Emergencies in Psychiatry

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Medical emergencies: preventable harms

- What's expected of you, given your training level
- You might be "junior" on the team: out of hours, you will have the most expertise on physical healthcare (with some teams, in office hours too). Ask others too
- Cant cover every emergency – common ones, based on last 15 years' experience in ELFT
- Important learning in Intermediate Life Support day
- Better to prevent →act on deterioration→ (debrief)

Five cases

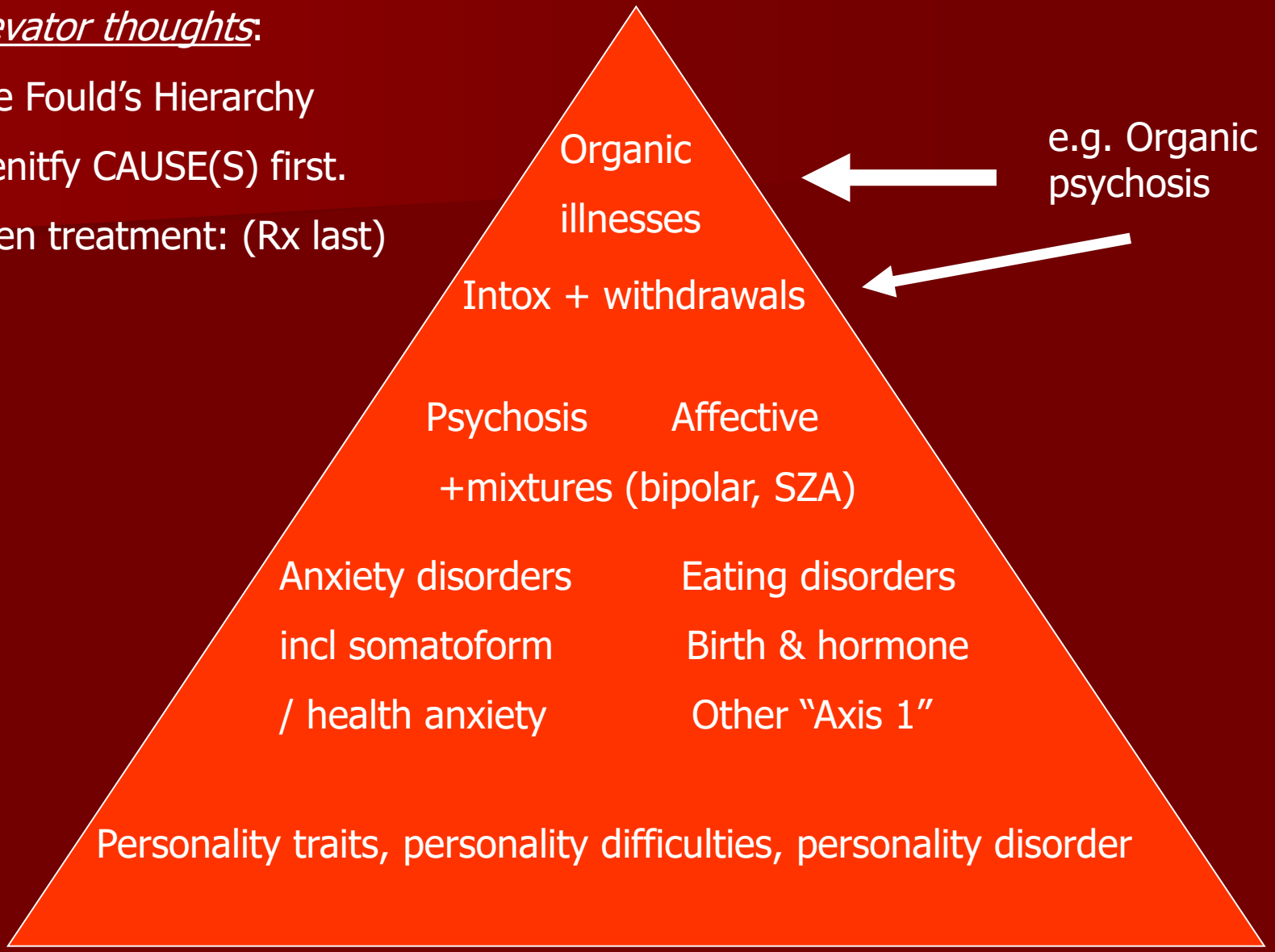
- 1. Female (61) picked up on the street "behaving strangely"
- 1B/C. Rising agitation in unknown pt (28)
- 2. the medically deteriorating patient. Transfer safely
- 3. Singing man (32) brought in by police
- 4. Suicidal act / thoughts… what now?
- 5A. Female (58) fearful / seeing rats
- 5B. Male (46) who stopped all drugs
- 6. Falling weight in 23 y.o. woman: BMI<15

