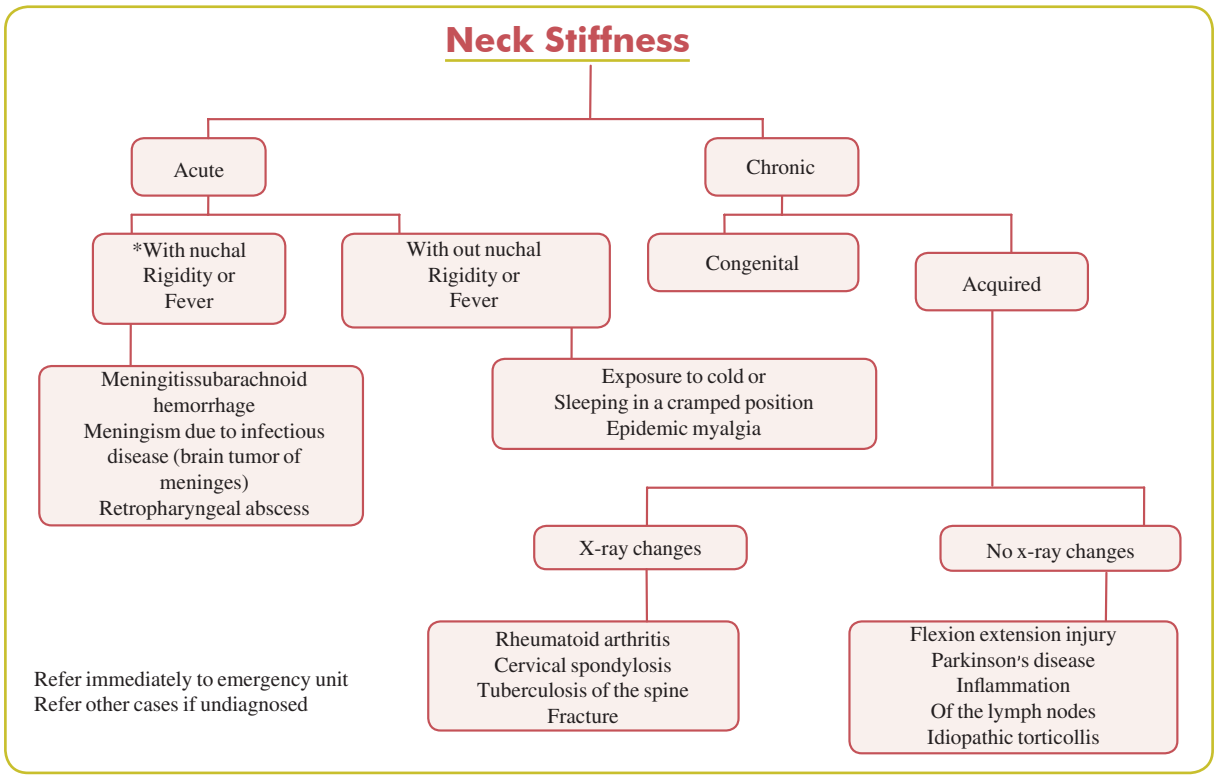


Figure "29": Flow Chart Diagram For DD of Neck Stiffness

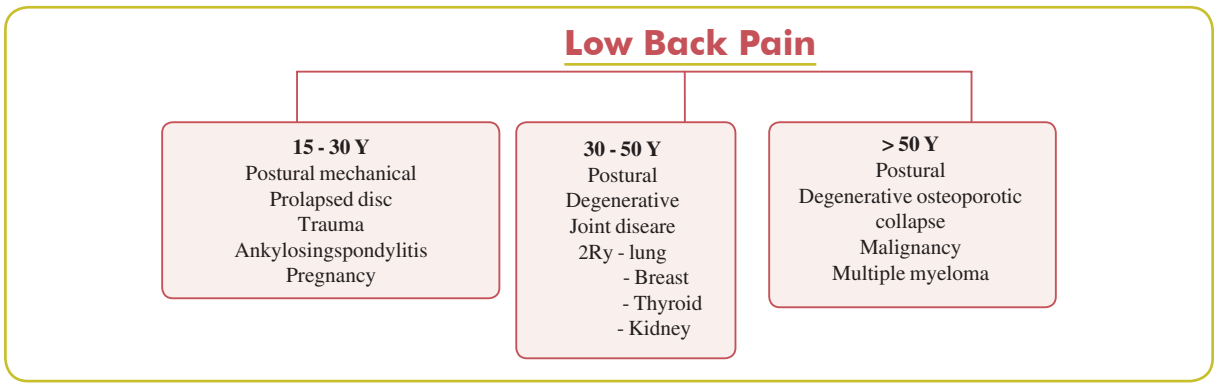


Figure "30": Flow Chart Diagram For DD of Low Back Pain

- **Other Rare Causes :**

o Referred Pain
o Spinal Canal Stenosis
o Cauda Equina Tumours
o Spinal Infection

Do Not Forget

- **Red Flag Signs:**
  - o < 20 or > 55 y
  - o Non mechanical pain
  - o Thoracic pain
  - o Past history of carcinoma
  - o HIV
  - o Taking steroids
  - o Weight loss
  - o Structural deformity

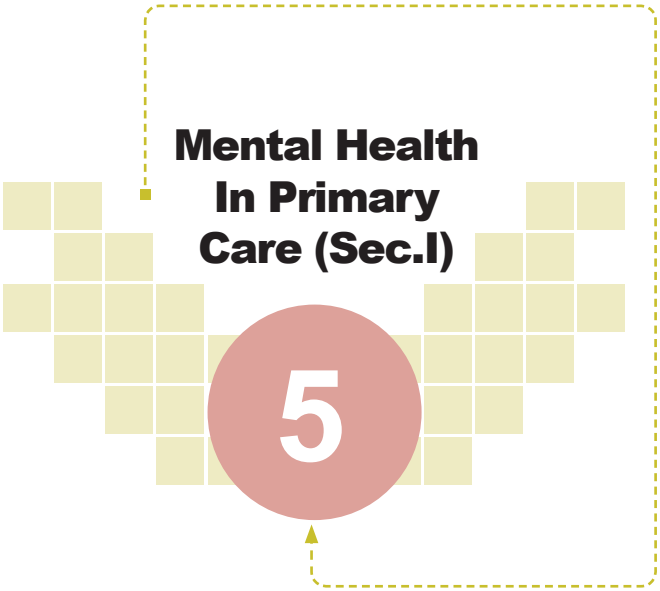
- **Referral:**
  - o Undiagnosed Cases With Joint Pain Or Swelling
  - o Red Flag Signs

- **Multiple Myeloma**

Disease characterized by presence of paraprotein in the serum leading to: bone destruction→ bone fracture and vertebral collapse.

Bone marrow infiltration → anemia

Renal impairment


Mental Health
In Primary
Care (Sec.I)
5

Ministry of Health and Population

Mental Health Secretariat

Mental Health Programme in Egypt

Diagnostic and Management Guide for Mental Disorders in Primary Care

Adapted for Egypt

From WHO Diagnostic and Management Guidelines for Mental Disorders in Primary Care

ICD-10 Chapter V Primary Care Version.

Introduction

Psychological problems in general health care settings are frequent. Research shows that 24% of the patients who present themselves to primary care physicians suffer from a well defined ICD-1O mental disorder. The majority of these patients (69% across the world) usually present to physicians with physical symptoms and there is ample scientific evidence that many of those cases remain undetected. Knowing the high prevalence of common mental disorders, their susceptibility to treatment and the fact that the primary care physicians (PCPs) will continue to manage them in their practice, the following version has been developed.

This version is to assist primary health care providers in the diagnosis and treatment of mental disorders. It contains information modules concerning common mental disorders in Egypt: anxiety disorders, chronic tiredness, depression, dissociative disorders, drug use disorder (Benzodiazepines), enuresis, sleep problems unexplained somatic complaints disorders, as well as, how to diagnose and refer epileptic cases and the following conditions which are:

F05 Delirium

F23 Acute Psychotic Disorders

F31 Bipolar Disorder

F41.2 Mixed Anxiety And Depression

F90 Hyperkinetic (Attention Deffcit) Disorder

F91# Conduct Disorder

In Egypt dissociative disorders are very common and treated by traditional healers leading to catastrophe; these conditions are frequently seen in primary care settings, and primary care providers are in a key position to identify and manage them effectively. In short, ICD-1O PC Chapter V presents the knowledge of mental health science in an easily understandable form for the practitioner at the primary care level.

The categories were chosen as a result of a selection process that reflects

The public health importance of disorders (i.e, prevalence, morbidity or mortality disability resulting from the condition, burdens imposed on the family or community, health care resources need);

- Availability of effective and acceptable management (i.e, interventions with a high probability of benefit to the patient or her/his family are readily available within primary care and are acceptable to the patient and the community,

- Consensus regarding classification and management (i.e, a reasonable consensus exists among primary care physicians and psychiatrists regarding the diagnosis and management of the condition);
- Cross-cultural applicability (i.e, suggestions for identification and management are applicable in different cultural settings and health care systems;)
- Consistency with the main ICD-10 classification scheme (i.e, each diagnosis and diagnostic category corresponds to those in ICD-10).

Brief Guide to Use The Booklet Implementation

1. Conduct A brief Mental Health Assessment Of Patients

- Use the screening questions along the top section of the Mental Disorders Checklist. This checklist is based on the International Classification of Diseases, Chapter V, Primary Care Version (ICD-1O PC).
- If any of the screening questions are positive, then complete appropriate diagnostic guideline section below in order to help reach a correct diagnosis.

2. Use The Appropriate Interactive Summary Card And Flow Chart

If the patient has an Identified mental disorder (s).

- Use the appropriate summary card (s) interactively with the patient to help explain the disorder.
- Determine a treatment plan and explain it to the patient.
- Set-up a follow-up visit(s) to review treatment. In general; e.g. medication , compliance with recommendations and overall progress.
- If the patient appears to have sub threshold disorder(s).

i.e. positive responses to many of the questions but not enough to fulfill the diagnostic criteria for a disorder, medications may not be necessary and use the relevant summary card (s) interactively with the patient .

- Indicate that you are available for consultation should the need arise.

3. The Arabic Questionnaire:

The questionnaire in Arabic can be completed by patients prior to the consultation or after their first visit, either alone or with the help of a PCP assistant.

4. The Symptom Index and The General Flow Charts

A "symptom index provides different entry points to the classification symptom.

Flow-charts to facilitate learning and assist general practitioners in their every day decision making.

How to Have A Successful Interview

During the interview be aware of vague or evasive responses to questions. Often for various reasons patients are reluctant to talk about their problems, therefore:

- Ask open Ended questions
- Understand and acknowledge patients' responses
- Be sensitive to patients' emotions
- Pay attention to patients' body language and tone of voice
- Allow patients to talk freely and express their emotions
- Assure patients of confidentiality. Keep an open mind
- Encourage the patient to seek support from family and friends

Referral

It is important for the primary care providers and specialists to understand that the main objective of the educational initiative is not to replace specialists, but to extend the expertise of the primary care physician and improve the cooperation and communication between the Primary Care Providers and specialty mental health services. With this understanding in mind the following guidelines have been prepared.

Referral to a psychiatrist or to a treatment center should be considered in the following circumstances:

- The patient is displaying signs of suicidal intent or if there seems to be a risk of harm to others
- The patient is so disabled by their mental disorder that they are unable to leave their

home, look after their children or fulfill other activities of daily living

- The GP requires the expertise of secondary care to confirm a diagnosis or implement specialist treatment
- The GP feels that the therapeutic relationship with the patient has broken down
- There is severe physical deterioration of the patient
- Particular psychotropic medication is required, e.g. clozapine, lithium or donezepil
- If the patient requests a referral

When making a referral to secondary mental health services, social services or voluntary / non-statutory organizations, the GP should:

- Have access to a local resource directory.
- Consider coordination issues around the referral.
- Consider implications for the continuing care of the physical health of the patient.

All referral criteria constitute part of the guideline for that particular disorder and assume that, as far as possible, the guideline for diagnosis and management has been followed.

It is helpful if referral letters include as many as possible of the following:

- The patient's name, hospital number (if known), date of birth, address and telephone number, national number.
- The presenting complaint.
- The reason for referral, including whether for advice only for GP to manage, or for psychiatrist to manage.
- Past psychiatric history.
- Background.
- Current mental state.
- Current medication, details of any medication tried in the past few weeks.
- Drugs history.
- Details of carers and significant others.

Assessment Under The Egyptian Mental Health Act 141 in 1944

A Basic Guide for Primary Care Physician

Compulsory admission for assessment and/or treatment can only occur when:

- There is mental disorder; and
- It is in the interest of the health and /or safety of the patient; or
- It is in the interest of the protection of others.
- The compulsory admission is in governmental or private hospital authorized or in home after taking the permission of the Supervision board (مجلس المراقبة) Section 4.

How Patient is Admitted to The Hospital

- The doctor reports to the police station that a person has a mental disorder of (section 4) the police in 24 hours should provide a doctor to assess the patient.
- If the doctor is in doubt, he could reserve him in a general hospital for a period not exceeding eight days under daily observation, then to decide to free him or to put him in a mental hospital .In all cases he should write a report.(Section5).
- A written consent from a relative with two separate medical certificates from two physicians one of them working in the ministry of health, the date of the certificate should not surpass ten days from the admission day (Section7).

Section 21 allows informal admission by the patient or his relative, with the following conditions a written consent by the patient or his relative and two medicals certificates their date not surpassing ten days from the date of admission. The hospital should inform the supervision board in two days.

Section I:

Diagnostic Guidelines

Mental Disorders in Primary Care

Anxiety Disorders

Generalized Anxiety Disorder F41.1

Presenting Complaints

The patient may present initially with tension-related physical symptoms (e.g. headache or a pounding heart) or with insomnia. Enquiry will reveal prominent anxiety.

Diagnostic Features

Multiple symptoms of anxiety or tension include:

- Physical arousal (e.g. dizziness, sweating, a fast or pounding heart, a dry mouth, stomach pains, or chest pains).
- Mental tension (e.g. worry, feeling tense or nervous, poor concentration, fear that something dangerous will happen and the patient won't be able to cope).
- Physical tension (e.g. restlessness, headaches, tremors, or an inability to relax).

Symptoms may last for months and recur regularly. Often, they are often triggered by stressful events in those prone to worry.

Differential Diagnosis

- **Depression – F32#** (if low or sad mood is prominent).
- **Chronic mixed anxiety and depression – F41.2.**
- **Panic disorder – F41.0** (if discrete attacks of unprovoked anxiety are present).
- **Phobic disorders – F40** (if fear and avoidance of specific situations are present).
- **Alcohol misuse – F10** or **Drug-use disorders –F11#** (if heavy alcohol or drug use is present).
- Certain physical conditions (e.g. thyrotoxicosis) or medications (e.g. methylxanthines and beta agonists) may cause anxiety symptoms.
- Anxiety can be a symptom of **Post-traumatic stress disorder – F43.1**.

Essential Information for Patient and Family

- Stress and worry have both physical and mental effects.
- Learning skills to reduce the effects of stress (not sedative medication) is the most effective relief.

  Anxiety disorders are common and treatable.

  Anxiety does not mean weakness.

  Anxiety does not mean loosing the mind.

  Anxiety does not mean personality problems.

  Severe anxiety does mean a medical disorder, which requires treatment.

Advice and Support to Patient and Family

- Encourage the patient to use relaxation methods daily to reduce physical symptoms of tension.
- Advise reduction in caffeine consumption.
- Avoid using cigarettes to cope with anxiety.
- Encourage the patient to engage in pleasurable activities and to resume activities that have been helpful in the past.
- Identify and challenge exaggerated worries to help patient reduce anxiety symptoms:
  - Identify exaggerated worries or pessimistic thoughts (e.g. when daughter is five minutes late from school, patient worries that she may have had an accident).
  - Discuss ways to question these exaggerated worries when they occur (e.g. when the patient starts to worry about the daughter, the patient could tell him/herself, 'I am starting to be caught up in worry again. My daughter is only a few minutes late and should be home soon. I won't call the school to check unless she's an hour late'.
- Identify practice or non-statutory resources for problem-solving, relaxation.
- Regular physical exercise is often helpful.
- Structured problem-solving methods can help patients to manage current life problems or stresses which contribute to anxiety symptoms.
  - Identify events that trigger excessive worry. (For example, a young woman presents with worry, tension, nausea and insomnia. These symptoms began after her son was diagnosed with asthma. Her anxiety worsens when he has asthmatic episodes).
  - List as many possible solutions as the patient can think of (e.g. meeting with the nurse to learn about asthma management, discussing her concerns with other parents of asthmatic children, writing down a management plan for asthma episodes).
  - List the advantages and disadvantages of each possible solution. (The patient should do this, perhaps between appointments).
  - Support the patient in choosing his or her preferred approach.

- Help the patient to work out the steps necessary to achieve the plan.
- Set a date to review the plan. Identify and reinforce things that are working.

Medication

Medication is a secondary treatment in the management of generalized anxiety. It may be used, however, if significant anxiety symptoms persists despite the measures suggested above.

Valeriana root capsule: 2 capsules QDS for one month then removal of 2 capsule each fortnight.

Antidepressant drugs, for example imipramine (30-75mg), may be helpful (especially if symptoms of depression are present). They do not lead to dependence or rebound symptoms, but can lead to withdrawal symptoms and so should be tapered gradually.

- Beta-blockers (30-80mg) may help control physical symptoms such as tremor.

Referral

See general referral criteria.

Non-urgent referral to secondary mental-health services is advised if the patient's symptoms are sufficiently severe or enduring to interfere with his/her social or occupational functioning.

If available, consider cognitive / behavioural therapy or anxiety management.

Panic Disorder F41

Presenting Complaints

Patients may present with one or more physical symptoms (e.g. chest pain, dizziness or shortness of breath) or unexplained episodes of intense fear. Further enquiry shows the full pattern described below.

Diagnostic Features

The patient experiences unexplained attacks of anxiety or fear, which begin suddenly, develop rapidly and may last only a few minutes.

The panics often occur with physical sensations such as palpitations, chest pain, sensations of choking, churning stomach, dizziness, feelings of unreality, or fear of personal disaster (losing control or going mad, sudden death or having a heart attack).

A panic often leads to fear of another panic attack and avoidance of places where panics have occurred.

Differential Diagnosis

Many medical conditions may cause symptoms similar to panic (e.g. arrhythmia, cerebral ischaemia, coronary disease, asthma or thyrotoxicosis). It is not uncommon for individuals with these conditions to additionally suffer from panic. History and physical examination should exclude many of these and should reassure the patient. However, avoid unnecessary medical tests or therapies.

- Drugs may induce symptoms of panic.
- **Phobic disorders** - F40 (if panics tend to occur in specific situations).
- **Depression** - F32# (if low or sad mood is also present).

