From the Editor

How did you become a neuropsychiatrist?

I have been asked this question a number of times and my attempts to provide a succinct answer have been mostly unsuccessful. Often the best I can do is to quote Albert Einstein:

"The only thing that interferes with my learning is my education"

Training in neuropsychiatry seems to involve an often random blend of personal interest, serendipity and opportunity. Opportunity in neuropsychiatry is directly related to access to core clinical experiences. Such access is usually limited to Major Teaching Hospital or Research Institutes within large urban centres. This is different from other advanced training schemes in psychiatry such as psychiatry of old age. However, mentorship is the glue that holds this together.

The definition of what entails clinical experience in neuropsychiatry adds another level of complexity to this process.

There is however no argument that exposure to more complex neuropsychiatric disorders such as younger onset neurodegenerative disorders and medical disorders with neuropsychiatric consequences provides a very rich training experience for any psychiatrist. The shift for training within the RANZCP to a competency based programme brings additional challenges to training in neuropsychiatry.

My own experience of neuropsychiatry began as a registrar in neurology and general medicine, evolving into geriatric medicine and then to training in psychiatry, Neuropsychiatry at Melbourne Neuropsychiatry Centre and advanced training in Psychiatry of Old Age in both rural and Urban settings in Victoria. This allowed me to develop experience of medical and psychiatric problems in the aged into work with younger groups with neurodegenerative disorders.

In this issue of the newsletter Sophia Adams and Brad Hayhow discuss how they sought experience and training in neuropsychiatry. I will speak about how a year lecture series for trainees evolved into a combined neuropsychiatry and behavioural neurology conference at the Melbourne brain centre. Readers will also notice that a clinical neuropsychiatry section is now included as are notices regarding training opportunities in New South Wales and Victoria.

I welcome any suggestions or contributions for the next edition in October this year.

Best wishes

Ramon Mocellin
A Trainee Perspective on Neuropsychiatry Training

Dr Brad Hayhow, Senior Registrar in Neuropsychiatry, Royal Melbourne Hospital

There is something enigmatic about the way in which neuropsychiatry articulates with both the past and the future. The modern roots of the discipline can be traced at least as far back as the work of such legendary 19th century physicians as Charcot and Tourette, not to mention the extraordinary and near-contemporary neural doctrine of Ramon y Cajal, to which neurology owes a special debt. At the same time, psychiatry and neurology have developed along quite separate trajectories in the 20th century, and their somewhat regrettable estrangement has resulted in a shared inter-disciplinary space of unrealized potential. The enigma of neuropsychiatry is therefore that it is both proto-disciplinary and inter-disciplinary: it is old and young at once. At the current point in the history of medicine, that makes it a very exciting field in which to be training.

In recognition of the way in which neuropsychiatry exist in relation to other disciplines, my earliest engagement probably arose while studying the philosophy of mind and cognition in parallel with neurosciences as an undergraduate. Neuropsychiatry also featured prominently in my basic training rotations in consultation-liaison and old age psychiatry, and in retrospect I think the basic curricula of these two sub-specialties are largely the appropriate basic curricula of neuropsychiatry, perhaps fortified with some general neurology. As an advanced trainee I have had the rare opportunity to train in three neuropsychiatry posts of 12 months duration, each of which has had its own unique characteristics and emphases.

My first placement was in a Federally-funded STP post at Fremantle Hospital in 2011, in which I provided psychiatry liaison to neurology while also working in the capacity of an outpatient neurology registrar and conducting clinics in general neurology, adult epilepsy and stroke. I attended EMG clinics and EEG reporting sessions and spent about a session per week in the MRI suite “getting my eye in” and reviewing interesting cases with the hospital’s consultant neuroradiologist. I also gained some experience treating adults with intellectual disability and autism, and performed structured neurological and psychiatric assessments in an outpatient research clinic. I think I would in fact go so far as to argue that engagement in research is fundamental to the discipline.

