

# **MIND the GAP**

March 2008 Vol 1 N° 1

## **A Newsletter for General Adult Psychiatrists in the West Midlands Deanery**

**Welcome to the first edition of MIND the GAP. The newsletter aimed at senior trainees in General Adult Psychiatry in the West Midlands Deanery, and those who train them.**

**Edited by Giles Berrisford**

## Letter from the Editor

Dear Reader,

Welcome to the first edition of MIND the GAP. This newsletter has been created as a result of the vision of the General Adult Psychiatry (GAP) SpR Peer Group and especially our Peer Group Chair, Rajashree Ray. Its objective is to share information within the Peer Group and also with our trainers. The 3-year gap between junior training and the receipt of the CCT is a crucial and exciting time. This time period gives the trainee a myriad of training, research and development opportunities. It is hoped that by sharing the different experiences obtained by trainees and offered by trainers, these options can be explored comprehensively to the benefit of all.

The newsletter is divided into different sections focussing on the various facets of training essential to ensure the successful transition from trainee to independent practitioner. Namely these will consist of Research and Audit, Special Interest Sessions, Review of Training and Study Courses, and information about impending conferences and meetings.

In this edition we have had a variety of excellent contributions – many thanks to all of our authors. We have a review of 2 locally run courses, one for CBT and one for Management. We have a comprehensive guide for the RITA review process, which will help to clarify what is needed for the portfolio and log books: useful information for trainees and trainers alike. In our

research section we have an article of original research from Dr Alf White exploring the possible link between serum amylase and eating disorders. Prof Weich has provided us with an introduction to the Dept of Psychiatry at Warwick Medical School, showcasing the research opportunities available.

We have included a copy of the BMI programme and bring news about the inaugural West Midlands General Adult Psychiatry Conference to be held on 25<sup>th</sup> April.

We are hopeful that this newsletter will become a permanent fixture of the training programme. In order to achieve this it is important that it meets your needs as a reader. To ensure this, it is essential that we obtain feedback about this newsletter, with your suggestions as to how we could improve it for future editions. It is also necessary that we receive your contributions. Therefore your articles and comments can be submitted to me at [gilberri@aol.com](mailto:gilberri@aol.com). All articles should be between 400-800 words and give a concise overview of the topic you are covering. The newsletter will be produced on a quarterly basis, with the next edition out in June.

I hope you enjoy this edition and that you find it useful and informative. Thank you for reading and for your continued support.

Best wishes

**Giles Berrisford**  
GAP SpR Stafford  
Editor of MIND the GAP

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## USEFUL COURSES

### **CBT Training by Erin Turner GAP SpR Addictions Slade Road Birmingham**

I am a second year SpR, and I often struggle to find courses/conferences which are inspirational and which will benefit my practice. I have an interest in psychological therapies, but have often been put off CBT training, mainly because it seems rather cumbersome.. Administering the therapy is also time consuming, and for doctors, often impractical. Knowing the importance of psychological therapy , it can be extremely frustrating when we find ourselves having to refer our patients to colleagues for CBT, only to find that they have a 6 month waiting list I was therefore very interested when someone recommended a one day workshop on brief, solution focussed strategies for treating anxiety and depression.

The workshop is run by a college called Mindfields. They are the largest provider of psychological training to the NHS, and also run a diploma course. I was really impressed firstly by the dynamic

speaker(Joe Griffin-recently interviewed on Radio 4 programme"All in the mind"), who brought the subject to life. He didn't use any psychological jargon, which I appreciated and he had some interesting insights into causes of depression. We then split into groups and looked at a variety of CBT based solutions to help our patients suffering from depression and anxiety. The techniques I learnt are simple, effective and can be easily used during the outpatient consultation. Since attending the workshop I have carried out a number of brief psychological interventions with my patients, and have found it extremely rewarding. Although the workshop was stimulating, what I mostly achieved from it was the reminder that each consultation should be seen as a therapy session, not just a symptom check and medication adjustment.

The college run a number of different workshops in various different parts of the country, including Birmingham. If you are interested, check out their website [www.mindfields.org.uk](http://www.mindfields.org.uk).

