Discussion
Lipoma of the spermatic cord had been relatively unimportant and less focused in the practice of hernia repair. Their presence was accepted as an incidental finding at the time of hernia repair. It was an unimportant diagnosis. The fatty tissues were resected from the cord during open hernia operations and excised. With the advent of laparoscopic herniotomy, cord lipomas are more apt to be missed. Here lies the significance of cord lipomas. Laparoscopic hernia repair operations are relatively new procedures as compared to laparoscopic cholecystectomy. Now a days, it has gained popularity in the developed countries and more than 95% hernia operations are laparoscopic. TEP procedure is considered better in dealing with cord lipomas than TAPP.
Michel et al in their study found an incidence of 22.5% cord lipoma. This figure is much higher than the present study. Racial variations and obesity might be associated with it. Indirect inguinal hernia had more association with cord lipomas. This finding is similar to that of other studies. True lipoma of the cord is also far less common than seen in other studies. Size or length of the lipoma had no relation with age of the patient which is a similar finding to that of some other studies.

Conclusion
Cord lipoma is the commonest tumour of spermatic cord. Though it is not that common, it is getting more important with the use of laparoscopic surgery for hernia operations. Missed lipoma of the cord is a pitfalls unique to TAPP laparoscopic hernia repair. This problem occurs when a palpable inguinal mass is noted preoperatively, but no hernia or intraperitoneal defect is found at the time of laparoscopy and the procedure is terminated. With the more and more use of laparoscopic procedures for hernia repair, this unimportant tumour has gathered much of surgical attention. High frequency, high resolution ultrason probe can be used in selected cases. More studies are needed to be done to have better understanding of the matter.

References

Original Paper

STRESSFUL LIFE EVENTS AMONG PATIENTS WITH DISSOCIATIVE AND SOMATOFORM DISORDER
Tabassum R1, Haque M1, Chowdhury SH1

Abstract
Introduction: Stressful life events are part of the fabric of daily existence and often produce disturbed emotional, cognitive and physiological functioning. Somatoform and dissociative disorder categories emerge from a common root, hysteric of the hysteric patients present with features for which there are no apparent anatomical or physiological basis and which has a temporal relationship to a precipitating event.
Objectives: This comparative cross sectional study was carried out to compare various stressful life events between diagnosed somatoform and dissociative disorder patients.
Methods: A total 220 patients participated. They were interviewed through a structured Bengali questionnaire through face to face interview schedule. For the purpose of the comparison each of the somatoform and dissociative disorder patients participated equally from each group.
Results: The younger population was prone to develop dissociative disorder than somatoform disorder (33.8% to 12.7%). Married people seemed to be more likely to develop somatoform disorder than dissociative disorder (97.2% to 64.5%). While unmarried people more likely to develop dissociative disorder (35.5% to 12.8%). House wives were observed to be more likely to develop somatoform disorder than dissociative disorder (78.1% vs 60.4%). There was statistical significance between the incidence of divorce/separation of the respondents and development of either somatoform or dissociative disorder (p=0.05).

Majority of the respondents with unplanned pregnancy by the spouse (7.27%) appearing for examination or interview (2.73%), marriage/engagement (5.45%) and gain of a new family member (4.55%) tend to develop dissociative disorder. While majority of respondents with sexual problems (18.25%), burden of large loss (11.8%) seem to develop somatoform disorder.

Conclusion: There are certain factors which require equal consideration in such patients of these may shed some light on stressful life events associated with dissociative disorder and somatoform disorder.