My second placement was in an inpatient post at the Royal Melbourne Hospital Neuropsychiatry Unit in 2012, in which I coordinated comprehensive multidisciplinary assessments of patients with predominantly rare and unusual neuropsychiatric syndromes. Once again I was afforded the opportunity to observe neurologists and psychiatrists of considerable neuropsychiatric experience, and I learned to utilise the assessment and management skills of neuropsychologists, occupational therapists, speech pathologists and social workers dedicated to the unit. An unanticipated aspect of the work was the extent to which it demanded an astute psychological awareness and psychotherapeutic engagement to navigate the complex individual and systemic needs of patients and families, and the challenge it presented in terms of not just grasping the nuances of organic psychiatry, but learning to integrate them into a more comprehensive formulation for the digestion of wide interdisciplinary audience.

My current placement is in a mixed clinical/academic Fellowship through the Melbourne Neuropsychiatry Centre that balances outpatient clinics in general neuropsychiatry and Huntington disease with dedicated teaching and research in structural and functional neuroimaging. In my research role I am pursuing a higher degree based on the neuroimaging of Parkinson patients with psychiatric syndromes, and in my teaching role I am developing a public neuropsychiatry case library integrating neuropsychiatric, neuropsychological and neuroradiological data for in-
Interactive online learning. This very rich training experience has again been made possible by Federal STP investment, and I believe our challenge in the future will be finding ways to maintain breadth and quality of training in neuropsychiatry under increasingly lean fiscal circumstances.

I think it is important to acknowledge that my advanced training experiences in neuropsychiatry could not have been accommodated if not for the existence of the Generalist Stream of Advanced Training. In some ways I think this is very appropriate, given the extent to which neuropsychiatry interacts with other disciplines such as adult psychiatry, consultation-liaison, old age psychiatry and even psychotherapy. One can easily imagine interactions with other fields, to the extent that is difficult to imagine an area of psychiatry in which our perspective would not be of some potential relevance – neuropsychiatry both underpins and extends general psychiatry. My parting comment is therefore to encourage the Section to bear in mind the potential benefits of flexible training should it eventually be in a position to implement an Advanced Certificate programme. It would certainly be in keeping with the innovative tradition of our specialty.

By Sophie Adams

How Did I Become A Neuropsychiatrist?

How did I get here? Well the most accurate answer is I met a man in a pub who asked me about cognitive testing over a few beers and I volunteered to help him as I saw a chance to become involved in neuropsychiatric research. I had always hoped to do some research and had chosen to train at NWMH as I believed it had more opportunities in that area. So this was a golden opportunity for me.

I then contacted Dennis Velakoulis as the Director of Neuropsychiatry at RMH and presented him with the opportunity to do some research in MS and volunteered my time. Dennis initially thought it would be better for an RA to do the testing as I would be busy being a registrar. I insisted I wanted to do it. Of course the research wasn’t that great but I did the cognitive testing and managed to impress Dennis enough to get a position as a neuropsychiatry registrar 18 months later. The guy in the pub went back to Ireland with my data. But we did contribute the work to a greater evaluation of the NUCOG so it wasn’t wasted.

In the meantime, I had my first child, so when Dennis developed the capacity to offer a part time but not full time position, I jumped at the chance to take that role. I don’t know that I even knew it was in epilepsy. It was just fortuitous for me that John Lloyd was just retiring and they needed someone to take over his regular sessions seeing epilepsy patients.

On my first day as a neuropsychiatric registrar, Dennis said we’re going to meet someone about your role. That’s how I met Terry O’Brien, the then head of the epilepsy service at RMH, now
Professor of Medicine. Of course Dennis didn’t know that I already knew Terry. At least I knew his little sister. I like to think my natural charm and competence since was a more important component of my subsequent longevity in the role. At any rate, since then I have worked in epilepsy, first as a registrar and then as a consultant. Mid way through my first year, I started my PhD data collection, which has been ongoing ever since. I finished my CL certificate over the next few years part time, was admitted to Fellowship of the College, had 2 more children and somewhere along the way people started calling me a neuropsychiatrist.