Essential Information for Patient and Family

- Panic is common and can be treated.
- Anxiety often produces frightening physical symptoms. Chest pain, dizziness or shortness of breath are not necessarily signs of a physical illness; they will pass when anxiety is controlled. Explain how the body's arousal reaction provides the physical basis for their symptoms and how anxiety about a physical symptom can create a vicious cycle. A diagram may be helpful.
- Panic anxiety also causes frightening thoughts (e.g. fear of dying, a feeling that one is going mad or will lose control) and vice versa. These also pass when anxiety is controlled.
- Mental and physical anxiety reinforce each other. Concentrating on physical symptoms will increase fear.
- A person who withdraws from or avoids situations where panics have occurred will only strengthen his/her anxiety.

Advice and Support to Patient and Family

- Advise the patient to identify the early warning signs of an impending panic attack and take the following steps at the first sign of panic:
  - Stay where you are until the panic passes, which may take up to an hour. Do NOT leave the situation. Start slow, relaxed breathing, counting up to four on each breath in and each breath out. Breathing too deeply (hyperventilation) can cause

Different between heart attack and panic attack

	Heart Attack	Panic Attack
Pain	• May or may not be present • If present, the pain is often described as a crushing feeling (like someone standing on the chest) • This pain is usually located in the central chest and may extend to the left arm, neck and back. • Pain, if present, is not usually made worse by breathing or by pressing on the chest. • Pain, if present, is usually persistent and lasts longer than 5-10 minuteS.	• Any pain is usually described as 'sharp' • The pain tends to be localised over the heart • Pain is usually made worse by breathing in and out and pressing on the centre of the chest. • Pain usually disappears within about 5-10 minutes.
Tingling	Tingling, if present, is usually in the left arm.	Tingling is usually present all over the body.
Vomiting	Common.	Nausea may be present but vomiting is less common.
Breathing	A heart attack does not cause you to breath too quickly or too deeply (hyperventilation) - panic does. With a heart attack you may feel a little short of breath. It is possible however, to have a heart attack and then start panicking. In this case, hyperventilation is a symptom of panic not of the heart attack.	Breathing too quickly or too deeply (hyperventilation) is an extremely common panic response which precedes most panic attacks.

some of the physical symptoms of panic. Controlled breathing will reduce physical symptoms. Do something to focus your thinking on something visible, tangible and non-threatening (e.g. look at a green zone).

- o If hyperventilation is severe, sit down and breath into a paper bag so that the increased carbon dioxide will slow down your breathing (unless the patient has asthma or cardiovascular disease).
- o Concentrate on controlling anxiety and not on the physical symptoms.

Tell yourself that this is a panic attack and that frightening thoughts and sensations will eventually pass. Note the time passing on your watch. It may feel like a long time but it will usually only be a few minutes.

- Identify exaggerated fears that occur during panic (e.g. patient's fear that he/she is having a heart attack).
- Discuss ways to challenge these fears during panic (e.g. the patient could remind him/herself, 'I am not having a heart attack. This is a panic, and it will pass in a few minutes').
- Monitor and, if necessary, reduce caffeine intake.
- Avoid using alcohol or cigarettes to cope with anxiety.

Medication

Many patients will benefit from the above measures and will not need medication, unless their mood is low.

- If attacks are frequent and severe, or if the patient is significantly depressed, antidepressants, including tricycles, may be helpful. Imipramine (30-75 mg) is currently licensed for panic There can be a slight worsening of symptoms initially, so advise the patient to plan reduced activities for the week following the first prescription.

Referral

See general referral criteria.

Panic commonly causes physical symptoms; avoid unnecessary medical referral for physical symptoms if certain of the diagnosis.

Consider self-help/voluntary/non-statutory services

Phobic Disorders F40

(Agoraphobia and Social Phobia)

Presenting Complaints

Patients may avoid or restrict activities because of fear. They may have difficulty traveling to the doctor's surgery, going shopping or visiting others. This may lead to unemployment and social or financial problems.

Patients sometimes present with physical symptoms (e.g. palpitations, shortness of breath or 'asthma'). Questioning will reveal specific fears.

Diagnostic Features

The patient experiences an unreasonably strong fear of people, specific places or events. Patients often avoid these situations altogether.

Commonly Feared Situations Include:

- Leaving home.
- Crowds or public places.
- Open spaces
- Travelling in buses, cars, trains or planes.
- Speaking in public.
- Social events.

Patients may avoid leaving home or being alone because of fear.

Differential Diagnosis

- **Panic disorder – F41.0** (if anxiety attacks are prominent and not brought on by anything in particular).
- **Depression– F32#** (if low or sad mood is prominent).

Panic disorder and depression may co-exist with phobias.

Many of the guidelines below also may be helpful for specific (simple) phobias (e.g. fear of water or heights).

Essential Information for Patient and Family

- Phobias can be treated successfully.
- Avoiding feared situations allows the fear to grow stronger.
- Following certain steps can help someone overcome fear.

Advice and Support to Patient and Family

- Assess the patient's understanding of the problem and readiness to change.
- Encourage the patient to practice controlled breathing methods to reduce physical symptoms of fear. See advice on **'Panic disorders – F41.0'**.
- Ask the patient to make a list of all situations that he/she fears and avoids although other people do not.
- Discuss ways to challenge these exaggerated fears (e.g. patient reminds him/herself, 'I am feeling anxious because there is a large crowd. The feeling will pass in a few minutes').
- Help the patient to plan a series of progressively more challenging steps whereby the patient confronts and gets used to feared situations.
- Identify a small, first step toward the feared situation (e.g. if afraid of leaving home, take a short walk away from home with a family member).
- Practice this step for one hour each day until it is no longer frightening.
- If entering the feared situation still causes anxiety, carry out slow and relaxed breathing, saying the panic will pass within 30-60 min. See advice on **'Panic disorder – F41.0'.**
- Do not leave the feared situation until the fear subsides. Do not move onto the next step until the current situation is mastered.
- Move on to a slightly more difficult step and repeat the procedure (e.g. spend a longer time away from home; then do this alone).
- Take no anti-anxiety medicine for at least four hours before practicing these steps.
- Ask a friend or family member to help plan exercises to overcome the fear . Self-help groups can assist in confronting feared situations.
- Keep a diary of the confrontation experiences described above, to allow step-by-step management.
- Avoid using benzodiazepines to cope with feared situations.

Medication

With use of these behavioural methods, many patients will not need medication.

- If depression is also present, antidepressant medication may be indicated. Fluoxetine (20 mg/day) may be helpful in social phobia.
- Encourage patients to face fears without use of benzodiazepines.
- For management of performance anxiety (e.g. fear of public speaking), beta-blockers (30-80 mg/day) may reduce physical symptoms.

Referral

See general referral criteria.

Non-urgent referral to secondary mental-health services is advised:

- If disabling fears persist (e.g. the patient is unable to leave home).
- To prevent problems with long-term sickness and disability.

If available, cognitive behavioural psychotherapy

and exposure may be effective for patients who do not improve with simple measures outlined above.

Recommend self-help/non-statutory/voluntary services in all other cases where symptoms persist.

Chronic Tiredness - Chronic Tiredness and Chronic Tiredness Syndrome – F48

Presenting Complaints

Patients may report:

- Lack of energy.
- Aches and pains.
- Feeling tired easily.
- An inability to complete tasks.

Diagnostic Features

- Mental and physical tiredness, made worse by physical and mental activity.
- Tiredness after minimal effort, with rest bringing little relief.
- Lack of energy.

Other common, often fluctuating, symptoms include:

- Dizziness.
- Headache.
- Disturbed sleep.
- inability to relax.
- Irritability.
- Aches and pains e.g. muscle pain, chest pain, sore throat.
- Decreased libido.
- Poor memory and concentration.
- Depression.

The disorder may be triggered by infection, trauma or other physical illness.

Chronic Tiredness Syndrome is diagnosed when substantial physical and mental tiredness lasts longer than six months, significantly impairs daily activities and where there are no significant findings on physical examination or laboratory investigation. It is associated with other somatic symptoms.

Differential Diagnosis

- Many medical disorders can cause tiredness. A full history and physical examination is necessary, which can be reassuring for the doctor and therapeutic for the patient. Basic investigations include a full blood count, ESR or CRP, thyroid function tests, urea and electrolytes, liver function tests, blood sugar and C-reactive protein. A medical disorder should be suspected where there is:
  - o Any abnormal physical finding, e.g. weight loss
  - o Any abnormal laboratory finding.
  - o Unusual features of the history, e.g. recent foreign travel, or the patient is very young or very old.
  - o Symptoms occurring only after exertion and unaccompanied by any features of mental tiredness.
- **Depression – F32#** (if low or sad mood is prominent).
- Chronic mixed anxiety and **depression – F41.2.**
- **Panic disorder – F41.1** (if anxiety attacks are prominent).
- **Unexplained somatic complaints – F45** (if unexplained physical symptoms are prominent).

Depression and anxiety may be somatized. Social, relationship or other life problems may cause or exacerbate distress.

Essential Information for Patient and Family

- Periods of tiredness or exhaustion are common and are usually temporary and self-limiting.
- Treatment for chronic tiredness is possible and usually has good results, although the outcome for chronic tiredness syndrome is more variable.
- Common triggers.
- Psychological triggers.
- Depression. Stress. Worry. Anxiety.
- Physical triggers.
- Doing too much activity. Doing too little activity.
- Medical problems.
- Anemia. Bronchites. Asthma. Diabetes. Arthritis.

Thyroid disorder. Influenza. Alcohol/Drug use.

- Bacterial, Viral and other infections.
- Medications.
- Steroids. Antihistamines.

Advice and Support to Patient and Family

- Explore what patients think their symptoms mean. Offer appropriate explanations and reassurance (e.g. symptoms are genuinely disabling and not 'all in the mind', but that symptoms following exertion do not mean physical damage and long-term disability).
- For chronic tiredness and chronic tiredness syndrome, advise a gradual return to usual activities. This may take time.
- The patient can build endurance with a programme of gradually increasing physical activity. Start with a manageable level and increase a little each week.
- Emphasize pleasant or enjoyable activities. Encourage the patient to resume activities which have helped in the past.
- Discuss sleep patterns. Encourage a regular sleep routine and avoid day time sleep. (**See 'Sleep problems [insomnia] – F51'**).
- Avoid excessive rest and/or sudden changes in activity.
- Try to have regular meals during the day.
- Try to keep to a healthy diet.
- Record feelings of tiredness.
- For the much rarer condition of chronic tiredness syndrome, a behavioural approach, including cognitive behavioural therapy, a graded programme of exercise, assessment of and assistance with activities of daily living can be helpful. Ideally, this would take place in a primary-care setting using clinical psychologists, nurse practitioners, practice counselors, physiotherapists, occupational therapists or other suitably trained practitioners.

Medication

- To date, no pharmacological treatment for chronic tiredness has been established.
- Mental disorders (e.g. depression) are common in chronic tiredness syndrome and may respond to pharmacological treatment.
- In the absence of depression, or obvious depressive symptoms low dose tricyclic antidepressants (e.g. imipramine 20 mg a day), may be effective for pain and poor sleep.

Referral

See general referral criteria.

- Consider referral to a physician if the GP is uncertain about diagnosis. (See Differential diagnosis' above.)
- Referral to secondary mental-health services, or a liaison psychiatrist, if available, should be considered if there are:
  - Other mental disorders, e.g. eating disorder or bipolar disorder.
  - A risk of suicide.

No improvement despite the above measures.

Depression F32

Presenting Complaints

The patient may present initially with one or more physical symptoms, such as pain or 'tiredness all the time'. Further enquiry will reveal low mood or loss of interest.

Irritability is sometimes the presenting problem.

Awide range of presenting complaints may accompany or conceal depression. These include anxiety or insomnia, worries about social problems such as financial or marital difficulties, increased drug or alcohol use, or (in a new mother) constant worries about her baby or fear of harming the baby.

Some groups are at higher risk (e.g. those who have recently given birth or had a stroke and those with physical disorders, e.g. Parkinson's disease or multiple sclerosis).

Diagnostic Features

- Low or sad mood.
- Loss of interest or pleasure.

At least four of the following associated symptoms are present:

- Disturbed sleep.
- Poor concentration.
- Disturbed appetite.
- Suicidal thoughts or acts.
- Guilt or low self-worth.
- Loss of self confidence.
- Pessimism or hopelessness about the future

- Tiredness or loss of energy.
- Agitation or slowing of
- Decreased libido.movement or speech
- Diurnal mood variation.

Symptoms of anxiety or nervousness are also frequently present.

Differential Diagnosis

- Acute psychotic disorder - F23 (if hallucinations [e.g. hearing voices] or delusions [e.g. strange or unusual beliefs] are present).
- Bipolar disorder - F31 (if patient has a history of manic episodes [e.g. excitement, rapid speech, elevated mood]).
- Alcohol misuse - F10 or Drug use disorder - F11# (if heavy alcohol or drug use is present).
- Chronic mixed anxiety and **depression – F41.2.**

Some medications may produce symptoms of depression (e.g. beta-blockers, other antihypertensives,H2blockers,oralcontraceptives, corticosteroids).

Unexplained somatic complaints, anxiety, alcohol or drug disorders may co-exist with depression.

Essential Information for Patient and Family

Depression is a common illness and effective treatments are available.

- Depression is not weakness or laziness.
- Depression can affect patients' ability to cope.
- Depression does not mean that you have no faith.
- Depression may have no external etiology and ins due to organic causes.
- Common triggers.
- Recent bereavernent, relationship problems, unemployment, moving house, stress at work.
- Financial problems, family history of depression, childbirth, menopause, seasonal changes.
- Illness, infectious diseases, influenza hepatitis, chronic medical conditions.
- Alcohol and substance use disorders.
- Medications as, antihypertensives, H2 blockers, oral contraceptives, corticosteroids
- Recommend information leaflets.

Advice and Support to Patient and Family Suicide

- Assess risk of suicide: Ask a series of questions about suicidal ideas, Ask about plans and intent (e.g. has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?)
- Close supervision by family or friends, or hospitalization may be needed. Ask about risk of harm to others. Consider high-risk groups, e.g. older people, men, those with physical illness, substance abuse, a family history of suicide, or those who have demonstrated self-harm previously.
- Identify current life problems or social stresses, including precipitating factors. Focus on small, specific steps patients might take towards reducing or improving management of these problems. Avoid major decisions or life changes.
- Plan short-term activities, which give the patient enjoyment or build confidence.
- Exercise may be helpful.
- If appropriate, advise reduction in caffeine intake and drug and alcohol use.
- Support the development of good sleep patterns and encourage a balanced diet.
- Encourage the patient to resist pessimism and self-criticism and not to act on pessimistic ideas (e.g. ending marriage, leaving job), and not to concentrate on negative or guilty thoughts.
- If physical symptoms are present, discuss the link between physical symptoms and mood (see 'Unexplained somatic symptoms - F45').
- Involve the patient in discussing the advantages and disadvantages of available treatments. Inform the patient that medication usually works more quickly than psychotherapies. Where a patient chooses not to take medication, respect the patient's decision and arrange another appointment to monitor progress.
- After improvement, plan with patient the action to be taken if signs of relapse occur.

Medication

Consider antidepressant drugs if sad mood or loss of interest are prominent for at least two weeks, and if four or more of these symptoms are present:

- Tiredness or loss of energy.
- Disturbed sleep.
- Guilt or self-reproach.
- Poor concentration.
- Thoughts of death or suicide.
- Disturbed appetite.
- Agitation or slowing of movement and speech.

There is no evidence that people with only few or very mild depressive symptoms respond to antidepressants to consider medication at the first visit.

At present, there is no evidence to suggest that any antidepressant is more effective than others. However, their side-effect profiles differ and therefore some drugs will be more acceptable to particular patients than others.

Choice of Medication:

- If the patient has responded well to a particular drug in the past, use that drug again.
- If the patient is older or physically ill, use medication with fewer anticholinergic and cardiovascular side-effects.
- If the patient is suicidal, avoid tricyclics and consider referral.
- If the patient is anxious or unable to sleep, use a drug with more sedative effects, but warn of drowsiness and problems driving.

Explain to The Patient That:

- The medication must be taken every day.
- The drug is not addictive.
- Improvement will build up over two to three weeks after starting the medication.
- Mild side effects may occur but usually fade in seven to 10 days.

Stress that the patient should consult the doctor before stopping the medication. All antidepressants should be withdrawn slowly, preferably over four weeks in weekly decrements.

Continue full-dose antidepressant medication for at least four to six months after the condition improves to prevent relapse. Review regularly during this time. Consider, with the patient, the need for futher continuation beyond four to six months.

If patient has had several episodes of major depression, consider carefully long-term, prophylactic treatment. Obtain a second opinion at this point, if available.

If sleep problems are very severe, consider the use of anxiolytics in the short term - no longer than two weeks - in addition to an antidepressant. A sedative tricyclic is often sufficient but, if not, a short-term anxiolytics may be helpful.

If using tricyclic medication, build up to the effective dose over seven to 10 days. For example, imipramine: start at 25-50 mg each night and build to 100-150 mg). medication to be continued at least 6 months after initial improvement.

Withdraw antidepressant medication slowly, and monitor for withdrawal reactions and to ensure remission is stable.

Drugs are not addictive.

improvement takes time, generally 2-4 weeks for response.

Progress

- Same medication should continue unless a different decision is made by the physician.
- Medication should not be discontinued without physician's knowledge.
- In case a medication is not effective, another medication may be tried.

Referral

The following structured therapies, delivered by properly trained practitioners, have been shown to be effective for some people with depression:

- Cognitive behavioural therapy (CBT).
- Behaviour therapy.
- Interpersonal therapy.
- Structured problem-solving.

Patients with chronic, relapsing depression may benefit more from CBT or a combination of CBT and antidepressants than from medication alone. Counselling may be helpful, especially in milder cases and if focused on specific psychosocial problems which are related to the depression (e.g. relationships, bereavement).

Referral to secondary mental-health services is advised:

- As an emergency, if there is a significant risk of suicide or danger to others, psychotic symptoms or severe agitation .

- As a non-emergency, if significant depression persists despite treatment in primary care. (Antidepressant therapy has failed if the patient remains symptomatic after a full course of treatment at an adequate dosage. If there is no clear improvement with the first drug, it should be changed to another class of drug.)

If drug misuse is also a problem, see the guidelines for these disorders.

Recommend voluntary/non-statutory services in all other cases where symptoms persist, where the patient has a poor or non-existent support network, or where social or relationship problems are contributing to the depression.

Severely depressed adolescents are difficult to assess and manage, and referral is recommended.

Dissociative (Conversion) Disorder – F44

Presenting Complaints

Patients exhibit unusual or dramatic physical symptoms, such as seizures, amnesia, trance, loss of sensation, visual disturbances, paralysis, aphonia, identity confusion or 'possession' states. The patient is not aware of their role in their symptoms - they are not malingering.