Key words: Stressful life events, dissociative, somatoform disorder

Introduction
Stressful life events are part of the fabric of daily existence and often produce disorganized emotional, cognitive and physiological functioning. Daily hassles, chronically stressful situations may play a role in experiencing stress by individual. In general practice, it is found that somatic symptoms, such as fatigue, chest pain and headaches are extremely common complaints by the patients. Studies have found that over 20% and as many as 75% of all patients in the primary care settings present with psychological problems through somatic symptoms without any organic disease.
Somatoform and dissociative disorder categories have emerged from a common root, hysteria, a diagnosis given to a group of patients who presented with features for which there was no apparent anatomical or physiological basis and

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which had a temporal relationship to a precipitating event. Clinical experience and research findings from the studies done on these two disorders independently also suggested that somatoform and dissociative disorders share some vulnerability factors such as dissociative experience, personality traits, illness behavior, alexithymia and that stress (e.g. sexual and physical abuse) may be important in the formation of both disorders. The answer probably lies in the interaction of stress and vulnerability factors. In ICD-10, the diagnosis of a dissociative or conversion disorder is made when there is no other physical cause for the symptom and there is evidence for a psychological causation, such as relationship with stressful events. Somatoform disorders represent a group of disorders characterized by physical symptoms suggesting a medical disorder. However, somatoform disorders represent a psychiatric condition because the physical symptoms present in the disorder cannot be fully explained by a medical disorder, substance abuse or another mental disorder. Often, the medical symptoms patients experience may be from both medical and psychiatric illnesses.

The American Psychiatric Association in the Diagnostic and Statistical Manual for Mental Disorders included a specific category for somatic symptoms related to psychiatric origins called the somatoform disorders. Specific somatoform disorder includes somatization disorder, conversion disorder, pain disorder, hypochondriasis and body dysmorphic disorder. Both disorders have been found to have significant co-morbidity with one another (15%-50%). A significant number of patients with conversion disorder have been reported to have dissociative symptoms and vice versa. Both groups of patients have been reported to have a comparable element of associated anxiety, which is presumed to be the causative mechanism in both disorders.

Dissociative disorders are a group of psychiatric syndromes characterized by disruptions of aspects of consciousness, identity, memory, motor behavior or environmental awareness. The American Psychiatric Association in their diagnostic and Statistical Manual include 4 dissociative disorders and one category for atypical dissociative disorder. These include dissociative amnesia (DA), dissociative identity disorder (DID), dissociative fugue, depersonalization disorder, and dissociative disorder not otherwise specified. The diagnostic differences of dissociative amnesia are: any organic mental disorders, dementia, delirium, transient global amnesia. Korsakoff's amnesia, substance abuse, other dissociative disorders and malingering factitious disorder. Present study was designed to compare the association of stressful life events between diagnosed somatoform and dissociative disorder patients with a same hospital set up.

Material and Methods

The study was comprehensive cross sectional study conducted at National Institute of Mental Health (NIMH), Chow-Rangha Noakhali during the period of January 2010 to June 2010. Patients reported to the outpatient department (OPD) of the hospital during the study period and willing to participate in the study were included in the study. The sample size was fixed at 220. As it was a comparative study between somatoform and dissociative disorder patients, 110 patients were included in each group of disorder. Non-probability purposive sampling method was deployed.

For smooth conduction of the study, an interview schedule was developed that consisted of two parts. Initial part contained questions regarding socio-demographic characteristics of both group of patients. Later part focused on various stressful life events. It was a structured questionnaire, taken from presumptive stressful life event scale (PSLES). Interview was conducted with the Bengali version of questionnaire. Data was collected through face to face interview. Each time only one participant was interviewed. All the data were checked and edited after collection. Observed data were entered into computer with the help of software SPSS windows program version 16. Data obtained were compiled in tabulated form. Statistical analysis of received data was performed as required. Values were considered statistically significant if p value is less than 0.05. Categorical data were expressed in percentage (%) and frequency (f).

