Ernakulam Psychiatric Society Oration

LITHIUM MEMOIRS

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Esteemed chairperson, colleagues, friends, and guests,

As I stand before you for this oration, besides being delighted and grateful, I am apologetic, too. Out of the country for most of the time during the last four years, I have not been in touch with organizational activities and academic events here. The existence of this prestigious honor of the Indian Psychiatric Society – Kerala State Branch was, therefore, not known to me until my consent for nomination to it was sought by my beloved colleagues in the Venad Guild of Psychiatry a couple of days back.

It is customary to choose an academic or professional topic of one's expertise and preference and prepare a scholarly exposition on it for the oration. Being committed to a series of successive short journeys in the ensuing days, such a preparation was not feasible for me. There was an issue of my mindset as well. I have just done a write-up on my experience of having moulded myself as a medical teacher and clinician during post-graduate training at NIMHANS in the early 1970s (article in SIPSCON 2023 Souvenir). The vibe of that reminiscence and flow of its narration was very much alive within me. With that mindset, l felt I would rather speak on some of my experiences in the early years of my mental healthcare career in Kerala, returning from NIMHANS with a mission mode in mind for a dedicated service. It was then that my debut and early experience of using lithium came descending to my mind. Naturally, academic or technical details are not much there in this presentation. It just says how a young aspiring psychiatrist, over four decades ago, dared to take a therapeutic initiative in a deprived clinical setting, assuming a certain sense of amateurish adventurism and how that was built upon and augmented mental healthcare services.

Learning and Sensitization

While in training at NIMHANS (1972-75), we had an opportunity to use almost all the psychotropic drugs independently in the outpatients and inpatients thanks to the understanding and liberal attitude of our teachers there. Lithium had not yet arrived in the institute in 1972 when I joined there. A few renowned private psychiatrists had been using Lithium, and one or two private labs were equipped for serum lithium monitoring in Bangalore at that time. In due course, a few of our Professors and Senior Consultants in the Institute started using Lithium, availing services from outside labs for regular blood level monitoring. Senior postgraduates like me were actively involved in the case workup and

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monitoring and documenting their lithium patients. This made us all well-versed with the scientific literature on Lithium therapy, familiar with all the procedures involved, convinced of its efficacy in controlling acute mania, and somewhat impressed with its prophylactic efficiency. We were all eager to and wishing for a day to use Lithium independently.

Debut and Initial Use

Returning to the gross deficiencies and miseries at the Mental Health Centre, Trivandrum was frustrating. Though expected somewhat, it was profoundly hurting. The Superintendent was a good clinician but was ambitious for wealth, power, and fame and quite autocratic. The hospital was run as his fiefdom with a mafia setup, as most mental hospitals in the country were then. Regret and frustration in resigning from the tutor post at NIMHANS, with good prospects of career advancement there, kept visiting and revisiting me.

Being fresh with an MD, willing to work for long hours, and having no personal private practice, the Superintendent probably considered me a harmless subordinate compared to others. He gave me the charge of two admission wards. Of course, there was no freedom to admit or discharge cases or run outpatient clinics independently. Within the ward, I was given a certain freedom for routine management of patients. Acute patient care with such a shortage of physical facilities, medicines, utilities, and caregiving staff was deeply frustrating at the end of the day.

With a network of good friends in different social and vocational groups and active involvement in literary and artistic programs, my evenings were bright. With my contact with some social service organizations and genuine social workers in Thiruvananthapuram, I could also bring some input from outside to supplement medicines and consumables for patients. Carrying out some enabled clinical work in this manner and taking classes for the newly started Diploma in Psychological Medicine (DPM) students, I spent my days with fleeting waves of enthusiasm and frustration – the former intrinsic to me and the latter, the imperative impact of the conditions prevailing in the hospital. I felt like a frustrated, but not yet disengaged, lover – mental healthcare being my sweetheart in this metaphor.

I have been wishing, all these days, dearly for the dawn of a day when my dream of therapeutic autonomy and actualization as an empowered mental healthcare expert would materialize. The day finally dawned.

