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PERKHIDMATAN MAKLUMAT KEPADA SISWAZAH JARAK JAUH UNIVERSITI SAINS MALAYSIA, CAWANGAN KELANTAN

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Pendahuluan

Pembangunan globalisasi pendidikan dan kurikulum universiti yang lebih memfokuskan maklumat telah memberikan impak terhadap perkembangan perpustakaan dewasa ini. Sebagai perpustakaan akademik yang menjurus kepada Perpustakaan maya (virtual library), ianya sentiasa mempelbagaikan sumber maklumat dan perkhidmatan yang berkualiti untuk menyokong program-program universiti yang menyumbang kearah kemajuan ilmu. Perpustakaan berfungsi sebagai hub kepada proses pembelajaran.

Mulai tahun 1996, satu program pengajian jarak jauh yang melibatkan Kementerian Kesihatan Malaysia dengan pusat-pusat pengajian perubatan di universiti seluruh negara telah dilaksanakan. Program yang dikenali sebagai Program Sarjana Perubatan secara sistem terbuka membolehkan pegawai perubatan menjalani pengajian sarjana disamping terus berkhidmat sepenuhnya dengan hospital kerajaan.

Selaras dengan perkembangan era teknologi maklumat dan menghadapi alaf baru, satu rangkaian perhubungan melalui kerjasama pintar atau perkongsian bestari diantara pihak universiti dengan Kementerian Kesihatan diwujudkan bagi merialisasikan misi universiti dan negara. Dalam konteks ini pembangunan prasarana diantara kedua pihak perlu diselaraskan bagi memastikan kelancaran dan keberkesanan perkhidmatan dapat disalurkan dan pegajaran yang inovatif dapat dilaksanakan. Dalam usaha untuk menjayakan program sarjana perubatan Universiti Sains Malaysia, Perpustakaan Perubatan sentiasa meningkatkan perkhidmatan secara taliannya (online) untuk menampung keperluan pengguna jarak jauh.

Siswazah (pegawai perubatan) dan pensyarah kehormat (Pegawai atau pakar perubatan yang dilantik oleh pihak universiti sebagai penyelia) boleh mendapatkan perkhidmatan maklumat yang ditawarkan oleh Perpustakaan Perubatan Universiti Sains Malaysia seperti berikut;

1.Perkhidmatan Pinjaman Bahan
Pengguna diminta melengkapkan borang keahlian perpustakaan dan mengemukakan satu salinan surat tawaran atau lantikkan daripada universiti serta sekeping gambar warna yang terbaru berukuran paspot. Kad keahlian perpustakaan akan dikeluarkan setelah proses memasukkan nama dan profail pengguna ke dalam sistem selesai dan pinjaman bahan boleh dilakukan. Perkhidmatan pinjaman bahan (buku) boleh dilakukan oleh pengguna melalui 2 cara iaitu;

1.1. Pinjaman melalui Kaunter Pinjaman

Pengguna yang ingin meminjam buku semasa berada di dalam kampus boleh datang terus ke kaunter pinjaman. Kad keahlian perpustakaan diperlukan semasa pinjaman dibuat. Bahan yang dipinjam melalui kaunter sewajarnya dikembalikan melalui cara yang sama. Walau bagaimana pun pemulangan melalui pos juga dibenarkan tetapi perbelanjaan pos dan risiko kehilangan atau kerosakan buku sekiranya berlaku hendaklah ditanggung oleh pengguna. Pengguna juga dibenarkan untuk memperbaharui pinjaman masing-masing dengan menghubungi pustakawan iaitu sebelum melewati tarikh pemulangan. Pengguna jarak jauh diberi tempoh kelonggaran (grace period) selama 7 hari dan 21 hari daripada tarikh pemulangan untuk mengelakkan dikenakan denda lewat.

Kelayakan pinjaman bagi pengguna jarak jauh yang terdiri daripada pensyarah kehormat dan siswazah lanjutan adalah berbeza seperti dalam Jadual 1 dan 2.

1.2. Pinjaman bahan melalui Perkhidmatan Pinjaman-Antara-Perpustakaan

Sekiranya pengguna memerlukan buku semasa berada di luar kampus, pinjaman boleh dibuat melalui perkhidmatan Pinjaman-Antara-Perpustakaan. Pengguna hanya perlu berhubung dengan staff

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Assalamualaikum dan salam sejahtera.

Abad akan datang menjanjikan beberapa kemungkinan. Ledakan maklumat menuntut pengamal perubatan sentiasa bersedia menyiapkan diri menghadapi era teknologi maklumat (IT). Konsep perpustakaan maya juga akan menjadi realiti. Perkara ini bukan lagi impian tetapi telah menjadi kenyataan. USM sendiri telah mengorak langkah ke arah itu dan diharapkan calon-calon sarjana perubatan tidak akan ketinggalan dalam memanfaatkannya.