I’m very glad I met that bloke in the pub because I have loved working with epilepsy patients. The work is fascinating, the people endlessly variable and the themes of coping, resilience and life development run through my work in ways that perhaps I wouldn’t see in general public work. Epilepsy is a life experience that impacts on people’s functioning in myriad ways and the complexity of the assessments, the capacity to make significant changes with sensible educated treatments and the opportunities to understand mental health in a complex world are ongoingly challenging. I enjoy the capacity to maintain an interest in research through my role and to work with neurologists with their different paradigms and approaches to the same subject matter, the brain. I love the challenge of representing psychiatry to non psychiatrists and the impact we can have when we help others see the value in our work. I am proud to be asked to speak to neurologists and neurology registrars to help change attitudes that may assist many more patients than I can see myself. It is an opportunity to have a real impact on the world outside of psychiatry. It is an honour to do this work and I hope I may in a small way be making a contribution to the greater good. That bloke in the pub has a lot to answer for….

What are my suggestions for others who want to be neuropsychiatrists? Look out for opportunities, then be presumptuous enough to talk to senior people about them and persistent enough to follow through on them. Other things I needed included luck, contacts (some of which I made and some of which unbeknownst to me I already had) and a bit of risk taking. Can others do this? Of course they can.
A Local Lecture Series Grows Up

For over 3 years the neuropsychiatry unit at the Royal Melbourne Hospital in concert with Melbourne Neuropsychiatry Centre has held a Spring Lecture Series in Clinical Neuropsychiatry. This was a series of 10 lectures delivered over 5 weeks aimed at psychiatry trainees covering basic neuropsychiatric topics such as cognitive testing, neuroimaging, atypical dementias, movement disorders, epilepsy and secondary psychiatric syndromes. This mainly didactic series was delivered on a low cost model with only provision of the traditional written notes.

Feedback from attendees as well as those unable to attend was that a weekend session would be well received. Seeking a broader audience, organisers were brought together from both the Section of Neuropsychiatry and the Australian and New Zealand Association of Neurologists Subcommittee of Behavioural Neurology. This collaboration was able to recruit outstanding international and national speakers covering topics including young onset dementia, movement disorders and deep brain stimulation. The Inaugural Australian Neuropsychiatry and Behavioural Neurology Conference was held at the Melbourne Brain Centre in Parkville on October 19th 2012, with neuroradiology and cognitive testing workshops held the following day. Both sessions were well attended by over 200 psychiatrists, psychiatry trainees, neurology advanced trainees and neurologists.

Given this success:

The Second Australian Neuropsychiatry and Behavioural Neurology Conference will be held in Melbourne at the Melbourne Brain Centre in the Parkville Neurosciences precinct on the 8th and 9th of November 2013.

Details of the registration and the scientific and social programme will follow in the latter half of this year. Access to the nearby Cunningham Dax Art Collection will be included.

This conference is supported by the RANZCP and attendees will be eligible for CPD credits in accordance with the RANZCP CPD guidelines. We would recommend all Section members and interested psychiatrists to keep these dates free for what promises to be an excellent opportunity to update professional knowledge in a collegiate atmosphere in the vibrant city of Melbourne.

Melbourne Brain Centre (left) and Dax Art Collection (right), Parkville
Clinical Neuropsychiatry

In this issue of the newsletter I have introduced a case vignette section. The intention is to present an interesting clinical case in a succinct manner. I particularly welcome submissions from Trainees in this section.

Bill*, a 56 year old single postman was transported to an outer suburban hospital emergency department after he was found confused and wandering near a local waste disposal facility. He was transferred to the Neurosurgical Service at an Inner City tertiary hospital after a CT scan demonstrated bilateral subcortical lesions. He was referred for review because of his confusional state and inability to give consent to a proposed diagnostic biopsy of the lesions.

The patient was unable to give an account of himself or his actions. He was irritable, confused and completely disoriented. He had a fluctuating conscious state and described disorganised persecutory delusions in which he felt he had become a 'medical experiment' and that medical and nursing staff wished to harm him. He struggled to give any details and the content of these delusions changes over a period of hours. He was completely amnestic, unable to recall his past or family history or any of the events that had occurred in the previous hour. He was often surprised when he was told when he was in hospital.