**Dr Erin Turner**

**Report on West Midlands Deanery  
Management Course for SpR's**

**By Dr Ram Ganapathy GAP SpR  
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This was a 5 day course consisting of 2 modules. Module 1 was for 2 days with module 2 extending for 3 days with duration of 1-2 months between the two modules. The course was titled as THE STEPPING UP PROGRAMME- 'Stepping up to your leadership role – The programme that facilitates your transition to consultant' and the facilitators were from The Institute for Clinical Leadership, University of Warwick.

Module 1 included topics such as leadership and leadership styles, developing working teams, update on NHS organisation, medical management and doctors involvement in the system, service development and [re]design.

Module 2 included sessions on making a business case for change and improvement – what actually happens in practice plus team preparation, exploring influencing styles, understanding the role of the consultant and preparing for "the job interview", negotiating efficiently and effectively in teams to achieve a wise outcome, managing myself and my performance and the performance of others, presenting the business cases for change and improvement, panel assessments and feed-back, learning review and evaluation.

The course was very well organized with an excellent venue which was at Stafford University. There were no problems with any of the resources required for the

course. The facilitators were very experienced, motivated and with backgrounds of being in positions such as chief executive, member of the board of directors etc in the past. The participants of the course were Specialist Registrars (SpR's) from various different specialties in medicine across West Midlands. There were approximately 18 participants divided into 4 smaller groups.

Some of the interesting parts of the course were the practical exercises on all the above topics within smaller and bigger groups with opportunities for reflection with the facilitators both individually and as a group. The best part of the course was presenting a business case as a group to the panel which consisted of members in senior managerial positions as mentioned previously. The space between the two modules was meant for the participants to liaise with each other within the respective small groups to work towards presenting a business case in module 2. In total there 4 business case presentations and the panel gave feed back on each of them at the end as well as choosing the best one. Attendance on this course is not only useful for the portfolio but also a tremendous learning opportunity which I would encourage every SpR to undertake. The course fees are also very reasonable and would not appear to be a problem with our study budget.

Perhaps the only drawback of the course for me was the limited coverage for certain issues specific to mental health trusts. There was also no representation amongst the facilitators or the visiting speakers from any mental health trusts.

## **BMI Programme**

**13 January 2009** – Valedictory address

**5<sup>th</sup> February 2008** – Professor Swaran Singh (University of Warwick)  
*'There is no such thing as society – lessons from social psychiatry'*

**4<sup>th</sup> March 2008** – **Dr Hugh Rickards Consultant** (NeuroPsychiatrist Birmingham and Solihull mental health trust) *Neuropsychiatry: Bridging the Cartesian Divide*

**8<sup>th</sup> April 2008** – Dr Martin Curtice (Old Age psychiatrist, Birmingham & Solihull Mental Health Trust)  
*'Incontinent, undernourished and undersexed – the comedic value of the older person on TV'*

**May 6<sup>th</sup> 2008** – Dr Chris Mace (Warwick University)  
*'What makes a case complex?'*

**3rd June 2008** – Professor Femi Oyebode (Birmingham & Solihull Mental Health Trust)  
*'Time, Space and the Self in Psychiatry'*

**9th September 2008** – Dr Martin Deahl, Shrewsbury Hospital  
*'War in the Middle East and Mental Health on the Home Front'*

**7th October 2008** – Professor Tom Burns, Warneford Hospital, Oxford  
*'Assertive outreach and home treatment - what does the evidence really mean?'*

**4th November 2008** – Annual Dinner – Professor Dinesh Bhugra, President, Royal College of Psychiatrists

**2<sup>nd</sup> December 2008** – Registrars Evening



the GAP March 2008

## West Midlands General Adult Psychiatric Conference

### **‘New Ways of Working – What are the implications for Psychiatrists?’**

The General Adult Psychiatry SpR/ ST 4 Peer Group of the West Midlands Deanery is organising their First Conference this year on 25<sup>th</sup> April 2008 at the Uffculme Centre, Moseley, Birmingham. The theme for the day is New Ways of Working and its implications on Psychiatrists. Dr Peter Kennedy, who is currently the Vice-President of the Royal College of Psychiatrists and has been an important figure in this field right from the start, is going to be present to talk to us of the general principles and theory of this change in working patterns.