Abad mendatang juga menjanjikan peningkatan taraf hidup dan dengannya penyakit-penyakit yang disebabkan oleh gaya hidup. Kemurungan (depression) adalah satu daripada natijah era modenisasi. Pendekatan yang holistic diperlukan untuk menangani dan pengamal perubatan tidak seharusnya ketinggalan dengan perkembangan mutakhir.

Akhir sekali jangan kita lupa bahawa walaupun abad mendatang akan membawa masalah baru yang mungkin lebih kompleks, pengamal perubatan masih dikehendaki peka dengan penyakit-penyakit 'tradisional'. Kes malaria yang dipamirkan dalam isu ini cukup menjadi pengajaran kepada kita semua.

Sekian, terima kasih.

Prof. Madya Dr. Abdul Rashid Abdul Rahman
Editor

Diari / Pengumuman

Tarikh/ Masa	Tempat	Event	Jabatan/Kakitangan Terlibat
10.10.99 (Ahad) 3.30 pm	DK 5	CPC Postgrad	Nama calon: Dr. Nik Hisamuddin (Per.Kecemasan) Penyelia: Prof. Madya Dr. Kamarudin
14.10.99(Khamis) 8.30 am	DK 5	Persembahan Kes	Jabatan: Pediatrik & ORL Pengerusi:Dr. Nik Zainal Abidin Nik Ismail
17.10.99 (Ahad) 3.30 pm	DK 5	CPC Postgrad	Nama calon: Dr. Tee Meng Hun (Perubatan) Penyelia: Dr. Nazmi Mohamad Noori
21.10.99(Khamis) 8.30 am	DK 5	CPC	Jabatan: Oftalmologi
24.10.99 (Ahad) 3.30 pm	DK 5	CPC Postgrad	Nama calon: Dr. Narinder Singh Shadan (O&G) Penyelia: Dr. Shah Riza b. Johan Noor
28.10.99(Khamis) 3.30 pm	DK 5	Research Presentation	1. Dr. Raja Azmi Mohd. Nor 2. Prof. Madya Jafri Malin Hj. Abdullah 3. Prof. Madya Mafauzy Mohamed
31.10.99 (Ahad) 3.30 pm	DK 5	CPC Postgrad	Nama calon: Dr. Siti Noor Ali Shibramulisi (Ped.) Penyelia: Dr. Nik Zainal Abidin Nik Ismail
11.11.99(Khamis) 8.30 am	DK 5	Persembahan Kes	Jabatan: Pediatrik & Psikiatri Pengerusi: Dr. Sharifah Ainon Ismail Mokhtar
18.11.99(Khamis) 8.30 am	DK 5	CPC	Jabatan: Perubatan
21.11.99 (Ahad) 3.30 pm	DK 5	CPC Postgrad	Nama calon: Dr. Abdul Muiz b Jasid (Surgeri) Penyelia: Prof. Madya Jafri Malin Hj. Abdullah
25.11.99(Khamis) 3.30 pm	DK 5	Research Presentation	1. Prof. Madya Ernest Teiko Larmie 2. Prof. Madya Rabinderjeet Singh 3. Prof. Madya Azhar Md. Zain
28.11.99 (Ahad) 3.30 pm	DK 5	CPC Postgrad	Nama calon: Dr. Naharudin A. Saifi (Ortopedik) Penyelia: Dr. Zulmi Wan

Jadual 1. Kelayakan Pinjaman Pensyarah Kehormat (Kategori Akademik–PJJ)

Koleksi	Buku Rak Terbuka	Monograf bersiri	Fiksyen	Bahan Media
Jumlah	25 naskhah	4 naskhah	2 naskhah	4 bahan
Tempoh Pinjaman	60 hari	14 hari	60 hari	14 hari
Denda (RM sehari)	0.10	0.10	0.10	0.10
Tempoh kelonggaran	21 hari	7 hari	21 hari	Tiada

Jadual 2. Kelayakan Pinjaman Siswazah (Kategori Lanjutan – PJJ)

Koleksi	Buku Rak Terbuka	Monograf bersiri	Fiksyen	Bahan Media
Jumlah	4 naskhah	4 naskhah	2 naskhah	4 bahan
Tempoh Pinjaman	60 hari	14 hari	60 hari	14 hari
Denda (RM sehari)	0.10	0.10	0.10	0.10
Tempoh kelonggaran	21 hari	7 hari	21 hari	Tiada

perpustakaan di Pusat Jarak Jauh (hospital yang telah dikenalpasti) dan memohon pinjaman melaluinya. Pinjaman dan pemulangan akan dilakukan di Pusat berkenaan. Kelayakan yang di beri bagi setiap Pusat ialah 30 naskhah buku dalam tempoh 2 bulan. Bayaran pengiriman pos dan sebagainya akan di tanggung oleh pihak Pusat pemohon. Sekiranya terdapat kelewatan pemulangan buku atau buku hilang, ianya akan diuruskan oleh Pusat terbabit.

