Psychiatric Emergency

Handbook for Medical Students

Department of Psychological Medicine
Faculty of Medicine
University Malaya

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This Handbook was prepared for the teaching of the undergraduate student (M.B.B.S.) of University of Malaya. It is intended to provide understanding of the basic psychiatric emergency knowledge which is relevant and useful for the students in the future practices in the local setting.

It is meant to educate, not replace consultation with senior colleagues / consultant who remain the best source of information and advice. Further, it is not a substitute for sound clinical judgement.

It was prepared by a group of experienced consultant psychiatrists from the Department of Psychological Medicine of University Malaya.

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1 To understand the principles of managing psychiatric emergency conditions.

2 To be familiar with the procedures involved while managing psychiatric emergency conditions.

3 To know the common medications used in psychiatric emergency conditions.

4 To understand some of the specific psychiatric emergency conditions.

INTRODUCTION

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To prepare the students for their future practice in clinical setting, they require certain level of knowledge about the types of psychiatric emergency conditions that commonly encountered in the local setting.

It is important to be aware that patients may present to us in various conditions that could be harmful to themself or others. These conditions could be related to underlying medical condition, mental health illnesses, substances used, environment or combination of all. The basic understanding of the presentation, intervention and prevention of psychiatric emergency is crucial in providing proper care for the patients and people surrounding.

This handbook is written as part of the educating module of Psychiatric Posting for the first year undergraduate medical student in University Malaya. Further reference and reading of other text books is deemed necessary to complete the knowledge in handling psychiatric emergency situations. It does not mean to replace consultation with senior colleagues or sound clinical judgment.

PSYCHIATRIC EMERGENCY CONDITIONS

PSYCHIATRIC EMERGENCY CONDITION

Psychiatric emergency condition is not purely defined as any condition that may cause harm to self or others. It is better defined as conditions that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behaviour) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters)[1].

Patients with psychiatric emergency condition could present with suicidal ideations, violent behaviour, abnormal or bizarre acts such as mute and lack or responsive to surrounding. Acutely, we need to secure the safety of the patient and the environment. Additional support and help are always necessary. In addition to routine examination and investigation, further information from family and friends are important to make a proper clinical decision and treatment plan for the patient.

Principles in Handling Psychiatric Emergency[1]

1. ***Avoid Harm***
   It is crucial to secure the environment to minimize the risk of harm to the patient, staffs and anyone surroundings.

2. ***Ask for Help and Support***
   Always ask for more support and help from peers. Person with psychiatric training or experience will be the priority. Shared responsibility among every party during the event is necessary.

3. ***Person-Centred Intervention***
   It is important to understand every single case from every possible aspect. Do not take psychiatric emergency as a routine procedure and neglect the individualized treatment need of patient.

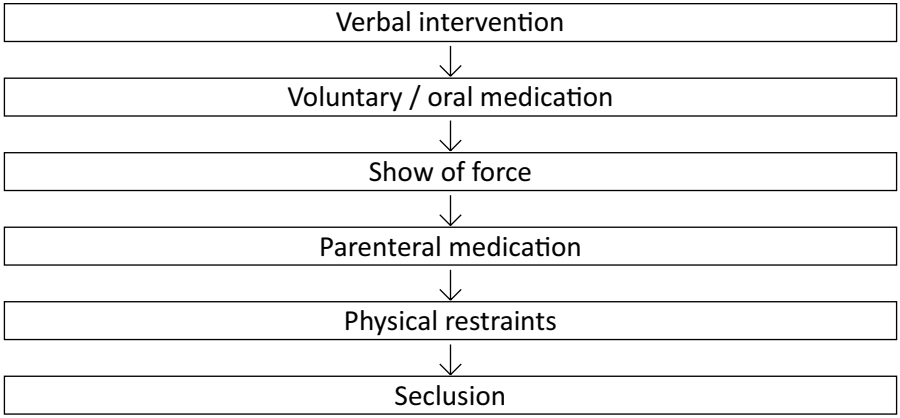
4. ***Ensure Feeling of Safety***
   Distress and fearful feeling are common experience for the patients in psychiatric emergency condition. It is helpful to assist the patient to achieve the subjective sense of security and safety.

5. ***Recovery and Prevention***
   An appropriate psychiatric emergency intervention should contribute to the journey of recovery and relapses prevention.

STAGING / LEVEL OF INTERVENTION

STAGING / LEVEL OF INTERVENTION[2]

The type of intervention method is selected depending on the cooperativeness of the patient and the severity of the mental condition.



MANAGEMENT ALGORITHM FOR AGGRESSIVE / AGITATED PATIENT

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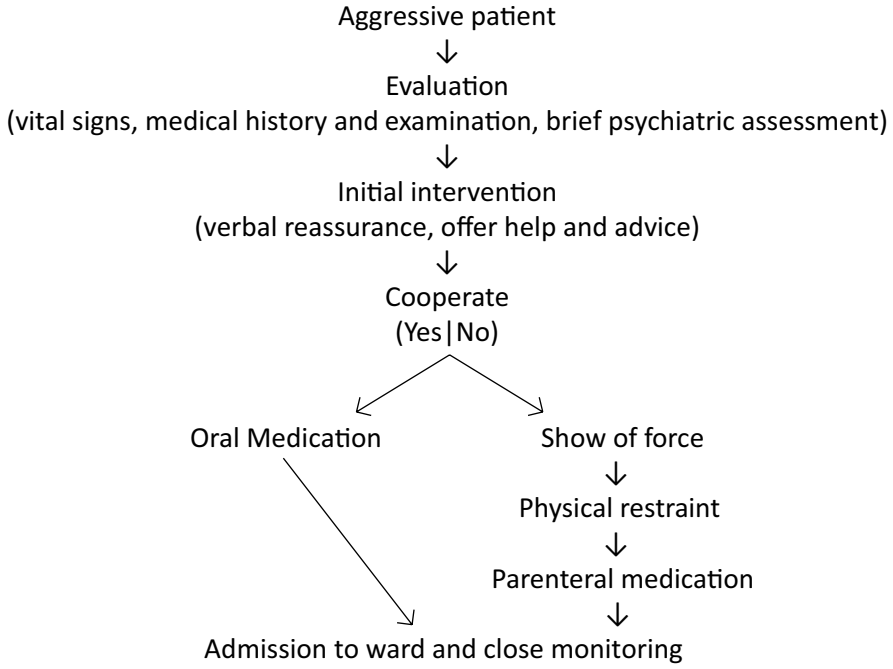