Table III - Distribution of the study population by occupation status (n = 220)

<table>
<thead>
<tr>
<th>Occupation status</th>
<th>Somatoform Disorder (%)</th>
<th>Dissociative Disorder (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>23 (10.48)</td>
<td>26 (11.86)</td>
<td>0.47</td>
</tr>
<tr>
<td>Service</td>
<td>0 (0.00)</td>
<td>2 (0.91)</td>
<td>0.47</td>
</tr>
<tr>
<td>Housewife</td>
<td>10 (4.55)</td>
<td>16 (7.27)</td>
<td>0.80</td>
</tr>
<tr>
<td>Others</td>
<td>10 (4.55)</td>
<td>26 (11.86)</td>
<td>0.76</td>
</tr>
</tbody>
</table>

Table IV - Incidence of divorce/separation of the respondents

<table>
<thead>
<tr>
<th>Group of disorder</th>
<th>Somatoform Disorder (%)</th>
<th>Dissociative Disorder (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>60 (27.27)</td>
<td>54 (24.55)</td>
<td>0.064</td>
</tr>
<tr>
<td>No</td>
<td>110 (100.00)</td>
<td>110 (100.00)</td>
<td></td>
</tr>
</tbody>
</table>

Table V - Distribution of the study population by marital status (n = 220)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Group of disorder</th>
<th>Somatoform Disorder (%)</th>
<th>Dissociative Disorder (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>98 (46.36)</td>
<td>72 (32.72)</td>
<td>167</td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>122 (53.64)</td>
<td>38 (17.28)</td>
<td>53</td>
<td></td>
</tr>
</tbody>
</table>

Relationship of the development of somatoform disorder and dissociative disorder to death of close family members, unsuccessful engagement or love affairs, personal illnesses, pregnancy (planned or unplanned), sexual problem and large loan burden are shown in following tables:

Table VI - Distribution of the respondents by death of close family members

<table>
<thead>
<tr>
<th>Group of disorder</th>
<th>Somatoform Disorder (%)</th>
<th>Dissociative Disorder (%)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5 (3.81)</td>
<td>6 (2.63)</td>
<td>0.05</td>
</tr>
<tr>
<td>No</td>
<td>110 (96.19)</td>
<td>110 (97.37)</td>
<td></td>
</tr>
</tbody>
</table>
which had a temporal relationship to a precipitating event. Clinical experience and research findings from the studies done on these two disorders independently also suggested that somatiform and dissociative disorders share some vulnerability factors such as dissociative experience, personality traits, illness behavior, alexithymia and that stress (e.g. sexual and physical abuse) may be important in the formation of both disorders. The answer probably lies in the interaction of stress and vulnerability factors. In ICD-10, the diagnosis of a dissociative or conversion disorder is made when there is no physical cause for the symptom and there is evidence for a psychological causation, such as relationship with stressful events.\(^{15}\)

Somatiform disorders represent a group of disorders characterized by physical symptoms suggesting a medical disorder. However, somatiform disorders represent a psychosomatic condition because the physical symptoms present in the disorder cannot be fully explained by a medical disorder, substance abuse or another mental disorder. Often, the medical symptoms patients experience may be from both medical and psychiatric illnesses.\(^{16}\)

The American Psychiatric Association in the Diagnostic and Statistical Manual for Mental Disorders included a specific category for somatic symptoms related to psychiatric origins called the somatiform disorders.\(^{17}\) Specific somatiform disorder includes somatoform symptom disorder, conversion disorder, pain disorder, hypochondriasis and body dysmorphic disorder. Both disorders have been found to have significant co-morbidity with one another (15%-50%). A significant number of patients with conversion disorder have been reported to have dissociative symptoms and vice versa. Both groups of patients have been reported to have a comparable element of associated anxiety, which is presumed to be the causative mechanism in both disorders.\(^{8}\)

Dissociative disorders are a group of psychiatric syndromes characterized by disruptions of aspects of consciousness, identity, memory, motor behavior or environmental awareness. The American Psychiatric Association in their diagnostic and Statistical Manual includes 4 dissociative disorders and one category for atypical dissociative disorder. These include: dissociative amnesia (DA), dissociative identity disorder (DID), dissociative fugue, depersonalization disorder, and dissociative disorder not otherwise specified.\(^{15}\) The differential diagnoses of dissociative amnesia see any organic mental disorders, dementia, delirium, transient global amnesia, Korsakoff’s syndrome, substance abuse, other dissociative disorders and malingering factitious disorder.\(^{18}\)

The present study was designed to compare the associated stressful life events between diagnosed somatoform and dissociative disorder patients with A2 as in a hospital set up.

