Psychiatric emergencies: Detection and treatment
Heidi Combs MD
Assistant Professor
Harborview Medical Center

Let's start with a case
- Male brought in as a John Doe found wandering in Pioneer Square appearing disoriented. Was belligerent with SPD. Appears to be in mid 40s, mildly disheveled.
- That's all the information you have...so what could be going on with him and what you want to do next?

Start with the usual gropogram
- Utox
- Chem 10
- CBC
- VS
- PE

At the end of this session you will be able to:
- Identify common psychiatric emergencies
- Manage agitated patients through behavioral and pharmacologic methods
- Complete a safety assessment
- Complete a violence assessment

Cast a broad differential dx net

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So this is what we get
- Utox + ETOH, BAL 185
- Na: 140 K+: 3.1 Mg: 2.0 Creat: 1.0 BUN: 14 ALT 218 AST 210 ALK phos 78
- WBC: 10.8, MCV: 99, Hct: 36
- BP: 120/84 HR: 94 temp: 37.2

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- PE: remarkable for mild tremor
- So what are you thinking?
- How to you want to manage this patient?
Dx: Tx
- Acute alcohol intoxication
- Given Lfts, CBC results appear to be a chronic ETOHic concern for WD.
- Either- get out of ED before starts going through WD or consider initiation of CIWA

Things that come to mind
- Acute ETOH WD
- If acute ETOH WD- initiate CIWA
- Delirium due to infectious process- PNA? Find out source and tx accordingly

What if in our case things went like this?
- Male brought in as a John Doe found wandering in Pioneer Square appearing disoriented. Was belligerent with SPD. Appears to be in mid 40s, mildly disheveled.

Several hours pass, pt indicated he wants to get clean and was beginning to sober up then...
- You notice he actually seems less with it than an hour ago and in fact appears to not know where he is.
- VS now BP: 142/90, HR:118, temp:38.9, RR:8
- What do you think is going on?
- What do you want to do?

Through your excellent care the patient is stabilized but what if...

Gropogram results are as follows:
- Utox + cocaine
- Na: 140  K+: 3.9  Mg: 2.2  Creat:1.0
- BUN: 14  ALT 33  AST 49  ALK phos 43
- WBC:10.8, Hct:44
- BP:130/94  HR:108  temp:37.1
- PE highlights: Psychomotor agitated appearing paranoid
- So what are you thinking?
- How to you want to manage this patient?
Acute cocaine intoxication

- Check EKG to make sure not having an MI!
- Tx with nothing, benzos, or antipsychotics depending on level of agitation and paranoia

Could also be an exacerbation of a primary psychotic illness such as schizophrenia

- Tx with antipsychotics or benzos depending on level of agitation and paranoia

So our patient story evolves

- When the RN attempts to get the ECG the patient jumps up and starts screaming "Get away from me! You are trying to stop my heart! Get away from me!!"
- When you enter the room he is standing next to his gurney looking at the door like he is getting ready to bolt

- So what are you thinking?
- How to you want to manage this patient?

Behavioral Predictors of violence

- Angry words
- Loud language
- Abuse language
- Physical agitation such as making fists, pacing and akathisia

Assessing the risk of violence

- Immediate past, recent past and more distant history of violence is the best predictor of future violence.
- Circumstances of violence and characteristics of people involved are important.
- Substance dependence or abuse carries a 30X increase risk than the general population!!

Assessing the risk of violence

- Antisocial personality disorder with co morbid substance abuse or dependence carries greater than 100X the risk compared to the general population.
- Mental illness carries a 9X greater risk than the general population particularly paranoid schizophrenia and confused states related to medical problems.
How to de-escalate a patient

- Use a calm voice
- Sit down with the patient
- Maintain adequate physical distance of at least 6 feet
- Attempt to establish rapport
- Listen to the patients concerns

Pharmacologic Support: Benzodiazepines

- Lorazepam is one of the most useful meds in the emergency setting. In the first 24 hours agitation is as effectively addressed with lorazepam as antipsychotics even if psychosis is present.
- Usual dose 1-2mg IM, IV or po q 1-2 hours

- There is always a risk of an allergic reaction although this is rare for benzodiazapines
- Patients can have a paradoxical reaction and actually become more agitated. This is seen in about 5% of the population.

When verbal de-escalation is not enough:

- When there is risk of imminent harm and verbal de-escalation has been ineffective either pharmacologic supports or physical restraints may be needed.