2.Perkhidmatan Pencarian Maklumat
Pengguna jarak jauh yang memerlukan perkhidmatan pencarian maklumat daripada mana-mana pangkalandata (seperti MEDLINE atau POPLINE dalam bentuk CD-ROM) bolehlah meminta secara langsung kepada perpustakaan atau pun melalui Pusat. Hasil pencarian maklumat adalah dalam bentuk citation dan juga teks penuh boleh dikirimkan melalui pos atau e-mail. Bagi maklumat yang bercetak bayaran akan dikenakan sebanyak RM0.20 semuka surat manakala maklumat yang dipindahkan kedalam disket (tanpa mengira jumlah topik pencarian) dikenakan bayaran RM2.20 sepencarian.

3. Perkhidmatan Penghantaran Dokumen atau Artikel

Pengguna yang memerlukan maklumat yang lengkap (dalam bentuk *fulltext*), sama ada daripada sumber maklumat bercetak atau elektronik (bentuk CD-ROM atau talian) boleh menghubungi Unit Rujukan dan Maklumat Perpustakaan Perubatan atau melalui Pusat masing-masing. Kos bagi salinan fotokopi artikel yang dipohon oleh pengguna jarak jauh (siswazah atau pensyarah kehormat) adalah RM0.20 semuka surat manakala permintaan yang dibuat oleh pengguna selain daripada kategori tersebut dikenakan bayaran yang berbeza iaitu RM10.00 bagi setiap artikel yang mengandungi 1 – 10 mukasurat dan RM0.50 semuka surat bagi muka surat tambahan. Bagi memastikan kategori bayaran yang perlu dikenakan, Pusat pemohon diminta menyatakan nama dan kategori pemohon semasa membuat permohonan. Pemohon yang memerlukan penghantaran segera seperti melalui faksimili atau pos laju, kosnya adalah mengikut kadar yang ditetapkan oleh agensi terbabit dan akan ditanggung oleh pemohon sendiri.

Sebahagian maklumat berbentuk elektronik yang diperolehi daripada sumber maklumat seperti majalah dalam bentuk CD-ROM atau talian boleh dihantar melalui e-mail dan sehingga kini masih tidak dikenakan apa-apa bayaran. Perpustakaan kini mempunyai sejumlah 1,493 tajuk majalah bercetak, 182 tajuk majalah yang boleh diakses secara talian dan 12 tajuk dalam bentuk CD-ROM. Bagi maklumat atau artikel yang dipohon oleh pengguna tetapi tidak terdapat di dalam perpustakaan, pihak perpustakaan akan memperolehinya daripada perpustakaan lain seperti perpustakaan tempatan atau melalui British Library Document Supply dengan kadar bayaran sebagaimana yang dikenakan oleh perpustakaan pembekal. Jangkamasa untuk perkhidmatan ini lazimnya 2 – 3 minggu bagi permintaan kadar biasa manakala permintaan kadar segera juga dibenarkan.

4. Perkhidmatan Pangkalandata ProQuest Medical Library

Perpustakaan Perubatan Universiti Sains Malaysia telah melanggan pangkalandata ProQuest mulai bulan April 1999. Pangkalandata ini boleh diakses secara talian melalui internet dan dalam bentuk CD-ROM. Pangkalandata ini menyenaraikan sebanyak 172 tajuk majalah secara talian dan 129 tajuk dalam bentuk CD-ROM yang kesemua tajuk merupakan majalah teras dalam bidang perubatan dan yang berkaitan dalam bentuk fulltext dan mempunyai grafik dan imej. Pengguna boleh mengaksesnya melalui laman web perpustakaan http://www.kck.usmnet/PUSTAKA/PUSTAKA.htm ketika berada di dalam kampus atau semasa di luar kampus melalui http://www.umi.com/proquest/ dengan memasukkan IP account dan password yang boleh diperolehi daripada pustakawan di Bahagian Rujukan dan Maklumat. Hasil pencarian boleh didownload, dicetak terus atau dihantar melalui e-mail kepada pengguna lain.