Material and Methods

The study was comparative cross sectional study conducted at National Institute of Mental Health (NIMH), Shere-Banga Hospital, Dhaka during the period of January 2010 to June 2010. Patients reported to the outpatient department (OPD) of the hospital during the study period and willing to participate in the study were included in the study. The sample size was fixed at 220. As it was a comparative study between somatoform and dissociative disorder patients, 110 patients were included in each group of disorder. Non-probability purposive sampling method was deployed.

For smooth conduction of the study, an interview schedule was developed that consisted of two parts. Initial part contained questions regarding socio-demographic characteristics of both group of patients. Later part focused on various stressful life events. It was a structured questionnaire, taken from prescriptive stressful life event scale (PSLES). Interview was conducted with the Bengali version of questionnaire. Data was collected through face to face interview. Each time only one participant was interviewed. All the data were checked and edited after collection. Observed data were entered into computer with the help of software SPSS windows program version 12. Data obtained were compiled in tabulated form. Statistical analysis of received data was performed as required. Values were considered statistically significant if p value is less than 0.05. Categorical data were expressed in percentage (%) and frequency (f).

Results

The mean age of the respondents was 26.19±7.20 years and the range of age was 19 to 58 years. Married people were observed to be more likely to develop somatoform disorder than dissociative, while unmarried people were more likely to develop dissociative disorder (Table II). House wives were found to be more likely to develop somatoform disorder than dissociative disorder (Table III) while students were more likely to develop dissociative disorder. Rural people were found to be more likely to develop somatoform disorder than dissociative disorder (61.82% vs. 44.55%), while urban people were more likely to develop dissociative disorder (55.45% vs. 38.18%). There was statistically significant difference (p<0.05) between incidence of disorder/sex of the respondents and development of either somatoform or dissociative disorder (Table IV).

\[
\text{Table III: Distribution of the study population by occupation} (n=220)
\]

\[
\begin{array}{|c|c|c|}
\hline
\text{Occupation} & \text{Somatoform Disorder} & \text{Dissociative Disorder} \\
\hline
\text{Unemployed} & 5 & 47 \\
\text{Student} & 11 (10.93%) & 16 (10.95%) \\
\text{Biology} & 2 & 4 \\
\text{Teacher} & 0 & 2 \\
\text{Housewife} & 15 (109.09%) & 70 (109.09%) \\
\text{Other} & 110 (59.09%) & 110 (59.09%) \\
\hline
\end{array}
\]

\[
\text{Table IV: Incidence of disorder/separation of the respondents}
\]

\[
\begin{array}{|c|c|c|c|}
\hline
\text{Sex of the} & \text{Somatoform Disorder} & \text{Dissociative Disorder} & \text{p value} \\
\hline
\text{Resident} & \text{OM} & \text{OM} & \text{OM} \\
\text{No} & 110 (5.09) & 110 (5.09) & 0.044 \\
\hline
\end{array}
\]

\[
\text{Table V: Distribution of the study population by marital status} (n=220)
\]

\[
\begin{array}{|c|c|c|}
\hline
\text{Marital Status} & \text{Somatoform Disorder} & \text{Dissociative Disorder} \\
\hline
\text{Married} & 110 (59.09%) & 70 (109.09%) \\
\text{Unmarried} & 110 (59.09%) & 16 (10.95%) \\
\text{Total} & 110 (59.09%) & 110 (5.09) \\
\hline
\end{array}
\]

\[
\text{Chi - square (16.51) df = 1} \quad p<0.05
\]

\[
\text{Table VI: Distribution of the residents of death by close family members}
\]

