

LECTURE NOTES

Psychiatry in the Emergency Room

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Psychiatric Emergencies

1. Psychological states:

- suicidal
- depression
- violence
- fugue states
- homosexual panic
- other panic reactions
- traumatic neurosis
- mania
- acute paranoid schizophrenia
- acute catatonic schizophrenia
- anorexia nervosa
- acute psychosomatic issues: eg. ICU and post-op patients

2. Organic factors:

- delirium
- alcoholism (esp. Wernicke-Korsakoff Syndrome; alcohol withdrawal states)
- drug abuse-intoxication, psychotic states, withdrawal, overdose
- psychotropic meds. abuse: anticholinergic delirium

3. Iatrogenic:

- acute intermittent porphyria--psychosis, severe abdominal pain, seizures
- dyskinesia secondary to neuroleptics
- hypertensive crises-MAOI's: severe occipital headache, palpitation, etc.
Rx.: phentolamine
- postseizure excitement (after ECT)
- heatstroke in patient on Phenothiazines
- agranulocytosis secondary to medications

Child Psychiatry Emergencies

- accidental poisoning (many are repeaters)
- hyperkinesia
- school phobia
- adolescence: adolescence crises of running away, psychosis, sexual acting out
- child battering
- anorexia nervosa
- fire setting
- sexual assault
- bereavement
- fatal illness

Psychiatric Problems you can handle yourself

- transient/situational anxiety, eg. work problems
- patients with chronic problems who run out of meds (often missed an appointment)
- people with longstanding problems which can be dealt with via the OPD

Sectorization

- hospitals responsible for geographic area for psychiatric treatment
- for JGH: Cote St. Luc, Hampstead, some of Snowdon, English-speaking population of St. Laurent, Laval
- patients belong to hospital where they have had psychiatric treatment (exc. ER) within past 6 months
- if no psychiatric treatment in 6 months, then sector based on patient's address

Intern's role in the ER

- chief complaint
- HPI
- brief functional enquiry
- mental status
- physical exam
- determine need for psychiatric consult
- fill out consult form
- speak to the consultant personally
- use the consultant as a learning resource

Physical Exam

- must be performed before asking for a psychiatric consult, except:
 - patient has had a physical in past 6 weeks, results are in chart and there is no change in patient's medical condition, eg. an OD
 - patient transferred from another hospital, if the accompanying documents include record of physical
 - too violent or agitated, exam may be deferred only until patient is sedated

Note: No transfers to other hospitals or PHA without physical

Filling in the Consult Form

- date
- identification of patient--include current and past psychiatric treatment, including meds.
- patient's complaint and/or your major findings
- your diagnostic impression
- rationale for a consult, ie the question you would like the consultant to answer

Evaluation of Suicidal Risk

- patients should be directly asked "do you feel so bad that you would like to end it all" or "kill yourself" or other words
- no evidence that this plants the thought
- instead, patient is usually relieved by invitation to talk re self-destructive feelings
- if answer is yes, go on to ask more specifically re a plan, its nature, timing, availability of means, previous suicidal preoccupations or attempts
- must not leave a high risk patient alone

Risk factors for Suicide

- more than 45 years
- male
- divorced, widowed, or separated
- living alone
- choice of highly lethal method (eg. hanging, firearms, jumping, drowning)
- unemployed or retired

Violent Patients brought by Police

- police should be asked to stay until patient has been calmed or restrained

- the police, not psychiatry or the orderlies or the security guards, should deal with:
 - patients who claim to have weapons
 - patients who claim to be Karate experts
 - violent criminals
 - if more than one violent patient arrives at the same time

-if police not there already, they should be called for such situations

Evaluating the Risk of Violence

- pay particular attention to:
 - threats of violence
 - a history of violence
 - paranoia and fear
 - cultural background where violence is frequent
 - your own reaction: if patient induces fear in you, don't ignore it, deny it, misinterpret it, or try to overcome it--consider it a very important warning signal

Code V

- Roman numeral V stands for "Violence"
- when a Code V is called (paged throughout hospital) a team of orderlies, specially trained as a team in safely restraining violent patients, come running
- the psychiatrist on call is the captain of the team--doesn't physically participate but directs the proceedings
- a code V can be called by you if necessary

"Discretion is the Better Part of Valour"

- potentially violent patients are often also themselves frightened--if they feel cornered or trapped, this may trigger violence
- therefore always make sure you leave an escape route--don't get between the patient and the way out
- if there is a risk of violence, let the patient run away if he bolts--don't try to stop him--call the police

Patients who have left the building

- our responsibility as doctors is limited to the building
- whether on the hospital grounds or on the street, our relationship to violent patients or patients creating a disturbance is that of an ordinary citizen, therefore we can call the security guards or the police
- remember that the patients' family or friends can request a court order to have the patient brought to hospital by police--Urgences Santé is best way

Cure Fermée

- any patient who is or may be dangerous to the health or safety of himself or others, may be "committed", ie put under close treatment or "cure fermée"
- normally done by a psychiatrist, but any physician can do it if no psychiatrist available
- the PSY-104 form is good for 96 hours
- examination by a second psychiatrist extends it for 21 days
- "cure fermée" does not authorize treatment, only containment
- the police need to see the signed form in order to bring a patient back to the hospital
- if you have any doubts about a patient who demands to leave, you have the legal responsibility and authority to keep the patient until assessed by psychiatry