Elevator thoughts:

Use Fould's Hierarchy

Idenitfy CAUSE(S) first.

Then treatment: (Rx last)



"Behaving strangely"

DELIRIUM

- Fluctuating consciousness: seen by clinicians or on collateral
- Fleeting psychotic features: on-off paranoia, unusual hallucinations: visual ++
- Fearful affect + vis halluc = alcohol withdrawals: BNZs to prevent seizure, B vits 4 brain
- Formication (under skin sensations) likely cocaine or its analogues (NPS)

PSYCHOSIS

- Age group: 15-25 for boys/men; older in women. +/- cannabis
- Usually >35: primary depress
- Evidence of gradual change in social function (prodrome)
- Delusions over a longer period, consistent and systematised
- Auditory hallucinations: third person likely Schizophrenia; second person – poss ↓↓Mood
- Plus features: delusions of reference; thought interference

1. General management of confused patient (delirium)

- General hospital: Frequent observation: 4 hourly or more
- Efforts by staff to repeatedly orientate the patient to surroundings recognised as a specific part of the management plan
- Effort made to avoid excessive staff changes: special nurse (one to one eye level obs) or named, key nurse
- Patient nursed in a single, side room.
- Uncluttered nursing environment: beds apart by an adequate distance, and no more than two objects in vicinity that are non-vital or non-orientating
- Use of an individual night light
- Specific efforts made to minimise noise levels: radio, TV
- Relatives of friends specifically requested to visit at regular times, and trained to help with reorientation

1. The confused, disturbed, aggressive … violent patient

- Brain= HEAD: intracranial bleed, SOL, infxn
- Brain needs gluc & O_2:↓ in 4 organ "failures"
- Systemic: (think of general, main causes of confusion) = infection, pain, retention etc
- 60% =Drugs: intox, withdrawal, S/E or ADR
- THEN list "Psychiatric" causes: mania or psychosis< Other drugs S/E- akathisia, 5HT
- (lastly) severe anxiety, dissociation, PD

1B Substances→ delirium/psychosis

Intoxication (**withdrawals)

- Alcohol **
- Amphetamines
- Cannabis
- Cocaine
- Hallucinogens (PCP)
- Solvents
- Opioids **
- Steroids **
- Sedative-Hypnotics ** (Benzos, barbiturates)
- GHB, new psychoactives**

Look up Derek Tracy's (London) perspective on NPS et on ELFT Intranet, medical educ/updates

Prescribed meds *(just the As)*

- Steroids (anti-immune)
- Analgesics & other OTCs, Opiods, PreGab, GabaP…
- Anticholinergics
- Antihistamines
- Antiepileptics
- AntiParkinson's: L dopa
- Antihypertensives
- Antiarrhythmias
- Antimicrobials (TB, HIV malaria)
- Anticancer: interferon
- B for beta blockers ETC ETC

