Zaporozhye State Medical University
Department of Psychiatry, psychotherapy, general and medical psychology, addiction and sexology

Approved on the methodical conference of department
psychiatry, psychotherapy, general and medical psychology,
addiction and sexology
Head of the Chair MD, professor V.V.Chuhunov
_____
“_____”_____2015 year

Methodological developments

to practical lessons on the topic "Schizoaffective and delusional disorders.

Affective disorders" for 4th year students of the Medical Faculty

(specialty "medicine")

Zaporozhye - 2015

Topic: "Schizoaffective and delusional disorders. Affective disorders "

I. Background.

In manic-depressive psychosis and schizoaffective disorder suffer together about 1% of the population worldwide is about 50-60 mln. People, mostly teenagers, and young adulthood. It is not only medical, but also the overall socio-economic problem in nearly all countries. In most cases the disease is caused by a hereditary burdened, resulting in reduced disability, social maladjustment and patients in need of long-term patients receiving medicines. Timely examination of the patient after the first debut of the disease is important for diagnosis, clarify the clinical features, differential diagnosis with other affective disorders and schizophrenia timely appointment of treatment. It is known that in case of early adequate therapy in affective psychosis in most cases intermisiya possible long-term normal level of social adaptation and conservation ability to work.

1. Whole lessons:

Overall Objective: To study psychopathological symptoms and syndromes affective and delusional disorders in general, as separate nosology, different clinical types, types of motion and treatment of this group of diseases.

Specific goals:

1. To collect and evaluate complaints and patients with a history of manic-depressive psychosis, schizoaffective disorder and delusional.
2. Examination of patient with endogenous psychoses.
3. Evaluate your patopsihologicheskogo study of patients with manic-depressive psychosis, schizoaffective disorder and delusional. The differential diagnosis of endogenous psychoses
4. Appointment of the patient adequate patient and supportive treatment depending on the clinical forms of the disease type and other characteristics of clinical manifestations in patients with schizophrenia.

5. Conducting prevent a recurrence of the disease and differential diagnosis of various forms of lymphoma endogenous psychoses

3. Educational goals.

Develop a sense of responsibility for the timeliness and accuracy of clinical diagnosis formulation, to assess the general condition, presence of complications and emergency care to patients with manic-depressive psychosis, schizoaffective disorder and delusional. Develop ethical attitude and keenness to develop on the future of professional features to the patient with schizophrenia.

4. Interdisciplinary integration.

Discipline	Know	Be able
evious disciplines rmal anatomy	now the structure of the cortex, subcortical centers and the vascular system of the brain.	be able to determine the possible location of abnormal cells in the CNS.
rmal physiology	arn the functionality of different parts of the brain in shaping the thinking and emotional and volitional processes arn the features of the brain.	be able to determine the parameters of the normal functioning of the various parts of the brain according to EEG.
athophysiology		e able to interpret typical pathological changes in the brain tissue and blood

		vessels in disorders of consciousness. be able to determine the clinical and laboratory signs of cerebral activity at shyzofrenopodibnyh disorders and various versions neuroleptic syndrome.
he following subjects urosurgery Neurology (pediatric neurology)	y the initial symptoms and clinical peculiarities of tumors, hematomas, birth defects of the brain. y the signs of clinical development and speech motor system, including in young children, the lag in development.	e able to put a diagnosis on pathology clinical signs of consciousness. e able to put a preliminary diagnosis (including - hereditary diseases) and treatment.
nternally substantive integration ganic violation brain (ischemic and hemorrhagic stroke,	y etiopathogenesis and clinical peculiarities of atrophic disorders, brain disasters and	e able to assign inspection plan, identify the main clinical symptoms.

subdural hematoma, meningitis, tumors, atrophic processes, etc.).	infectious diseases GM.	
hizophrenia	v etiopathogenesis and clinical peculiarities of the various forms of schizophrenia.	
agnostic and therapeutic measures for psychomotor agitation in various nosological forms of endogenous psychoses.	master the basic diagnostic criteria and therapeutic interventions for various forms of lymphoma endogenous psychoses.	e able to be differentiated treatment for different types of mood disorders and thinking.