Diagnostic Features

Physical symptoms that are:

- Unusual in presentation
- Not consistent with known disease.

Onset is often sudden and related to psychological stress or difficult personal circumstances.

In acute cases, symptoms may:

- Be dramatic and unusual
- Change from time to time
- Be related to attention from others.

In more chronic cases, patients may appear unduly calm in view of the seriousness of the complaint.

Differential Diagnosis

Carefully consider physical conditions that may cause symptoms. A full history and physical (including neurological) examination are essential. Early symptoms of neurological disorders (eg multiple sclerosis) may resemble conversion symptoms.

- If other unexplained physical symptoms are present, see 'Unexplained somatic complaints - F45'.
- Depression - F32#. Atypical depression may present in this way.

Essential Information for Patient and Family

- Physical or neurological symptoms often have no clear physical cause. Symptoms can be brought about by stress.
- Symptoms usually resolve rapidly (from hours to a few weeks), leaving no permanent damage.

Advice and Support to Patient and Family

- Encourage the patient to acknowledge recent stresses or difficulties (though it is not necessary for the patient to link the stresses to current symptoms).
- Give positive reinforcement for improvement. Try not to reinforce symptom
- Advise the patient to take a brief rest and relief from stress, then return to usual activities.
- Advise against prolonged rest or withdrawal from activities.
    - o If patient says that this is due to magic or demonic possession, tell him that god saying in sourah Elbakara that all magic taught by harout and marout to people will not hurt you unless god wants; so you are more strong than magic by being always with god.

Medication

Avoid anxiolytics or sedatives.

In more chronic cases with depressive symptoms, antidepressant medication may be helpful.

Referral

See general referral criteria.

Non-urgent referral to secondary mental health services is advised if confident of the diagnosis:

- If symptoms persist.
- If symptoms are recurrent or severe.
- If the patient is prepared to discuss a psychological contribution to symptoms.
- If unsure of the diagnosis, consider referral to a physician before referral to secondary mental-health services.

Drug Use Disorders – F11#

Presenting Complaints

Patients may have depressed mood, nervousness or insomnia.

Patients may present with a direct request for prescriptions for narcotics or other drugs, a request for help to withdraw, or for help with stabilising their drug use.

They may present in a state of intoxication or withdrawal or with physical complications of drug use, e.g. abscesses or thromboses. They may also present with social or legal consequences of their drug use, e.g. debt or prosecution. Occasionally, covert drug use may manifest itself as bizarre, unexplained behaviour.

Signs Of Drug Withdrawal Include:

- Opioids: nausea, sweating, hallucinations
- Sedatives: anxiety, tremors, hallucinations
- Stimulants: depression, moodiness.

Family may request help before the patient (e.g. because the patient is irritable at home or missing work.).

Whatever their motivation for seeking help, the aim of treatment is to assist the patient to remain healthy until, if motivated to do so and with appropriate help and support, he or she can achieve a drug-free life.

Diagnostic Features

- Drug use has caused physical harm (e.g. injuries while intoxicated), psychological harm (e.g. symptoms of mental disorder due to drug use), or has led to harmful social consequences (e.g. loss of job, severe family problems, or criminality).
- Habitual and/or harmful or chaotic drug use.
- Difficulty controlling drug use.
- Strong desire to use drugs.
- Tolerance (can use large amounts of drugs without appearing intoxicated).
- Withdrawal (e.g. anxiety, tremors or other withdrawal symptoms after stopping use).

Diagnosis Will Be Aided By:

- History - including reason for presentation, past and current (i.e. in the past four weeks) drug use, history of injecting and risk of HIV and hepatitis, past medical and psychiatric history, social (and especially child care) responsibilities, forensic history and past contact with treatment services.
- Examination - motivation, physical (needle tracks, complications, e.g. thrombosis or viral illness), mental state.
- Investigations (haemoglobin, LFTs, urine drug screen, hepatitis B and C).

Differential Diagnosis

- Alcohol misuse - F10 often co-exists. Polydrug use is common.
- Symptoms of anxiety or depression may also occur with heavy drug use. If these continue after a period of abstinence (eg about four weeks), see **'Depression – F32#'** and **'Generalized anxiety – F41.1'**
- Psychotic disorders - F23, F20#.
- Acute organic syndromes.

Essential Information for Patient and Family

- Drug misuse is a chronic, relapsing problem, and controlling, or stopping, use often requires several attempts. Relapse is common.
- Abstinence should be seen as the long-term goal. Harm reduction (especially reducing intravenous drug use) may be a more realistic goal in the short- to medium term.
- Ceasing or reducing drug-use will bring psychological, social and physical benefits.
- Using some drugs during pregnancy risks harming the baby.
- For intravenous drug-users, there is a risk of transmitting HIV infection, hepatitis or other infections carried by body fluids. Discuss appropriate precautions (e.g. use condoms, and do not share needles, syringes, spoons, water or any other injecting equipment).

Advice and Support to Patient and Family

Advice should be given according to the patient's motivation and willingness to change.

For all Patients:

- Discuss costs and benefits of drug-use from the patient's perspective.
- Feedback information about health risks, including the results of investigations.
- Emphasize personal responsibility for change.
- Give clear advice to change.

- Assess and manage physical health problems (e.g. anaemia, chest problems) and nutritional deficiencies.
- Consider options for problem solving, or targeted counselling, to deal with life problems related to drug use.

For patients not willing to stop or change drug use now:

- Do not reject or blame.
- Advise on harm-reduction strategies (e.g. if the patient is injecting, advise on needle exchange, not injecting alone, not mixing alcohol, benzodiazepines and opiates).
- Clearly point out medical, psychological and social problems caused by drugs.
- Make a future appointment to reassess health and discuss drug use.

If reducing drug-use is a reasonable goal (or if a patient is unwilling to quit):

- Negotiate a clear goal for decreased use (e.g. no more than one marijuana cigarette per day with two drug-free days per week).
- Discuss strategies to avoid or cope with high-risk situations (e.g. social situations or stressful events).
- Introduce self-monitoring procedures (e.g. diary of drug use) , and safer drug-use behaviours (e.g. time restrictions, slowing down rate of use)
- Consider options for counselling and/or rehabilitation.

If maintenance on substitute drugs is a reasonable goal (or if a patient is unwilling to quit):

- Negotiate a clear goal for less harmful behaviour. Help the patient develop a hierarchy of aims (e.g. reduction of injecting behaviour, cessation of illicit use and maintenance on prescribed, substitute drugs).
- Discuss strategies to avoid or cope with high-risk situations (e.g. social situations or stressful events).
- Consider withdrawal symptoms and how to avoid or reduce them.
- Consider options for counselling and/or rehabilitation.

For Patients Willing to Stop Now:

- Set a definite day to quit.
- Consider withdrawal symptoms and how to manage them.
- Discuss strategies to avoid or cope with high-risk situations (e.g. social situations or stressful events).
- Make specific plans to avoid drug use (e.g. how to respond to friends who still use drugs).
- Identify family or friends who will support stopping drug-use.
- Consider options for counselling and/or rehabilitation.

For patients who do not succeed, or who relapse:

- Identify and give credit for any success.
- Discuss situations which led to relapse.
- Return to earlier steps.

Self-help organizations (e.g. Narcotics Anonymous) are often helpful. If available.

Medication

To withdraw a patient from benzodiazepines, convert to a long-acting drug such as diazepam and reduce gradually (e.g. by 2 mg per fortnight) over a period of two to six months.

Withdrawal from stimulants or cocaine is distressing, and may require medical supervision under a shared-care scheme.

Withdrawal from opiates should be done in hospital . A multidisciplinary approach is essential and should include drug counseling / therapy and possible future rehabilitation needs.

Help with life problems, employment, social relationships, is an important component of treatment.

Shared care between all agencies (non statutory agencies, NHS mental health and drug misuse services) and professionals involved is essential. Clarity on who is responsible for prescribing and for the physical care of the patient is crucial.

Sleep Problems (Insomnia) – F51

Presenting Complaints

Patients are distressed by persistent insomnia and are sometimes disabled by the daytime effects of poor sleep (e.g. driving).

Diagnostic Features

- Difficulty falling asleep

- Restless or unrefreshing sleep
- Frequent or prolonged periods of being awake.

Differential Diagnosis

- Short-term sleep problems may result from stressful life events, acute physical illnesses or changes in schedule.
- Persistent sleep problems may indicate another cause, for example:
  - Depression - F32# (if low or sad mood and loss of interest in activities are prominent)
  - Generalized anxiety - F41.1 (if daytime anxiety is prominent).

Sleep problems can be a presenting complaint of Alcohol misuse - F10 or Substance abuse - F11#. Enquire about current substance use.

- Consider medical conditions which may cause insomnia (e.g. heart failure, pulmonary disease and pain conditions).
- Consider medications which may cause insomnia (e.g. steroids, theophylline, decongestants and some antidepressant drugs).
- If the patient snores loudly while asleep, consider sleep apnoea. It will be helpful to take a history from the bed partner. Patients with sleep apnoea often complain of daytime sleepiness but are unaware of nighttime awakenings.

Essential Information for Patient and Family

- Temporary sleep problems are common at times of stress or physical illness.
- Sleep requirements vary widely and usually decrease with age.
- Improvement of sleeping habits (not sedative medication) is the best treatment.
- Worry about not being able to sleep can worsen insomnia.
- Stimulants (including coffee and tea) can cause or worsen insomnia.

Advice And Support to Patient And Family

- Encourage the patient to maintain a regular sleep routine by:
  - Relaxing in the evening.
  - Keeping to regular hours for going to bed and getting up in the morning, trying not to vary the schedule or 'sleep in' on the weekend.
  - Getting up at the regular time even if the previous night's sleep was poor.
  - Avoiding daytime naps since they can disturb the next night's sleep.
- Daytime exercise can help the patient to sleep regularly, but evening exercise may contribute to insomnia.
- Simple measures may help (e.g. a milk drink or a hot bath).
- Recommend relaxation exercises to help the patient to fall asleep.
- Advise the patient to avoid caffeine and cola in the evenings.
- If the patient cannot fall asleep within 30 min, advise him/her to get up and try again later when feeling sleepy.
- Sleep diaries are often useful in assessment and monitoring of progress.

Medication

- Treat underlying psychiatric or physical conditions.
- Make changes to medication, as appropriate.
- Valerian may have a weak effect on sleep but without a hangover effect the next day.

Referral

See general referral criteria.

Referral to secondary mental-health services is rarely helpful.

Refer to a sleep laboratory, if available, if more complex sleep disorders (e.g. narcolepsy, night terrors or somnambulism) are suspected.

Where symptoms are severe and long-lasting and the above measures are unsuccessful, consider referral to a clinical psychologist or specially trained counsellor, if available, for therapies such as sleep hygiene training.

Unexplained Somatic Complaints - F45

Presenting Complaints

- Any physical symptom may be present.
- Symptoms may vary widely across cultures.
- Complaints may be single or multiple and may change over time.

Diagnostic Features

- Medically unexplained physical symptoms. (A full history and physical examination are necessary to determine this.).
- Frequent medical visits in spite of negative investigations.
- Symptoms of depression and anxiety are common.

Some patients may be primarily concerned with obtaining relief from physical symptoms. Others may be worried about having a physical illness and be unable to believe that no physical condition is present (hypochondriasis).

Differential Diagnosis

- **Drug use** disorders - F11# (e.g. seeking narcotics for relief of pain).
- If low or sad mood is prominent, see 'Depression - F32#'. (People with depression are often unaware of everyday physical aches and pains.)
- **Generalized anxiety disorder – F41.1** (if anxiety symptoms are prominent).
- **Panic disorder – F41.0** (misinterpretation of the somatic signs associated with panic).
- Chronic mixed anxiety and depression - F41.2.
- **Acute psychotic disorders – F23** (if strange beliefs about symptoms are present [eg belief that organs are decaying]).
- An organic cause may eventually be discovered for the physical symptoms. Psychological problems can co-exist with physical problems.

Depression, anxiety, alcohol misuse or drug use disorders may co-exist with unexplained somatic complaints.

Essential Information for Patient and Family

- Physical symptoms are real.
- Emotional stress can cause physical symptoms.
- Physical symptoms can lead to more emotional stress.
- Emotional stress can make physical symptoms worse.
- The focus should be on managing the symptoms, not on discovering their cause.
- Cure may not always be possible; the goal should be to live the best life possible even if symptoms continue.

Advice and Support to Patient and Family

- Acknowledge that the patient's physical symptoms are real to the patient.
- Ask about the patient's beliefs (what is causing the symptoms?) and fears (what does he/she fear may happen?).
- Be explicit early on about considering psychological issues. The exclusion of illness and exploration of emotional aspects can happen in parallel. Investigations should have a clear indication. It may be helpful to say to the patient, 'I think this result is going to be normal'.
- Offer appropriate reassurance (e.g. not all headaches indicate a brain tumour). Advise patients not to focus on medical worries.
- Discuss emotional stresses that were present when the symptoms arose.
- Explain the links between stress and physical symptoms and how a vicious cycle can develop (e.g. 'stress can cause a tightening of the muscles in the gut. This can lead to the development of abdominal pain or worsening of existing pain. The pain aggravates the tightening of the gut muscles'). A diagram may be helpful.
- Relaxation methods can help relieve symptoms related to tension (such as headache, neck or back pain).
- Encourage exercise and enjoyable activities. The patient need not wait until all symptoms are gone before returning to normal routines.
- Treat associated depression, anxiety.
- For patients with more chronic complaints, time-limited appointments that are regularly scheduled can prevent more frequent, urgent visits.
- Structured problem-solving methods may help patients to manage current life problems or stresses which contribute to symptoms
  - Help the patient to identify the problem.
  - List as many possible solutions as the patient can think of.
  - List the advantages and disadvantages of each possible solution. (The patient should do this, perhaps between appointments.)

- Support the patient in choosing his or her preferred approach.
- Help the patient to work out the steps necessary to achieve the plan.
- Set a date to review the plan. Identify and reinforce things that are working.
- Avoiding patterns of negative thinking.

Reassurance:

- This does not mean that there is nothing wrong.
- You are not going to develop a serious illness.
- There is something wrong, but it is not caused by physical disease.
- Record symptoms to see the link between your feelings, day-to-day problems and your physical symptoms.

Medication

Avoid unnecessary diagnostic testing or prescription of new medication for each new symptom. Rationalize polypharmacy.

Where depression is also present, an antidepressant may be indicated.

(See 'Depression - F32#'.)

Low doses of tricyclic antidepressant medication (e.g imipramine 20 mg a day) may be helpful in some cases (e.g. when there is headache, atypical chest pain).

Referral

- Patients are best managed in primary health-care settings. Consistency of approach within the practice is essential. Seeing the same person is helpful. Documenting discussions with colleagues can reduce stress by sharing responsibility within the primary-care team.
- Non-urgent referral to secondary mental-health services is advised on grounds of functional disability, especially inablility to work and duration of symptoms.
- Cognitive behaviour therapy, if available, may help some patients, though willingness of patients to participate is sometimes poor.
- Refer to a liaison psychiatrist, if available, for those who persist in their belief that they have a physical cause for their symptoms, despite good evidence to the contrary.
- Avoidmultiplereferralstomedicalspecialists. Documented discussions with appropriate medical specialists may be helpful from time to time as, in some cases, underlying physical illness eventually emerges.

Nonorganic enuresis F-98 Management Guidelines

Presenting Complaint

repeated urination, into clothes or bed

Diagnostic features

Diagnosis of enuresis is done when the child is 5 years old or with a mental age 4 years

The urination is usually involuntary though occasionally intentionally.

May be continuous from birth, or may follow a period of continence.

Sometimes occurs with more general emotional or behavioural disorder.

May begin after stressful or traumatic events.

Differential Diagnosis

Exclusion of the following condition is necessary.

- Lack of bladder control due to any neurological disorder (spina bifida).
- Epileptic attacks.
- Structural abnormality of the urinary trac.
- Cystitis.
- Polyuria (diabetes), or diuretic drugs.
- Generalized emotional imbalance.

In secondary enuresis the urination is also abnormal during the day.

In all cases of enuresis and especially of primary enuresis exclude organic causes if not sure of exclusion of organic causes refer to GUT clinic.

Essential Information for The Patient and The Family

- Enuresis is a curable disorder,it is part of a specific delay in development.it is often hereditary.
- It needs the cooperation of the family with the patient,it is not under the child control.

- Emotional stresses at home increases the severity of the enuresis.
- Punishment and scolding are unlikely to help and may increase emotional distress.

Counselling of The Patient and Family

- The patient should not be blamed or punished corporally.
- Avoid discrimination between siblings.
- The child should not feel ashamed, he will share and be responsible in his cure programm.
- Muscular exercise to the pelvic muscles by stopping voiding for 5 seconds than continue voiding.
- Limit the fluid intake (including tee and cola) and sugary diet two hours before sleep.
- The child should share in changing and cleaning the clothes.
- Availability of a pot near the bed.

Medication

Is prescribed if there is severe emotional disorder secondary to the disorder, imipramine 25-50 mg two hours before bed.

Behaviour therapy is the first line of treatment.

- Light-on the way to the bathroom by night.
- Make a diary sheet for wet days and nights ,put a star for unwet days and nights.
- Regular voiding of the urine every two hours while awake, and try to increase the duration by half an hour every month for three months.
- Give a gift weekly if there is 7 stars i.e. completely unwet all the week,in his diary sheet.

Specialist Consultation:

- Failure of the behaviour therapy.
- Need to introduce pharmacological treatment (ADH hormone).
- If it is associated with family conflict, or emotional disturbance.
- If doubts arise about sexual abuse, or physical abuse.
- If problem persists beyond age 10.
- In case of urinary infection or persistent daytime incontinence or an abnormal urinary stream consult GUT specialist.

Delirium – F05

Presenting Complaints

- Families may request help because patient is confused or agitated.
- Patients may appear uncooperative or fearful.
- Delirium may occur in-patients hospitalized for physical conditions.

Diagnostic Features

Acute onset, usually over hours or days, of:

- Confusion (patient appears disoriented and struggles to understand surroundings).
- Clouded thinking or awareness.

This is often accompanied by:

- Poor memory.
- Withdrawal from others.
- Agitation.
- Visions or illusions.
- Emotional upset.
- Suspiciousness.
- Loss of orientation.
- Disturbed sleep
- Wandering attention. (reversal of sleep pattern).
- Hearing voices.
- Autonomic features

(e.g, sweating, tachycardia).

Symptoms often develop rapidly and may change from hour to hour.

Delerium may occur in-patients with previously normal mental function or in those with dementia. Milder stresses (e.g, medication and mild infections) may cause delirium in older patients or in those with dementia.