However we know that as future Consultant Psychiatrists, alongside our knowledge of NWW, we need to be armoured with the skills of working in the Foundation Trusts, as most of the organisations are hoping to attain this status in the very near future. And therefore to address us on this day, we have none other than Neil Carr, OBE who is the Chief Executive of the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (voted Foundation Trust of the Year 2007). He will share with us his views and the implications of Foundation Trust status on Consultants’ working practices. We can also hear from him what the Chief

Executive of a Foundation Trust, looks for in his future Consultants while appointing them. We are sure this will be an invaluable piece of advice for us who are aspiring to move on to a Consultant post in the next 1-2 yrs.

We are organising Workshops in the afternoons to further develop our understanding of the principles of NWW and Foundation Trust and the implications of this on our patient care and our training. These are to be facilitated by Dr J Birtle and Dr PC Naik, Clinical Directors in Birmingham and Solihull Mental Health NHS Trust and Dr C Murphy, Training Programme Director, General Adult Psychiatry, West Midlands Deanery.

There is also a Special pre-lunch session by Prof R N Mohan, Deputy Medical Director, Birmingham and Solihull Mental Health NHS Trust on Consultant Interview Techniques to prepare us further in our mission to achieve our dreams of becoming a Consultant in the NHS.

For further enquiries please ring Amanda Barber on 0121 678 2890 or email her at [Amanda.barber@bsmht.nhs.uk](mailto:Amanda.barber@bsmht.nhs.uk).

Organised by  
**Dr Rajashree Ray** and **Dr Sanjay Khurmi**  
West Midlands SpR/ ST4 General Adult  
Psychiatry Peer Group



## **How to organise your Assessment Portfolio and Logbook**

### **Dr Rajashree Ray GAP SpR Psychotherapy Bridger House Birmingham**

When the time comes around for the RITA (or ARCP, as it is now going to be called), we sit at our desks burning the midnight oil, much to our great discomfort. We wonder then, 'If life was only a bit kinder, and the panel believed what we just said, it would all be so simple'. Well, life can still be simple with a little bit effort and organisation, right from the start. We do need to appreciate that producing evidence is the key factor, because though it seems tedious to do it, there is no other way to tell a group of people who sees you only for half an hour, what a productive year it has been for you.

An Assessment Portfolio is a systematic collection of a variety of trainee's work (educational activity and achievement) and trainer's observations, collected over time that monitors growth of the trainee's knowledge, skills, and attitudes in a specific subject area. It is a multi-faceted training tool involving the trainees actively to present a wide variety of materials, which acts as an effective means of communicating their developmental status and progress. With the new changes in training, it can contextualise and provide a basis for challenging formal test results. A logbook on the other hand is a periodic record of all day-to-day activities – clinical, educational, and teaching, research and management.

Here is an outline for a portfolio, which you may find helpful. It is divided into 12 sections and the important headings for each of the sections is highlighted.

#### **Section 1 Personal Details**

This section is like a snap-shot of yourself containing some key information like:

- Name
- GMC number
- National / visiting training number
- Deanery
- Date of commencement of training
- Full time or part time
- Provisional date of award of certificate of training
- Date of sec 12 (2) approval
- Date of sec 12 (2 ) refresher courses
- Career plans

## **Section 2 Curriculum Vitae**

In this section, keep a copy of your recent CV, outlining in particular the posts you have completed in Psychiatric training.

## **Section 3 Clinical Placement**

This section will contain details of your current clinical post.

An outline should contain the following headings as a minimum requirement –

- Speciality
- Name of hospital & trust
- Name of trainer
- Start date / end date
- Duration of training in months
- Weekly timetable
- Date and time of supervision
- What are my learning objectives
- How will I plan to achieve them
- What are the methods of assessment of the learning objectives
- What is the outcome
- What are the learning objectives that I need to explore further
- Record of topics covered in supervision.

Log-book - This is a place to record your clinical commitments including a record of out-patient clinics, multi- disciplinary reviews, brief notes of interesting clinical cases, mental health act assessments, domiciliary visits, preparation of reports, liaison work with inter-agency services, CPA reviews, case conferences attended and on call commitments. This log can also be useful to record activities during your research days, special interest days, study days, teaching and training commitments. You could include any other activities that you may be involved in your training period.

### **\* Personal reflections of the Training Post**

Record your perception of your achievements, difficulties, setbacks and plans to achieve the set competencies. This should be a space for you to self reflect on your training and inspire you to set targets to meet your training requirement

### **\* Trainers Report**

Outlining your achievements and agreed outcome

### **\* Record of Formal Assessments**

Record of the relevant work place based assessments that are required for your training.