Pharmacologic support: Antipsychotics

- Antipsychotics can be quite effective in reducing agitation.
- There are options in the following forms:
  - PO, IM, Quick dissolving tabs
IM Antipsychotics
- Ziprasidone (Geodon) 20mg IM q 4 hours or 10mg q 2 hours not to exceed (NTE) 40mg/24 hours
- Olanzapine (Zyprexa) 5-10mg IM NTE 20mg/24 hours (caution with the elderly)
- Haloperidol (Haldol) 1-5mg IM q 1 hour NTE 20-30mg/24 hours
- Droperidol (Inapsine) 2.5-5mg IM/IV- note black box regarding arrhythmias

PO antipsychotics
- Risperidone (Risperdal) 1-2 mg po NTE 6mg/24 hours. Also comes in a rapid melting tab called Risperdal M-tab.
- Olanzapine 10-20mg po NTE 20mg/24 hours. Also comes in a rapid melting tab called Zydis.
- Haloperidol 1-5mg po q 1-2 hours NTE 30mg/24 hours

Extrapyramidal symptoms
- Haldol is the most likely to cause extrapyramidal symptoms (eps) followed by risperidone with the other atypicals having less eps risk.
- EPS is most likely to occur in young males and older women.
- EPS is usually noted as muscle tightness in limbs, tongue thickness and neck tightness. More rarely laryngeal and pharyngeal spasm and a sense of choking.

EPS treatment
- Be ready to give O2 if breathing problems develop.
- PO, IM or IV diphenhydramine (Benadryl) 50mg q 4-5 hrs. IV form acts very quickly so great to use if pt has IV access already. If not may need to use IM. IM takes about 30 minutes to improve sx and po takes around 60 minutes.
- Benztropine (Cogentin) 1-2mg PO or IM q 8-12 hours.

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What if in our case things went like this?
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Our patient story evolves

- On interview pt stated he took “a bunch of meds because I’m tired...just worn out.”
- So what are you thinking?
- How to you want to manage this patient?

- He tells you he took “handfuls of my prozac”
- Is there anything you are worried about?

First things first

- Make sure he is safe in the current setting i.e. is he still actively suicidal or can he be safe while you are evaluating him. ALWAYS ERR ON THE SIDE OF SAFETY!
- Find out what this guy took and determine if he is going to need a lavage vs supportive tx, ECG, labs etc

Serotonin syndrome

- Rapid onset of symptoms
- 60% present within 6 hours after initial use of medication, an overdose, or a change in dosing
- 14 to 16 % overdoses on SSRI
- 26,733 incidences of exposure to SSRIs caused significant toxic effects in 7349 persons and resulted in 93 deaths (Toxic Exposure Surveillance System, 2002)

Drug interactions associated with severe serotonin syndrome

- Phenelzine and meperidine
- Tranylcypromine and imipramine
- Phenelzine and SSRI
- Paroxetine and buspirone
- Linezolide and citalopram
- Tramadol, venlafaxine, and mirtazapine

Diagnosis SS: Classic triad

- Mental status changes: confusion, restlessness, agitation, anxiety, decreased level of consciousness
- Neuromuscular abnormalities: tremor, rigidity, clonus, myoclonus, hyperreflexia, ataxia
- Autonomic hyperactivity: diaphoresis, hyperthermia, shivering, mydriasis, nausea, diarrhea
- Vital signs: tachycardia, labile BP changes
Spectrum of Clinical Findings.

Treatment SS
- Discontinuation of all serotonergic agents
- Supportive care, many do not require tx
- Consult with a medical toxicologist, clinical pharmacologist, or poison control center
- Cyproheptadine (serotonin antagonist)
- Intubation and ventilation: severe SS with hyperthermia (a temp. > 41.1°C)

Once you get a sense that medically he is stable a full suicide assessment is needed

Suicide assessment
- Ideation: acute vs. chronic, passive vs. active - if active is there a plan? lethality of method, intent.
- Demographic/Environmental: Risk factors include Caucasian or Native American, male, >65, unmarried, living alone, unemployed, family history of suicide of first degree relative, recent interpersonal loss, lethal means available (particularly firearms)

Suicide assessment cont.
- Clinical factors: Personal history of suicide attempt, substance use, chronic medical illness, agitation, psychiatric illnesses/Sx including severe anxiety, schizophrenia, depression, bipolar disorder, Borderline or antisocial personality disorder. H/o TBI, current hopelessness, anhedonia or apathy, current sleep disturbance, social isolation, recent psychiatric hospitalization

Suicide assessment cont.
- Protective factors: actively making plans for the future, verbalize hope for the future, cognitive flexibility, responsibility to dependents, therapeutic relationship with treatment provider, social network or family, belief that suicide is immoral or will be punished. Fear of social disapproval of suicide, fear of the act of suicide
• If not admitting the patient have a structured plan including who they will stay with and a contingency plan if SI returns including names, phone numbers and places to go. Plan for management of sx such as anxiety, drug cravings. Ask the money questions- Why do you feel you can be safe now? What is different now compared to when you walked into the emergency room?

• If admitting the patient- Evaluate for need for a sitter, admission to a psychiatric unit if available- remember patients can commit suicide while in the hospital!

Once again through your excellent care the patient is stabilized. It is time for your shift to end! Go home knowing you have done an outstanding job!

Key points of our multi-faced case
• Always keep a broad differential in mind
• Watch for evolution of sx and clinical findings
• You can manage agitation both behaviorally and pharmacologically
• Always assess safety- the patients and your own
• Always err on the side of safety