Kakitangan Perpustakaan yang boleh dihubungi.

Pengguna yang memerlukan keterangan lanjut atau bantuan berhubung dengan perpustakaan bolehlah menghubungi kakitangan berikut;

Puan Sofiah Hashim
Timbalan Pustakawan
e-mail: sofiah@kb.usm.my
Puan Rugayah Ali
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Encik Wan Zulkafli Abdullah
Pembantu Tadbir Unit Rujukan
e-mail: rujukan@kb.usm.my

Penutup.

Kami di Perpustakaan Perubatan Universiti Sains Malaysia sentiasa bersifat dinamik, berdaya saing dan akan terus berkembang mengikut keperluan semasa. Berbagai perkhidmatan yang disediakan oleh perpustakaan adalah seiring dengan keperluan program akademik dan menyeluruh kepada semua pengguna baik di dalam atau di luar kampus. Kami mengalu-alukan cadangan dan teguran membangun dari pengguna supaya pihak perpustakaan dapat memberikan perkhidmatan yang terbaik.

DEPRESSION: APPROACH TO MANAGEMENT

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(continued from previous issue)

Initial Assessment

The severity of depression and the degree of disruptive symptoms that have caused to a person's everyday functioning determine immediate management. If in doubt, relatives or friends may provide helpful information. Depression is a potentially fatal condition and enquiry about suicidal ideation is mandatory. A feeling of hopelessness is often concomitant with depression, and is particularly associated with suicidal ideation. This can be approached by asking questions such as 'how do you feel about the future? or 'what do you feelings about living and dying?'. Any detection of strong suicidal intent requires that the patient be provided with extra care in the form of support by relatives or friends, or admission to hospital. The profoundly depressed patient with psychomotor retardation, nihilistic delusions and a significant risk of suicide will clearly need special referral. At this stage, the practical issue of the need for compulsory detention in hospital (a gazetted psychiatric unit) if patient refused admission should be considered.

The Treatment Plan

The treatment plan, while determined by specific diagnoses to a certain extent, is influenced more by the severity of the depression. The mildly depressed can be managed more along psychotherapeutic lines, although there is a place for low dose antidepressants but not anxiolytic agents. The moderately and severely depressed are more likely to require and respond to biological treatments although still requiring psychotherapeutic support. All clinicians should possess the techniques require to cope with the initial interview, but there is no reason to feel obliged to continue further management personally. Not all doctors feels comfortably with such condition, and it is fair to say that to treat depression adequately is time consuming and may not fit into a busy general practitioner's or medical officers out-patient department daily schedule. A successful treatment usually required specific longer consultation.

Pharmacotherapy

Although depressed patients required some form of psychotherapy, not all required pharmacotherapy. Antidepressants should be reserved for moderate or severe depression. Even then only about 70% of patients will response to the drug as compared with 35% placebo response (1). A useful rule of thumb to guide the prescribing of antidepressants is that the more classical the biological features of depression in any patient, the more likely they are to respond to an antidepressant.

Antidepressants can be broadly classified as heterocyclics (which include tricyclic antidepressants, TCAs); monoamine oxidase inhibitors, MAOIs (which include non-selective MAOIs and reversible inhibitors of monoamine oxidase-A, RIMA); selective serotonin reuptake inhibitors (SSRIs); serotonin-noradrenaline reuptake inhibitors (SNRIs) and miscellaneous groups (Table 1). The mechanisms of action of antidepressant drugs involve monoaminergic neurotransmitter systems.

Table 1. Effective dose of selective antidepressants

Antidepressants	Dose (mg/day)
Tricyclics	
Amitriptyline	50 - 200
Imipramine	50 - 200
Doxepine	50 - 200
Clomipramine	50 - 200
Dothiepin	50 - 200
Tetracyclics	
Maprotiline	50 - 150
Mianserin	30 - 90
RIMAs	
Moclobemide	300 - 600
SSRIs	
Fluoxetine	20 - 80
Sertraline	100 - 200
Paroxetine	20 - 60
Fluvoxamine	100 - 300
Citalopram	20 - 60
SNRIs	
Venflaxine	75 - 375
Miscellaneous	
Nefazodone	400 - 600

Factors Influencing Selection of An Antidepressants

Although effective pharmacological agents, such as tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) have been available since the 1950s, some patients have been treated inadequately. The adverse effects of TCAs are attributed to their nonspecific interaction with cholinergic, histaminergic, serotonergic and dopaminergic receptors in the central nervous systems. They are cardiotoxic and overdoses are frequently fatal. Adverse affects including potentially fatal drug interactions with tyramine-containing foods, also limit the use of the MAOIs. Treatment of depression has improved in recent years because of the availability of effective and well-tolerated antidepressants, such as selective serotonin reuptake inhibitors (SSRIs) and serotonin-noradrenaline reuptake inhibitors (SNRIs). However their routine use in Malaysia is limited by high cost of the drugs.