He was dishevelled and disorganised with grossly impaired orientation and short term memory (visual and verbal) but relatively intact other cognitive domains. Physical and neurological examination was normal. All laboratory test were normal, including a urine toxicology screen. A lumbar puncture was not performed because of concerns regarding raised intracranial pressure.

An MRI scan revealed bilateral thalamic lesions, hyperintense on T2 weighted images (Figure 1). MR venography demonstrated thrombosis of the deep internal cerebral vein and part of the straight venous sinus. A diagnosis of bilateral venous thalamic infarcts due to thrombosis of the deep internal cerebral vein was made. Treatment with intravenous heparin was initiated but the patient made only a partial recovery and despite a 3 month period of rehabilitation required full residential care.

Figure 1. MRI brain (T2) : Bilateral thalamic venous infarcts (red arrows).

Bilateral Thalamic venous infarcts can result in a number of clinical features ranging from impairment of conscious state, an amnestic syndrome (indicating mammillothalamic tract involvement) vertical gaze palsy or bilateral sensory and motor signs. Larger lesions can produce akinetic mutism. The variability in the presentation results from anatomic variations of the venous system and the propensity of venous infarcts to be accompanied by extensive vasogenic oedema. Prothrombotic states require exclusion, but many cases are idiopathic. Prognosis for a full recovery is poor.¹

Training Opportunities in Neuropsychiatry

Victoria

Neuropsychiatry Unit, Royal Melbourne Hospital, Registrar positions 2014
The Neuropsychiatry Unit is a statewide specialist service staffed by a multidisciplinary team providing diagnostic assessments for patients with organic mental disorders, early onset dementia, neurodegenerative conditions such as Huntington’s disease, epilepsy, chronic psychotic disorders, DBS for OCD, somatoform and movement disorders.

1. Inpatient registrar (12 months)
The inpatient registrar has responsibility for an 8-bed neuropsychiatry inpatient unit. This position provides an opportunity to work with patients with a wide range of clinical presentations and their families / carers.

2. Neuropsychiatry Epilepsy Fellow (12 months)
A joint position with the Comprehensive Epilepsy Program, Royal Melbourne Hospital. The role includes neuropsychiatry consultation to the video telemetry unit, clinical experience in epilepsy clinics and a research component.

The Neuropsychiatry Unit offers a training opportunity unique within Australia and New Zealand. The registrar positions are highly sought after positions of outstanding training value to trainees whether interested in a future career in neuropsychiatry or not. All registrars will have access to teaching and educational activities within the Royal Melbourne Hospital as well as research opportunities.

Completion of both written and clinical FRANZCP examinations is preferred, but not essential, for both positions.

Application timeline:
August 9th - applications close
August 2013 - interviews (Skype interviews possible for interstate applicants)
end of August - appointments made

For further details and submission of applications:
Ms Lisa Stokes
Neuropsychiatry Unit
Royal Melbourne Hospital
Parkville, 3050
Phone: 03 9342 8750
Lisa.stokes@mh.org.au
www.neuropsychiatry.org.au

New South Wales

Intellectual Disability (+/- Neuropsychiatry/Child Adolescent Psychiatry) Trainee Position (part-time/ full-time/ job-share) available, South Eastern Sydney Local Health District (SESLHD), Sydney, New South Wales.
A 6-12 month STP position is available for a trainee in Intellectual Disability Mental Health. The position may also be combined with experiences in Neuropsychiatry or Child and Adolescent Psychiatry, if desirable. A minimum of 2 years accredited training is a pre-requisite. SESLHD offers a dynamic program of training and is at the forefront of service developments and education in ID mental health.

Further details:
Dr Bruce Chenoweth Bruce.Chenoweth@sesiachs.health.gov.au or
A/Prof Julian Trollor J.Trollor@unsw.edu.au