Differential Diagnosis

Identify and correct possible, underlying physical causes of delirium, such as:

- Alcohol intoxication or withdrawal.
- Drug intoxication, overdose or withdrawal (including prescribed drugs).
- Infection.
- Metabolic changes (e.g liver disease, dehydration, hypoglycaemia).
- Head trauma.
- Hypoxia.

- Epilepsy.

If symptoms persist, delusions and disordered thinking predominate, and no physical cause is identified, see **'Acute psychotic disorders – F23'**.

Acute Psychotic Disorders – F23

Includes: acute schizophrenia-like psychosis, acute delusional psychosis, and other acute and transient psychotic disorders

Presenting Complaints

Patients may experience:

- Hearing voices when no one is around.
- Strange beliefs or fears.
- Apprehension, confusion.

Families may ask for help with behaviour changes that cannot be explained, including strange or frightening behaviour (e.g, withdrawal, suspiciousness, and threats).

Young adults may present with persistent changes in functioning, behaviour or personality (e.g, withdrawal) but without florid psychotic symptoms.

Diagnostic Features

Recent onset of:

- Hallucinations (false or imagined sensations, e.g, hearing voices when no one is around).
- Delusions (firmly held ideas that are often false and not shared by others in the patient's social, cultural or ethnic group, e.g, patients believe they are being poisoned by neighbours, receiving messages from television, or being looked at by others in some special way).
- Disorganized or strange speech.
- Agitation or bizarre behaviour.
- Extreme and labile emotional states.

Differential Diagnosis

- Physical disorders that can cause psychotic symptoms include:
  - Drug induced psychosis.
  - Alcoholic hallucinosis.
  - Infectious or febrile illness.
  - Epilepsy.

Refer to 'Delirium - FO5' for other potential causes.

- Chronic psychotic disorders - F20#, if psychotic symptoms are recurrent or chronic.
- Bipolar disorder - F31', if symptoms of mania (e.g, elevated mood, racing speech or thoughts, exaggerated self-worth) are prominent.
- Depression (depressive psychosis) - F32#, if depressive delusions are prominent.

Essential Information for Patient and Family

- Agitation and strange behavior can be symptoms of a mental illness.
- Acute episodes often have a good prognosis, but long-term course of the illness is difficult to predict from an acute episode.
- Advise patient and family about the importance of medication, how it works and possible side effects.
- Continued treatment may be needed for several months after symptoms resolve.

Remember that prophet Mohamed (PBUH) had taught us that insane recovers from their insanity

If the patient requires treatment under the Mental Health Act, advise family about related legal issues

Advice and support of patient and family

- Ensure the safety of the patient and those caring for him/her:
  - Family or friends should be available for the patient if possible
  - Ensure that the patient's basic needs (e.g, food and drink and accommodation) are met.
- Minimize stress and stimulation.
- Do not argue with psychotic thinking (you may disagree with the patient's beliefs, but do not try to argue that they are wrong).
- Avoid confrontation or criticism, unless it is necessary to prevent harmful or disruptive behaviour.
- If there is a significant risk of suicide, violence or neglect, admission to hospital or close observation in a secure place may be required. If the patient refuses treatment, legal measures may be needed.

- Assess ability to drive safely. Inform his place of work, if the patient is a heavy goods vehicle driver.
- Encourage resumption of normal activities after symptoms improve.

Specialist Consultation

Referral should be made under the following conditions:

- As an emergency, if the risk of suicide, violence or neglect is considered significant.
- Urgently for ALL first episodes, to confirm the diagnosis and arrange care planning and appointment of key worker. A home visit may be required. Specific interventions for people experiencing their first episode of psychosis, including specific psycho-education of the patient and family, may be available.
- For ALL relapses, to review the effectiveness of the care plan, unless there is an established previous response to treatment and it is safe to manage the patient at home.
- If there is non-compliance with treatment, problematic side effects, failure of community treatment, or concerns about co-morbid drug and alcohol misuse.

If there is fever, rigidity and/or labile blood pressure, stop antipsychotic medication and refer immediately to the on-call physician for investigation of neuroleptic malignant syndrome.

Bipolar Disorder – F31

Presenting Complaints

Patients may have a period of depression, mania or excitement with the pattern described below.

Referral may be made by others due to lack of insight.

Diagnostic Features

- Periods of mania with:
  - Increased energy and activity.
  - Elevated mood or irritability.
  - Rapid speech
  - Loss of inhibitions.
  - Decreased need for sleep
  - Increased importance of self.
- The patient may be easily distracted.
- The patient may also have periods of depression with:
  - Low or sad mood.
  - Loss of interest or pleasure.
- The following associated symptoms are frequently present:
  - Disturbed sleep.
  - Guilt or low self-worth.
  - Tiredness or loss of energy.
  - Poor concentration.
  - Disturbed appetite.
  - Suicidal thoughts or acts.

Either type of episode may predominate. Episodes may alternate frequently or may be separated by periods of normal mood. In severe cases, patients may have hallucinations (hearing voices or seeing visions) or delusions (strange or illogical beliefs) during periods of mania or depression.

Differential Diagnosis

- Alcohol misuse - F10′ or ‘Drug use disorder - F11#′ can cause similar symptoms.

Essential Information for Patient and Family

- Unexplained changes in mood and behaviour can be symptoms of an illness.
- Effective treatments are available. Long-term treatment can prevent future episodes.
- If left untreated, manic episodes may become disruptive or dangerous. Manic episodes often lead to loss of job, le.g,al problems, financial problems or high-risk sexual behaviour. When the first, milder symptoms of mania or hypomania occur, referral is often indicated and the patient should be encouraged to see the specialist straight away.
- Inform patients who are on lithium of the signs of lithium toxicity (give the arabic leaflet).

Counselling of Patient and Family

- During depression, assess risk of suicide. (Has the patient frequently thought of death or dying? Does the patient have a specific suicide plan? Has he/she made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?) Close supervision by family or friends may be needed. Ask about risk of harm to others. (See **‘Depression – F32#′**).

- During manic periods:
  - Avoid confrontation unless necessary to prevent harmful or dangerous acts.
  - Advise caution regarding impulsive or dangerous behaviour.
  - Close observation by family members is often needed.
  - If agitation or disruptive behaviour are severe, hospitalization may be required.
- During depressed periods, consult management guidelines for depression (See **'Depression – F32#'**).
- Describe the illness and possible future treatments.
- Encourage the family to consult, even if the patient is reluctant.
- Work with patient and family to identify early warning symptoms of mood swings, in order to avoid major relapse.
- For patients able to identify early symptoms of a forthcoming 'high', advise:
  - Ceasing consumption of tea, coffee and other caffeine-based stimulants.
  - Avoiding stimulating or stressful situations (e.g, parties).
  - Planning for a good night's sleep.
  - Taking relaxing exercise during the day, e.g, swimming or a walk before bed.
  - Avoiding making major decisions.
  - Taking steps to limit capacity to spend money (e.g, give credit cards to a friend, a near relative take his salary).
- Assess ability to drive safely. If he has the first or second driving license ,he should stop driving

If lithium is prescribed to the patient to prevent recurrence be aware of signs of lithium toxicity (e.g, tremors, diarrhoea, vomiting, nausea or confusion),refer immediately to the specialist.

Mixed Anxiety and Depression – F41.2

Presenting Complaints

Patient may present with one or more physical symptoms (e.g, various pains, poor sleep and tiredness), accompanied by a variety of anxiety and depressive symptoms, which will have been present for more than six months. These patients may be well known to their doctors, and have often been treated by a variety of psychotropic agents over the years.

Diagnostic Features

- Low or sad mood.
- Loss of interest or pleasure.
- Prominent anxiety or worry.
- Multiple associated symptoms are usually present, e.g,:
  - Disturbed sleep.
  - Tremor.
  - Tiredness or loss of energy.
  - Palpitations.
  - Poor concentration.
  - Dizziness.
  - Disrupted appetite.
  - Suicidal thoughts or acts.
  - Dry mouth.
  - Loss of libido.
  - Tension and restlessness.
  - Irritability.

Differential Diagnosis

- If more severe symptoms of depression or anxiety are present, see **'Depression – F32#'** or **'Generalized anxiety – F41.1'.**
- If somatic symptoms predominate that do not appear to have an adequate physical explanation, see **'Unexplained somatic complaints – F45'**.
- If the patient has a history of manic episodes (e.g, excitement, elevated mood and rapid speech), see **'Bipolar disorder – F31'**.
- If the patient is drinking heavily or using drugs, see **'Alcohol misuse – F10'** and **'Drug use disorders – F11#'**. Unexplained somatic complaints, alcohol or drug disorders may also co-exist with mixed anxiety and depression.

Hyperkinetic Disorders F-90 Management Guidelines

Presenting Complaint

Patients

- Can not sit still.
- Are always moving.
- Can not wait for others.
- Will not listen to what others say.
- Have poor concentration.

Diagnostic Features

- Inability to perform task.
- Interrupting other's activities.
- Prematurely answering the questions before they have ended.
- Impaired attention and overactivity both are necessary for diagnosis and should be evident in more than one situation{ classroom, home, clinic).
- Impaired attention as shown by breaking off from tasks prematurely and leaving activities unfinished.
- Over activity implies excessive restlessness, especially in situations requiring relative calm.
- Associated features: disinhibition in social relationships, recklessness in situation involving danger.
- The characteristic behaviours should be present before the age of six and for long duration.
- Avoid premature diagnosis ,high levels of physical activity are not necessarily abnormal.

Differential Diagnosis

- Specific physical disorder(e.g, epilepsy, fetal alcohol syndrome, thyroid diseases).
- Anxiety disorders.
- Mood disorders (agitated depression).
- Pervasive developmental disorder.
- Schizophrenia.
- Conduct disorder(See Conduct disorder F91.
- Pervasive developmental disorder take priority over hyperkinetic disorder, and hyperkinetic disorder take priority over conduct disorder in diagnosis.

Essential Information for The Family and Patient

- Constitutional abnormalities play a role in this disorder.
- Boys are more affected than girls.
- Problems of inattention constitute a central feature of this disorder.
- Make them prone to accident.
- Affect their scholastic achievement.
- Need pharmacological treatment as well as psychological treatment.
- It is not the child fault, he is ill.
- The outcome is better if the parent are calm.
- This disorder need the cooperation of both parent.
- This disorder will improve as the child grows.

Counselling of the Patient and Family

- Pass the majority of time in an open safe place.
- Try to hold his attention for 5 minutes, by continuous practice and offer him gift if he succeeds.
- Be sure that he will benefit from medication, help him to be compliant to it, if it is described.
- Avoid punishment, disciplinary control must be immediate (within seconds).
- The teacher should be informed by the parents.
- Stress the need to minimize distractions.
- Allow play in open yards, the place should be secure.
- Encourage parent to face the problem and meet the social worker at school.

Medication

Are necessary and prescribed by secondary mental services,

All cases should be referred to secondary mental services

Referral:

To behavioural treatment, if available, can improve attention and self control

Follow up could be done at the primary care center.

Conduct Disorders F-91 Management Guidelines

Presenting complaint

- Repetitive and persistent pattern of dissocial, aggressive, or defiant conduct, the conduct is noticed at school and /or home.

- Usually the child is referred for evaluation from school.

Diagnostic Features

- The child's developmental level should be considered when we judge a conduct disorder (temper tantrums are normal part of a 3-years old's development.
- Excessive level of fighting or bullying.
- Cruelty to animals or other people.
- Severe destructiveness to property.
- Fire setting
- Stealing
- Lying
- Truancy from school
- Absconding from home
- Severe temper tantrums
- Persistent severe disobedience
- Defiant provocative behaviour

The presence of any of these diagnostic features for longer than six months allows the diagnosis of conduct disorder.

Differential Diagnosis

The co-existence of emotional disorders should lead to a diagnosis of conduct disorders associated with emotional disorders.

Hyperkinetic disorder F-90 if the condition meets also conduct disorder, the priority is to hyperkinetic disorder.

Essential Information for Patient and Family

- Acknowledge to the child and his family that he is not bad.
- He has a disorder which is amenable to correction.
- Time is necessary to modify behaviour.
- Reward is better than punishment.
- The discipline should be clear, consistent, but not harsh.

Counseling of The Family and Patient

- The child is in need for firmness as well as kindness.
- The child should be prevented from doing the misbehaviours whenever possible.
- The child should engage in a sport such as (Judo, Taikondo) to learn that he can be strong to defend himself and weak others.
- Give him a supervised responsibility (distributing the papers at class, distributing the gifts to his siblings.).
- The family should avoid any physical or verbal aggressiveness at home or with neighbours.
- Stop watching the T.V films of aggressive nature.
- Encourage the values of love, patience and altruism.
- Instruct him our prophet "Haddith" that the strong is the one who controls himself in anger.
- Avoid discrimination between siblings.
- When you are in anger displays your aggression to inanimate object (e.g. a cushion, a piece of clothes.
- Try modification of behavior (A diary sheet will be done recording by himself his misbehaviors, his estimation to the level of badness of the behavior (0-10, 10 is the worst, and if he wishes not to do it now next time to be done).
- A 3 diary sheet by each parent and teacher separately recording misbehaviors.

Weekly visits of the child and one of the parent brings the 3 sheets with him

For the first 2 months then followed two visits/ month for another 2 months

Then a monthly visit till the behavior is modified.

In case of unmodified behavior consider referral

Referral

To secondary mental health services

Epilepsy

Presenting Complaint

Attacks (stereotyped) of:

- Loss of consciousness ± convulsions.
- Alteration of level of consciousness + automatism (lip sucking, swallowing,etc.).
- Absence attacks: either simple or associated with myoclonic jerks or atonic attack

(dropping).

- Focal fits without impairment of consciousness:
  - Motor: tonic ± clonic movement in one limb.
  - Sensory: in one limb.
  - Visual: flashes of light, formed objects.
- Paroxysmal psychic phenomena on:
  - Paroxysmal stereotyped hallucinations.
  - Paroxysmal fears.

Differential Diagnosis

From paroxysmal conditions like:

- Narcolepsy.
- Migraine.
- Breath holding spells.
- Cardiovascular syncope.
- Hysteria (conversion disorders).
- Malingering.

Essential Information for Patient and Family

- Epilepsy is a treatable disease that needs long term therapy so treatment should be continued at least two years form the clinical control.
- Epilepsy in children specially absence attacks may be a case of scholastic failure.
- Epilepsy may endanger life of patient.
- Patient should avoid dangerous situation (coming near to machines-driving cars-swimming).

Section II:

Mental Health Checklists

Anxiety

A. A.Feeling tense or anxious?	☐
B. Worrying a lot about things?	☐

If YES to any of the above, continue below

1.Symptoms of arousal and anxiety?	☐

2. Experienced intense or sudden fear unexpectedly or for no apparent reason?	
• Fear of dying	☐
• Fear of losing control	☐
• Pounding heart	☐
• Sweating	☐
• Trembling or shaking	☐
• Chest pains or Difficulty breathing	☐
• Feeling dizzy, Lighthearted or faint	☐
• Numbness or tingling Sensations	☐
• Feelings of unreality	☐
• Nausea	☐

3. Experiences fear/anxiety in specific situations	
• leaving familiar places	☐
• travelling alone, e.g. train, car, plane	☐
• crowds confined places/public places	☐
4. Experienced fear/anxiety in social situations	
• speaking in front of others	☐
• social events	☐
• eating in front of others	☐
• worry a lot about what others think or self-conscious?	☐

Summing Up

Positive to A, B and 1, recurring regularly, negative to 2, 3 and 4:	☐
• Indication of Generalized anxiety	☐
• Positive to 1 and 2: indication of panic disorder	☐
• Positive to 2 and 3: indication of agoraphobia	☐
• Positive to 3 and 4: indication of social phobia	☐

Drug treatment is the second line

Chronic Tiredness

Always check for depression / stressful situations / anxiety

A. Do you get tired easily?	☐
• Tired all the time?	☐
• Easily tired out while performing every day tasks?	☐
• Difficult to recover from the tiredness, despite rest?	☐

If YES to any of the above, continue below

1.Do you have any medical problems or physical pains?	☐
2. Are you taking any medication?	☐
3. Low mood or loss of interest or pleasure?	☐
4. Worried, anxious or tense?	☐
5. Are you doing too much at home and/or work?	☐
6. Do you fail to set time aside for leisure activities?	☐
7. Have you been having problems with sleep?	☐

Chronic Tiredness Syndrome is a much rarer condition, diagnosed when substantial physical and mental tiredness lasts longer than six months and there are no significant findings on physical examination or laboratory

investigation.