Neurological causes / precipitants of organic psychosis

Young adults

- Epilepsy, esp temporal lobe & occipital epilepsy
- migraine,
- head injury,
- primary tumours,
- aneurysm, subarachnoid haemorrhage,
- abscess (HIV, TB)
- multiple sclerosis,
- Encephalitis (NMDA, VGK)
- Huntington's disease, Wilson's disease, other genetic diseases

Older adults

- Delirium and dementia: too many individual causes to list
- cerebrovascular disease,
- head injury and other traumas,
- space occupying lesions: tumours (usually secondaries), abscess, cerebral haemorrhage (especially subdural haematoma),
- normal pressure hydrocephalus

Systemic illness → Psychosis

Both get Covid infx

Young

- Infection: HIV, syphilis, encephalitis, mumps, parasites, septicaemia
- Immunolgical: SLE
- Endocrine/metabolic: Thyrotoxicosis, Addison's disease, porphyria hyperparathyroidism
- Cardiorespiratory: (rare) pneumonia, isch enceph
- Deficiency states: (B12), Wernicke's = thiamine deficiency in alcohol misuse

Older people

- Infection: ANY infection compromises vulnerable patients e.g. UTI, chest sepsis
- Immunological: temporal (giant cell) arteritis
- Endocrine/metabolic: Thyrotoxicosis, Cushing's syndrome, hypercalcaemia
- Cardiorespiratory: hypoxia + all causes of acute confusion: cardiac failure, pleural effusion, pulmonary embolism
- Deficiency states: Wernicke's encephalopathy, B12, folate / nicotinic acid deficiency, hypothermia

Delirium evidence: antipsychotics

Yi-Cheng Wu (JAMA, 2019): 58 RCTs: HPD plus lorazepam, OR =28

- Haloperidol: longest experience, watch QTc
- As a rule, BNZs only for withdrawals/fits: ↑ SEs
- Risperidone: gaining its place, poss ahead of HPD
- Olanzapine: close to HPD if sedation required

Lonergan (2007) Cochrane review: HPD = Risp = OLZ (but not S/Es)

- Both Risp & OLZ have orodispersible preps
- Rapid reviews in Covid delirium: low potency APs
- Quetiapine: small trials; 59% XS sedation by day
- Aripiprazole: newest of the novel antipsychotics

Cochrane: no trial support BNZs for nonDT delirium

1C. Management of violent patient

- Safety of self, others, patient. *?weapon*
- Exit strategy, environmental hazards
- Someone - (you?) - must take charge
- Assess in safe setting with other staff
- Calm voice, patient's preferred name
- Confirm the diagnosis: think out loud
- No promises, explain what will happen

Most preferred options

- Staff consensus
- Engage patient
- Least restrictive
- Consent
- Oral medications
- Make clear how your plan will help now and in future
- Review nurs obs