Heterocyclic Antidepressants

TCAs are the most widely used antidepressant in Malaysia, especially the new generation such as dothiepin, which is thought to be less cardiotoxic and the have fewer anticholinergic side-effects than older drugs. TCAs

produce a number of anticholinergic symptoms, and those most commonly complained of are dry mouth, constipation and blurred vision. Patients often need considerable support in the first few days after the prescription of these drugs, otherwise there may be premature discontination. Patients should be informed that although insomnia and agitation may settle a little in the first few days, an antidepressant effect is usually delayed for 10 to 14 days. They should also avoid alcohol and adrenergic drugs. Other less frequent side effects are postural hypotension, cardiac conduction defect which may cause arrhythmias and gastrointestinal disturbances. Before prescribing TCAs it is important to establish whether a person has history of glaucoma, cardiac disease or prostatism. Such conditions are not absolute contraindicators to the TCAs, but they should certainly be prescribed with great caution if these conditions are evident. Patients with bundle branch blocks can experience complete heart block.

For out-patients, it is recommended to start with a nightly dose, e.g. dothiepin 50 mg nocte. The dosage may be increased gradually, e.g up to 75 mg nocte, then 150mg nightly as necessary. Some patients may require a short-term anxiolytic if agitation and insomnia are severe. A maximum of 50 mg each morning and 100 mg at night should be sufficient for most of patients in this region. The maximum dose depends in part on the patient's ability to tolerate the side effects. The maximum tolerated dose should be continued for about 2 months before reducing to approximately half that level for a further 3 months and then gradually phasing the drug out. Continued medication with antidepressants results in a lower relapse rate. Further maintenance depends on the individual patients, i.e. those who have a history or recurrent depression may need a longer period of prophylactic treatment e.g. 50 mg nocte for a few years.

It is difficult to predict which patients will experience adverse drug reactions with particular antidepressants. Many patients on TCAs do not experience any distressing adverse effects and are able to tolerate these drugs well. Nevertheless, some individuals may be predisposed to untoward reactions and therefore special caution is indicated for them. For example the elderly appear to be more vulnerable to adverse reactions and are especially susceptible to anticholinergic and antiadrenergic effects. In such situation it is better to change to SSRIs or tetracycline antidepressants. Since SSRIs are widely available nowadays, the author strongly recommended changing to SSRIs. The tetracyclics such as maprotiline and mianserin have high sedative (antihistaminic) activity. If tetracyclics are considered, maprotiline is the drug of choice. Mianserin was reported to have high incidence of blood disorders.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Currently the SSRIs that available locally are fluoxetine, sertraline, fluvoxamine, paroxetine and citalopram. No SSRI has been consistently shown to be superior to other classes of antidepressants. They do not differ in onset of action or efficacy to the standard tricyclics (2). However, the SSRIs have two important advantages over tricylics and related antidepressants; they are better tolerated generally and less toxic in overdose. SSRIs are non-lethal in overdose; they have minimum cardiovascular risk. For example, following acute overdose of up to 1,500 mg of fluoxetine, patients remain asymptomatic.

Although SSRIs act selectively on the serotonergic neurotransmitter system, they are not free from adverse effects. None of the SSRIs differ significantly in the frequency and severity of their side-effects. Most frequent side effects are gastrointestinal disturbances; CNS side effects such as anxiety, nervousness and insomnia; autonomic side effect; weight changes; and sexual dysfunction such as a ejaculatory delay and impotence in men, and anorgasmia in women (3).

At present, there is considerable debate as to whether SSRIs should be considered first- or second-line drugs in the treatment of depression. Interestingly, a meta-analysis of efficacy and acceptability of SSRIs revealed no statistically or clinically significant difference in the acceptability of SSRIs and TCAs in patients with major depression (4). Nevertheless, SSRIs should be strongly considered in sub-group of patients in whom other treatments are contraindicated or have failed.

Monoamine Oxidase Inhibitors (MAOIs)

The only MAOIs available locally is moclobemide, a sub-group of reversible inhibitors of monoamine oxidase-A (RIMA). The non-selective MAOIs had been deregistered a few years ago. The drug is not as popular as SSRIs and not easily available in public hospital. Atypical depression such as depression with marked anxiety and phobic symptoms, depression with the reversed functional shift and non-endogenous depression in general have been reported to respond better to non-selective MAOIs (5).