Summing Up

Positive to A: indication of tiredness problem	□
Positive to any of 1 and 2: consider management of the underlying problem	□
Positive to 3: consider depression	□
Positive to 4: consider anxiety	□
Positive to 5 or 6: consider lifestyle change	□
Positive to 7: consider sleep problem	□

Depression

A. Low mood/sadness	□
B. Loss of interest or pleasure	□
C. Decreased energy and/or increased tiredness	□

If YES to any of the above, continue below

1. Sleep disturbance:	
• Difficulty falling asleep	□
• Early morning wakening	□

2. Appetite disturbance:	
• Appetite loss	□
• Appetite increase	□

3. Concentration difff culty	□
4. Psychomotor retardation or agitation	□
5. Decreased libido	□
6. Loss of self-confidence or self-esteem	□
7. Thoughts of death or suicide	□
8. Feelings of guilt	□

Summing Up

Positive to A, B or C and at least four positive from 1–8	
all occurring most of the time for two weeks or more	
Indication of depression	□

Drug treatment : Imipramine(Tofranil) 25-75 mg/day for six months

Dissociative Disorder

1. Do you sometimes loose memory?	□
2. Do you sometimes find yourself in an altered state of consciousness?	□
3. Do you sometimes exhibit loss of sensation and/or paralysis?	□
4. Do you sometimes complain of loss of vision?	□
5. Do you sometimes complain of inability to speak?	□
6. Do you sometimes complain of being possessed by a jinny?	□
7. Does these symptoms come and disappear suddenly and/or have a chronic course?	□

The answer to any question from (1to 6) indicates the presence of dissociative disorder, if answer to question (7)YES and these symptoms are not consistent with any physical known disease

If the condition become chronic probe for depression

Drug Use Disorder

1. Did you at any time take any drugs to feel pleasure or better or change your mood?

If yes check the following:

• Stimulant: speed, ritalin, max,tablets for loosing weight (tenuate), Cocaine	□
• Narcotics Heroin, opium, codiphen, dihydrocodeine,nubain	□
• Hallucinating drugs: ecstasy, acid	□
• Cannabis,bango	□
• Sedatives:valium , xanax, rohypnol, commital	□
• Others parkinol, tegretol, akineton	□

2. What group you use?

3. Do you mix drugs from different group?	□
4. Do you have to increase the dose to have the same effect?	□
5. Do you have any of the following symptoms if you stop or decrease the dose? aches, nausea, sweating, hallucinations anxiety, tremors, depression, moodiness	□
6. Did you fail to stop or to decrease the dose?	□
7. Did the drug use affect badly your social/work/family life?	□
8. Did you have been in legal trouble because of drug use?	□

Answer to all questions is a mixed drug user showing tolerance(4) withdrawal(5) relapse(6) harmful consequences(7) legal consequences(8)

Sleep Problems

A. Have you had any problems with sleep?	□
• Difficulty falling asleep?	□
• Restless or unrefreshing sleep?	□
• Early morning awakening	□
• Frequent or long periods of being awake?	□

If YES to any of the above, continue below

1. Do you have any medical problems or physical pains?	□
2. Are you taking any medication?	□
3. Do any of the following apply?	□
• Drink alcohol, coffee, tea or eat before you sleep?	□
• Take day time naps?	□
• Experienced changes to your routine e.g. shift work?	□

• Disruptive noises during the night?	□
4. Do you have problems at least three times a week? o	□
5. Has anyone told you that your snoring is loud and disruptive?	□
6. Do you get sudden uncontrollable sleep attacks during the day?	□
7. Low mood or loss of interest or pleasure?	□
8. Worried, anxious or tense?	□

Summing Up

Positive to any of 1, 2 or 3: consider management of the underlying problem	□
Positive to 4: indication of sleep problem	□
Positive to 5: consider sleep apnoea	□
If positive to 6: consider narcolepsy	□
Positive to 7: consider depression	□
Positive to 8: consider anxiety	□

Unexplained Somatic Complaints

Check for multiple doctors and negative test results / dramatic presentation / unusual symptoms

A. Have you been bothered by continuing aches or pains or other physical complaints for which a cause has not been found (e.g. nausea/vomiting/ diarrhoea/shortness of breath/chest pain/headaches/abdominal pain)?	□

If YES to any of the above, continue below

1.Have you seen more than one doctor for these problems?	□
2. Have you seen any specialists about these problems?	□
3. Have you experienced these pains or different physical problems for longer than six months?	□
4. Low mood or loss of interest or pleasure?	□
5. Worried, anxious or tense?	□

Summing up

Positive to A and also to at least one positive from 1-3, and negative to 4, 5 and 6: consider unexplained somatic complaints	□

Functioning and Disablement

A. During the past month, have you been limited in one or more of the following activities most of the time?	□
Self-care: bathing, dressing eating?	□
Family relations: spouse, children, relatives?	□
Going to work or school?	□
Doing housework or household tasks?	□
Social activities, seeing friends?	□
Remembering things?	□

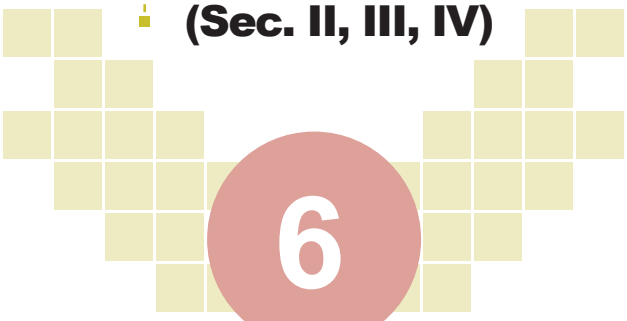
B. Because of these problems during the past month:

how many days were you unable to fully carry out your usual daily activities?

---

how many days did you spend in bed in order to rest?

Mental Health In Primary Care (Sec. II, III, IV)

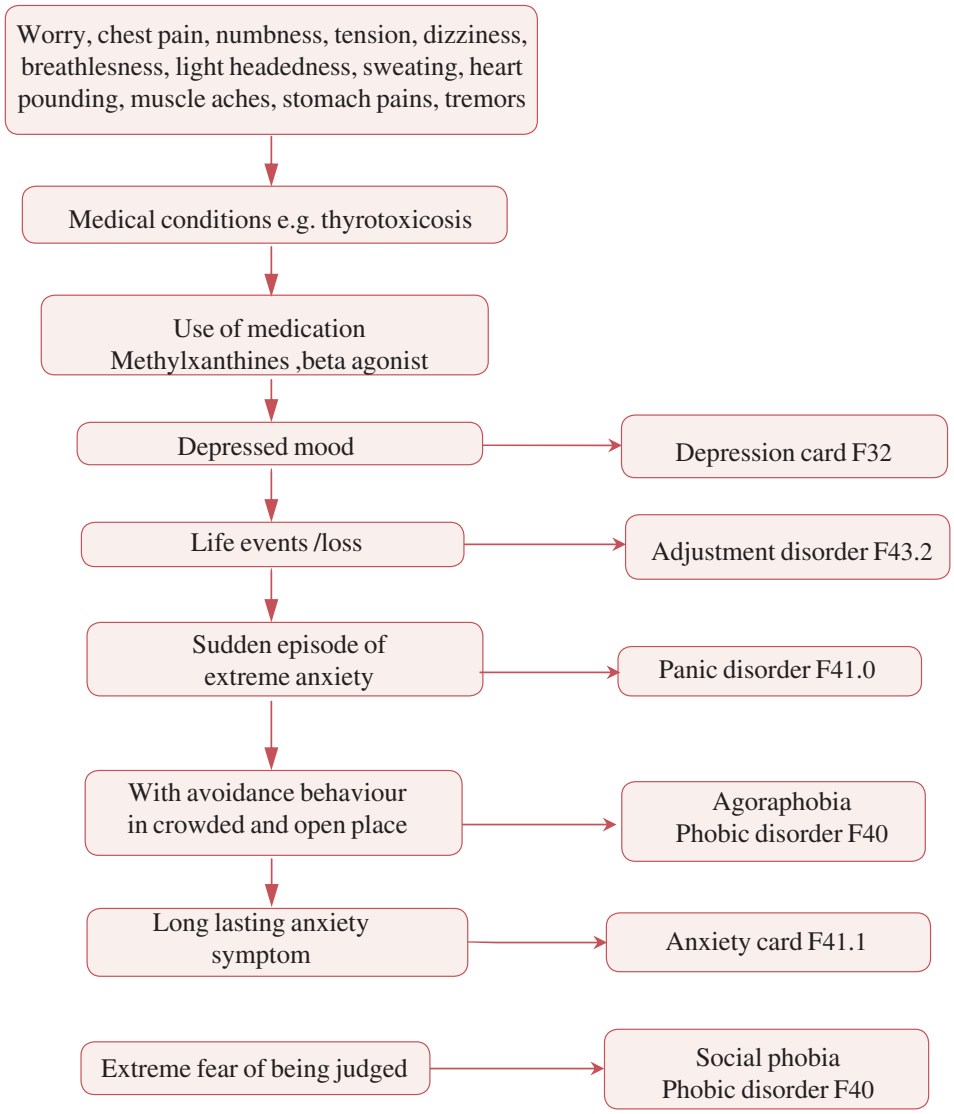


Interactive Summary Cards and Flow Chart Assessment Guide

To be used with I C.D10 PC

Anxiety

Common Symptoms



Interactive Summary Card of Anxiety

Common symptoms

Psychological		Physical	
Tension	Fear of going	Trembling	Muscle tension
Worry	Crazy	Sweating	Nausea
Panic	Fear of dying	Heart pounding	Breathlessvness
Feelings of unreality	Fear of losing control	Light headedness	Numbness
		Dizziness	Stomach pains
			Tingling sensation

Disruptive to work, social or family life

Anxiety disorders are common and treatable

- Anxiety does not mean weakness
- Anxiety does not mean losing the mind
- Anxiety does not mean personality problems

Severe anxiety *does* mean a disorder which requires treatment.

Common Forms of Anxiety (Generalized Anxiety)

disorder:	Panic disorder:	Social phobia:	Agoraphobia:
Persistent/ excessive	Sudden intense	Fear/avoidance	Fear/avoidance of situations
Worry	Fear	Social situations	Where escape is difficult
Physical symptoms.	Physical symptoms.	Fear of being criticized	Leaving familiar places alone
	Psychological symptoms.	Physical symptoms.	Physical symptoms.
		Psychological symptoms	Psychological symptoms

What Treatments Can Help?

Both therapies are most often needed:

Supportive therapy for:	Medication
Slow breathing/relaxation	For severe anxiety
Exposure to feared situations	For panic attacks
Realistic/positive thinking	Imipramine (30-75mg)
Problem-solving.	

About medication

Short term	Side-effects	Ongoing review
Use for severe anxiety can be addictive and ineffective when used in the long term	Are important to report	Of medication use is recommended
	Counselling (emotional support and problem-solving) is always recommended with medication	

Slow Breathing to Reduce Physical Symptoms of Anxiety

Breath in for three seconds and out for three seconds, and pause for three seconds before breathing in again.

- Practice 10 minutes morning or night (five minutes is better than nothing).

Use before and during situations that make you anxious.

Regularly check and slow down breathing throughout the day.

Change attitudes and ways of thinking

'My chest is hurting and I can't breathe, I must be having a heart attack'.	Instead:	'I am having a panic attack, I should slow my breathing down and I will feel better'.
'I hope they don't ask me a question, I won't know what to say'.	Instead::	Whatever I say will be OK, I am not being judged. Others are not being judged, why should I be?
'My partner has not called as planned. Something terrible must have happened'.	Instead::	They might not have been able to get to a phone. It is very unlikely that something terrible has happened'.

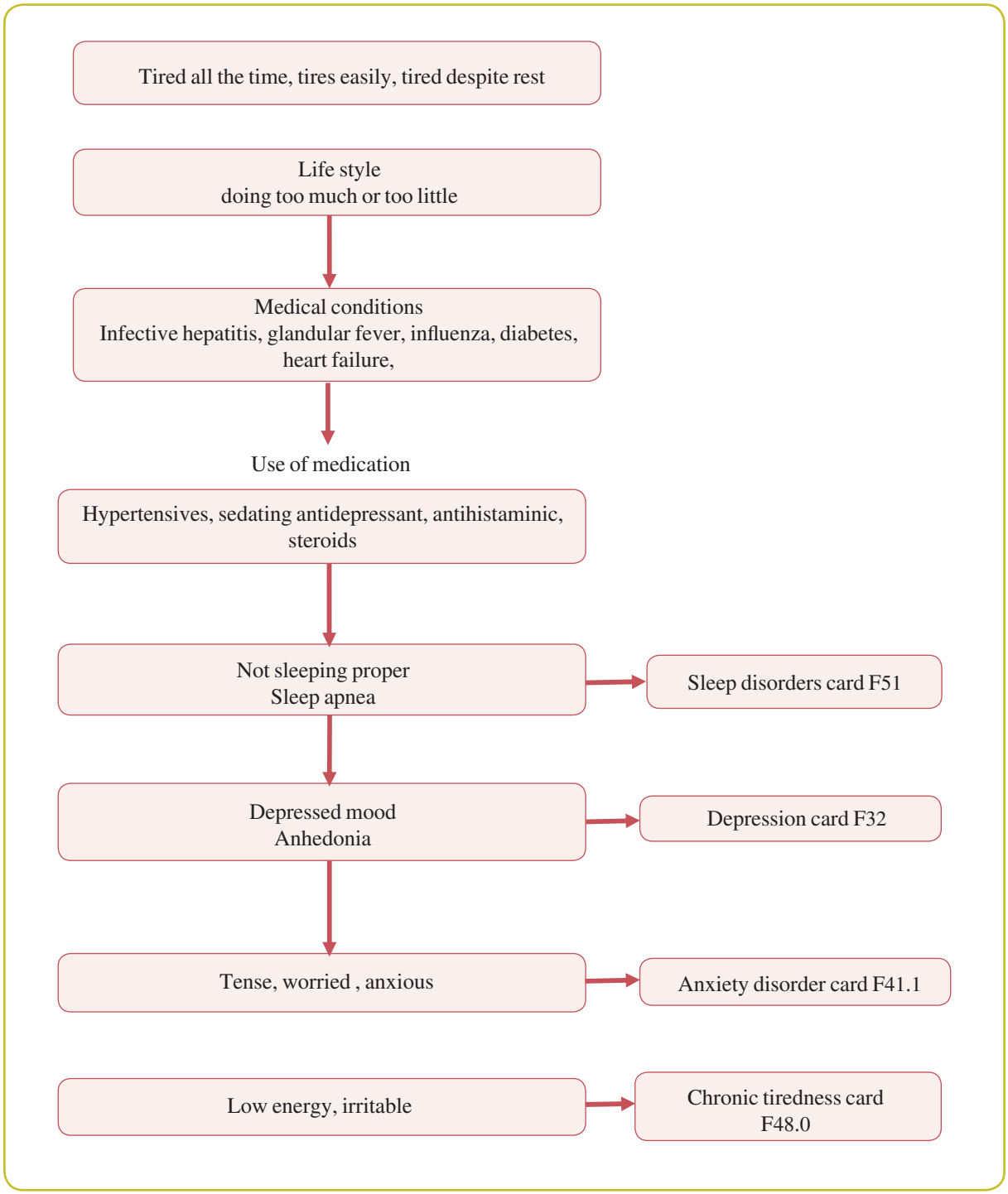
Exposure to overcome anxiety and avoidance

Easy stage (e.g. walking on own) Moderate stage (e.g. lunch with a friend) Hard stage, (e.g. shopping with a friend)

- Use slow breathing to control anxiety
- Do not move to the next stage until anxiety decreases to an acceptable level.

Flow Chart Assessment Guide to be Used With I.C.D10 PC
Chronic Tiredness (Neurasthenia)

Common Symptoms



Interactive Summary Card of Chronic Tiredness

Common Symptoms

Compared with previous level of energy, and compared to people known to you:

Tired all the time — Tire easily — Tired despite rest

Disruptive to work, social and family life Affects ability to carry out routine and other tasks Feelings of frustration.

Chronic Tiredness Syndrome is a much rarer condition, diagnosed when substantial physical and mental tiredness lasts longer than six months and there are no significant findings on physical or laboratory investigation.

Common Triggers

Psychological triggers:		Physical triggers:		Medication:
Depression	Doing to much activity	Anaemia	Thyroid disorder	Steroids
Stress		Bronchitis		Antihistamines.
Worry		Asthma		Influenza
Anxiety.	Doing to little activity	Diabetes	Alcohol/ drug use	
		Arthritis	Bacterial, viral and other infections.	

What Treatments Can Help?

Both therapies are most often needed:

Supportive therapy for:	Medication:
depression	for other mental or physical disorders
worry/anxiety	anti-depressants are sometimes useful
stress/life problems lifestyle change level of physical activity.	there are no effective medications specific to tiredness and the main treatment follows psychological lines. Imipramine (30-75mg)

Interactive Summary Card of

Chronic Tiredness

Behavioural Strategies

Examine how well you are sleeping	Plan pleasant/ enjoyable activities into your week.	Try to have regular meals during the day.
Have a brief rest period of about 2 weeks, in which there are extensive activities	Gradually build up a regular exercise routine	Try to keep to a healthy diet.
After the period brief rest, gradual return to your usual activities	Do not push yourself too hard; remember to build up all activities gradually and steadily	Use relaxation techniques, for example slow breathing.

Slow breathing for relaxation

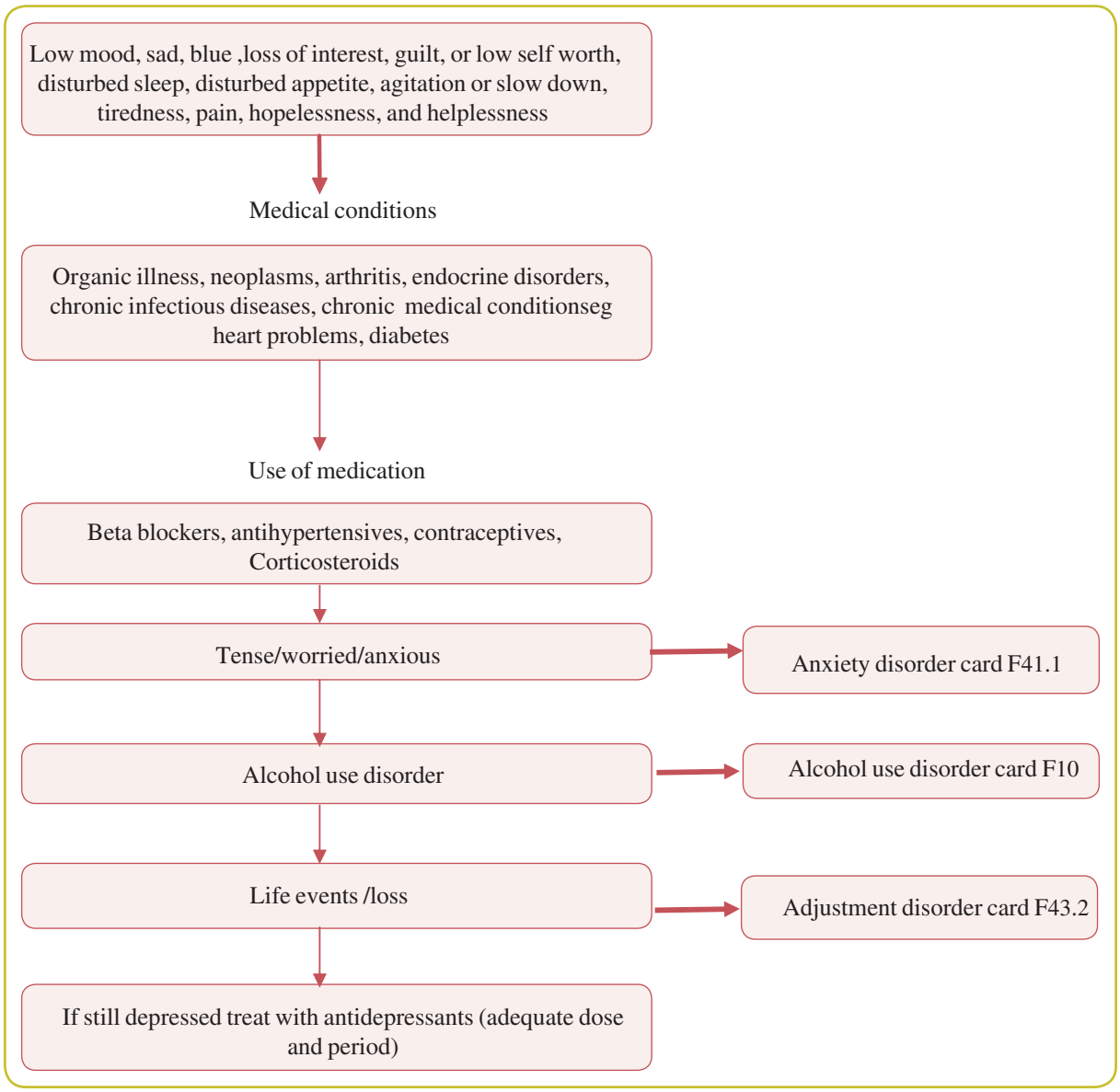
- Breath in for three seconds
- Breath out for three seconds
- Pause for three seconds before breathing in again
- Practice for 10 minutes at n ight (five minutes is better than nothing).