Least

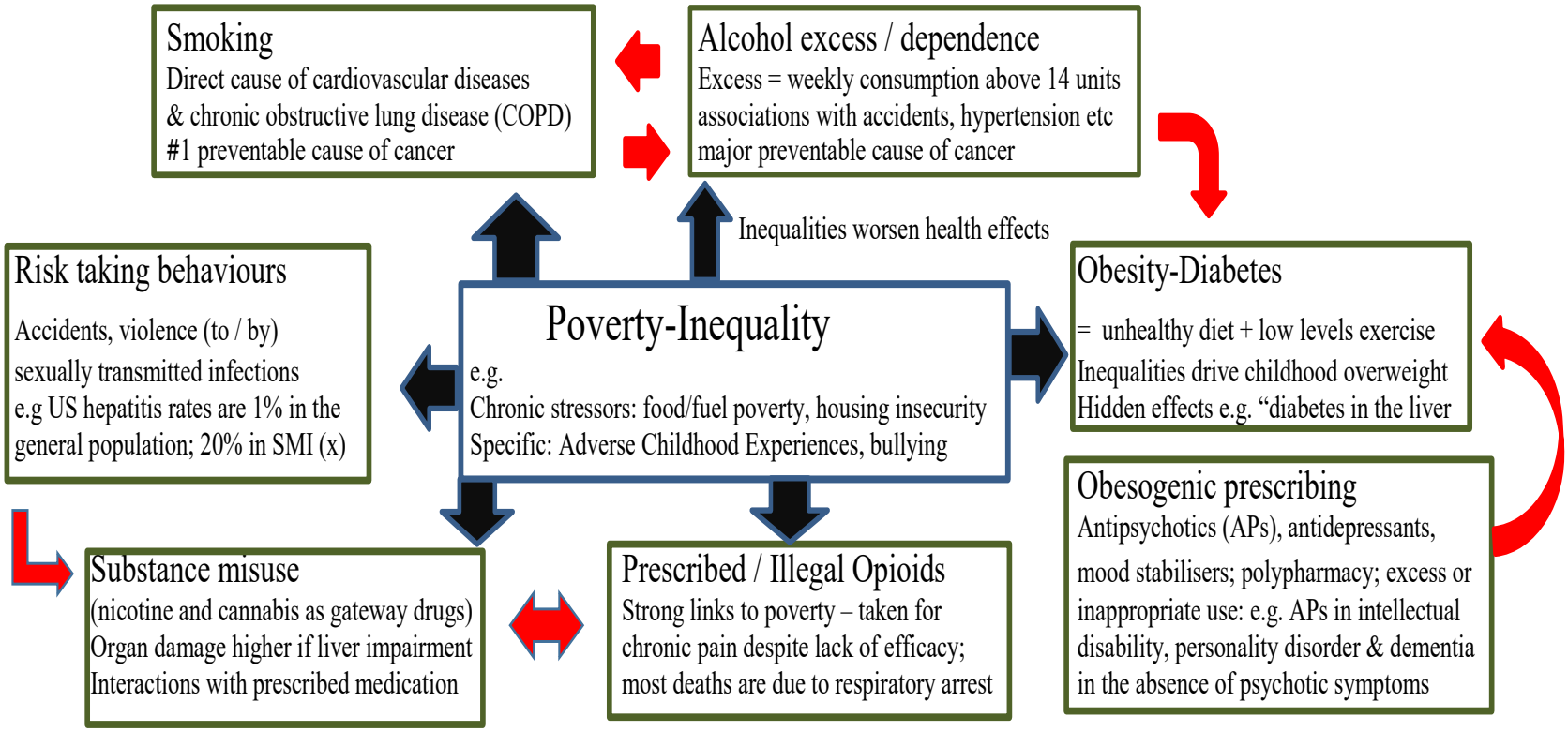
- Restraint: check training of at least four other staff
- Duty of care: treat
- I/M medications
- Note medical Hx and drug allergy
- Document degree of restraint
- Increase nurs obs

Trust your instincts: not safe here

- Psychiatric hospital is for functional disorders
- Delirium, delirium tremens (unless mild), seizures, extremes of diabetic control / infections (vomiting patient) etc all need to go to general hospital
- SBARD: situation, b/ground, assess (NEWS!), (your) recommendations (e.g. transfer now) + decision
- NEWS= pulse rate, BP, resps, temp and oximetry
- Most important MSE finding is Consciousness level
- peri-arrest: Resps less than 8 (per min), ventilate

Seven drivers of Premature Mortality in people with severe mental illness. (SMI)

Byrne, 2023: *Irish Journal Psychological Medicine*



What does a safe handover look like?