#### **Section 4 Special Interest**

Give an outline of the post and your achievements in that time. You may find these headings useful to use -

- Areas of interest
- Consultant trainer
- Name of Hospital/ Trust
- No of sessions/ week
- Learning objectives
- Plans to achieve learning objectives
- Methods of assessment
- Outcome
- Letter from Trainer/ Supervisor

#### **Section 5 Study Leave**

- Record of Study Days – list of the courses, conferences, workshops and on-line modules attended with dates, place, themes, brief outline of topics and speakers and organising body.
- Record of higher degrees,
- Assessments of other trainees.
- Keep programmes, minutes of meetings, lecture notes, certificates of attendance and participation.

The ‘key’ is to document what you have learnt by attending the course, and how it meets your overall learning objectives.

#### **Section 6 Teaching Activities**

Record formally the date, place, time and the group you have been teaching. You should include the topic of the session, any comments, feedback forms and letters from organisers. Record your opportunities to act as Examiners as well.

#### **Section 7 Research Activities**

This section is to record progress towards achievement of your research projects, which can be done under the following headings -

- Research Activities
- Days
- Base of Research
- Supervisors
- Selection of Research topic
- Literature Search
- Study Design and Methodology
- Ethical Approval
- Collection of Data

- Statistical Analysis
- Interpretation of findings
- Writing up the Project
- Publication
- Letter from Supervisor/ Copies of Publication

### **Section 8 Audit Activities**

Use this Section of your Portfolio to record all Audit Activities during your Training Programme. Ideally record details of Clinical Audits where you have actively participated, your experiences of attending MDT Audit Meetings, Memorable Case Audits and any Serious Untoward Experiences where you/ your team was involved and what you learnt from the proceedings. The headings below are just guidelines to help you record your experiences. Please include any other details you think are relevant.

- Title
- Supervisor
- Nature of involvement
- Expected start/finish date
- Outline of methodology
- Outcome
- Recommendations
- Presentation
- Re-audit

Moreover, remember to keep printouts of presentation/ publication/ comments.

### **Section 9 Management Experiences**

The management experiences can be recorded under the following two headings --

(I) Organizational Experience including Training and Learning the Structure of NHS, awareness of PCT, Commissioning, New Ways of Working, Contracts, Recruitment Procedures, Roles of Mental Health Act Department.

(II) Management Skills including Time Management, Leadership Skills, Communication Skills, Attending/ Chairing MDT meetings, Working with Administrative Staff, Peer Group Representation, Organizing Events, Management Projects.

It may be useful to establish Learning Objectives and Plans to achieve them. Ways to achieve the Objectives can include attending Management Courses, shadowing Clinical/ Medical Directors, chairing Meetings under Supervision and Supervising Clinical Work of Junior Staff. Assessment of your progress towards achievement can be carried out during Consultant Supervisions. It will be a good idea to reflect on what you observe in the Meetings, as this will enrich your experiences even further.

### **Section 10 360-degree appraisals**

Include summary sheet of the results of the 360-degree appraisal

### **Section 11 NHS appraisal**

Please record dates and summary forms of your Annual Appraisal

### **Section 12 Miscellaneous**

Place to record details of your Honorary University posts, prizes, awards, fellowships, committee memberships and activities, experiences with the Judicial system, meetings with Educational Advisors.

I hope you find this format useful, as it should give you great flexibility to adapt it to the different needs during the training period, whilst at the same time providing a structure to record all relevant and useful information. It is user-friendly, and not too time consuming, as completing the monthly planner is a great tool to record day-to-day activities. It should provide a good starting point to collect further information and demonstrate at a glance how effectively you are using your training time.

The division of the 12 sections in this portfolio flows logically and covers all the aspects of your training. The space for self-reflection is very challenging but extremely useful, and can help to identify areas of strengths and weakness and plan your future training needs. In discussion with my Programme Director I have realised that the assessors in fact see this ability in trainees as a potential strength as it promotes personal growth and development.

Article submitted by

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## Serum amylase activity in bulimia nervosa and anorexia nervosa

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### Abstract

**Background:** Eating disorders are difficult to diagnose, and patients will go to great lengths to hide their condition.