Serotonin-Noradrenaline Reuptake Inhibitors (SNRIs)

Serotonin-noradrenaline reuptake inhibitors (SNRIs), a new class of antidepressants, selectively inhibits both the serotonin and noradrenaline neuronal uptake pumps, but without affecting muscarinic, histaminergic, and alpha 1- adrenergic receptors or sodium fast channels. Evidence suggested that dual inhibition of serotonin and noradrenaline reuptake might enhance efficacy (6). Venlafaxine, the world's first SNRIs anti-depressants was launched in Malaysia last year.

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Miscellaneous Group

Nefazodone is an antidepressant classically related to trazodone. It is a weak inhibitor of serotonin and norepinephrine uptake into the presynaptic nerve terminal and antagonist at 5-HT2 receptors. Nefazodone was launched in Malaysia early this year. It was shown that nefazodone significantly relieves depression-related anxiety in the first week of treatment, remarkably improves quality and time of sleep; and unlike SSRIs has minimal effect on sexual function. The common observed side-effects with nefazodone are somnolence, dry month, nausea, giddiness and constipation.

Psychotherapy

The psychotherapy of depression may involve simply listening and clarifying the issues that have led to mild depression, time limited grief work, environmental manipulation, traditional intensive psychotherapy, one of the behavioural therapies, supportive contact aimed at ensuring compliance with medication, or a combination of these. Ventilation and abreaction are useful for reactive depression, especially during initiation of treatment. Supportive psychotherapy is mainly to encourage the patient to bear with the suffering, reassure him that he will recover from his illness and urge him to continue with the medication. The patient's relatives should be given the same reassurance and be advised to give the same support to the patient. Counseling and guidance are also necessary at an appropriate stage of the treatment to help patients to cope with their problems.

The two most favoured psychotherapies for depression are interpersonal psychotherapy and cognitive therapy (7). Interpersonal psychotherapy is based on the premise that depression occurs in psychosocial and interpersonal contact. The overall aim in interpersonal psychotherapy is to elicit, clarify and place into perspective those feelings that have arisen from interaction with others. The aim of cognitive therapy is to identify the patient's errors in cognition of self, to modify these by cognitive and behavioural techniques. Therapy is designed to counteract these errors of cognition, and involves both cognitive and behavioural technique. Detail technique of the two psychotherapies is beyond the scope of this article.

Electroconvulsive Therapy (ECT)

The response rate to ECT for patient with major depression is 80 to 90 %. ECT treatment yields a quicker therapeutic response and fewer adverse effects than does treatment with antidepressants. Agitated depression, depression with marked biological symptoms, delusional or psychotic depression is particularly responsive to ECT.

Treatment of Resistant Depression

About one-third of patients do not respond to initial antidepressant therapy. In summary, the approaches to the resistant cases are as follow (8).

1. Optimisation of the current antidepressant treatment. Adequate doses of TCAs are usually considered to be 150 to 300 mg/day of imipramine or equivalent. Individual antidepressant trial should be at least four week's, and preferably six week's duration of adequate dosages.

2. After optimisation, substitution is the next most commonly applied approach in the management of non-responsive patients. This involves stopping the initial agent and initiating a second. Depending on the agents considered for use, wash out periods might be required. In general, changing to an antidepressant of a different class yields an enhanced response.

3. Combination of antidepressants agents. Accentuation of the adverse effect is a weakness of this strategy.

4. Augmentation of the initial treatment through the addition of a second agent which alone does not possess inherent antidepressant properties. The best evaluated strategies are augmentation with lithium carbonate and L-tri-iodothyronine (T3). Lithium (serum level between 0.6 to 0.8 meq per liter) can be added to the existing TCAs for 7 to 14 days. The augmentation may lead to a rapid clinical response in 50 to 60% patients. This response may occur as quickly as 48 hours after initiation of therapy but in most individuals occurs within two weeks. The addition of 25 to 50 microgram a day of T3 to the TCAs regimen for the same period may convert TCAs non-responders into responders.

References.

1. Livingston M. Tricyclics and newer antidepressants. Prescriber's Journal 1990; 30 (4): 139 -147.
2. Johnson GF. New antidepressant (Editorial). Current Therapeutic, November 1991. PP. 11-12.
3. Cookson J. Side effects of antidepressants. British Journal of Psychiatry 1993; 163: 20-24.
4. Hotopf M. Hardy IL, Lewis G. Discontinuation rates of SSRIs and tricyclic antidepressants: A meta-analysis and investigation of heterogeneity. British Journal of Psychiatry 1997; 170: 120-127.
5. Tyrer P. Towards rational therapy with monoamine oxidase inhibitors. British Journal of Psychiatry 1976; 128: 354-60.
6. Seth R et al. Combination treatment with noradrenaline and serotonin reuptake inhibitors in resistant depression. British Journal of Psychiatry 1992; 161: 562-565.
7. Rush AJ. Short-term psychotherapies for depression. Guildford Press: New York, 1982.
8. Sokolov ST and Joffe RT. Treatment-resistant depression. Medical Progress, July 1996. PP 17-21.