- One page of key medical knowns, drugs, allergies, and an understandable psych diagnosis ("?EUPD ?ADHD")
- In a sentence, "here's what I found, what we did…"
- You are not likely to be on the street → give Oxygen, adrenaline, glucose, benzos (fit, DTs)… morphine
- You may be in the same building: direct conversation
- Secure the right transport, right staff member, Obs lev
- RiO notes important for patient, you, and liaison team

3. Mania & hypomania

- Core 3 in depression: Energy, Mood & Interest
- Low in depr – opposite when high: boundless energy, no need for sleep, irritable & intrusive
- Mania means psychotic features too (voices, ideas): manic patients can "hold it together" for 30 mins
- More disinhibited than psychotic patients (who don't have mood features)→more likely to ACT
- Medication is a balance of reducing risks to self & others and patience for a slow, soft landing
- Antipsychotics: SZ + mania; add BNZs in mania

4. The suicidal patient (self harm has led to medical compromise)

- Document the degree of current suicidality: passive death wish, suicide thoughts, intent, current suicide plan in context of MSE
- Management is based on past attempts, current circumstances + mental state (MSE)
  - MSE: list intolerable symptoms e.g. voices
  - Has this self harm made his/her life worse?
- Supervision: define 1 to 1 obs as "eye level", safe transfer, ?MHA Section, restraint, ?meds

Why must we write 1 to 1 obs as "eye level" observations

You are worried about a suicidal / violent patient

- The first assessment is the single, best chance we will get it right
- Just cos your worry levels fall with time (as you see the next one), the risks do not fall automatically
- Assess then document: if you haven't written it down CAPS FOR HIGH RISK, you haven't done it

The risks <u>rise</u> with MHA section, transfer, staff Δ

- "I thought she was for routine obs"
- "we were never told, never got the handover, that he was high risk"
- "Our policy of 1 to 1 is fine, but staff need their breaks…"
- "the ward was very busy"

5. Delirium tremens (DTs)

- Consequence of physical dependence on alcohol
- Alc Dep Sy = craving, neglect of other activities, tolerance, withdrawal (tremor, sweating ,↓sleep) that is relieved by alcohol or similar drug (BNZs)

< CAGE screens for problem drinking > use AUDIT

- Withdrawals: mild (shakes, nausea), moderate (agitation, fearful) to DTs (confusion, halluc, fits)
  - Visual misperceptions +/- halluc with fearful affect
- DTs: autonomic + electrolyte abn, dehydration
- BNZs →GABA receptors, not Glutamate XS (cell death)

Treatment of delirium tremens

- Low risk dependent patients: ambulatory detox
- Higher risk (incl psych risk): gen hosp detox
- Medical admission: seizures, GI probs, cardiac ↓nutrition, previous complicated detoxes = ↑risk
- Chlordiazepoxide 20mg QID, reducing + PRN
- Consider i/m or i/v BNZs in debilitated patients
- Incipient Wernicke's: 2 pairs Pabrinex TDS for 3/7
- At risk Wernicke's (wt loss, poor diet, malabsorption): 1 pair of Pabrinex TDS / 3 days
- THEN thiamine 300mg BD + Vit B compound strong

5B. Opiate withdrawals

At 8-12 hours:

- Sweating, lacrimation
- Yawning, rhinorrhoea
- Dilated pupils, irritable
- Tremor, restless, ↑PR

Methadone withdrawal:

- Starts **after** 24 hours
- Can last for 4 weeks

From 24 – 36 hours

- Nausea + vomiting
- ↑BP and ↑PR
- Muscle & abdominal cramps
- Insomnia, nightmares

Heroin withdrawal:

- Never fatal. (DTs = 15%)
- Subsides at 10 days

Methadone

- Community 1/day but 2/day in hospital
- Give once/day dose only if overnight leave
- Never prescribe without checking dose, last prescription / TTAs with prescriber
- If can NOT confirm, no methadone unless signs of withdrawal + opiate positive UDS
- Initial dose: methadone 15mg BD
- Tell community pharmacist about changes
- Community Naloxone proven to save lives

Buprenorphine (Subutex)