\[
\begin{array}{|c|c|c|}
\hline
\text{Death of the} & \text{Somatoform Disorder} & \text{Dissociative Disorder} & \text{p value} \\
\hline
\text{No} & 110 (59.09) & 110 (5.09) & 0.005 \\
\text{Total} & 110 (59.09) & 110 (5.09) \\
\hline
\end{array}
\]

\[
\text{Chi - square (2.19) df = 1}
\]

\[
\text{NIMC Bangladesh, Vol 8, No 1 (June 2012)}
\]

\[
\text{JNMC Bangladesh, Year 8, No 1 (June 2012)}
\]
Table VI: Distribution of the respondents by unassuasive engagement or low affairs

<table>
<thead>
<tr>
<th>Somatoform disorder</th>
<th>Dissociative disorder</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO (%)</td>
<td>NO (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>110</td>
<td>106</td>
</tr>
<tr>
<td>No</td>
<td>110</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>110</td>
</tr>
</tbody>
</table>

Chi-square: 0.001

Table VII: Distribution of the respondents by major personal injury or illness

<table>
<thead>
<tr>
<th>Somatoform disorder</th>
<th>Dissociative disorder</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO (%)</td>
<td>NO (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>110</td>
<td>106</td>
</tr>
<tr>
<td>No</td>
<td>110</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>110</td>
</tr>
</tbody>
</table>

Chi-square: 0.001

Table VIII: Distribution of the respondents by pregnancy of wife (married respondents)

<table>
<thead>
<tr>
<th>Somatoform disorder</th>
<th>Dissociative disorder</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO (%)</td>
<td>NO (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>110</td>
<td>106</td>
</tr>
<tr>
<td>No</td>
<td>110</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>110</td>
</tr>
</tbody>
</table>

Chi-square: 0.001

Table IX: Distribution of the respondents by sexual problem of the respondents

<table>
<thead>
<tr>
<th>Somatoform disorder</th>
<th>Dissociative disorder</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO (%)</td>
<td>NO (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>110</td>
<td>106</td>
</tr>
<tr>
<td>No</td>
<td>110</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>110</td>
<td>110</td>
</tr>
</tbody>
</table>

Chi-square: 0.001

Discussion

Dissociative and somatoform disorders form a significant proportion of the caseload in psychology clinics in a developing country. For these disorders the subtypes prevalent in developing countries are different from those in developed countries, hence research findings from developed countries may not be easily compared for developing countries.

The mean age of the respondents was 26.19±7.20 years (ranging from 19 - 58 years). There was statistical significance between age of developing somatoform or dissociative disorder (p<0.05). Most (81.8%) of the somatoform disorder was observed to be among the age group of 20-40 years. Younger population was prone to develop dissociative disorder than somatoform disorder (35.6%-12.7%). There was statistical significance between the marital status while considering development of either somatoform or dissociative disorder (p<0.05). Married people were observed to be more likely to develop somatoform disorder than dissociative disorder (37.1%-25.6%), while unmarried people mostly developed dissociative disorder (35.5%-12.8%). There was statistically significant relationship between the occupational status with development of either somatoform or dissociative disorder (p<0.05). Housewives were more likely to develop somatoform disorder than dissociative disorder (78.1%-60.0%), while students were more likely to develop dissociative disorder (30.6%-11.8%). Again, there was statistically significant influence of place of residence while considering development of either somatoform or dissociative disorder (p<0.05). Rural people developed somatoform disorder more than dissociative disorder (61.8%-44.5%), while urban people were more likely to develop dissociative disorder (55.4%-38.18%).

A study by Saxe et al revealed that mental disorders were more common among rural population. As the average urban population spent more time in interacting so they utilized the family support in a better manner. This finding is consistent with this study, which reveals increasing somatoform disorder patients in rural areas than dissociative disorder patients which might be associated with low educational level and low socioeconomic status.

