Management of subclinical hypothyroidism after treatment initiation with lithium salts continues to raise controversy. In general if the serum TSH is ≥10 mU/L there is a high risk of progression to hypothyroidism and treatment should be initiated with levothyroxine. If the serum TSH level is between 5–10 mU/L monitoring of the TSH is recommended and treatment could be justified in some cases,[10] especially if there is goitre, and symptoms of hypothyroidism, including symptoms of depression and raised level of antithyroid antibodies.

Obvious hypothyroidism should be treated with replacement therapy with levothyroixine and in the case of hyperthyroidism treatment should vary depending on the aetiology.

In cases where replacement therapy is required, doses of 12.5.–25 μg/day in elderly patients or with cardiovascular risk may be used to begin with. Doses of levothyroxine of 25–75 μg/day are usually appropriate for restoring the levels of TSH in most paitents,[10] and on occasion the levothyroxine dose may be increased to 1–1.5 μg/kg/day (100 μg/day) in young patients with no cardiovascular risk.

It is important to consider that it is not useful to carry out any analytical assessment before 6 months of treatment have passed of after modification of a levothyroxine dose, since this is the minimum time requirement to reach stable hormonal plasmatic levels.

The aim of replacement treatment is to achieve normal levels of thyroid hormones with non stimulated TSH. It has also been postulated that in patients where thyroid and psychiatric disease coexist, TSH levels must be lower than 3 mU/L, and not 5 mU/L as proposed for the psychiatric disease-free population.

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The training of Psychiatry resident: Summary of the discussion table held during the XXII National Congress of Psychiatry. Spain, 2019[☆]

La formación del residente de Psiquiatría: Resumen de la Mesa de Debate realizada durante el XXII Congreso Nacional de Psiquiatría. España, 2019

Dear Editor,

In accordance with the *Union Européenne des Médecins Spécialistes* (UEMS, European Union of Medical Specialists),the quality of medical care and expertise of healthcare professionals is directly related to the quality of their training.[1]

Competency based training (CBT) has become the dominant approach in training healthcare specialists[2,3] and has been used in the United Kingdom, the United States and Canada.[4–6]

This training model is the one recommended by the psychiatry Section of the UEMS[7]. The World Psychiatric Association also recommends assessment based on competences as part of the training programmes in psychiatry which seek excellence.[8]

Against this backdrop, during the 22nd National Psychiatry Congress (Bilbao, 2019) a round table debate took place where the authors of this letter participated as speakers. Among the attendees were resident tutors and psychiatrists interested in the subject matter. During the course of the forum the 2 representative from Spain in the UEMS Psychiatric Section were present.

The aim of the round table was to debate competency based training (CBT), the previous experience applying this model in hospitals in Spain and the opportunities of extend-

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ing it to Specialist Training in Psychiatry in Spain. The following conclusions were reached.

Competency-based training in the Spanish resident system

In Spain there was no CBT background in the training of internal resident doctors (MIR for its initials in Spanish) until the period between 2008–2012 with the creation, implementation and assessment of a competency based model in the Hospital Universitario Cruces (Basque country).[9] During the application of this model in all hospital specialties (including Psychiatry), it was determined that a need existed for a definition of professional profiles for the healthcare professionals, together with the integration of specific technical scientific competences for each speciality with common core subject competences in all specialities, such as ethics, professionalism, practice based on the healthcare system, and team work.

Application of the CBT in the psychiatry MIR programme

The termination of the core subject decree has delayed the appearance of a regulatory framework to support specialised healthcare competency based training in Spain. This has provided to be an obstacle for the extension of this model to the different teaching units, and to research and contextualisation in the Spanish environment. Despite these delays, with the CBT international recommendations and experience, it is hoped that this will be established in the near future in Spain.

Towards a CBT culture

In the expectation of a regulatory framework, the extension of a CBT culture, through education to all levels (tutors, residents, teaching units and healthcare personnel) would enable greater facility in the transition to this type of model and would improve the training of current resident physicians.