DYING BUT STILL DANGEROUS

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The "bad air", as it was known thousand of years ago, the disease still maintain the name even after we know that it has nothing to do with air. Since Sir Ronald Ross discovered *Anopheles (An.)* mosquitoes as the responsible vectors and Laverance described the *Plasmodium*, malaria research has undergone tremendous development. Yet, after exhaustive years of laborious and financial efforts, the disease is still a threat to millions of people around the world. Till now, an estimated 1 million people still die of malaria worldwide.

Malaria is disappearing in Malaysia. Or so it seems. We see less and less cases and seldom talk about malaria anymore. Many areas known because of malaria are gradually forgotten.

To many, Kg Batang Begedik doesn't ring any bell. Situated 50 km from the town of Tanah Merah, this tranquil village is an example of a traditional village in remote areas of Kelantan. The tar road stop short outside the village and the journey will have to be continued on land road. There are 33 houses occupied by 193 people in the village. Used to be a high-risk area for malaria, there has been no cases reported from this quiet village for several years.

In June 1998, one case of falciparum malaria was detected in Kg Batang Begedik. The source of infection could not be determined. Six months later another case was detected. The author warned the staff that there must be a source for the infection and they have to be very vigilant in anticipation of a wider spread of the disease. Case investigations conducted by the malaria team did not reveal the source of infection. The author was sure that the source could be from around the village or quite nearby since malaria just could not occur spontaneously. However, since there was no source found, the thought was not pursued.

On the 1st of June 1999, one year after the first recent case was detected, malaria was again reported from the village. This time, it was no longer a single case. Case investigations revealed a few more cases, and till 20th June 1999, a total of 14 cases were reported with one death. The source was Thai workers who work in nearby rubber plantations. Fourteen cases might not be many, but one death is very much regrettable since it was preventable.

The victim was a 32-year-old Malay bachelor from Kota Bharu who went to the village to work in his plantation. Information from his uncle revealed that he never took any prophylaxis despite being a newcomer to the village. The victim complained of fever on and off for 4 days but did not go for check-up. Instead, he took medications prescribed for other member of the family. When the fever did not subside, he went back to Kota Bharu. He went into coma 3 days later and died of cerebral malaria after 3 days of admission.

The death was unfortunate, but the whole event was an act of ignorance. The patient could have been saved if he was diagnosed earlier, and what he has to do was just go to the nearest health centre for diagnosis and treatment. Furthermore, the villagers were given impregnated bednets on the 22nd May 1999, 10 days before the patient complained of fever. Yet, he did not heed the warning and use even ordinary bednet. Was it lack of knowledge, or sheer ignorant? We might not know the true answer.

The occurrence of disease among human groups can ultimately be traced to their cultural practices and beliefs, socio-economic characteristics and how they interact with the environment. This is true for almost all kind of diseases, especially malaria. The relationship between human and malaria is very complex and sometimes unpredictable. Every aspect of human life, social, behaviour patterns, customs and beliefs, economic activities and location of residences, can affect the interaction between malaria and man. Previous work has shown that failure to understand the importance of human factors and the complex epidemiological problems of malaria have significantly contributed to the disappointing results of malaria control programmes.

Malaria in Malaysia is basically confined to forest and forest fringe areas. There are more than 70 potential vector Anopheles species in Malaysia, but the principal vectors are An. maculatus in Peninsular Malaysia, An. balabacensis in Sabah and An. leucosphyrus in Sarawak. Vector control is very difficult because of the behaviour and eco-habitat of the vectors. The latest strategy being adopted in Malaysia now is the use of insecticide-impregnated bednets. Although it is cost-effective and convenient, the coverage is still very limited. Users need to be educated not only on the benefits but also on how to maintain the effectiveness of the method.

As far as treatment is concerned, we are quite fortunate in Malaysia for still being able to use the drugs from the sixties. Chloroquine, primaquine and fansidar are the 3 essential drugs for treating falciparum, vivax and malariae malaria. Although there has been cases of choloroquine resistance reported by patchy studies conducted every now and then, the problem is not serious and basically

confined to R1 and R11. In other malarious areas in South East Asia, mefloquine, artemesinine and artemisinine derivatives are being used as the first line of treatment because of multiresistant cases. We reserve the use of mefloquine to confirmed-choloroquine and fansidar resistant cases.