In this study statistically significant (p<0.05) relation between incidence of divorce/separation of the respondents and development of either somatoform or dissociative disorder (p<0.05) was observed. All the respondents with unsuccessful affair tend to develop dissociative disorders. This study also showed statistically significant relation of developing dissociative disorder in respondents with personal injury, unplanned pregnancy and having illness of family member. Some events are commonly experienced by general population, e.g. death of a close family member, getting engaged or married, pregnancy of wife, illness of family member, etc. as compared to death of spouse, divorce, wife begins or stops working, and outstanding personal achievement, which are experienced less often in the population. These observation are similar to previous studies.

Present study revealed majority (18 out of 22) respondents with sexual problems and teasing were (13 out of 16) seen to develop dissociative disorder. Various studies showed that masculin patients experienced a variety of life events in different walks of life more often than dissociative disorder. Life events, namely broken engagement or love affair, failure in examination were more common in dissociative disorder than in somatoform disorder.

The findings of this study are not similar to the findings of another study that reveals that, dissociative and somatoform disorder patients experienced the events that were commonly experienced by general population but it does not show any significant difference between them.

Conclusion

It has often been contented that mere exposure to stress is not sufficient explanation of illness in ordinary human experience. There are certain other factors which require equal consideration. The above profile of a small group of such patients shows some light on stressful life events associated with dissociative disorder and somatoform disorder. Psychiatry or mental health of such a long been a much neglected area in our health service. Time has come to rethink on mental health and related health services as dis 1 anxiety and socio - economic burden of mental health problem are not small.

References
Table VI. Distribution of the respondents by unsuccessful engagement or love affair

<table>
<thead>
<tr>
<th>Somatoren disorder</th>
<th>Dissociative disorder</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>0.21</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

Chi-square test df = 1

Table VII. Distribution of the respondents by major personal injury or illness

<table>
<thead>
<tr>
<th>Somatoren disorder</th>
<th>Dissociative disorder</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>0.23</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

Chi-square test df = 1

Table VIII. Distribution of the respondents by pregnancy of wife (parental responsibility)

<table>
<thead>
<tr>
<th>Somatoren disorder</th>
<th>Dissociative disorder</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>0.001</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100</td>
</tr>
</tbody>
</table>

Chi-square test df = 1

Discussion
Dissociative and somatoforic disorders form a significant proportion of the caseload in psychology clinics in a developing country. For these disorders the subtypes prevalent in developing countries are different from those in developed countries, hence research findings from developed countries may not be easily compared for developing countries.

The mean age of the respondents was 26.19±7.20 years (ranging from 19 - 58 years). There was a statistical significance between age of developing somatoforic or dissociative disorder (p=0.01).

Most (81.8%) of the somatoforic disorder was observed to be among the age group of 20-40 years. Younger population was prone to develop dissociative disorder than somatoforic disorder (33.6%-12.7%). There was a statistical significance between the marital status while considering development of either somatoforic or dissociative disorder (p=0.05). Married people were observed to be more likely to develop somatoforic disorder than dissociative (57.2%-44.5%), while unmarried people mostly developed dissociative disorder (55.5%12.8%).

There was statistically significant relationship between the occupational status with development of either somatoforic or dissociative disorder (p=0.001). Housewives were more likely to develop somatoforic disorder than dissociative disorder (78.1%-60.0%), while students were more likely to develop dissociative disorder (50.9%-11.8%). Again, there was statistically significant influence of place of residence while considering development of either somatoforic or dissociative disorder (p=0.05). Rural people developed somatoforic disorder more than dissociative disorder (61.8%-44.5%), while urban people were more likely to develop dissociative disorder (55.5%-18.1%).

A study by Saxe et al revealed that mental disorders were more common among rural population. As the average urban population spent more time in interacting so they utilized the family support in a better manner. This finding is consistent with this study, which reveals worsening somatoforic disorder patients in rural areas than dissociative disorder patients which might be associated with low educational level and low socioeconomic status.