**Aim:** To investigate serum amylase activity and vomiting in patients with eating disorders.

**Patients:** Of 69 patients attending an eating disorder unit, a diagnosis of anorexia nervosa was made in 42, bulimia in 22, a binge eating disorder in 3 and no eating disorder was found in 2. The eating patterns of a subgroup of 25 patients with anorexia nervosa were studied in detail. An age matched control group of 30 blood donors and 4 patients with hyperemesis gravidarum were also studied

**Methods:** Serum amylase was measured in each patient category and the significance of differences compared using the Mann Whitney U test.

**Results:** Median (SD) serum amylase activities for the anorectic patients of 190.5 (115) u/L and for the bulimic patients of 181.0 (81) u/L, were significantly higher than the median for the control group of 127.5 (40) u/L. ( $p=0.0002$  and  $p=0.0047$  respectively) Serum amylase activity was  $< 124$  u/L in patients with hyperemesis gravidarum, binge eaters and the subjects with no eating disorder. In the subgroup of anorexics, the median amylase activity in 11 patients known to vomit and 14 restrictors of 241.0 (43.9) and 189.5 (23.8) u/L respectively were not significantly different ( $p=0.146$ ). However the median amylase activity in restrictors was significantly higher than that for the control group. ( $p=0.0078$ )

**Conclusions:** Hyperamylasemia is associated with eating disorders, but not associated with vomiting and may be due to excessive chewing releasing salivary amylase.

**Key words:** amylase: anorexia: bulimia

### Introduction

The incidence of both anorexia nervosa and bulimia nervosa has been estimated

between 0.24 - 14.6 per 100 000 of the female population per annum with other reports suggesting a prevalence of

between 1 - 2 per cent of young females. These wide variations may reflect the difficulty in diagnosis. Anorexia does become obvious if weight falls rapidly and parotid enlargement may be evident in patients with bulimia. Nevertheless patients will go to great lengths to hide the real nature of their disorder and even when suspected, doctors often undertake many investigations before making the diagnosis.

For this reason a simple and inexpensive biochemical marker would be of diagnostic value and might be used to screen patients in whom there was clinical suspicion of an eating disorder. Previous studies have suggested that serum amylase activity may be elevated in patients with eating disorders, possibly due to excessive vomiting. This study was undertaken to investigate the association between serum amylase activity and vomiting in patients with eating disorders compared with age and sex matched controls.

## **Methods**

### Patients

Sixty nine consecutive patients mean age (range) 30.6 ( 21-39 ) years attending South Birmingham Mental Health NHS Trust Eating Disorder Unit were entered into the study. The study was approved by the research and ethical committee, and informed consent was obtained from all the patients. Blood was drawn for clinical purposes, in particular to measure serum potassium concentration, since hypokalaemia is a frequent complication of persistent vomiting. The diagnosis of the type of eating disorder was based on the international classification of diseases ICD 10.

A diagnosis of anorexia nervosa was

made in 42 patients, bulimia in 22, a binge eating disorder in 3 and no eating disorder was found in 2. Detailed information on eating patterns was available for 25 anorexics, and they were classified as vomiters (11) or restrictors (14). One male patient was in the anorexia group, but all other patients were female. Serum amylase was also measured in serum from 30 female blood donors mean (range) age 30.2 (21-38) years within 48 hours of collection. Serum was also made available from blood taken for clinical purposes from 4 patients with hyperemesis gravidarum with mean gestation 11.8 (8-11) weeks.

### Amylase Measurement

Serum amylase activity was measured on the day of receipt together with other biochemical investigations as clinically indicated. Amylase activity was determined spectrophotometrically using an IL 900 random access analyser (Instrumentation Laboratories (Uk) Limited, Warrington). The substrate used was 5 ethylidene-G7-p-nitrophenol ( Boehringer Mannheim UK Limited, Lewes) with between match coefficients of variation of 3.6% and 1.6% at 112 U/L and 872 U/L respectively. The laboratory reference range was < 220 u/L.

### Statistical Methods

Median values for the anorexic, bulimic and control groups were compared using the Mann Whitney U test. Results were displayed as box and whisker plots (Figure 1).