Evaluation of underlying medical condition, substance use and head injury while determining the psychiatric aetiology

MEDICATION FOR PSYCHIATRIC EMERGENCY

MEDICATION FOR PSYCHIATRIC EMERGENCY [3-8]

Oral Formulation		Potential side effects
1	Benzodiazepines (alprazolam, lorazepam, clonazepam, diazepam)	Excessive sedation, ataxia, dysarthria, dysphoria, euphoria, hypotension, abuse potential, respiratory depression
2	Conventional antipsychotic (haloperidol, chlorpromazine)	Movement disorders (including acute dystonia), profound sedation, dysphoria, postural hypotension
3	Atypical antipsychotic (oral solution risperidone, oral disintegrating formulation of olanzapine, quetiapine)	Weight gain, prolactin elevation, hyperlipidemia, metabolic syndrome, sedation
4	Anticholinergic	Cognitive disturbance
Parenteral Formulation		**Potential side effects**
1	Benzodiazepines (diazepam)	Excessive sedation, respiratory depression, hypotension
2	Conventional antipsychotic (haloperidol, clopixol accuphase)	Movement disorders (including acute dystonia), profound sedation, dysphoria, postural hypotension
3	Atypical antipsychotic (ziprasidone)	QT prolongation

SPECIFIC PSYCHIATRIC EMERGENCY CONDITION

SPECIFIC PSYCHIATRIC EMERGENCY CONDITION

1. Extrapyramidal Symptoms (EPS)[9]

Extrapyramidal symptoms include akathisia, dystonia, parkinsonism, and dyskinesia. These are antipsychotic-induced side effects and more commonly found for persons who receive conventional antipsychotic medications. The clinical manifestations include involuntary muscle contractions / stiffness, tremor, feeling of inner restlessness / akathisia and slowness in movement / bradykinesia. The symptoms can develop acutely, be delayed, or overlap making diagnosing a challenge.

Preventive interventions include selective prescribing of antipsychotic, gradual titration of the dosage and close monitoring of the emergence side effects.

Most EPS will subside with discontinuation or lowering the dose of the antipsychotic. Replacing the conventional with atypical antipsychotic will reduce the risk of EPS. Symptoms of akathisia typically respond to discontinuation of the antipsychotic coupled with benzodiazepines such as lorazepam, clonazepam or diazepam. Beta blockers such as propranolol is effective in reducing tremor. Dystonic reactions, which can develop acutely, require immediate interventions to minimize symptoms. Anticholinergic such as benzhexol or muscle relaxants are the first line of treatment during acute dystonic reactions.[10-12]

2. Neuroleptic Malignant Syndrome (NMS)[13]

The neuroleptic malignant syndrome (NMS) is a rare, but life-threatening, idiosyncratic reaction to a neuroleptic medication. The syndrome is characterized by fever, muscular rigidity, altered mental status, autonomic dysfunction (blood pressure fluctuation) and raised creatinine kinase.

Although conventional antipsychotics are more frequently associated with NMS, atypical antipsychotic may also precipitate the syndrome. Other agents have been associated with NMS are prochlorperazine and promethazine.

NMS is not only a psychiatric emergency but a medical emergency. Successful treatment requires prompt recognition, withdrawal of antipsychotic agent, exclusion of other medical conditions, aggressive supportive care, and administration of medical resuscitation procedures such as securing the airway, breathing and circulation.

3. Delirium Tremens[14]

Delirium tremens (DTs) is the most severe form of alcohol withdrawal manifested by altered mental status autonomic hyperactivity, which can progress to cardiovascular collapse. DTs is a medical emergency with a high mortality rate, making early recognition and treatment essential.

DTs is the most severe manifestation of alcohol withdrawal. It occurs 3-10 days following the last drink. Clinical manifestations include agitation, global confusion, disorientation, hallucinations, fever, hypertension, diaphoresis, and autonomic hyperactivity (tachycardia and hypertension).

Similar to other medical emergency, DTs requires immediate hospitalization for stabilization such as intravenous fluids for securing the circulation, anticonvulsants to prevent or stop seizures, benzodiazepines to control the agitation, antipsychotic for hallucinations and medication to reduce hyperthermia.

SUICIDE

SUICIDE

Suicide is defined as a deliberately performed act with expectation of fatal outcomes. Assessment of suicidal risk is a 'must' in psychiatric evalution. It is related to most of the common psychiatric illnesses and other condition such as relationship crisis, argument, poor impulse control and maladative coping skills.[15]

Risks of suicide include:

1. Intent of the previous suicide attempt (precaution during the act, planning, dangerous method, suicide note, making a will etc.)
2. Previous suicide attempts
3. Presence of depressive symptoms
4. Alcohol or other substances use
5. Personality disorder
6. Male
7. Old age
8. Unemployment
9. Social isolation
10. Underlying mental condition (depression, schizophrenia)
11. Underlying medical condition

It is important to exclude psychotic symptoms during assessment of suicide.

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