V. The content and structure of the lesson topics:

1. Etiology, pathogenesis theory of manic-depressive psychosis, psychosis and shyzoaffektyvnoho delusional disorders.
2. Classification, clinical manifestations of different forms and types of motion of manic-depressive psychosis, psychosis and shyzoaffektyvnoho delusional disorders.
3. Basic principles of treatment of manic-depressive psychosis, delusions and psychosis shyzoaffektyvnoho disorders.
4. Types of acute psychotic states.

Schizoaffective disorder etiological can be seen as the result of interaction of genetic bilateral obtyazhenosti with schizophrenia and affective disorders. There are, however, indications of independence genetic disorders, their tendency to piknychnoyi constitution. Factor frequency data brings disorder of epilepsy is confirmed by EEG: some patients have paroxysmal activity in the right temporal region and diencephalic region.

Schizoaffective disorder is transient endogenous functional disorder that almost is not accompanied by a defect which accompany affective disorders and occur for more than productive symptoms of schizophrenia (F20). Attacks are characterized by high polymorphism. Structure attacks, depressive-paranoid and expansively (manic) -paranoyidni picture.

Depressive-paranoid attacks typically manifest lowered mood, which joined delusions of self-incrimination, the idea of poisoning of AIDS, cancer or other incurable diseases. At the height of the attack possible depressive or depressive stupor Oneyroid immersion into the depths of hell. The likely inclusion of first-rank symptoms peculiar to schizophrenia, such symptom openness thoughts, auditory hallucinations imperative. Ideas total destruction and decomposition (delirium Kotar, nihilistic delusions) eternal sin syndrome (Wandering Jew) and hippopotamus delirium can end depression.

Expansive (manic) -paranoyidnyy attacks can manifest with expansive or manic affect, reduce the duration of sleep and unbridled fun and accompanied by ideas of grandeur (expansive parafrenyeyu) ideas hypnosis, psycho-energetical or hardware influence the thoughts, behavior, feelings, and incentives. At the height of psychosis may include space oneyroydni content, delusions and magical change of pace over time. Out of psychosis may be accompanied hipomanyyeyu.

When mixed states observed fluctuations affect hipomaniakalnoho from manic to depressive and with ambivalent (Manichean) delirium, whose content is woven into the struggle between good and evil with corresponding positive and negative auditory hallucinations that are contradictory and mutually exclusive. Mixed status may also be characterized by alternating depressive-paranoid and paranoid disorders expansively, the type of happiness, fear psychosis.

Duration of psychosis at least 2 weeks. In intermisiyi usually signs of emotional and volitional defect no, but after a while acute psychosis may persist or schizophrenic or affective symptoms

The disease should be differentiated from schizophrenia, depression and organic postshyzofrenycheskoy - shyzofrenopodibnymy states. For schizophrenia is characterized by a combination of productive and negative disorders, the latter usually not observed in schizoaffective disorder. In schizophrenia affect the modified duration of less than productive disorders, in other words, these affective states are specified only at the height of psychosis. When postshyzofrenycheskoy atypical depression clinical depression, and a history marked by typical schizophrenic psychosis. Organic state can be differentiated on the basis of paraclinical, neurological and neuropsychological studies.

In the treatment of separated treatment and prophylactic therapy attacks further attacks. In the treatment of depressive-paranoid attack used antipsychotics and tricyclic, tetracyclic antidepressants (amitriptyline, melypramyn, velbutryn). In the treatment of paranoid states expansively, antipsychotics (sometimes beta blockers) and lithium or carbamazepine. Preventive therapy is based on the use of maintenance doses of lithium carbonate (kontemnola, litosanu) at doses of 400 - 500 mg or carbamazepine at doses up to 200 mg, and sometimes drugs valproic acid. When depressive-paranoid episodes also applies ECT.