## Results

Median (SD) serum amylase activities for the anorexic and bulimic patients were 190.5 (115) u/L and 181.0(81) u/L respectively, which was significantly higher than the median for the control group of 127.5(40)u/L ( $p < 0.0002$  and  $p = 0.0047$  respectively). The difference in mean amylase activity between the anorexic and bulimic groups was not significant ( $p = 0.577$ ). In the subgroup of 25 anorexics patients, median amylase activity in 11 patients known to vomit and 14 restrictors of 241.0 (43.9) and 189.5 (23.8) u/L respectively were not significantly different ( $p = 0.146$ ). However the median amylase activity in restrictors was significantly higher than that for the control group. ( $p = 0.0078$ ) Serum amylase activity was below 40u/L in patients with hyperemesis gravidarum, between 84 and 119 u/L for the binge eaters and 124 and 81u/L respectively for the two subjects with no eating disorder. (Figure 1)

## Discussion

Gwirtsman et al<sup>2</sup> showed that normal volunteers did not show a change in serum amylase activity after ingesting a large meal, but both anorectic and bulimic patients showed increased serum amylase activities. In their series they were able to distinguish between restricting anorexics and bulimic anorexics with the bulimics showing a two fold to four fold increase in serum amylase values after a controlled period of binge eating and vomiting. They concluded that the raised levels were secondary to binge-vomiting episodes.

Walsh et al<sup>4</sup> determined the total serum amylase activity and salivary and pancreatic isoenzymes and found that in bulimic patients salivary amylase levels

were significantly elevated and there was a correlation between the frequency of binge eating and vomiting and salivary amylase. They found however that the ability to discriminate patients from controls on the basis of serum amylase activity was limited.

Kinzl et al<sup>5</sup> found hyperamylasemia in 61% of bulimics and in 20 % of restricting anorexics but in no patients with binge eating syndrome. They felt that in more than 75% of bulimics there was a close positive correlation between the frequency of vomiting and total serum amylase activity. They felt also that both the frequency and type of vomiting seemed to be related to the extent of salivary gland hypertrophy. From these studies it is not clear whether hyperamylasemia is associated with excessive vomiting or parotid enlargement.

Patients admitted to hospital with acute abdominal pain frequently have their serum amylase activity measured in order to exclude a diagnosis of pancreatitis. However serum amylase activity is not diagnostic for acute pancreatitis below 10 times the upper limit of the reference range. Other causes of moderate hyperamylasaemia include, peptic ulceration, peritonitis, ectopic pregnancy, salivary gland inflammation (e.g. mumps or calculi) renal failure, malignancies and diabetic ketoacidosis. Since vomiting is a very frequent symptom in a general hospital population, were it to be a cause of increased serum amylase activity, an association might be expected to have been noted.

Patients with anorexia nervosa often only restrict food intake. In a series of

patients attending the South Birmingham Eating Disorder Service only 45% admitted to vomiting. Whereas this is likely to be an underestimate, it is a much lower rate than found in bulimic patients of whom the vast majority are known to vomit. Bulimia is characterised by overeating followed by vomiting and / or the use of purgatives. Were vomiting the cause of hyperamylasemia, the bulimic group would be expected to show higher amylase values, yet there was no significant difference in amylase activities between the bulimic and anorectic groups. In the sub group of anorectics whose eating patterns were closely monitored, there was no difference in amylase activity between those known to vomit and those solely restricting food intake, yet both groups showed significantly higher amylase activities compared with the control group. Finally were vomiting to cause hyperamylasemia, patients suffering from hyperemesis gravidarum would similarly be expected to have raised serum amylase activities, which the small group studied did not.

An alternative explanation for hyperamylasemia in patients with eating disorders, is chronic salivary gland stimulation. Anorectics frequently chew their food for lengthy periods and bulimics eat excessive amounts of food over short periods of time followed by vomiting. It is possible that both of these eating patterns may cause excessive salivary gland stimulation and release of salivary amylase causing hyperamylasemia. An association between hyperamylasemia originating from salivary glands and acute parotid enlargement was described by Moriai et al in a patient with an eating disorder,