In this study statistically significant (p ≤0.05) relation between incidents of divorce/separation of the respondents and development of either somatoforic or dissociative disorder (p=0.03) was observed. All the respondents with unsuccessful affair tend to develop dissociative disorders. This study also showed statistically significant relation of developing disseriative disorder in respondents with personal injury, unplanned pregnancy and having illness of family members.

Some events are commonly experienced by general population, e.g. death of a close family member, getting engaged or married, pregnancy of wife, illness of family member, etc. as compared to death of spouse, divorce, being homeless or unemployed and outstanding personal achievement, which are experienced less often in the population. These observation are similar to previous studies.

Present study revealed majority (18 out of 22) respondents with sexual problems and loan burdens (13 out of 16) seem to develop dissociative disorder. Various studies showed that marital patients experienced a variety of life events in different walks of life more often than dissociative disorder. Life events, namely broken engagement or love affair, failure in examination were more common in dissociative disorder than in somatoforic disorder.

The findings of this study are not similar to the findings of another study that reveals that, dissociative and somatoforic disorder patients experienced the events that were commonly experienced by general population but it does not show any significant difference between them.

Conclusion
It has often been contented that mere exposure to stress is not a sufficient explanation of illness in ordinary human experience. There are certain other factors which require equal consideration. The above profile of a small group of such patients sheds some light on stressful life events associated with dissociative disorder and somatoforic disorder. Psychiatry of mental health or illness has long been a much neglected area in our health service. Time has come to rethink on mental health and relevant health services as a part of the health services and socio-economic burden of mental health problem are not small.

References
Original Paper

COMPARATIVE STUDY BETWEEN EFFICACY OF MAGNESIUM SULPHATE AND LIGNOCaine IN ATTENUATING HAEMODYNAMIC RESPONSE TO LARYNGOSCOPY AND ENDOTRACHEAL INTUBATION

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Abstract

Introduction: Laryngoscopy and endotracheal intubation during general anaesthesia predictably lead to hypertension and tachycardia. It has detrimental effects on other organ system. Many drugs before have been suggested to obtund these effects.

Objectives: This prospective study was designed to assess and compare the efficacy of magnesium sulphate for attenuating haemodynamic response to direct laryngoscopy. Methods: One hundred patients of both sexes, age between 18 - 50 years, American Society of Anaesthesiologists (ASA) physical status I and II, scheduled for elective surgery in combined military hospital (CMH), Dhaka were included in the study. Duration of the study was from January 2009 to November 2009. The patients were divided into two equal groups (patients in each group). Then the group I patients were injected with 20% lignocaine 1.5 mg/kg body weight intravenously and group II patients with magnesium sulphate 50 mg/kg intravenously just before induction. Baseline parameters like heart rate (HR), systolic blood pressure (SBP), diastolic blood pressure (DBP), mean arterial pressure (MAP) were measured non-invasively and rate pressure product (RPP) was calculated and were recorded on 1, 3 and 5 minutes after laryngoscopy and endotracheal intubation.

Results: Heart rates were more in group I than group II at 1, 3 and 5 minutes after intubation and differences were statistically significant. Blood pressure changes were more in group I than group II at 1, 3 and 5 minutes after intubation and differences were statistically significant. Rate pressure products (RPP) were more in group I than group II at 1, 3 and 5 minutes after intubation and differences were statistically significant.

Conclusion: Therefore we can conclude that magnesium sulphate is superior to lignocaine for attenuation of haemodynamic response to laryngoscopy and endotracheal intubation and patients with hypertension, ischaemic heart disease, myocardial infarction and brain tumour will be benefited from preoperative administration of magnesium sulphate during laryngoscopy and endotracheal intubation.

Keywords: Endotracheal intubation, laryngoscopy, haemodynamic change, magnesium sulphate, lignocaine

Introduction

Haemodynamic stability is an integral and essential goal of any anaesthetic management plan. Hypertension and tachycardia have been reported since 1950 during intubation under light anaesthesia uncomplicated by hypoxia, hyperventilation or cough3. Increase in blood pressure and heart rate occurs most commonly

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