Manic type (F25.0) For this type of characteristic criteria shyzoaffektyvnoho disorder or manic-manic expansively background

Depressive type (F25.1) criteria for depressive disorders shyzoaffektyvnoho background.

Mixed (F25.2) criteria shyzoaffektyvnoho disorder and mixed bipolar affective disorder.

Manic-depressive psychosis (bipolar affective disorder)

The disease is characterized by repeated (at least two) episodes in which mood and motor activity levels significantly affected - from manic to depressive inhibition of hyperactivity. Exogenous factors have no influence on rhythm. Border episodes are defined as the transition or mixed episode of opposite polarity or yntermyssyyu (remission). Attacks have tropism for seasons, spring and autumn often acute, although there may be individual rhythms. Yntermyssyy duration of 6 months to 2-3 years. Duration manic states from one month to four months for the dynamics of disease in about depression from one month to six months. Relapses can be about the same length, but can increase with shortening remissions. Depression are clearly endogenous in nature: daily fluctuations in mood, vitality elements. In the absence of therapy seizures tend to spontaneous breakage, though they are more persistent.

As the disease is sometimes observed social decline.

Diagnosis is based on detection of recurrent episodes of changes in mood and level of motor activity in the following clinical variants. In the diagnosis of directly observed celebrated episode of affective disorders, such hypomanyakalnыy, manic without psychotic disorders or psychotic disorders, moderate or mild depression, severe depression with psychosis or not. If the disorder is not marked, indicated a diagnosis of remission, which is often associated with prophylactic therapy.

Differential diagnosis

Bipolar affective disorder often differentiated with shyzoaffektyvnыm disorder.

Shyzoaffektyvnoe disorder is transient endogenous functional disorder, which is also accompanied by almost no defect which accompany affective disorders and occur for more than productive symptoms of schizophrenia (F20). These symptoms are not specific to bipolar affective disorder.

Therapy shared treatment of depression, mania and prophylactic therapy attacks. Features are defined depth treatment of affective disorders and the presence of other productive symptoms. In depressive episodes often used tricyclic antidepressants, ECT, treatment of sleep deprivation, disinhibition nitrous oxide. In manic episodes combination of neuroleptics and lithium carbonate. As maintenance therapy, carbamazepine, valproate sodium or magnesium carbonate.

Chronic delusional disorder.

The cause of chronic delirium could be explained with particular personality structure, psychoanalytic, and based on the situation meaningless environment. paranoyidnaya personality structure with suspicion, distrust and hostility is likely due to genetic mechanisms, but it is embodied in behavior and psychosis in certain situations as a result of education or hit in a particular environment. Most of the proceeds in the outpatient setting, and some of them find their social niche, for example, they are courts, political parties, sects. Often marked induction relatives.

Clinic

This group is actually the classical paranoia and systematic parafreniya. In the strict sense, this conference a delirium, which again can lead to depression if the patient can not realize their monoideyi or aggression against possible enemies. The ideas of persecution, grandeur, relationships, invention or reformism, jealousy or love and belief in the presence of a disease, emotionally charged religious ideas. Remissions are observed, but there is no emotional and volitional defect. Stenichnist patients often leads others to believe them, and they are included in plane fight. When the idea of persecution patient can not realize itself only object tracking, which leads him to a permanent change of residence, but also prosecute one person or group of people based on "moral purity". Ideas of grandeur and religious

ideas lead patients to guide heretical sects and new messianic currents. The ideas of love and jealousy syndrome (Klerambo) meaningless, and the object of love, which can be a known person (actor, singer) may be a long time not suspect that is the object of interest. The belief of the patient in the presence of a particular disease often convinces doctors whose manipulations (eg, diagnostic laparatomyya), in turn, lead to negative consequences (Munchausen syndrome) and disability.