- Buprenorphine, a mixed opioid agonist-antagonist
- Must verify withdrawal symptoms first: if you do not (up to 36hrs), you will precipitate withdrawal
- Day One (divided): 4-12mg; Maintain = 8-24mg
- Opiate agonists do not “cure” addiction: CBT+ too
- Specialist centre for prescribing in pregnancy: less neonatal withdrawals on Buprenorphine BUT can never be given with Naloxone
- During labour, standard opioid use

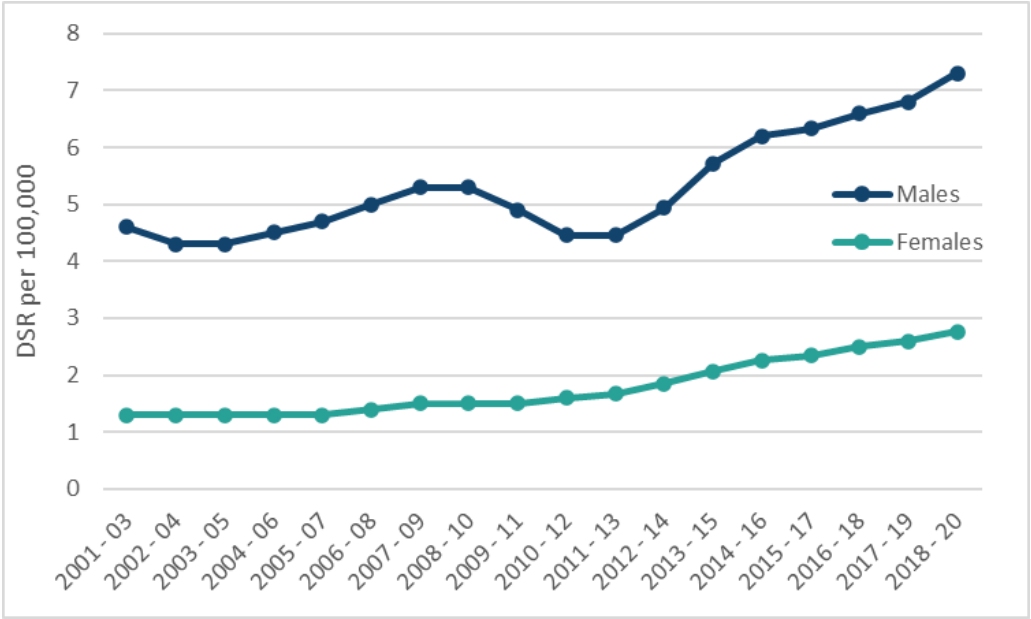
Deaths from drug misuse

ONS 2021 –

In the context of the UK –
Comparing Standardised Rate of Deaths -

- Scotland had the highest at 25.0 –
- N Ireland second highest rate 9.4
- England & Wales had 5.3

per 100,000 Population



6. Starvation: anorexia, (severe depression, alcoholism, SZ)

- Cardiac: ↓rate, ↓ BP but ↑QT and
↑ ↑ arrhythmias (electrolytes) … LVF
- GI: teeth, parotiditis, GI ulcers, dilation, SMA, rupture, constipation, ↑LFTs, ↓glucose
- Renal: ↑ urea ↑pH (alkalosis) but ↓ K ↓ Na ↓ Cl ↓Ca …↓PO4 ↓Mg (indicates more risk)
- ↓Hb ↓platelets ↓WCC, BM hypoplasia, ↑ESR, ↓T4; in advanced stages, multiorgan