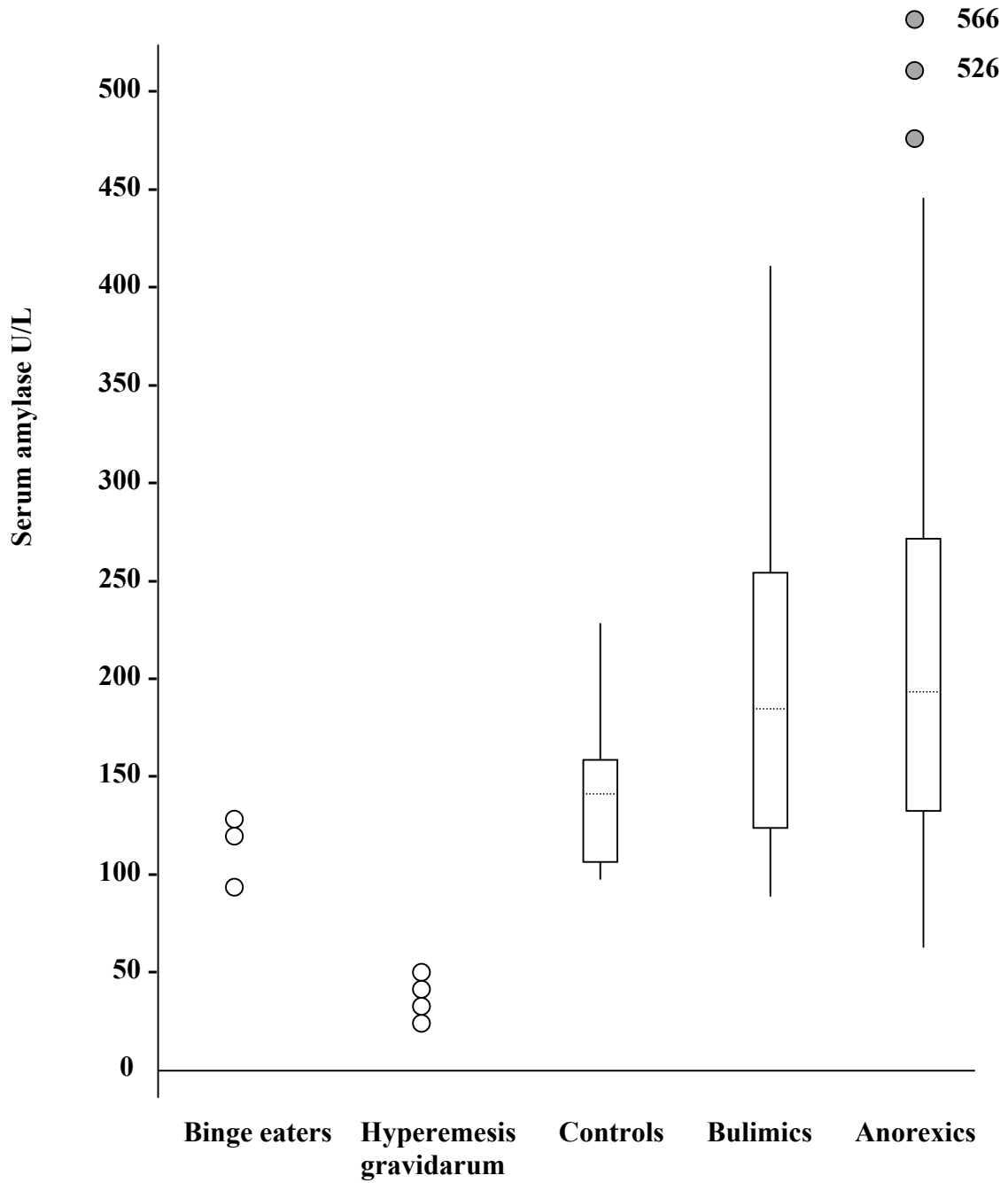
which complicated the diagnosis of a pancreatic pseudocyst.

Since patients with eating disorders are reluctant to admit to their condition both to themselves and to their doctor, the diagnosis can be difficult, often resulting in unnecessary investigations. A simple biochemical test, which assists in the diagnosis of an eating disorder would be helpful. Whilst results to date suggest that total serum amylase activity is a poor discriminant, if the hyperamylasemia of eating disorders is due to excessive salivary amylase isoenzyme, then the latter's measurement may provide a clinically useful test. Measurement of serum salivary isoamylase in eating disorders deserves further study.

#### **Legend to figure**

Box and whisker plot of serum amylase activity in patient groups. The dotted line indicates the median, the box the interquartile range (midspread) and the whiskers the limits of results within 1.5 midspreads of the interquartile ranges. Results falling outside these limits or where numbers are too small for data analysis are marked individually.