The diagnosis is based on the following criteria:

1. Dreams persecution value relationships, jealousy, erotic, hippopotamus.
2. Duration of more than 3 months.
3. Some include hallucinations or depression.

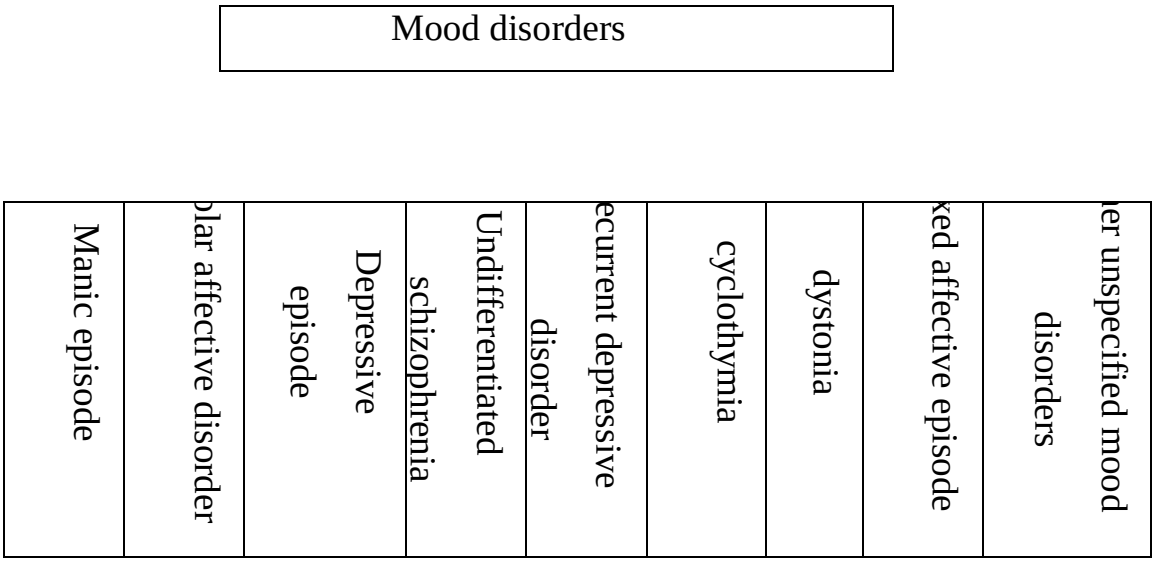
Differential diagnosis

Delusional disorders should be differentiated from paranoid schizophrenia and paranoid psychosis when consuming alcohol. For more paranoid schizophrenia polythematic characterized by delusions, emotional and volitional disorders typical of schizophrenia. In patients with alcoholism patients can be paranoyyalni ideas of jealousy that happen to experience the loss of their own sexuality. In history are symptoms of dependence and withdrawal, as well as typical personality changes.