Increase level of physical activity

A little activity one or two times a week	Daily activities not much effort	Activity that makes you out of breath for20 minutes or more, three to ffve times a week
(e.g. walking)	(e.g. fast walking, shopping, cleaning	(e.g. jogging)
▼	▼	▼
Inactive	Some activity	Active

Flow Chart Assessment Guide to Be Used with I.C.D10 PC Depression

Common symptoms



Interactive Summary Card of Depression

Common symptoms

Mood and motivation	Psychological	Physical
Continuous low mood	Guilt/negative attitude to self	Slowing down or agitation
Loss of interest or pleasure	Poor concentration/ memory	Tiredness/lack of energy
Hopelessness	Thoughts of death or suicide	Sleep problems
Helplessness	Tearfulness	Disturbed appetite (weight loss/increase)
Worthlessness		

Difficulties carrying out routine activities Difficulties performing at workDifficulties with home life
Withdrawal from friends and social activities

Depression is common and treatable

Note

Depression does not mean weakness

Depression does not mean laziness

Depression does mean that you have a medical disorder which requires treatment.

Common Triggers

Psychological:	Other:	Illness:	Medication:
Major life events, e.g. Recent bereavement Relationship problems Unemployment Moving house Stress at work Financial Problem	Family history of depression Childbirth Menopause Seasonal changes Chronic medical conditions Alcohol and substance use disorders.	Infectious diseases Influenza Hepatitis.	Antihypertensives H2 blockers Oral contraceptives Corticosteroids.

What Treatments Can Help?

Both therapies are most often needed:

Supportive therapy for:	Medication:
stress/life problems patterns of negative thinking prevention of further episode	for depressed mood or loss of interest/ pleasure for two or more weeks and at least four of the symptoms mentioned earlier for little response to supportive therapy (counselling) for recurrent depression for a family history of depression

About medication

Effective	Side-effects	Time period
Usually works faster than other methods	must be reported, but generally start improving within 7-10 days	Medication to be continued at least four to six months after initial improvement

Treatment Plan

must be strictly adhered to.

Drugs	Progress	Ongoing review
are not addictive improvement takes time, generally three weeks for a response Imipramine (75-150mg)	same medication should continue unless a different decision is taken by the doctor medication should not be discontinued without doctor's knowledge in case a drug is not effective, refer.	is necessary over the next few months.

Increase Time Spent on Enjoyable Activities

Set small achievable, daily goals for doing pleasant activities	Plan things to look forward to in future
Plan time for activities and increase the amount of time spent on these each week	Keep busy even when it is hard to feel motivated
	Try to be with other people/ family members.

Problem- Solving Plan

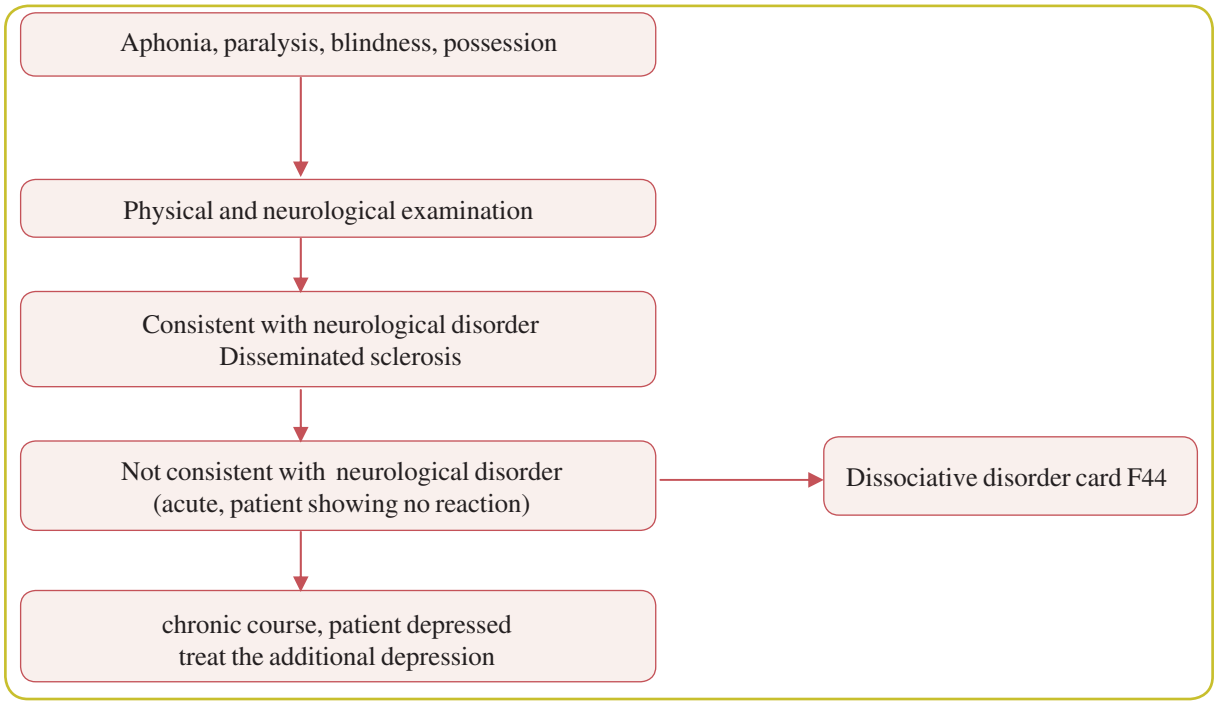
Discuss	Options	Set a time frame
problems with partner/family members, trusted friend or counsellor.	Work out possible solutions to solve the problems	to examine and resolve problems
Distance	Pros and cons	Make an action plan
yourself to look at problems as though you were an observer.	Examine advantages and disadvantages of each option.	for working through the problems over a period of time.
		Review
		Progress made in solving problems

Change Attitudes and Way of Thinking

'I will always feel this way; things will never change'.	Instead:	These feelings are temporary. With treatment, things will look better in a few weeks'.
'It's all my fault. I do not seem to be able to do anything right'.	Instead:	'These are negative thoughts that are the result of depression. What evidence for this do I really have?'

Flow Chart Assessment Guide to be used with I.C.D10 PC Dissociative Disorder

Common symptoms



Interactive Summary Card of Dissociative (Conversion) Disorder

Common symptoms

unusual or dramatic physical symptoms:

seizures

amnesia

trance

loss of sensation

visual disturbances

paralysis

aphonia

identity confusion or 'possession' states.

Physical Symptoms

not consistent with known disease → dissociative disorder

consistent with known disease. → physical disorder

Common Triggers

psychological stress

difficult personal circumstances

What Treatments Can Help

The physician should be convinced that they are not malingering

Medication	Supportive therapy
Avoid anxiolytics or sedatives.	Acknowledges recent stresses positive reinforcement for improvement
Antidepressants in chronic cases.	Brief rest
	No prolonged rest
	Rapid resolution of symptom
	No reinforcement of symptoms

How To Change The Pathological Ideas

- a jinny is responsible for the symptom

  +How a weaker creature the jinny influences you the stronger creature
- If you feel that this is due to magic or demonic possession, please remember god saying in sourah Elbakara that all magic had been taught by harout and marout to people will not hurt you unless god wants; so you are more strong than magic by keeping always reading coran versus.
- -I lost sensation in my limb
- +I am sure that your symptom will resolve rapidly, but what is important for me is that next time you will be able to confront the overwhelming situation.
- In overwhelming situation the individual has three options

First	Second	Third
React and express His feelings	Patience Adaptation	No overt reaction Unawareness of Inner feelings
		Dissociative disorder

Interactive Summary Card of Drug Use Disorders

Presenting complaints

Depressed mood	Asking for drugs	Intoxic ation
Nervousness Insomnia	Help to withdraw	Withdrawal
Help to Stabilise	Abscess or thrombosis	Unexplained behavior
Legal consequences	social consequences	

Signs of drug withdrawal

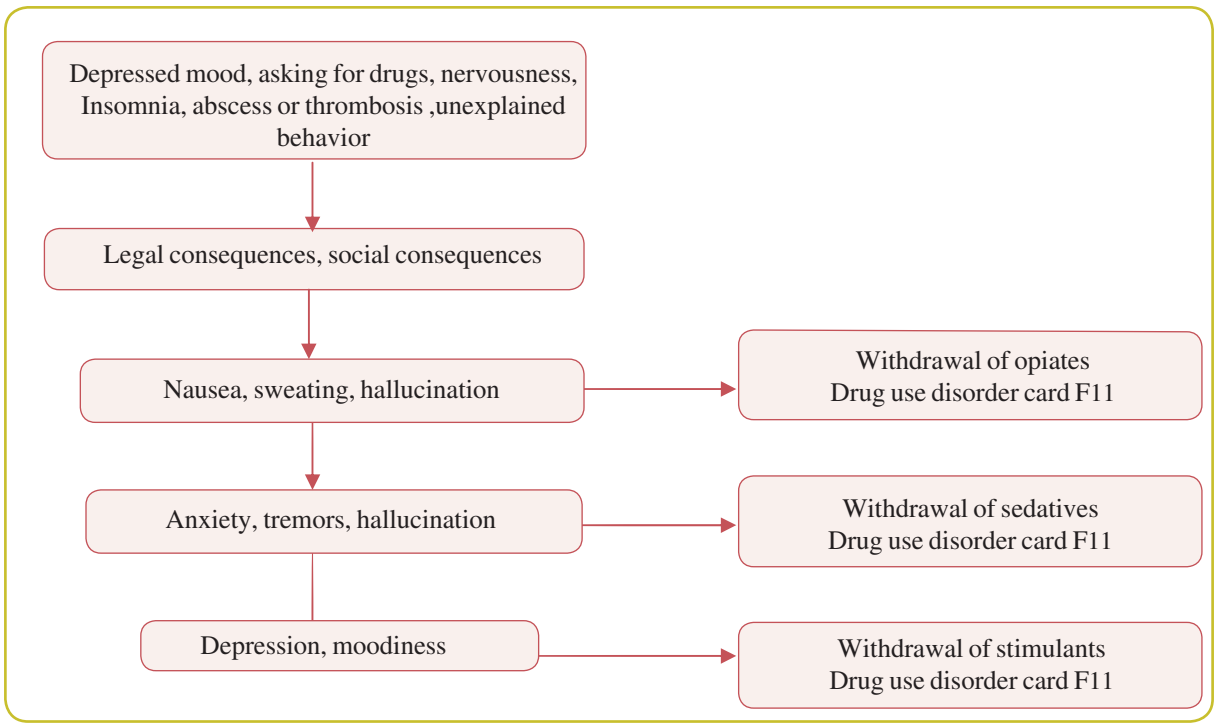
Opioids	Sedatives	Stimulants
nausea	Anxiety	Depression
Sweating	Tremors	Moodiness
Hallucinations	Hallucination	

Drug Use Disorders Are Treatable

- They are maladaptive behaviour
- Chronic
- High rate of relapse
- Harmful social ,physical, and Psychological consequences

Flow Chart Assessment Guide to Be Used With I.C.D10 PC Drug Use Disorder

Common symptoms



How treatment can help

For all patients

- Cost and benefit of drug use
- Information about health risk
- Your own responsibility
- Manage physical problems
- Counselling for life problems

Willing to stop	Not willing to stop	Decreasing dose
Fix the day to quit	No rejection/blame	Goal of decreased dose
Manage withdrawal	Reduction of harm	Avoid high risk situation
Avoid high risk situation	Drug problems	Self-monitoring
Response to Addic tion's	Future health assessment	Counselling
Friends Mix with good friends		

Relapsing Group

- Credit for any success
- Discuss situation leading to relapse
- Return to earlier step

Medication

Benzodiazepines	Stimulants	Opiates
convert to a long-acting drug such as diazepam and reduce gradually (e.g. by 2 mg per fortnight) over a period of two to six months.	Distressing Medical Supervision	Detoxification Hospitalization

Flow Chart Assessment Guide to Be Used with I.C.D10 PC Sleep Problems

Common Symptoms

Difficulty falling asleep, early morning awakening, frequent or long periods of awakening restless or unrefreshing sleep

life style

Exercise before sleeping, day-time naps, changed routine, partner snoring, drinking coffee, eating immediately prior to sleeping

Medical conditions

Heart failure, pulmonary disease, pains Diabetes mellitus

Use of medications

Steroids, theophylline, decongestant, some Antihypertensives , alcohol use

Rare sleep conditions Narcolepsy, sleep apnea

Depressed mood Anhedonia → Depression card F32

Tense, worried, anxious → Depression card F32

Interactive Summary Card of Sleep Problems

Common symptoms

Difficulty falling asleep

Frequent awakening

Early morning awakening

Restless or unrefreshing sleep

Difficulties at work and in social and family life
Makes it difficult to carry out routine or desired tasks.

Common Causes

Psychosocial:	Physical:	Lifestyle:	Environmental:
Depression Anxiety Worries Stress.	Medical problems: Overweight Heart failure Nose, throat and lung disease Sleep apnoea Narcolepsy Pains	Too hot or too cold Tea, coffee and alcohol Heavy meal before sleep Daytime naps Irregular sleep schedule.	Noise Pollution Lack of privacy Over-crowding.

Medications:

Steroids

Decongestants

Others.

What Treatments Can Help?

Supportive therapy is the preferred treatment

Supportive therapy for:	Medication:
stress/life problems	for temporary sleep problems
depression	for short term use in chronic problems
worry changes in lifestyle and sleep habits.	to break sleep cycle.

About Medication

Short term	Side-effects	Ongoing review
use for short period of time.	are important to report.	of medication use is recommended.
Long-term	Harmful	
when alcohol and other drugs are used.	when used in the long term, there may be difficulties stopping, leading to dependence	
Lifestyle change strategies		
Try to minimize noise in your sleep environment, if necessary consider ear plugs.	Try to avoid eating immediately before going to sleep.	Reduce mental and physical activity during the evenings.
Try to make sure that the room in which you are sleeping is not too hot or cold Reduce the amount of alcohol, coffee and tea that you drink, especially in the evenings. Breath in for three seconds Breath out for three seconds Pause for three seconds before breathing in again Practice for 10 minutes at night (five minutes is better than nothing).	Try to have your dinner earlier in the evening, rather than later. Don't lie in bed trying sleep. Get up and do something relaxing until you feel tired. Have regular ti mes for going to bed at night and waking up in the morning.	Increase your level of physical activity during the day; build up a regular exercise routine. Avoid daytime naps, even if you have not slept the night before. Use relaxation techniques, for example, slow breathing.

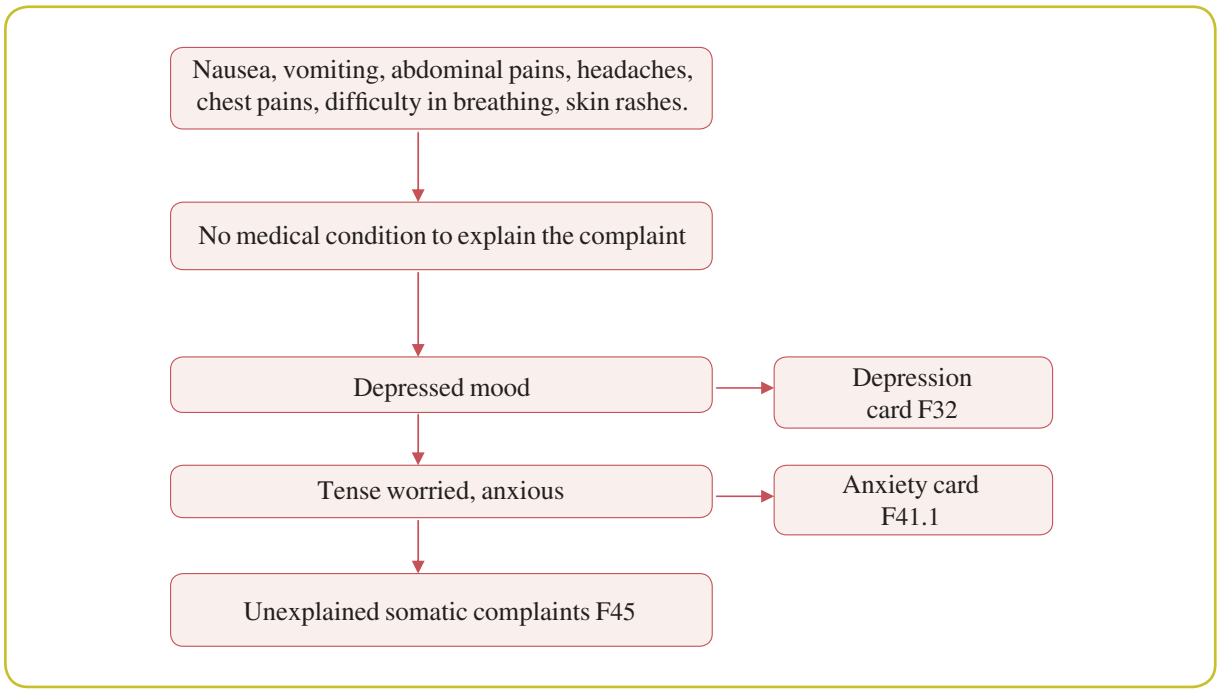
More Evaluation May Be Needed:

if someone stops breathing during sleep (sleep apnoea)

if there is a daytime sleepiness without possible explanation.

Flow Chart Assessment Guide to Be Used With I.C.D10 PC Unexplained Somatic Complaints

Symptoms



Interactive Summary Card of Unexplained Somatic Complaints

Common, unexplained physical problems

Headaches	Nause	Skin rashes
Chest pains	Vomiting	Frequent urination
Difficulty in breathing	Abdominal pain	Diarrhoea
Difficulty in swallowing discomfort.	Lower back pain	Skin and muscle

Associated Worries and Concerns

Associated symptoms and problems

Beliefs (about what is causing the symptoms)

Fear (of what might happen).

Physical Symptoms Are Real

A vicious circle can develop:

Emotional stress can cause physical symptoms or make them worse.

Physical symptoms can lead to more emotional stress.

Emotional stress can make physical symptoms worse.

Headaches	may all be
Difficulty in swallowing	caused or made worse
Chest pain/difficulty in breathing	by stress, anxiety
Abdominal pain/nausea/vomiting	Worry, anger, depression
Frequent urination/diarrhoea/impotence	
Skin rashes	

What Treatments Can Help?

Supportive treatment most often needed:

- Effective reassurance, after history and detailed physical examination.
- Management of stress/life problems.
- Treatment of associated depression, anxiety, alcohol problems.
- Learning to relax.
- Avoiding patterns of negative thinking.
- Increasing levels of physical activity.
- Increasing positive/pleasurable activities.