Figure 1



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**Psychiatric Research @ Warwick**  
**Prof Scott Weich and team**

The medical school at Warwick has an expanding group of academic psychiatrists keen to encourage and support trainees throughout the West Midlands in their research interests. As a group, we conduct research across the whole life span and use a wide variety of methodologies. Our interests range from the biological to the social. The psychiatrists at Warwick benefit by being part of a high calibre research university and have existing collaborations with the psychology, sociology, engineering, primary care, medical education, and neuroscience departments as well as ongoing national and international research, and strong links with the universities of Birmingham, Keele and Leicester, and the allied Coventry and Warwickshire Partnership Trust.

**Dr Matthew Broome:** Matthew's clinical work is with the Coventry Early Intervention Team. Outside of early psychosis, his other clinical interests include refractory psychosis and neuropsychiatry. Matthew's research is predominantly in the prodromal phase of psychosis, the formation of delusions, and mechanisms of transition to the first episode. His studies have involved both structural and functional neuroimaging, cognitive psychology, treatment interventions, and service development. Many of these are ongoing and in collaboration with colleagues at the Institute of Psychiatry. He also publishes in the philosophy of psychiatry, the pathophysiology of hallucinations and thought disorder, and neuropsychiatry. Together with Professors Singh and Birchwood, he is currently developing research at Warwick utilizing Virtual Reality to study the effects of the urban environment on reasoning, paranoia and affect. He is also developing studies in basic neuroscience to examine the effects of the protein products of the putative genes for schizophrenia. Matthew also works with biomedical ethicists and philosophers at Birmingham to examine the ethical consequences of certain interviewing styles in psychiatry.

**Dr Moli Paul**

Moli is a child and adolescent psychiatrist. Research interests include health services research, such as young peoples's transitions between child/adolescent and adult services, staff wellbeing and morale, user involvement; family-related themes, such as family decision-making about health and social care interventions, parental mental health and children's wellbeing; research on applied ethics and healthcare law, including consent and rights; and, evaluation of interventions for mental health promotion and prevention and treatment of mental health problems in children and young people. She is often involved in inter-disciplinary research projects.

**Dr Bart Sheehan**

Bart is an old age psychiatrist clinically and his research has a strong clinical focus. His main interest is the effect of care environments on mental health in older people, particularly on depression in care home residents. The current research grants he is involved in include trials of exercise for depression in care homes, drug treatments in later stage Alzheimer's disease, neuropsychological deficits in dementia and the effect of

built ward environments. He supervises two SpRs/ST4s in a project examining the effect of moving to care on people with dementia, which has already led to a publication for the SpRs. This reflects a wider existing role providing research mentoring and advice to SpRs on the West Midlands old age psychiatry higher training schemes.

**Prof Swaran Singh:** Swaran runs the East Birmingham early intervention in psychosis service. He has developed, run and evaluated EI services since 2001 and been instrumental in improving and testing various models of service delivery nationally. His initial research was on psychosocial determinants of deliberate self-harm and violence. Since early 90s he has been conducting research on early psychosis, especially epidemiology, onset, acute and transient psychotic disorders, outcome and ethnic differences. He has also conducted research into ethnic and cultural differences in mental health generally, pathways into care, medical education, health services evaluation and mental health law. Recently he was involved in several systematic reviews on mental health law as part of the evidence base for the new Mental Health Bill. He has research links and projects in Eastern Europe. His ongoing research projects include a programme of projects into ethnicity and early psychosis, a multisite study of transition of care from CAMHS to adult services, social defeat and psychosis, refugee and asylum seeker mental health, and ethnic differences in EE and burden of care.

**Prof Scott Weich:** Scott's research interests include the broad range of inequalities in the onset, treatment and outcome of mental disorders. He has studied social and economic determinants (and consequences) of the most common mental disorders, anxiety and depression, as well as the effects of place and other contextual factors. He has undertaken research on the under-treatment of depression in primary care, and on gender and ethnic differences in rates of mental disorder. Most recently he has been involved in studies concerned with ethnic differences in the experiences and outcomes of mental health service users. He has an interest in positive mental health and well-being, resilience and the prevention of mental disorders. Scott is also involved in trying to understand - and reverse- the causes of poor metabolic and cardiovascular health, and increased mortality, among people with serious mental illness.

We are all very pleased to meet trainees who want to discuss research. If trainees do want to discuss ideas informally with any of us, they are welcome to contact Matthew Broome ([m.r.broome@warwick.ac.uk](mailto:m.r.broome@warwick.ac.uk)) in the first instance and he can help guide them to the appropriate member of the team.