EMERGENCIES IN PSYCHIATRY

What is a 'Psychiatric emergency'?

Russo-Japanese war (1904-05) - Brief crisis-intervention

Gerson & Bassuk, 1980 - APA taskforce on Psychiatric emergency services (PES)

"TRIAGE" Model - Evaluation, Containment & Referral

Justified use of Emergency intervention:
- Direct threat/assault
- Refusal to cooperate
- Intense staring
- Motor restlessness
- Purposeless movement
- Affective lability
- Loud speech
- Irritability
- Intimidating behavior
- Aggression to property
- Demeaning/hostile verbal behavior

The First Priority, ALWAYS - SAFETY

- The Room
- Other personnel
- Exit

DO NO HARM

Goal of intervention - Short-term: Safety
- Long-term: Collaboration with patient

Suspect medical etiology

EXAMINATION:
- Clouded consciousness
- Disorientation
- Abnormal vital signs
- Visual/olfactory hallucinations
- Cognitive deficits

HISTORY:
- Age: >40, < 12
- Acute onset
- Fluctuating course
- H/o medical or neurological illness
- No previous psychiatric history
- Medication
- Substance

Visual examination of patient - "Eyeballing" Can the patient be interviewed? History from family / accompanying persons about immediate concern

Immediate intervention
- Verbal
  - Offering assistance / voluntary medication
  - Medication / restraint / seclusion

RULE OUT MEDICAL ETIOLOGY
- vital signs
- medical history / substance
- visual examination: detailed/focused GPE
- brief cognitive assessment

Investigations:
- What we do... LFT, RFT, S.electrolytes, RBS
- CBC
- ECC
- Toxicology and substance screen
- BAC
- Neuroimaging (... LP)
- Ammonia levels
### Medication selection:
- Available i/m or liquid form
- Speed of onset
- H/o response to medication
- Production of clinically useful sedation
- Limited liability for side-effects
- Patient preference

Benzodiazepines > Conventional antipsychotics > Atypicals

 molest (10 + 4) or (5 + 2)
- greater efficacy
- faster onset
- lesser side-effects

### Special considerations in medication selection:
- Pregnancy
- H/o EPS
- H/o substance use
- COPD
- Frail elderly
- Cardiac problems
- MR / developmental delay

### VIOLENT / AGITATED BEHAVIOR

<table>
<thead>
<tr>
<th>Cardiovacular</th>
<th>Hyper tension</th>
<th>MVP</th>
<th>Pulmonary embolism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>Hyper ventilation syndrome</td>
<td></td>
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<tr>
<td>Endocrine</td>
<td>Hyper thyroidism, Pheochromocytoma</td>
<td></td>
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<tr>
<td>Metabolic</td>
<td>Hypokalemia, Hyponatraemia</td>
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### SUBSTANCE WITHDRAWAL

<table>
<thead>
<tr>
<th>ALCOHOL</th>
<th>Tachycardia, Hypertension Tremors, sweating Nausea, Vomiting Agitation Seizures, Delirium</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENZODIAZEPINES</td>
<td>Vital signs raised Nausea, vomiting, loss of appetite Seizures, Delirium</td>
</tr>
<tr>
<td>OPIATES</td>
<td>Nausea, vomiting, diarrhoea Mydriasis Muscle cramps Lacrimation, rhinorrhoea 'flu-like' weakness</td>
</tr>
</tbody>
</table>

### SUBSTANCE INTOXICATION

<table>
<thead>
<tr>
<th>ALCOHOL</th>
<th>Mood, Decrease in mood Judgment, Impaired judgment, Coordination Agitation Transient hallucinations Autonomic instability Medical conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPiates</td>
<td>Drowsiness, Sleepy, Slurred speech Respiration, Arrhythmias Pupils, Blurred Needle marks</td>
</tr>
</tbody>
</table>

### CANNABIS
- Euphoria
- Anxiety
- Slowing of time
- Impaired judgment, coordination
- Increased appetite
- Concomitant ingestion
- Tachycardia

### DELIRIUM TREMENS
A toxic confusional state associated in alcohol withdrawal state

- Triad: clouding of consciousness and confusion
  - Multimodality hallucinations
  - Marked tremor
  - Delusions, agitation, insomnia, autonomic arousal
- Peak: 72-96 hours
- R/F: Severity and duration of dependence Severe withdrawal symptoms at presentation
- Pt h/o DT

### MANAGEMENT
- Rule out medical causes
- Setting
- Minimal use of medication; BZDs, Antipsychotics low dose
- Vitamin supplementation
- Hydration, nutrition
SUICIDAL PATIENT

Brought with recent attempt / intent

General principles of care hold good

Medical condition (ALWAYS SUSPECT)

Evaluation... leading to a Multi-axial diagnosis for suicidal patient

1) Suicidality
2) Psychiatric diagnosis
3) Previous attempts
4) Psychosocial situation

Risk for suicide

Treatment setting: No suicide contract

Current presentation of suicidality

- SUICIDALITY
- Psychiatric diagnosis
- Previous attempts
- Psychosocial situation

Risk for suicide

GOAL: DECREASE RISK

Current presentation of suicidality

- Suicidal or self-harming thoughts, plans, behaviors, and intent
- Specific methods considered for suicide, including their lethality and the patient’s expectations about lethality, as well as the likelihood of success
- Evidence of hopelessness, impulsiveness, anhedonia, panic attacks, or anxiety
- Reasons for living and plans for the future
- Alcohol or other substance use associated with the current presentation
- Thoughts, plans, or intentions of violence toward others