At present both the Spanish Society of Specialist Healthcare training (SEFSE) and the Spanish Society of Psychiatry (SEP) have made efforts at this level. The former has organized annual congresses for tutors and study managers and the latter has joined in the petition for a new tutor statute to guarantee recognition and accreditation of this figure, as well as recertification of psychiatry professionals. A reference book is also being created for the training of resident doctors and tutors based on competences.

During the debate the following questions were raised by the public:

1 The current assessment system is unable to reward professionals of excellence and hinders non concession of the title of specialist to resident doctors who do not achieve minimum objectives. To facilitate these processes, organised copies and forms of all resident assessment processes have to be made available by tutors and teaching units.
2 The teaching units and psychiatric services must provide quality markers in health education as part of hospital management.
3 It is important to specify the role and participation of other social agents in CBT implementation.

Conflict of interests

Daniel Martínez-Uribe, Jon-Iñaki Etxeandia-Pradera, Julio Bobes García, Margarita Sáenz-Herrero and Eduardo-Jesús Aguilar García-Iturrospe have no conflicts of interest to declare.

Jesús Morán-Barrios and Pilar Ruiz de Gauna participated in the training, research and dissemination of the competency based training in different institutions in Spain.

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Antipsychotic consumption and diabetes mellitus. A causality analysis☆

Consumo de antipsicóticos y diabetes mellitus. Un análisis desde la causalidad

Dear Editor,

It is a fact that patients with schizophrenia run a high risk of developing metabolic problems, among them diabetes mellitus (DM). The biological mechanisms of the disorder, psychosocial repercussions and the adverse effects of antipsychotic (AP) drugs are all intermingled here.

The inference of causality is a major subject of debate in the field of epidemiology. On the one hand, different theoretical models encompass this. On the other, there is controversy over whether it is possible to demonstrate causality in an absolute manner. In epidemiology the Bradford Hill criteria are still considered as an appropriate reference to determine the possible casual association between 2 variables, since they lead to rigorous assessment of what is known and what is unknown about this possible relationship.[1]

Given the high consumption of AP, we believe it is of interest to review recent references on the relationship of these drugs with DM from the perspective of causality, using the Bradford Hill criteria to report our findings.

Strength of association

In a primary care cohort of over 200,000 people we observed a DM incidence in patients with AP which was higher than that observed in the general population (OR 1.45; 1.22–1.73). Schizophrenia did not prove to be a separate risk factor from DM.[2]

Evidence suggests that the association is higher with ''second generation'' AP (and, among them, with olanzapine and clozapine). The measurements which compare incidence (RR) or their analogues (OR) showed a mean increase in risk of 2–3 times when comparing treated patients with non treated patients or patients treated with an AP of poorer profile with one of lower hyperglycaemic capacity. When the difference of means was used it was observed that values were between 4 and 10 mg/dl of blood sugar.

Putting the Bradford Hill criteria into practice has shown that this criterion should not be reduced to the measure of association magnitude, but should include aspects such as the statistical significance or internal validity of the study. In the literature there is great disparity in presentation of the resulting event, and a lack of control on potentially important factors of confusion, such as level of psychiatric symptomatology.

Consistency

Adults with schizophrenia are the most common study group, but the development of DM from AP in adults with bipolar disorder and in children (with diverse disorders) has been observed.[3]

The growing interest in studying this issue in the child and teenage population is notable, particularly because there may be a certain lack of vigilance in this age group of this and other adverse AP effects.[4]

In the elderly, the repercussions of AP on blood sugar may be lower.[5] In diabetic patients it has been observed that taking these drugs worsens metabolic control.[6] The association between the use of AP and the development of DM has been studied using different types of designs, both observational and experimental.

Temporary sequence

A large part of the available evidence is based on cross-sectional studies, but meta-analyses and systematic reviews with longitudinal studies exist which confirm the effect of the AP.

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