Useful strategies

Reassurance

Stress often produces physical symptoms or makes them worse. There are no signs of serious illness. You can benefit from learning strategies to reduce the impact of your symptoms.

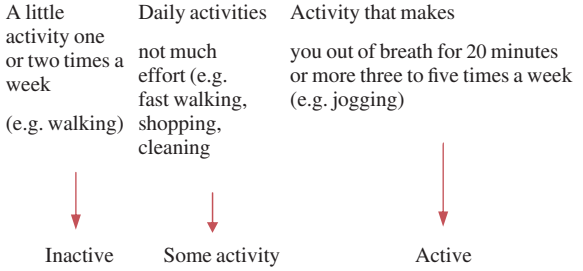
Slow breathing to reduce common physical symptoms

(e.g. muscle tension, hot and cold flushes, headaches, chest tightness) Breath in for three seconds and out for three seconds and pause for three seconds before breathing in again. Practice 10 minutes morning or night (five minutes is better than nothing). Use before and during situations that make you anxious. Regularly check and slow down breathing throughout the day.

Change Attitudes and Way of Thinking

'I can't understand why the tests are negative. I feel the pain; it is probably something really unusual that I have'.	Instead:	The pain is real, but I've been checked out physically and I have had all the relevant tests. Many other things, such as worry and stress, can cause these pains'.
'Maybe my doctor has missed something. I should try another doctor or better still a specialist instead.	Instead:	It is very unlikely that these doctors have missed something. It is unlikely that a specialist' would say anything different. Maybe I should examine whether stress, tension, or my lifestyle is contributing to the pain'.
'Why won't this pain go away. I'm not feeling well; I've probably got cancer'.	Instead:	This is not the first time that I've thought that there was something terribly wrong and in fact nothing serious developed. I should learn to relax and focus my thoughts on other things to distract myself from the pains'.

Increase Level of Physical Activity



Section IV. Appendix

A. Techniques to Manage Some Mental Disorders

I. Solving Problems and Achieving Goals

Structured problem-solving is a simple and effective technique for dealing with problems in your life. It is a step by step approach for tackling those aspects of a problem that can be changed. Tackle only one problem at a time.

Step 1: Identify the problem

This first step sounds simple and sometimes it is. But sometimes it is hard to get clear what exactly the problems are and which is the best one to tackle first. If this is the case, it may help to talk to someone you trust and who knows you well. Then write down exactly what you believe to be the main problem or goal.

Step 2: List as many solutions as possible

List all ideas that occur to you, even if some seem silly or 'way out'. Don't censor any solutions at this stage. List *all* possibilities without any evaluation of them.

Step 3: Discuss the pros and cons of each possible solution

Go down the list of possible solutions and assess the main advantages and disadvantages of each one. Keep going even if all options seem unpleasant. Sometimes there is no easy answer.

Step 4: Select the best or most promising solution

Choose the solution that can be carried out most easily with your present resources (time, money, skills etc). It may help to discuss this with someone you trust.

Step 5: Plan how to carry out your chosen solution

List the resources needed and the main problems that need to be overcome. Practise difficult steps and make notes of information needed.

Step 6: Try it out, review what happens and praise all efforts

The solution you have chosen may work perfectly or it may not. It doesn't, go back to your list of solutions and try something else. Many solutions are helpful, but do not provide the complete answer. Whether

your solution has worked completely, partially or not at all, praise yourself for your efforts. Revise your plans if necessary. Continue with the problem solving process until you have resolved your problem or achieved your goal.

II. Learning to Relax

Many people find that learning to relax helps them reduce worry and anxiety. It can also help improve sleep and relieve physical symptoms caused by stress, such as headaches or stomach pains. Learning to relax is a skill and takes practice before it can be done properly.

This is a guide on how to relax. This exercise should take about 15-20 minutes. However, if you have only 5 minutes to spare, 5 minutes is better than nothing.

1. Find a quiet and relaxing place .

Choose a comfortable chair where you won't be disturbed. Make sure you take the phone off the hook. You may need to explain to your family or friends what you are doing so that they do not disturb you. Telling them may also reduce any embarrassment you may feel.

2. Clear your mind

Try to clear your mind of all worries or disturbing thoughts. If these worries or thoughts drift back into your mind while you are relaxing, do not try to stop them, just let them float gently across and out of your mind without reacting to them. Let your mind be clear and calm.

3. Practice the slow breathing method

Breathe in for 3 seconds and breath out for 3 seconds, thinking the word *Allah* every time you breathe out. Let your breathing flow smoothly. Imagine the tension flowing out of your body each time you breathe out.

4. Relax your muscles

For each of the muscle groups in your body, tense the muscles for 7-10 seconds, then relax for 10 seconds. Only tense your muscles moderately (not to the point of inducing pain). Don't try to relax. Simply let go of the tension in your muscles and allow them to become relaxed. Relax your muscles in the following order:

Hands: clench one fist tightly, then *relax*. Do the same with the other hand.

Lower arms: bend your hand down at the wrist, as though you were trying to touch the underside of your arm, then *relax*.

Upper arms: bend your elbows and tense your arms. Feel the tension in your upper arm, then *relax*.

Shoulders: lift your shoulders up as if trying to touch your ears with them, then *relax*.

Neck: stretch your neck gently to the left, then forward, then to the right, then to the back in a slow rolling motion, then *relax*.

Forehead and scalp: raise your eyebrows, then *relax*.

Eyes: screw up your eyes, then *relax*.

Jaw: clench your teeth (just to tighten the muscles), then *relax*.

Tongue: press your tongue against the roof of your mouth, then *relax*.

Chest: breathe in deeply to inflate your lungs, then breath out and *relax*.

Stomach: push your tummy in to tighten the muscle, then *relax*.

Upper back: pull your shoulders forward with your arms at your side, then *relax*.

Lower back: while sitting, lean your head and upper back forward, rolling your back into a smooth arc thus tensing the lower back, then *relax*.

Buttocks: tighten your buttocks, then *relax*.

Thighs: while sitting, push your feet firmly into the floor, then *relax*.

Calves: lift your toes off the ground towards your shins, then *relax*.

Feet: gently curl your toes down so that they are pressing into the floor, then *relax*.

5.*Enjoy the feeling of relaxation*

Take some slow breaths while you sit still for a few minutes enjoying the feeling of relaxation.

Practice once or twice a day for at least eight weeks.

During the day, try relaxing specific muscles whenever you notice that they are tense.

III. Recognising Tension

Many people find learning to relax difficult. This is because being tense has become a habit.

Use the chart below to help you see where and when you get tense. Write in the situations when you've noticed different muscles becoming tense.

You might have been doing something (such as shopping). Or waiting to do something (such as a test). Write in what it was. Write it in next to the muscles which became tense. As you become more aware of when you get tense, add the situations to your chart. In those situations, practise parts of your relaxation routine to overcome the tension

IV. Breathing Relaxation Technique

- Breathe in slowly to the count of 3 seconds.
- When you get to 3, slowly breathe out to the count of 3 seconds.
- Pause for 3 seconds. before breathing in again.
- After 5 min or so, say the word 'relax' or "Allah" to yourself as you breathe out.
- Breathe in using your abdomen (not your chest) and through your nose.
- Practice 5 to 10 minutes at night in a comfortable chair.
- Keep in mind that the benefits of relaxation will not occur unless you practice.
- Do not try hard to relax or to sleep; just carry out the exercise.

V. Identify Negative Thinking

Anxiety

Negative and frightening thoughts can be difficult to spot because they become a habit, they can flash quickly into your mind and most of us are not used to noticing our thoughts. Learning to spot and catch these troublesome thoughts is a skill you can master with time.

When you are anxious, you tend to think in particular ways that are distorted. These are called 'thinking errors'.

thinking the worst, eg 'The pain in my chest means there is something wrong with my heart'

predicting that the worst will happen, eg 'They won't like me. They'll think I'm stupid'

exaggerating negatives, eg 'I made a complete mess of it. It was an absolute disaster'

over generalizing – if something happens once, you think it will always happen, eg if you feel anxious at the supermarket checkout, thinking 'I'm always anxious when I go out'

all of nothing thinking, eg 'Unless I do it with no mistakes at all, I have failed'

imagining that you know what other people are thinking, eg 'I can tell they are thinking what a fool I am'.

Chronic Tiredness Syndrome

Learning to recognise unrealistic, negative thoughts and to balance them with more realistic, positive ones can be very helpful. However, changing your way of thinking is quite difficult at first and you will need to keep working at it. It may help to enlist the help of someone you trust.

First, write down your negative thoughts as soon as possible. If it's difficult to notice any thoughts, try noticing when you feel down and ask "what went through my mind just before I started feeling hopeless or frustrated or angry"

Second, ask yourself , 'I*s what I believe TRUE?'*

- Look for any evidence against the belief. Imagine the belief is on trial and you are collecting all the evidence you can against it.
- It will be useful to consult someone outside the situation for their opinion.
- Ask yourself if everyone would have the same belief in this situation. If you are being hard on yourself try the 'best friend technique': what would you say if you were your own best friend?
- Ask yourself if you could be making a mistake in the way you are thinking.
- Are there any other ways of looking at the situation? s
- If you had thought differently about the situation, would that have changed the way you handled things?
- Third, balance each negative/unreasonable thought with more realistic ones.
- These should be different to the unreasonable belief.
- Try and come up with realistic statements.
- Try to think of as many counter examples as possible.

Situation: Another day ahead and have very little energy

Unreasonable/negative thoughts:

- The whole house needs cleaning. I can't possible do it.
- Last time I cooked, I made a mess of the rice. I can't cook any more.
- My life is a mess. It will never get better.
- I should be able to do the Feast cleaning
- I feel weak and my legs ache. My system has

been permanently destroyed.

- I am a failure

Resulting feelings: Hopelessness, depression.

Now lets look at the same situation from a different angle:

Reasonable/positive thoughts:

- Making the living room tidy is good enough for today. I can do that and feel proud of it.
- I've managed to cook on other days. I'll make a simple meal this time.
- There are some good things in my life. I still enjoy reading and I have some very loyal friends.
- I can do some housework. Doing the Feast cleaning in my current state is an unrealistic expectation, which I do not have to meet.
- There is no permanent damage to my system. The aching and tiredness will get better if I gradually increase what I do.
- I am not a failure, I have achieved many good things in the past. I can achieve some smaller good things today.

Resulting feelings: Still tired, but also enthusiasm and hope.

Depression

Negative thinking can also trigger depression and it slows down recovery. Everyone has negative thoughts, but they also have positive ones. A healthy balance seems to be about two positive thoughts to 1 negative one. When you are depressed, this balance is disturbed. You may also have thoughts that are distorted and don't fit the facts, such as 'I am a waste of space' and 'I am a complete failure'.

Notice the differences in the way people think about events?

A colleague was promoted at work rather than you

Person A	**Person B**
She is more experienced	I will never get promoted
She has been here longer	I am not appreciated
She has the necessary skills	I am not liked
It will be my turn next time	I am worthless
Disappointment	*Prolonged unhappiness*

Learning to recognise unrealistic, negative thoughts and to balance them with more realistic, positive ones can be very helpful. However, changing your way of thinking is quite difficult at first and you will need to keep working at it. It may help to enlist the help of someone you trust.

Unexplained Physical Problems

Situation: Developed a new rash on leg which doctor said I should not worry about

Unreasonable / Negative Thoughts:

- My sister had a rash like that and she developed arthritis
- My doctor is not telling me the truth
- I should see a specialist
- This could spread much further

Resulting feelings: Worry and more physical symptoms brought on by anxiety

Reasonable / Positive Thoughts:

- My doctor says there is nothing wrong but he will continue to monitor it
- There is no reason why he should not tell me the truth
- Many people get rashes and don't develop arthritis
- There is nothing else I can do about it just now
- Apart from this I feel well

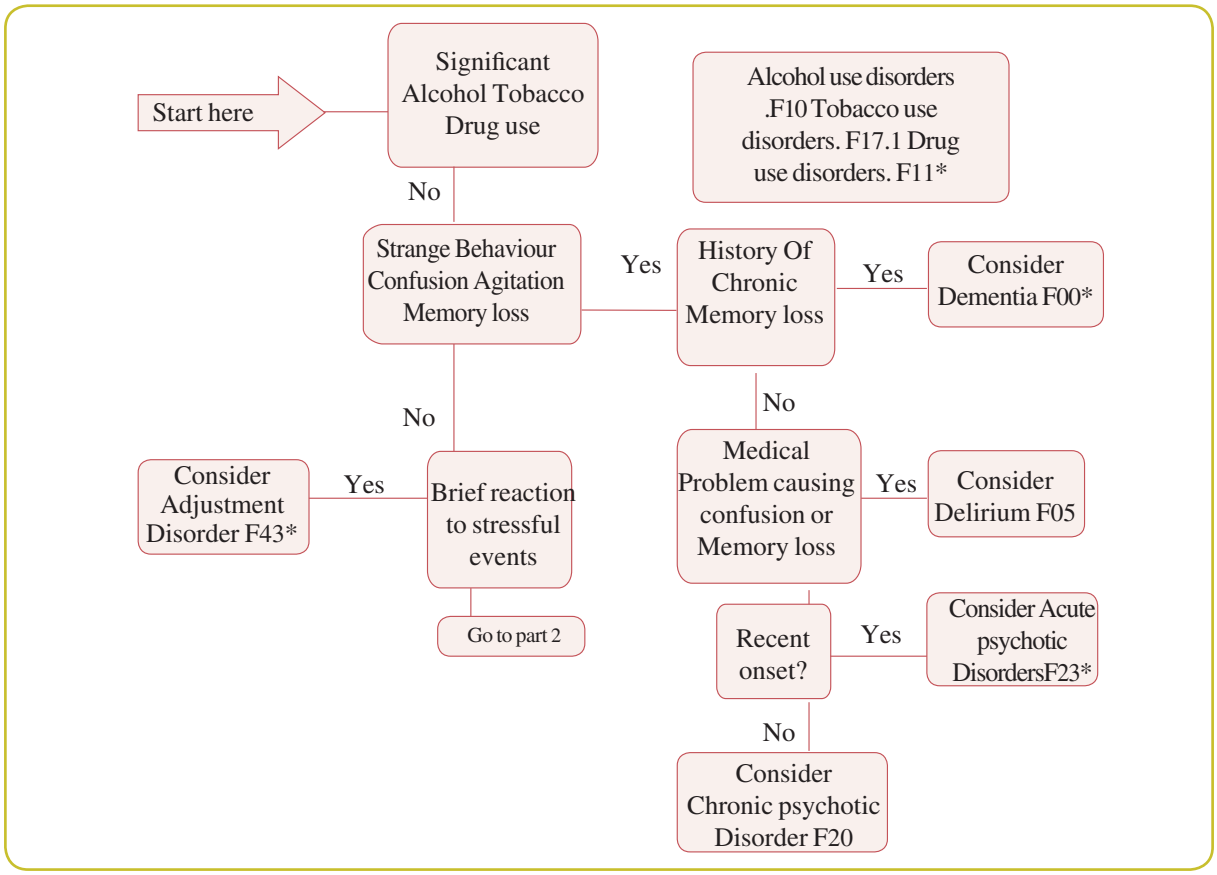
Resulting feelings: Acceptance; able to stop worrying

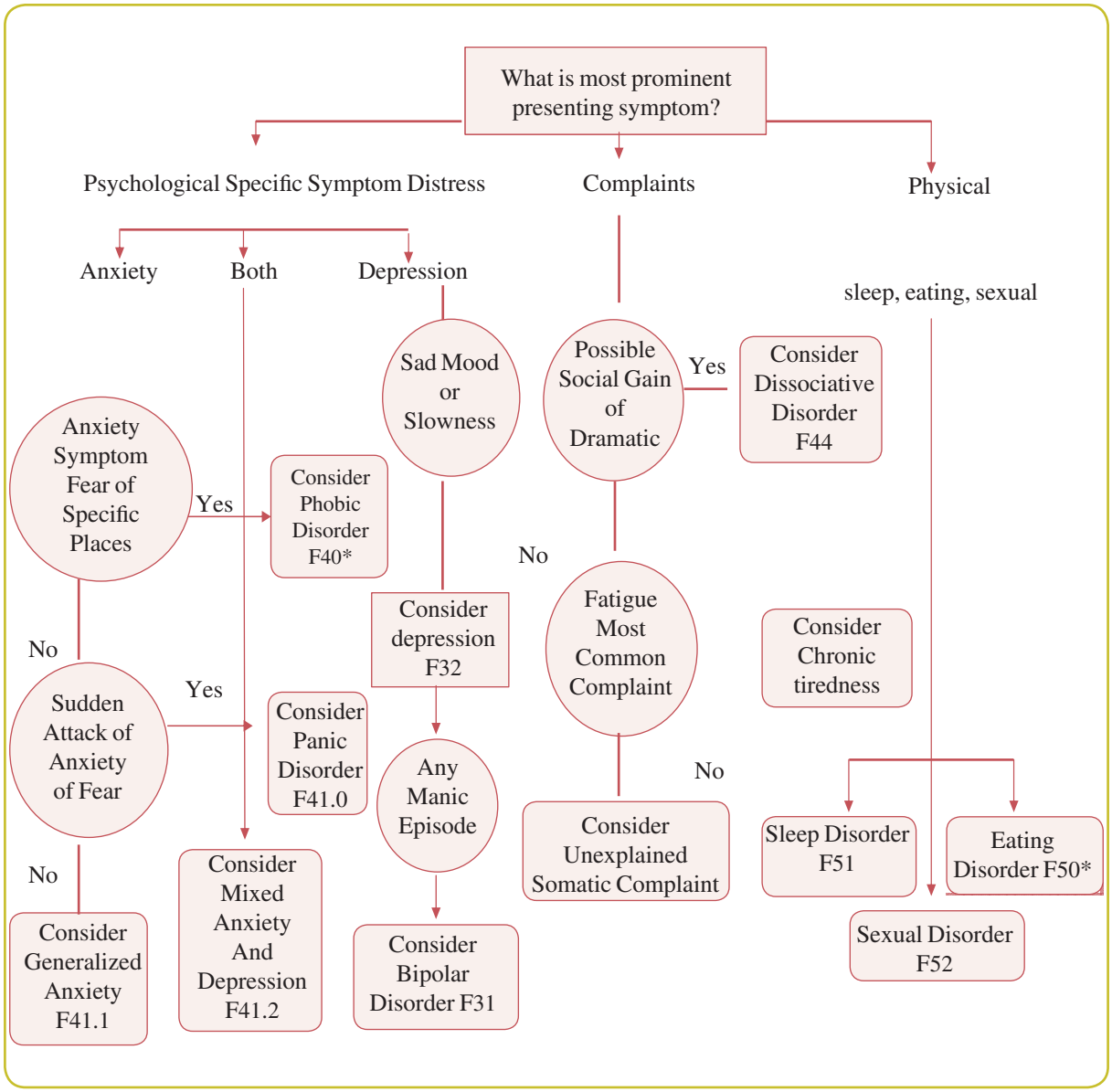
B. Symptom Index for Adults

Symptom Index for Adults	
Agitation of excitement	Acute psychotic disorder -F23 Delirium - F05 Chronic psychotic disorders - F20#
Anxiety	Generalized anxiety - F41.1 Panic disorder - F41.0 Phobic disorder - F40 Adjustment disorder - F43.2 Drug use disorders- F11#
Confusion	Delirium F05 Dementia F00#
Delusions or bizarre beliefs	Acute psychotic disorders - F23 Delirium - F05 Chronic psychotic disorders - F20# Dementia -F00 Drug use disorders- F11#
Tiredness	Neurasthenia - F48.0 Depression - F32#
Hallucinations	Acute psychotic disorders - F23 Delirium - F05 Chronic psychotic disorders - F20# Drug use disorders- F11#
Poor Hygiene / Self – care	Chronic psychotic disorders - F20# Dementia -F00 Drug use disorders- F11#
Insomnia	Sleep problems -F51 Depression- F32# Drug use disorders- F11#