Sasidharan Pillai (name changed), suffering from an annually recurring severe bipolar affective disorder (BPAD), was admitted to the ward of the Mental Health Centre. I was in charge of the ward. He and his family members were familiar with me during his early hospitalization in 1972, soon after my joining as a tutor there. He was extremely violent at that time, got into a violent altercation with some nursing assistants, and got brutally beaten up in retaliation. He hailed from a reputed, influential, wealthy landlord family in central Kerala (known to me), with much influence socially and politically. The issue flared up and created turbulence in the hospital. After that, he gained the image of a villain or an anti-hero in the hospital. Though a young, fresh graduate doctor then, I played some role in de-escalating the friction between the family and hospital staff. His BPAD episodes would relapse almost every year, causing much damage and disruption to family matters.

Seeing me now as a full-fledged young psychiatrist in charge of the ward, the family was reassured. They narrated the damage and destruction he would unleash during each episode and pleadingly asked me whether there was any way of more effectively treating him and preventing another episode. Considering his typical dysphoria and clinical profile, I was already toying with the idea of starting Lithium on him. I briefed them on the prospect of starting a new effective medicine but highlighted the mandatory necessity of regular

blood testing, which was unavailable – not just in Thiruvananthapuram, but anywhere in Kerala. At that time, the nearest place with a Blood Lithium testing facility was at Coimbatore, and the sample had to be physically taken there to get it done. The family was wealthy and closely knit, with four resourceful brothers and three brothers-in-law. They assured me that the commutation of the blood sample and the result the next day could be arranged without fail. They ardently appealed to me to start Lithium treatment on Sasidharan Pillai. The best part was that Sasidharan Pillai, despite or because of his expansive mood, also joined in that collective appeal.

I realized that the time had come for me to fulfill my dream of starting Lithium treatment. I went to the Superintendent requesting permission to start Lithium on a patient in my ward. He was initially shocked and rejected the request outright, saying that there were enough problems already in the hospital and that starting a potentially risky treatment procedure need not be added to it. The identity of the patient and the family infuriated him. He reminded me of all the trouble they created in the hospital on a previous occasion. He warned me about taking their assurance at face value and jumping into a potentially risky treatment endeavor. The repeated appeals and relentless persuasion of the family members, who by then had become quite close to me; my ardent wish to start using Lithium; and the firm rejection of my request by the Superintendent together put me in much distress.

I have always had the trait of augmenting my motivation, gathering momentum, and escalating efforts in such compressed situations. I repeatedly met the Superintendent and informed him that a couple of renowned psychiatrists at Kochi and Thrissur were already giving treatment with Lithium. This, as expected, worked. The Superintendent was a highly aspiring practitioner who would not like to lag behind anyone in the field of private practice. He got ignited. He made me write and sign an undertaking, assuming full responsibility for the treatment, writing down daily notes, and reporting to him daily the progress/problems in treatment. Keeping my signed undertaking inside his office table drawer, he gave me a 'Go Ahead' order.

While exiting his office and running to the ward, I was on top of the world. With the help of an efficient, cooperative ward nurse, Jayalakshmi, and a couple of fine nursing assistants, and the enthusiastic support of the patient's family, I could start Lithium treatment on Sasidharan Pillai (Tab. Lithocarb 300mg bid). The family meticulously attended to the task of commuting the morning blood sample to Coimbatore and bringing the result on the third day. Everything went on well. From the fourth or fifth day onwards, I could sense that the manic dysphoria of Sasidharan Pillai was getting dissipated into thin air. His dosage was increased to 900mg a day. I would go to the Superintendent every afternoon to present to him the report on the treatment progress, serum level, and side effect tally. His face generally tight and serious, seemed getting relaxed and brighter, day by day. He visited Sasidharan Pillai in the ward, exchanged pleasantries with his family, and appreciated the nursing staff for their involvement and full cooperation. After two weeks, when I went to him to discuss the discharge and lithium prophylaxis plan of Sasidharan Pillai, the Superintendent triumphantly declared, "I don't think anyone in any mental hospital or psychiatry units of any district hospital has so far used Lithium. Kumar, we are the first in Kerala." To the best of my knowledge, he was right. That was the first use of Lithium in a government hospital.

This was my debut with Lithium. The Superintendent gained confidence and started using Lithium on a few of his private patients duly. However, due to the lack of lab facilities and supportive families, not many patients in the mental hospital could be given Lithium treatment for a long time.

Lithium Experience in Bipolar Disorders

A few months later, I got promoted to Assistant Professor and was posted at Medical College, Kottayam. The Psychiatry unit in Kottayam was small and compact, with sixteen inpatient beds. The staff consisted of just one assistant professor (myself) and one tutor. The latter had only a three-month Diploma/Certificate in Psychiatry from the UK and was running his private psychiatric hospital illegally. He was neither interested in the psychiatry unit of the medical college hospital nor cooperative in running it. For a couple of years, I had to run it as a single doctor department, with an occasional house officer to assist – often with no one.