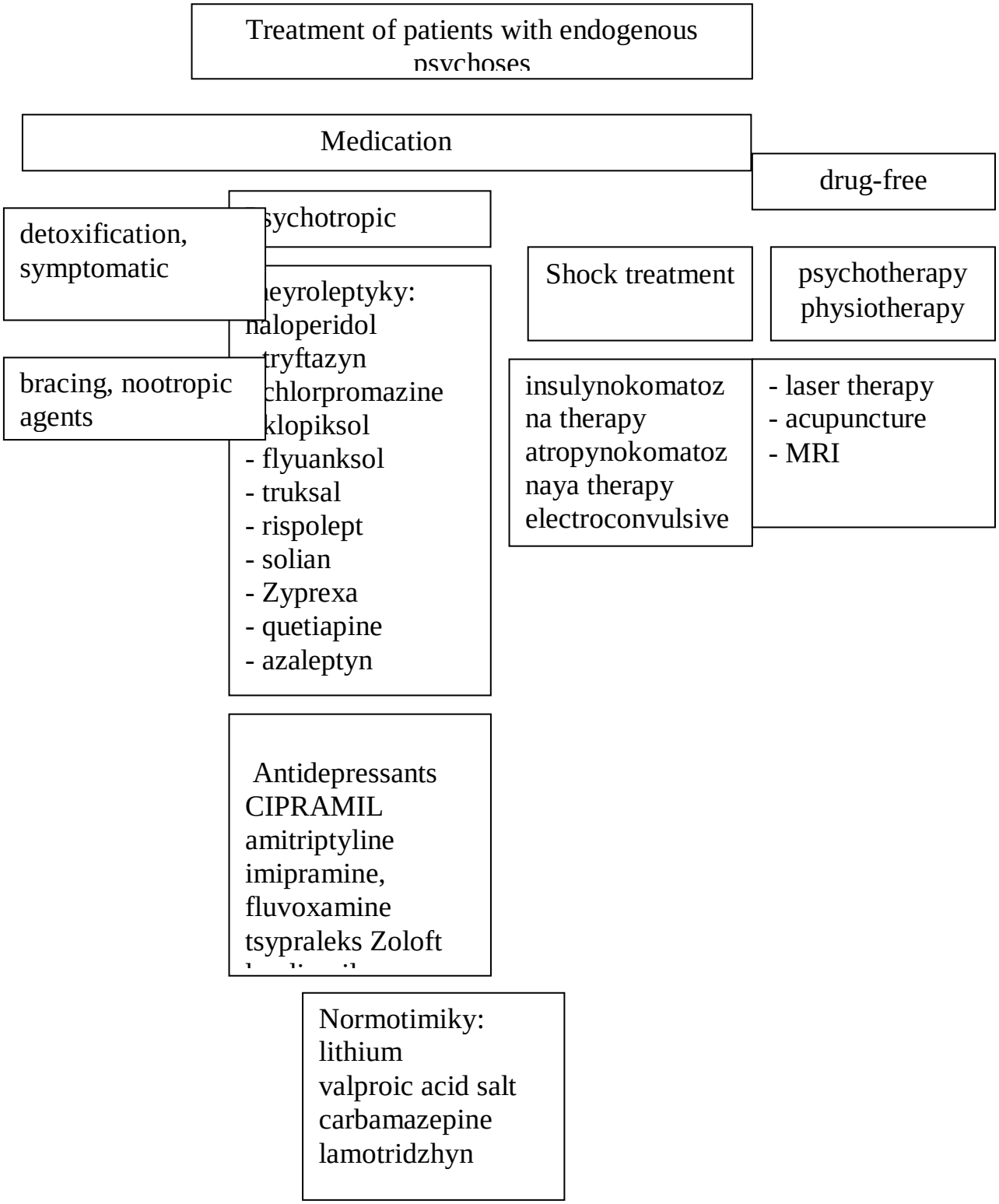
Chronic delusional disorder hardly amenable to therapy, since patients refuse taking neuroleptic drugs and dysymulyuyut their opinions, they often do not trust psychiatrists. Only in detention manages to slightly alleviate the symptoms of neuroleptic useless, but maintenance therapy without control patients relatives refuse, so should be given antipsychotics-prolonhy. Recommend individual psychotherapeutic approach and emphasis in contact to other areas of interests and experiences of the patient, such as a somatoform symptoms affect. Control of violating indirectly helps in the treatment of the underlying disease.

Graphology structure of employment by topic:

International Classification of Diseases ICD-10



Differential diagnosis between schizophrenia and other endogenous psychoses


Treatment of patients with endogenous psychoses
Medication
drug-free
sychotropic
detoxification, symptomatic
Shock treatment
psychotherapy physiotherapy
eyroleptyky:
haloperidol
tryftazyn
chlorpromazine
klopiksol
- flyuanksol
- truksal
- rispolept
- solian
- Zyprexa
- quetiapine
- azaleptyn
bracing, nootropic agents
insulynokomatoz na therapy atropynokomatoz naya therapy electroconvulsive
- laser therapy
- acupuncture
- MRI
Antidepressants
CIPRAMIL
amitriptyline
imipramine,
fluvoxamine
tsypraleks Zoloft
Normotimiky:
lithium
valproic acid salt
carbamazepine
lamotridzhyn

ORGANIZATION OF THE LESSON: schizoaffective disorder, manic-depressive psychosis, delusional disorder.