With the advance in molecular biology, malaria vaccines offer the most promising future in malaria disease control. But till now, none is available ready-to-use. Even if we have one available, what criteria should we use to decide on the target population to receive the vaccine? In the era of limited financial resources, will the vaccine be cost-effective?

The debate on this issue will go on forever as long as we have the current epidemiological pattern of malaria. However, the most important measure now is to keep on educating people about malaria and what they can do to control and prevent the disease. Just because you did not see any case, or because patients did not come to your centre, it does not mean that the disease has been eradicated. Experts worldwide always caution responsible teams to be on the lookout for the re-emergence of malaria in high-risk areas. What happened in Kg. Batang Begedik should be a reminder to us. Malaria epidemic is a dying scenario, yet it still kills.

Bibliography.

1. Abdullah, M.R., Ahmad, C.K., Abdullah, W.P.W. and Nafuri, H. (1996). A review of the malaria control strategy in Jeli District, Kelantan, Malaysia. Health System Research. Kelantan State Health Office. HSR/ MAL/KEL.JELI96.
2. ADB. (1992). Guidelines for the health impact assessment of development projects. ADB Environment Paper No. 11. Office of the environment, Asian Development Bank, November.
3. Alonso, P. L.; Lindsay, S.W. and Armstrong, J.R.M. (1990) The effect of insecticide treated bednets on mortality of Gambian children. *Lancet,* **337**:1499 - 502.
4. Andy, J.R.. (1972). Aspects of human behaviour interfering with vector control. In: PAHO. Vector control and recrudescence of vector-borne diseases. Proceedings of a symposium held during the 10th meeting of the PAHO Advisory committee on medical research, 15 June 1971, Washington DC. Scientific Publication NO.238, PAHO/WHO, 67-82.
5. Arasu, G.D. (1992). Risk behaviour in malaria in Malaysia. *The Southeast Asian Journal of Tropical Medicine and Public Health,* 23: Supplement 1 - 51 - 6.
6. Bermeejo, A. and Veeneken, H. (1992). Insecticide-impregnated bednets for malaria control: a review of the field trials. *Bulletin of the World Health Organization,* 70: 293 - 6.
7. Bradley, D.J. (1995). The epidemiology of malaria in clinical infectious disease. In Bailliere's clinical infectious diseases: International practice and research - malaria. (Pasvol G., ed.). Bailliere Tindall (London), 2(2): 211 - 16.
8. Bruce-Chwatt, L.J. (1985). Essential malariology, 2nd edition. William Heinemann Medical Books (London).
9. Burkot, T.R. (1985). Non-random host selection by *Anopheles* mosquitoes. *Parasitology Today,* 4:156 - 162.
10. Butraporn, P., Sornmani, S. and Hungsapruek, T. (1986). Social, behavioural, housing factors and their interactive effects associated with malaria occurrence in East Thailand. *The Southeast Asian Journal of Tropical Medicine and Public Health,* 17(3): 386 - 392.
12. Chooi, C.K. (1985).. Status of malaria vectors in Malaysia. *The Southeast Asian Journal of Tropical Medicine and Public Health,* 16:133 - 138.
13. Chow, C.Y. (1970). Bionomics of malaria vectors in the Western Pacific Region. *The Southeast Asian Journal of Tropica. I Medicine and Public Health,* 1: 40 - 57.
14. Coggeshall, L.T. (1943). Immunity in malaria. *Medicine (Baltimore),* 22: 87-98.
15. Cohen, S., McGregor; I.A. and Carrington, S.P. (1961). Gamma-globulin and acquired immunity to human malaria. *Nature (London).* 192: 733-737.
16. Coimbra, Jr., C.E.A. (1988). Human Factors in the epidemiology of malaria in the Brazillian Amazon. *Human Organization,* 47 (3): *255* - 260.
17. Curtis, C.F. (1992). Personal protection methods against Vectors of Disease. *Review of the Medical Veterinary Entomology,* 80 (10): 543.-553.
18. Curtis, C.F., Lines, J.D. and Carnevale, P. (1990). Impregnated bednets and curtains against malaria mosquitos. In. Appropriate methods of vector control (Curtis C.F., ed.). Boca Raton: CRC Press (Florida): *5* - 46.
19. Davidson, G. and Ganapathipillai, A. *(1956).* Observations on the bionomics of the adults of some Malayan anopheline mosquitoes. *Annals of Tropical Medicine and Parasitology,* 50:137 - 146.

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