However, the acceptance and cooperation from other faculty members of different clinical departments enabled me to develop clinical services and academic programs. Being a teaching hospital psychiatry unit, drug supply and lab services were much better. Patients and their families, in general, were more responsible and reliable. Besides the hospital work, I had a limited private practice at my residence on permissible lines. It was a setting conducive to the use of Lithium on indicated patients. However, a lab facility for testing lithium levels was neither available at the medical college nor in the private sector at Kottayam till 1980. It was available in a private hospital in Kochi.

At Kottayam, I came into close association with Dr. Baker Fenn, one of the most renowned and highly respected senior psychiatrists in Kerala. He was like an elder brother to me, besides a beloved friend. His patients were drawn from the upper social strata of society. When we got acquainted, Dr. Baker Fenn, though interested in Lithium, had not yet been used to prescribing Lithium in practice. We decided to start it regularly on well-indicated, suitable BPAD patients. A doctor-owned lab at Kottayam agreed to collect blood samples from our patients, send them to Kochi, deliver the result to us directly, and make it available to the patient's family. Dr. Baker Fenn and I formed an active Lithium dyad at Kottayam. SKF's Tab. Eskalith 300mg and E-Merck's Tab. Lithocarb 300mg were the proprietary preparations of Lithium available at that time. When E-Merck introduced Lithocarb 150mg in the early 1980s, they organized a seminar at Kochi where Dr. Baker Fenn and I shared our therapeutic experience with Lithium as invited speakers.

With a prescription preference for low initial dosage and small increments, both Dr. Baker Fenn and I were happy with the introduction of 150mg Lithium Carbonate tablets by E-Merck. Over the next several months, Dr. Fenn and I placed many patients with bipolar disorder on Lithium prophylaxis. The lack of a local lab facility for serum lithium monitoring at Kottayam was indeed a limitation that constrained us to use the drug in a lower dosage. Most of the patients were maintained on a serum lithium level of 0.3 to 0.5, and clinical monitoring was done more astutely and regularly. We gained an impression that even in such low serum levels, Lithium works splendidly as a mood stabilizer and prophylactic agent. Seven to ten years later, clinical reports and review articles started appearing prominently in international journals from renowned centers, stating serum levels in the 0.3-0.5 range are effective in the prophylaxis of bipolar disorders. Had we organized our observations and published them in journals, we would have been the first to publish this observation; 'Fenn & Kumar' would have become celebrities in Lithium Therapy research in the country – a sense of loss visited both of us, albeit transient. As the number of lithium clients increased, a profile of typical lithium responders emerged in my mind.

Beyond Bipolar Disorders

Gaining confidence, I started using it on patients with conditions other than bipolar disorders, as well as with an inquisitive mind. A renowned surgeon friend of mine from Kochi, ripped up by frequent and florid anger outbursts of his wife, brought her to me for consultation. She was an

active social worker and the owner of a flourishing garment business. After a lot of hesitation and argument, she agreed to take lithium as prescribed by me. With each follow-up visit, she turned positive to the drug. After a couple of weeks, she and her husband came to meet me with beaming faces. They both felt as if she had taken a rebirth or undergone a highly benevolent mutation, and their home, once a bitter battlefield, was turning into 'a garden of peace and tranquility.' Both of them became ardent lithium admirers – the lady more so. She went on to narrate her positive lithium experience and appreciation to her friends and relatives. The husband got upset and started distancing himself from me – not an unusual experience in a psychiatrist's career. Very often, our patients would be grateful to us and delighted to meet and greet us anywhere. Still, their spouse/family member would be uncomfortable in such situations – especially when the latter is a medical person.

Subsequently, I could help anger dyscontrol issues in many persons and save many a marriage, dysfunctional family, or work setting with systematic, careful, and monitored use of Lithium. The response in such clients was satisfying, though not always, and often not as much, as what was obtained in bipolar cases.

Returning to Trivandrum Medical College in 1986 as Professor and Head of Psychiatry, I continued using Lithium actively and frequently. By the end of the 1990s, Lithium was widely used in all psychiatric units, both in the government and private sector in Kerala. More and more awareness dawned on the profession about its positive therapeutic benefits and adverse effects in a realistic sense.