Determination of baseline knowledge.

Determining the source of knowledge held by addressing the students of tests. The teacher checks them according to the standards of answers, discusses the results.

Survey on main issues to one theme.

By individual survey for each student questions about topics class, the instructor is able to determine the theoretical knowledge of students. Answers discussed all students, supplemented, distributed under the guidance of a teacher.

Independent study students.

Students conduct a survey of patients on employment, giving attention to the complaints, history of life and disease, determine basic symptoms and syndromes that suggest the disease. Students determine the main directions of examination and treatment, offering individual and group drugs dose. During the self-study teacher corrects answers, discussing various options for psychotherapy and pharmacotherapy.

Analysis and outcome of students.

Summary of lessons conducted the final test control solution. Students are encouraged to solve STEP-format tests 1.2. The teacher validates the solution by the standards of answers. The analysis of each student in class.

Place and time of the class.

Classes are conducted with students during 180 minutes. Classes are held in the educational room. Curation of patients is in the palace of the psychiatric hospital departments.

Equipment classes.

1. Table.
2. Scheme.
3. Sets problems baseline.
4. Sets the final control tests.

TECHNOLOGY MAP PRACTICAL LESSON

	Steps	ne n.)	Tutorials		Location
			learning Tools	uipment	
	ol of initial level of knowledge		ol questions, tests on the topic		ing room
	w of individual work		s, figures, algorithms	show	ing room
	the thematic patients, analysis of leaf medical appointments		ry, letters medical appointments		ber offices
	decision of situational problems		tuational problems		ing room
	ol of final level of knowledge				ing room

Questions for Initial knowledge: (a II-III)

1. Endogenous psychoses. History views of affective and delusional disorders.
2 Theories of etiology and pathogenesis.
3. Clinical assessment and methods of experimental psychological studies in manic-depressive psychosis, schizoaffective psychosis and delusional disorders.
4. Characteristics clinic in a manic-depressive psychosis, schizoaffective psychosis and delusional disorders. Pathomorphosis endogenous psychoses.

5. Types course of affective disorders. Phases in manic-depressive psychosis and shyzoaffektyvnomu disorder.
6. Differential diagnosis of affective psychosis, delusional disorders and schizophrenia.
7 psychopharmacology and psychotherapy in manic-depressive psychosis, schizoaffective psychosis and delusional disorders

Tests II level

1. Patient, 45, complained periodically (mainly in autumn vesnyano-) without apparent cause pain occurring in the heart, iradiyiyuyuchi under the shoulder blade, tachycardia, decreased appetite, weight loss, weakness, lethargy. The experts examined repeatedly, but serdevo- pathology of the vascular system is not found, the suggested therapeutic measures do not give effect. Which option is most likely depressive syndrome in this patient?

a. Neurotic depression
b. Panic Depression
a. Azhitirovannaya depression
g hypochondriacal depression
d. masked depression.

2. The patient, 17 years old, depressed mood, sad, crying often, says its uselessness and futility, betrays suicidal thoughts. Determine the type of violation of emotions.

a. Euphoria be. Dysphoria
a. Inadequate emotions
g Depression
d. Slaboduhist.