Psychiatric illnesses

- Current signs and symptoms of psychiatric disorders, with particular attention to mood disorders, primarily major depressive disorder or mixed episodes, schizophrenia, anxiety disorders, substance use disorders, and personality disorders (need for treatment, or extent of previous or current psychological symptoms)

Psychosocial situation

- Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect
- Employment status, living situation (including whether or not there are infants or children in the home), and presence or absence of external supports
- Family constellation and quality of family relationships
- Cultural or religious beliefs about death or suicide
- Individual strengths and vulnerabilities
- Cognitive abilities
- Perceptual abilities
- Past experiences vs. trauma
- Capacity for reality testing
- Ability to tolerate psychological pain and satisfy psychological needs

UNRESPONSIVE PATIENT

First things first – A B C ?, Immobilisation?, i.v. fluids?

Cause could be anything from head to toe!

Psychiatric

- Locked-in syndrome
- Isolated frontal lobe damage
- Akathisia
- Isolated global aphasia
- Catatonia
- Severe depression
- Malingering

Psychiatric

- Catatonia
- Severe depression
- Conversion reaction
- Malingering

Management

- General principles for ‘unresponsive’ patients
- Benzodiazepines
- ECT

Use of antipsychotics... controversial!

NEW CASE OF PSYCHIATRY

SYMPTOM

- RELAPSE
- Drug default
- Breakthrough
- Toxicity
- Side-effects

Lithium toxicity
Akathisia
Dystonias
Neuroleptic malignant syndrome
Serotonin syndrome
Drug overdose

Always, ask for reason for current presentation.
**NEUROLEPTIC MALIGNANT SYNDROME**

The constellation:
- Muscle rigidity & Elevated temperature
- Rapid or gradual onset
- Dilatation, mydriasis, elevated or labile BP
- Dysphagia or incontinence
- Tremor
- Varying consciousness
- Mutism
- Lab evidence: CPK, LFT, Leukocytosis

- Young Male
- Concurrent medical - Dehydration
- Psychomotor agitation
- Encephalitis / TBI
- Low serum iron
- Psychiatric diagnosis - Mood disorder
- Preexisting catatonia
- H/o NMS
- Medication - Acute parenteral antipsychotics
- High potency FGAs
- Concurrent Li
- High dose
- Increase dose; intermittent noncompliance

Again, there is always a differential to be ruled out!

- Primary CNS disorders
- Systemic disorders
- Psychiatric medication related

To ask for -
- Fever, headache, vomiting
- Seizures
- Trauma
- Heat exposure
- Endocrine changes
- Exactly what medication
- Drug abuse

**LITHIUM TOXICITY**

- Gastrointestinal: Anorexia
- Nausea
- Diarrhea
- Neurological: Dysarthria
- Ataxia
- Coarse tremor
- Ominous: Altered consciousness
- Myoclonus
- Excessive intake
- Reduced excretion
- Renal insufficiency
- Dialysis
- Drug interactions
- Usual level above 1.0-1.5 meq/L taken as "toxic"
- Correction involves -
- Discontinuation of lithium
- Correction of dehydration
- Electrolyte balance
- Above 2 meq/L - osmotic or forced alkaline diuresis
- Above 3 meq/L - Dialysis

**MANAGEMENT**

- Early identification of risk factors and features
- Stop antipsychotics
- IV support, vitals monitoring
- Parenteral BZDs are useful
- Persisting or worsening clinical picture requires referral to medical ICU
- Re-challenge with antipsychotics (5 days/completion of resolution)
- Start low, go slow with close monitoring

**ACUTE DYSTONIA**

Within minutes-days
- Increase antipsychotic; decrease THP
- Deviation of eyes
- Impaired breathing
- Protrusion of tongue, dysfunction
- Impaired swallowing
- Tics
- Torticollis
- Posturing of limbs and trunk
R/F - Young black man with F/h/o movement disorder started on high potency neuroleptics

**ACUTE AKATHISIA**

Within weeks
- Urgent
- Diphenhydramine 50mg IM stat
- Decreased prevalence with HPL + LZM
- Anticholinergic medication

R/F: Older age female with mood disorder / preponderance of negative symptoms/cognitive dysfunction and anemia rapidly started on high dose of high potency antipsychotics

**MANAGEMENT**

- BZDs / Propranolol
- Adjusting antipsychotic dosages
### ANTIDEPRESSANT DISCONTINUATION SYMPTOMS
- On stopping / skipping
- Mostly with: Amitryptiline, Imipramine, Paroxetine, Venlafaxine

**Symptoms:**
- Affective
- GI
- Neuromotor
- Vasomotor, Flu-like symptoms
- Neurosensory
- Other neurological

**R/F:** Children or adolescents, had anxiety after start of therapy, discontinued drug after >8 weeks, and then on other medication, have relapsed.

### Management
- Re-introduction and gradual taper
- Use of anticholinergic agents in TCA withdrawal
- Use of Fluoxetine in venlafaxine and clomipramine withdrawal

### Other important issues:
- Confidentiality
- Documentation
- Privileged communication
- Informed consent