A Glimpse of History

In 1987, I got a visiting fellowship at the renowned Duke University Medical Centre, USA. Prof. Bernard Carroll, who developed the Dexamethasone Suppression Test (DST), was the Chairman. I could get to meet him only three weeks after joining. In the course of the interview, he enquired whether I have been using Lithium on patients back home. When I answered in the affirmative, he asked me to elaborate on my experience of using it. I could confidently narrate it and read appreciation on his face as my narration proceeded. From his table drawer, he pulled a file and handed it over to me. I was delighted to find original case files where Prof. John Cade, a former teacher of Bernard Carroll, entered his observations on the first bipolar patients ever put on Lithium in the world. Not having a camera or mobile phone in hand, I could not capture it for my album.

Irritants and Setbacks

There were some unexpected experiences as well. A post-graduate student of ours had a severe manic breakdown just before his DPM Part 1 examination. With lithium, the mania quickly subsided, but he was soon found sitting immobile and mute like a stone statue in the hostel room. It was identified as an instance of too quick a phase shift. With antidepressants, he improved but declined to go for the practical cum viva examination in Neuroanatomy scheduled shortly. He was one of our best PG students in that batch. With great difficulty, he could be made to present for practical and viva examinations. He was taken to the internal examiner – a senior lady professor – for reassurance. When the latter offered to ask simple questions in viva to help him, his face turned grim for a while. Then he shouted and threatened to kill her if she asked anything but the most difficult questions. This strange behavior frightened the gentle lady professor, and I had a hard time consoling and reassuring her. Bizarre psychotic symptoms emerging along with a rapid phase shift from mania to depression, brought on by Lithium, were responsible for this.

A young psychiatrist with rapid cycling BPAD, well maintained on Lithium prophylaxis, got admitted with a severe mania. On careful history taking, it emerged that his wife was instrumental in making him discontinue

Lithium prophylaxis because of his sexual dysfunction. Spouses of many male BPAD patients, harassed and distressed by hypersexuality in husbands in the manic phase, generally feel relieved when hyposexuality caused by lithium supervenes. Not all of them, as this case taught me.

Many academicians complained of a reduction in cognitive functions. Artists, singers, and writers complained of loss of creativity and blunting of aesthetic sense. Bureaucrats felt their comprehension and decision-making had come down. But in most cases, such adverse effects were mild, not incapacitating, and reversible with titrated medication adjustment.

As lithium use became widespread and got mainstreamed, the care and monitoring of patients on lithium, which was meticulously carried out by the older generation of psychiatrists like me, receded. Subtle adverse effects of long-term Lithium prophylaxis got less and less explored or elicited in routine case taking.

Major Adverse Events and Challenges

However, sensitivity to more serious adverse effects and difficult clinical situations in lithium therapy remained alive in psychiatric practice. Continuing lithium on pregnant patients referred from other centers imperatively was a challenging task I had to undertake often. In due course, patients on long-term effective lithium prophylaxis started presenting with features of nephrotoxicity. Whether the latter is lithium-induced per se or just coincidental is not so much a concern to the psychiatrist as the substitution with another mood stabilizer without compromising the effective prophylaxis hitherto maintained. Such situations make lithium-loving psychiatrists (like myself) recognize that Lithium, which is generally patient-safe and physician-friendly, is not always so. With many bipolar patients with multiple major co-morbidities, discrete selection or substitution of Lithium vs other mood stabilizers has become an important clinical task.

Outweighing Benefits

These challenges and deficiencies notwithstanding, Lithium was still one of the most useful psychotropic drugs for us in those difficult years. Its benefits far outweigh its adverse effects or limitations to its use. Electro Convulsive Therapy (ECT) was the main treatment modality available in mental health centers and government hospital psychiatry units for severe cases of BPAD. In the 1990s, a particular lobby of self-styled Clinical Psychologists and Human Rights Activists in Kerala was on a vigorous anti-ECT media campaign. Though a few of us psychiatrists were trying to counter it, negative notions and prejudice against ECT were still growing in the public mind. Making family members of bipolar patients accept ECT was often difficult and time-consuming. Lithium emerged as an alternative that helped these bipolar patients, their families, us psychiatrists too. Facilities for Lithium testing became available in private labs in many towns. Psychiatrists, both in the government and private sector, started prescribing lithium liberally. As major side effects were very infrequent, the meticulous monitoring and caution exerted by elders like me in the early days of lithium therapy in Kerala receded to its history. Apart from bipolar patients and schizoaffective disorders in mainstream Psychiatry, impulse dyscontrol, oppositional defiant disorder and hyperactivity, anger management issues, cluster B personality disorder, etc., got into the Lithium therapy spectrum. Many individuals with such diverse behavioral issues could be tamed with lithium. Many dysfunctional marriages, families, workstations, social settings, and political units could be saved. Apart from its seminal role in treating and preventing bipolar disorders effectively, its efficacy in reasonably containing such diverse behavior issues expanded the spectrum of Lithium clientele and enhanced its reputation as a therapeutic agent.