3. Patient 45, in a state of complete immobility, the question the doctor meets certain words, selectively. Byraz sad face. The pupils were dilated, pressure 100/60 mm Hg. Art., pulse 100 / min. Byznachit emotional and volitional disorders:

A catalepsy
B Catatonia
C Depressive stupor

D hallucinatory-delusional stupor

E Psychogenic stupor

4. Patient cheerful, multilingual, it accelerated, you can not always understand what he says. Without a moment's sitting. Interfering in all affairs staff, makes remarks to patients in private nursing observation does not respond. Do not get tired. The voice hoarse. Sometimes witty jokes. Determine the type of excitement.

a. Hebefrenichne

b. Compulsive

a. Catatonia

General psychomotor g

d. due to violation of consciousness.

5. Technical Institute student, 23 years. The disease developed without apparent reason. He became lethargic, lost interest in learning, communicating with friends, art and music, which had "only he lived." There pseudohallucinations hearing, delusions of persecution and hypnotic action. Said that his opinion "read by others". Almost was absolutely inactive and indifferent, almost always ridiculous idea vykazuvav different content. Patients themselves are not considered. Identify syndrome.

a. Syndrome Kandinskoho- Klerambo

b. Depressive

a. Paranoid g Apatiko-abulicheskimi

d. psychopathic syndrome.

6. The patient, 27 years old, entered the clinic after suyitsidalnyh attempts tried to hang himself, vykynutysya the window. Mood humbled, countenance sad, difficult sighs. Thinking slowed. Talking softly, phrases poor. Tachycardia, dry mucous membranes, poor appetite. He says that physicians worthy of note, deserves punishment for past sins. What the patient syndrome?

a. Apatiko- abulicheskimi

b. Paranoid

a. Depressive

g psychoorganic d. Asthenic.

7. The patient, 18 years, complains that experiencing discomfort alienation opinions, exclusion of mental processes. Ob'yektyvno- awake all night, morning feeling no camping, complaining that not "batted an eye." Identify syndrome.

a. Asthenic

b. Depressive

a. Depersonalization

g derealization

d. Kandinskoho- Klerambo.

8.Zhinka '35 '10 suffering from pulmonary tuberculosis. In the TB clinic soon began to behave strangely, faces painted bright makeup, gathered around a sick, danced, sang with them. Was excited all the time spent in the company of men koketkuvala, flirted, they started conversations on sexual topics. Bsyu night was absent in the unit ("was a date"). Byznachit psychopathological syndrome:

AManiakalnyy

B psychopathic

C Hebefrenichnyy

D Moriopodibnyy

E Isteroformnyy

9. Patient 45, in a state of complete immobility, the question the doctor meets certain words, selectively. Byraz sad face. The pupils were dilated, pressure 100/60 mm Hg. Art., pulse 100 / min. Byznachit emotional and volitional disorders:

A depressive stupor

B Catatonia

C catalepsy

D hallucinatory-delusional stupor

E Psychogenic stupor

Level 3 Challenges

1. The mental state of the patient N., 35, a decrease mood, difficulty associative process, language and motor retardation. Byslovlyuye delusions of self-blame, self-abasement. State of improved in the afternoon. Located on account of a psychiatrist 6 years. Byznachit diagnosis:

A manic-depressive psychosis

B Circular schizophrenia

C Involutional psychosis

D neurasthenic neurosis

E Reactive depression

Assign treatment in hospital and give recommendations at discharge from office.

2. frenzied attack a violation of extremely strong emotions affect of sadness and fear should vynachaty as:

A catatonic excitement

In agitation

Pathological affect C

D Melanholichnyy raptus

E All of the above

What should be the therapeutic tactics? What medications should be used first?

3. Male 40, expresses the thought of betraying his wife, citing "evidence". Repeatedly zchynyav wife jealousy scenes at home and at work, demanding that she confessed to betraying, insulted her and threatened murder. Substantiate the measures to be taken to prevent socially dangerous acts in this state ?:

A conduct outpatient treatment

B Assign consultation psychiatrist

C Assign counseling therapist

D Assign counseling psychologist

E Hold family therapy

Set syndromic diagnosis and prescribe treatment.

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