Symptom Index for Adults	
Memory loss	Delirium F05 Dementia F00#
Suspiciousness	Acute psychotic disorders - F23
Feeling persecuted	Delirium F05 Dementia F00# Chronic psychotic disorders - F20# Drug use disorders- F11#
Physical symptoms (without physical cause)	Unexplained somatic complains - F45 Dissociative disorders (conversion hysteria) - F44 Panic disorder - F41.0 Generalized anxiety disorder- F41.1 Adjustment disorder - F43.2
Sad mood	Adjustment disorder - F43.2 Drug use disorders- F11# Depression - F32#
Strange speech or behaviour	Acute psychotic disorders - F23 Delirium - F05 Chronic psychotic disorders - F20#
Suicidal thoughts or acts	Drug use disorders- F11# Depression - F32#
Worry or fear	Generalized anxiety - F41.1 Panic disorder - F41.0 Phobic disorder - F40 Adjustment disorder - F43.2 Drug use disorders- F11#
Violent behaviour	Acute psychotic disorders - F23 Delirium - F05 Chronic psychotic disorders - F20# Drug use disorders- F11#

C. General Flow Charts




What is most prominent presenting symptom?
Psychological Specific Symptom Distress
Complaints
Physical
Anxiety
Both
Depression
sleep, eating, sexual
Sad Mood or Slowness
Possible Social Gain of Dramatic
Yes
Consider Dissociative Disorder F44
Anxiety Symptom Fear of Specific Places
Yes
Consider Phobic Disorder F40*
No
Fatigue Most Common Complaint
Consider Chronic tiredness
Consider depression F32
No
Sudden Attack of Anxiety of Fear
Yes
Consider Panic Disorder F41.0
Any Manic Episode
No
Consider Unexplained Somatic Complaint
Sleep Disorder F51
Eating Disorder F50*
No
Consider Generalized Anxiety F41.1
Consider Mixed Anxiety And Depression F41.2
Consider Bipolar Disorder F31
Sexual Disorder F52

استبيان اضطراب الاكتئاب

في خلال الشهر الماضي هل كنت تعاني من أي شكوى من الشكاوى الآتية معظم الوقت لمدة أسبوعين على الأقل:

إذا كانت الإجابة نعم علم (✓) في المكان المخصص:

هل كنت تشعر بالحزن أو الكآبة؟	☐
هل فقدت الاهتمام أو الاستمتاع بالأشياء التي كنت تستمتع بها من قبل؟	☐
هل شعرت أن حيويتك قلت أو أنك تشعر بالتعب معظم الوقت؟	☐

إذا أجبت بـ (نعم) ضع علامة (✓) على أي سؤال من الأسئلة السابقة. أكمل التالي :

هل عندك مشكلة في انك تنام أو تستيقظ مبكراً؟	☐
هل فقدت الشهية أو بدأت تأكل بشراهة اكثر من العادي؟	☐
هل عندك مشكلة في التركيز (مثلاً: الاستماع إلى الآخرين، مشاهدة التليفزيون ، سماع الراديو)؟	☐
هل لاحظت أي كسل في التفكير ؟	☐
هل اهتمامك بممارسة الجنس قل؟	☐
هل فقدت الثقة في نفسك أو نظرت إلى نفسك نظرة دونية؟	☐
هل فكرت في الموت/ أو تمنيت الموت/ أو حاولت الانتحار؟	☐
هل عندك غالبا شعور بالذنب؟	☐

بسبب هذه المشاكل في الشهر الماضي:

١. ما هو عدد الأيام التي لم تكن فيها قادراً على القيام بأعمالك اليومية؟

٢. ما هو عدد الأيام التي أمضيتها في الفراش لكي ترتاح؟

استبيان اضطراب القلق

في خلال الشهر الماضي هل كنت تعاني من أي شكوى من الشكاوي التالية معظم الوقت؟

إذا كانت الإجابة بنعم علم (✓) في المكان المخصص:

هل شعرت بالقلق أو التوتر؟	☐
هل قلقت كثيراً على حاجات معينة؟	☐

إذا كانت الإجابة بنعم لأي من السؤالين السابقين اكمل ما يلي:

هل شعرت في الشهر الماضي:

بالخوف من الموت؟	☐
بالخوف من فقدان السيطرة على النفس؟	☐
بقلبك هيفط من صدرك؟	☐
بالعرق؟	☐
بالرعشة أو بالرجفة؟	☐
بالغثيان أو بالدوخة أو بعدم الاتزان أو الإغماء؟	☐
بالتنميل أو بالخدر.	☐
بأن الأشياء حولك غريبة، غير حقيقية؟	☐

هل شعرت بهذه الأعراض أثناء:

الذهاب إلى أماكن غير مألوفة؟	☐
السفر بمفردك (سيارة/ قطار/طائرة)؟	☐
الزحام (الأماكن المغلقة / الأماكن العامة)	☐
ركوب المصاعد.	☐

خوف وقلق وتوتر في المناسبات الاجتماعية الآتية :

التحدث أمام الآخرين.	☐
المناسبات الاجتماعية (أفراح ، عزاء)	☐
الأكل أمام الآخرين.	☐

هل تأثرت في واحد أو أكثر من المجالات الآتية خلال الشهر الماضي معظم الوقت؟

العناية الشخصية: استحمام / ملبس / مأكل.	☐
علاقات أسرية : الزوج / الأقارب / الأولاد.	☐
الذهاب إلى العمل أو المدرسة	☐
الأعمال والواجبات المنزلية	☐
تذكر الأشياء	☐

بسبب هذه المشاكل خلال الشهر الماضي

ما هو عدد الأيام التي لم تستطع القيام فيها بنشاطك اليومي؟

ما هو عدد الأيام التي لازمت فيها الفراش من أجل الراحة؟

استبيان مشاكل النوم

١- في خلال الشهر الماضي هل كنت تعاني من أي شكوى من الشكاوي التالية معظم الوقت؟

صعوبة في بدء النوم.	☐
فترات طويلة من الأرق.	☐
الاستيقاظ مبكراً قبل موعدك المعتاد.	☐
النوم غير المستقر أو عدم الشعور بالرضا عن نومك في الليلة السابقة.	☐

ب- كم عدد ساعات نومك في المتوسط:

في أي ساعة تدخل إلى الفراش.

إذا أجبت بنعم على أي سؤال من الأسئلة السابقة فأكمل ما يلي:

هل تأخذ أي أدوية؟	☐
هل تعاني من أي شكوى جسدية أو مشكلة طبية ؟	☐
هل تشرب كحوليات / قهوة / شاي / أو تأكل قبل النوم؟	☐
هل تنام أثناء النهار؟	☐
هل هناك تغير في نظام حياتك(ورديات ليلية / سفر بالطائرة عبر القارات) ؟	☐
هل تعاني من عدم النوم لأكثر من ثلاثة أيام في الأسبوع؟	☐
هل أخبرك أحد انك تشخر أثناء النوم (شخير مزعج وعالي)؟	☐
هل تشعر بنوبات من الرغبة في النوم أثناء النهار لا تستطيع أن تقاومها؟	☐
هل تشعر بالحزن أو الاكتئاب أو فقدت الاهتمام أو الاستمتاع بأشياء كنت تستمتع بها من قبل؟	☐
هل كنت قلق أو مهموم أو متوتر؟	☐

هل تأثرت في واحد أو أكثر من المجالات الآتية خلال الشهر الماضي معظم الوقت؟

العناية الشخصية: استحمام / ملبس / مأكل .	☐
علاقات أسرية : الزوج / الأقارب / الأولاد	☐
الذهاب إلى العمل أو المدرسة	☐
الأعمال والواجبات المنزلية	☐
تذكر الأشياء	☐

بسبب هذه المشاكل خلال الشهر الماضي

ما هو عدد الأيام التي لم تستطع القيام فيها بنشاطك اليومي؟

ما هو عدد الأيام التي لازمت فيها الفراش من أجل الراحة؟

استبيان التعب المزمن

إذا كنت تعاني من أي شكوى من الشكاوي الآتية فضع علامة (✓) في المكان المناسب:

هل تشعر بالتعب معظم الوقت؟	☐
هل تتعب بسهولة وأنت تؤدي متطلباتك اليومية؟	☐
هل من الصعب عليك التخلص من التعب حتى بعد الراحة؟	☐
هل عندك أي مشاكل طبية / أو آلام جسدية؟	☐
هل تأخذ أي أدوية؟	☐
هل شعرت بالحزن أو الاكتئاب أو هبوط المعنويات أو فقدت الاهتمام أو الاستمتاع بأمور كنت تستمتع بها من قبل؟	☐
هل كنت قلق أو مهموم أو متوتر؟	☐
هل تعمل فوق طاقتك في البيت أو العمل؟	☐
هل نادراً ما تحدد وقت للاستمتاع بوقت الفراغ؟	☐
هل عندك مشاكل بالنسبة للنوم؟	☐

هل تأثرت في واحد أو أكثر من المجالات الآتية خلال الشهر الماضي معظم الوقت؟

العناية الشخصية: استحمام / ملبس / مأكل .	☐
علاقات أسرية : الزوج / الأقارب / الأولاد.	☐
الذهاب إلى العمل أو المدرسة	☐
الأعمال والواجبات المنزلية	☐
تذكر الأشياء	☐

بسبب هذه المشاكل خلال الشهر الماضي

ما هو عدد الأيام التي لم تستطع القيام فيها بنشاطك اليومي؟

ما هو عدد الأيام التي لازمت فيها الفراش من أجل الراحة؟

استبيان الأعراض الجسمانية مجهولة السبب

هل كنت تعاني من أي شكوى من الشكاوي التالية معظم الوقت في خلال الشهر الماضي؟

إذا كان نعم ضع علامة (✓) في المكان المناسب:

هل كنت تشكو من آلام أو أوجاع أو أعراض جسمانية لم يتضح لها سبب (مثلاً: غثيان / قيء / إسهال / اضطراب في التنفس / آلام في الصدر / صداع / مغص)	☐

إذا كانت الإجابة نعم بالنسبة لما سبق فأكمل ما يأتي:

هل ذهبت لأكثر من طبيب بسبب هذه المشاكل؟	☐
هل ذهبت إلى أخصائي لهذا السبب؟	☐
هل شعرت بهذه الآلام أو المشاكل الجسمانية لفترة أكثر من ستة شهور؟	☐
هل تشعر بالحزن؟	☐
فقدت الاهتمام أو الاستمتاع بأمور كنت تستمتع بها من قبل؟	☐
هل كنت قلق أو مهموم أو متوتر؟	☐

هل تأثرت في واحد أو أكثر من المجالات الآتية خلال الشهر الماضي معظم الوقت؟

العناية الشخصية: استحمام / ملبس / مأكل .	☐
علاقات أسرية : الزوج / الأقارب / الأولاد.	☐
الذهاب إلى العمل أو المدرسة	☐
الأعمال والواجبات المنزلية	☐
تذكر الأشياء	☐

بسبب هذه المشاكل خلال الشهر الماضي

ما هو عدد الأيام التي لم تستطع القيام فيها بنشاطك اليومي؟

ما هو عدد الأيام التي لازمت فيها الفراش من أجل الراحة؟

استبيان الإضطراب الإنشقاقي

هل كنت تعاني من أي شكوى من الشكاوي التالية معظم الوقت في خلال الشهر الماضي؟

إذا كان نعم ضع علامة (✓) في المكان المناسب:

هل تعاني في بعض الأحيان من نوبات تشنج (غزلنه).	☐
هل في بعض الأحيان يحدث أن تفقد الذاكرة لفترة ثم تسترجعها؟	☐
هل تفيق في بعض الأحيان وتجد نفسك في أماكن لا تعرف كيف وصلت إليها؟	☐
هل في بعض الأحيان تفقد الإحساس أو القدرة على الحركة في أي جزء من أجزاء جسمك؟	☐
هل في بعض الأحيان تعاني من فقد البصر الوقتي؟	☐
هل في بعض الأحيان تعاني من انحباس الكلام؟	☐
هل في بعض الأحيان تشعر بوجود جني (أسياد) عليك؟	☐
هل هذه الأعراض تظهر فجأة وتختفي فجأة؟	☐
هل استمر أحد هذه الأعراض مدة طويلة؟	☐
هل تشعر بحزن داخلي مع بقاء الشكوى التي تعاني منها؟	☐

بسبب هذه المشاكل خلال الشهر الماضي:

ما هو عدد الأيام التي لم تستطع القيام فيها بنشاطك اليومي؟

ما هو عدد الأيام التي لازمت فيها الفراش من أجل الراحة؟

استبيان اضطراب تعاطي المواد المؤثرة على الحالة النفسية

١- هل في أي وقت من الأوقات استخدمت واحد أو اكثر من العقاقير التالية لتستمتع أو تسعر بتحسن أو تغير مزاجك؟

إذا كان نعم ضع علامة (✓) أمام العقاقير التي تستخدمها:

المنبهات: سبيد / ريبارين / ماكس / أقراص التخسيس / كوكايين.	☐
مخدرات: هيروين / أفيون / كوديفان / دايهيدروكودايين / نوبين.	☐
مهلوسات : اكتازي / أسيد / الحشيش / البانجو.	☐
مهدئات : فاليوم / زانكس / روهينول / كوميتال / ترانكومون.	☐
أنواع أخرى : باركينول / تجريتول / اكينيتون / سومادريل.	☐

٢. هل تستعمل أكثر من مجموعة في وقت واحد معاً؟

٣. هل تشرب كحول مع العقاقير؟

٤ - هل تضطر إلي زيادة الجرعة لتحصل على التأثير المطلوب؟

٥ - هل تعرضت بحدوث أي من الأعراض التالية عند محاولة التوقف أو تقليل الجرعة (قيء أو غثيان أو أوجاع أو عرق أو هلاوس أو قلق أو رجفة أو كآبة أو تقلب في المزاج أو تشنج (غزلنه).

٦ - هل فشلت في تخفيض أو وقف الجرعة؟

٧ - هل للتعاطي تأثير سيئ عليك في حياتك الاجتماعية والعملية والأسرية؟

٨ - هل حدثت لك أي مشاكل هرمونية بسبب التعاطي؟

٩ - هل استمريت في التعاطي مع علمك بأنه يزيد حالتك الصحية سوءاً؟

هل تأثرت في واحد أو أكثر من المجالات الآتية خلال الشهر الماضي معظم الوقت؟

العناية الشخصية: استحمام / ملبس / مأكل .	☐
علاقات أسرية : الزوج / الأقارب / الأولاد.	☐
الذهاب إلي العمل أو المدرسة	☐
الأعمال والواجبات المنزلية	☐
تذكر الأشياء	☐

بسبب هذه المشاكل خلال الشهر الماضي

ما هو عدد الأيام التي لم تستطع القيام فيها بنشاطك اليومي؟

ما هو عدد الأيام التي لازمت فيها الفراش من أجل الراحة؟

Guideline Development Group Acknowledgements

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3- Additional Support and First Draft Revision:

MOHP Level

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5- Revision By High Committee of Egyptian Board of Family Medicine

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Dr. Emad Latif Metiass	El Shik Yosef FHU
Dr. Komyl Wdiee Danial	Bahta FHU
Dr. Kadry Mohamed Attia	Erabat Abu Ezize FHU
Dr. Emad Naeeim Loka	Bahatyl El Gizira FHU
Dr. Hala Samuaeil Fares	TST Quality Specialest
Dr. Frag Ahmed Mahmoud	TST Primary Health Care Director
Governorate level " Qena"	
Dr. Nahla Shikoon	El Mkrbya FHU
Dr. Nesreen Abu El Abass Elian	El Hragia FHU
Dr. Eiman Mohamed Mahfouz	Gzyra Motira FHU
Dr. Mona Fakhry Ali	El Hogirat FHU
Dr. Mohamed Mohamed Ashour	El Homer Wal Gaafraa FHU
Dr. Mostafa Glal Osman	El Tob FHU
Dr. Ahmed Saad Ahmed	TST Coordinator
Dr. Mamdouh Abuel Kasem	TST
Governorate level " Monoffya"	
Dr. Tamer Farag Ali	Mastay FHU
Dr. Alaa El Dine Abdel Razek	Ashliem FHU
Dr. Sherif Mosaad Labib	El Remally FHU
Dr. Asmaa Mahmoud El Sayed	Shobra Bakhom FHU
Dr. Waleid Mohamed Rashad	Meit Bara FHU
Dr. Nahed Sobhy Mahmoud	Tymor FHU
Dr. Gehad Ibrahim Mohamed	TST

Governorate level " Alexandria"	
Dr. Naira Niazy	Alexandria Central Coordinator
Dr. Nagwa Mostafa Abuel Nazar	El Gomrok FHU
Dr. Ghada Mohamed Abdel Allah	El Gomrok FHU
Dr. Marian Nashaat	El Manshia2
Dr. Ihab Zaky Iraheeim	El Laban1 FHU
Dr. Riham Sabry	El Laban1 FHU
Dr. Nadia Khaliel Fahmy	El Laban2 FHU
Dr. Anas Mohamed Helal	TST
Dr. Maha Mogib Haseib	TST
Dr. Nader Faik Fatoh	TST
Governorate level "Suez"	
Dr. Zein El Abedein Abdel Motelb	El Safaa FHU
Dr. Saher Mahmoud Hussien	El Amal FHU
Dr. Amany Keshk	El Sweiz1 FHU
Dr. Mervet Gharieeb	El Mothalath FHU
Dr. Suzan Gamiel	24 October FHU
Dr. Hany Anter	El Mashroo FHU
Dr. Nadia Mohamed Esmaeil	TST
Dr. Magda Ahmed Mohamed	TST Coordinator