To Conclude

I was planning to conclude this presentation somewhere here. But then, my eleven-year-old grandson Bharath, engaged in preparing PowerPoint slides for me, threw a question.

"Achchachchan (Grandfather)!!, you must be using many medicines as a psychiatrist. Then, why are you so fond of this medicine, Lithium?"

Instantly, I was glad to note that the little guy was not just mechanically preparing slides as per my dictation but also taking in the content of what I was dictating to him.

"Bharath, I like many medicines I use, but Lithium a little more – that's all."

He gave an approving look and went back to his task. A bit later, he asked another question.

"Achchachchan!! Are there other doctors who like other medicines?"

I gave him some answer and made him continue slide preparation.

But these two questions did not leave me that easy. I started searching within for answers.

Personal Take

I have already indicated the immense benefits Lithium brought to patients with bipolar and schizoaffective disorders plus other behavior disorders (maybe we can term it as other uses of Lithium) and their families or associates. It has also eased the task of us psychiatrists called on to handle them.

Okay, really fine.

But beyond that, how did lithium impact me as a clinician? What is my personal take on it?

Myself and some of us who initiated the use of lithium as fresh entrants and young members of the profession in the 1970s and 1980s did not have the essential serum level test facility readily. We were sensitized – rather stiffly warned, about its toxic propensity. We were not yet established or secure in our professional careers. A therapeutic mishap at that initial stage could have well demolished our career. These limitations made me exert utmost care in evaluating the cases for initiating lithium therapy and monitoring the patient carefully and regularly – not just serum levels or known side effects, but their physiological and behavioral aspects. It became a routine in due course, not just for lithium clients but for all articulate patients on all drugs. The statement that psychopharmacology has to be individualized, which was just a small print statement in books, emerged and got established in my clinical approach as a personal binding principle. I was enabled as a clinician, and my early days with Lithium helped a lot in that transformation.

Then the question, while knowing and using many medicines, is, why do you like one of them – or some of them?

Looking back, I always had that trait in me. I would fall in love with some medicine on some occasions. Inj. Lasix was the first drug I fell in love with in the medical wards as an undergraduate student. I would watch the anxious and helpless struggle of breathing of an orthopneic patient with Left Ventricular Failure (LVF). Once the physician ordered it and the staff nurse gave the Inj. Lasix intravenously, as the needle got withdrawn, the breathing got even and effortless; a pleasant smile replaced the contortions on the patient's face. Instantly, I fell in love with that drug. That was in 1967-68 in the medical wards of Trivandrum Medical College. Then, Inj. Baralgan intravenous, which instantaneously relieved unbearable colics with which patients were wriggling. Oral medications, which bring convincing immediate relief to suffering patients, also became dear to me. Later, as I matured into an engaging physician with a long-term perspective, a few other medicines joined my favorite list.

As physicians, medicines are our constant companions, our breadwinners too. They are generally seen as weapons we use to fight the battle of healing – with skill, discretion, and due caution. This applies to me as much as to any other doctor.

But, besides a battle, or more than a battle, I experience the pursuit of Clinical Medicine as a participant journey to take the patient out of the rough and rumble of physiological and behavioral morbidities. In that perspective, medicines become my aides, associates, and participants in the journey of healing.

Inspired by the greatness of Medicine, fresh as a psychiatrist, amidst limitations and uncertainties, I started my Lithium walk – over four decades back.

I am talking that walk here now in this oration. It tells us how young and enthusiastic psychiatrists of India (including myself) laid their hands on Lithium in the last two decades of the last century despite the limitations with which we worked then and mainstreamed it – the Story of Lithium in India.

It also represents aspects of the evolution of my therapeutic approach and the becoming of my Clinician Self.

Thank you all for your time and involved listening.

Jai Bharat.