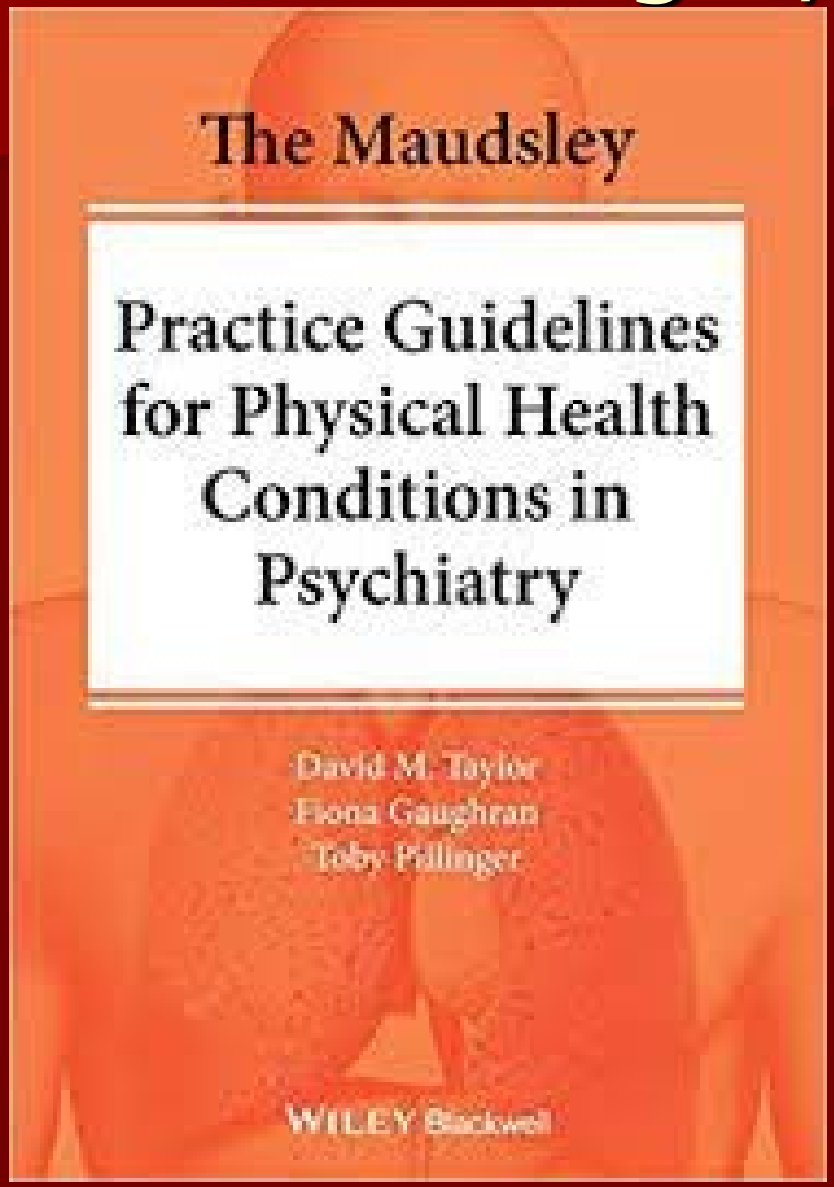
Starvation: anorexia late stages

- Including death by suicide, death rate from anorexia nervosa is 25%
- X5 more likely to die prematurely in women; X7 in men (Canada)
- Consult + share MARSIPAN now MEED guidelines link – for general hospital care
- Musculoskeletal: delayed bone maturation to osteoporosis at 2 yrs, plus dry skin, bruising, lanugo
- ECG!! recent patient had ribcage so thin, ECHO not possible

In any list of psychiatric emergencies, many are medical

- ☑ Confusion, agitation … hypoactive delirium does worst
- ☑ Psychosis or mania: diagnose then AP / BNZs
- ☑ Think aloud about potential injuries, self harm
- ☑ For risks (suicide, harm incl children): evaluate capacity & how long would s/he last outside
- ☑ Starvation, lax/diuretics; Alcohol / drug withdrawals
- Panic attacks: reduce RR, reassure, SSRI> BNZs
- Physical / sexual assault: "hidden" injuries, support
- Conversion / dissociation (NEAs): safety first

That's right, can't cover it all



- ILS, Breakaway training essential
- Use peer meetings and supervision to debrief, to learn