Court Order

- the most frequent court orders are those for a psychiatric examination--read the document carefully to make sure the JGH is specifically mentioned. If not, attempt to have the police bring the patient to his sector hospital
- occasionally, you may get a municipal court order to hold a patient for 30 days (usually awaiting trial). These patients, if the JGH is the designated hospital, need to be admitted

Referrals to Psychiatry OPD

- for patients whose problem can stand a wait of 3 to 4 weeks, you yourself can refer the patient to the OPD--ask them to call the Institute of Community and Family Psychiatry, tel. 340-8210 and ask for the "Screening Clinic"--they will be given an appointment
- remember to let them know that they can return to the ER if things get worse

Crisis Service

- the OPD includes a crisis service which can see patients usually within 2-3 days, but always within a week
- if the patient's problem is of crisis proportion, where the crisis service is necessary, it would usually be the psychiatrist who makes the referral

Drug Abuse

- JGH psychiatry department does not have a detoxification program; we do have a list of resources which we can pass on to you, to suggest to the patient who requests detoxification
- acute intoxication: treated by medicine; normally, psychiatry will only assess the patient when no longer intoxicated, eg. free of ataxia or slurred speech

Rape Cases

- refer directly to MCH or MGH, depending on age

Rapid Tranquilization

- rapidly assess age and general physical and medical status
- tentative differential diagnosis
- vital signs q $\frac{1}{2}$ hour and prior to giving meds (incl. temperature)
- haloperidol is drug of choice: available in PO and in PO liquid, and in parenteral forms
- most side effects are relatively benign, eg. EPS
- hypotension only occasionally
- dosage: usually 5-10 mgs. q $\frac{1}{2}$ hr - q 1 hr., max. 80 mgs./day
- lower dose for delirium or OBS
- control means no longer belligerent
- sedation (ie. sleepiness) is not the goal
- Alcohol: BDZ are drugs of choice for withdrawal; thiamine IV stat for Wernicke's.
- Pregnancy: Avoid benzodiazepines, Haloperidol probably safer. ECT may be treatment of choice.

Serious Neuroleptic Side Effects

- neuroleptic malignant syndrome (severe EPS, hyperthermia, altered consciousness, autonomic dysfunctions) (increased HR, diaphoresis, fluctuating BP)--up to 20% mortality
- neuroleptic-induced catatonia with high-potency neuroleptics; may lead to death from dehydration
- laryngeal/pharyngeal dystonia--usually young males. Treatment parenteral antiparkinsonians or intubate

Antiparkinson Agents

- for acute dystonic RXNs:
- cogentin 1 or 2 mgs. IM or IV
- diphenhydramine (benadryl) 50 mgs. IM or IV
- diazepam 10 mgs. IV slowly

Tardive Dyskinesia

- abnormal involuntary, choreoathetotic movements involving tongue, lips, jaw, face, extremities, occasionally the trunk; common: lipsmacking, chewing, puckering lips, protrusion of tongue, puffing of cheeks
- often appears on withdrawal of antipsychotic meds, or decrease in dosage
- may also see a time-limited "withdrawal dyskinesia"

- there are a number of uses of phenothiazine drugs, eg. antiemesis, Gilles de la Tourette, which may not be seen as psychiatric problems, therefore, diagnosis of T.D. may be missed
- an interesting presentation may be T.D. involving the respiratory muscles, may see respiratory compromise especially if medication has been suddenly stopped. Parenteral haloperidol is diagnostic as well as rapidly therapeutic

Consultation Psychiatry

- consider carefully whether the problem may be neurological, a social service problem, or something truly psychiatric
- Psychiatry cannot do much for OBS patients except to sedate them adequately--we do not transfer them to 4-East
- we do not treat alcoholics in JGH psychiatry: they should be referred directly to MGH without involving us
- for patients who refuse treatment--clarify patient's complaint before concluding it's a psychiatric problem; it may be a misunderstanding or one of many things

Sedation

- consider possibility of inducing a toxic delirium in elderly patients with long half-life BDZ's
- low dose eg. 1-2 mgs. 2-3x/day of high potency neuroleptics eg. haloperidol are often effective in treating agitation and troublesome behaviour in dementia patients
- remember, more brain damage means greater sensitivity to psychotropic drugs
- consider possibility of pseudodementia (depression causing cognitive impairment)
- extrapyramidal side effects can be treated with antiparkinson meds. but be careful re anticholinergic delirium

Sedation of the Older Person

- consider that $\frac{1}{2}$ -life for BDZ's may be 3-4x longer than for young adults
- also, elderly are more sensitive to psychiatric tropic meds
- BDZ with long $\frac{1}{2}$ -lives, eg. diazepam, flurazepam have active metabolites with 100 hours $\frac{1}{2}$ lives--4 days in young, 2 weeks in elderly
- takes several $\frac{1}{2}$ -lives for steady state, therefore, won't see final effect for weeks, example: okay initially, but confused weeks later--seemingly no cause--effect; no change when stop meds for weeks