



**International Journal Of Medical Science And Clinical Inventions**

Volume 2 issue 06 2015 page no. 1010-1019 ISSN: 2348-991X

Available Online At: <http://valleyinternational.net/index.php/our-jou/ijmsci>

**Clinical Evaluation Of Psychiatric Emergencies**

*Dr. Samyak Jain<sup>1</sup>, Dr. S.P.Goel<sup>2</sup>, Dr. V.K.Goel<sup>3</sup>, Dr. Sidhant Kapila<sup>4</sup>*

<sup>1</sup>M D (Psychiatry) DPM (Psychological Medicine), Chief Consultant Neuro Psychiatrist , Meerut Neuro-Psychiatry and Headache Centre, Meerut.

<sup>2</sup>M. D. (Med.) FIAMS FFIACM FICP ,Professor Post Graduate Department of Medicine,Subharti Medical Institute,Meerut (U.P.)

<sup>3</sup>M.D. (Pediatrics) ,Professor Post Graduate Department of Pediatrics Subharti Medical Institute,Meerut

<sup>4</sup>M.D (Pediatrics),Child specialist & Neonatologist, Kapila's child care hospital Naushera Road Mukerian ,Dist- Hoshiarpur, Punjab 144211

**ABSTRACT:** A psychiatric emergency is acute behavioral disturbance requiring urgent intervention, manifesting with mood, thought disorder or behavioral signs and symptoms. Psychiatric emergencies can have a variety of presentations and occur in a variety of settings:. A psychiatric emergency can be conceptualized under following broad categories: Acute onset of illness in a person with no past background of a psychiatric illness Acute exacerbation of a chronic psychiatric illness or an acute relapse in a psychiatric illness of recurring nature Psychiatric symptoms resulting from an underlying medical illness or use of a psychoactive substance or prescription drug. Behavioral symptoms occurring related to use of psychoactive substances Common Psychiatric Emergencies

**Suicide :**

Suicide can be defined as intentional self inflicted death. There are three terms frequently used while discussing suicide: suicidal ideation or intent, suicidal attempt or attempted suicide, and completed suicide. Suicide, as such, means completed suicide.

**Delirium:**

Transient disorder of brain function manifested by global cognitive impairment, alteration of consciousness and behavioral disturbances.

**Alcohol Related Emergencies:**

It is maladaptive behavior after the recent consumption of alcohol. Blood serum alcohol levels range from 10-20 mg/dl in patients who have pathological intoxication to 400- 500 mg/dl or more in patients who are obtunded or near death.

Others include:- Delirium Tremens, Psychiatric Emergencies in Disaster Survivors, Rape and Sexual Abuse etc.

**References :**

1. Hales RE and Yudofsky SG (Eds) (2004) Textbook of Clinical Psychiatry. American Psychiatric Publishing Inc. Washington.

2. Levenson JL (Ed) (2005) Textbook of Psychosomatic Medicine. American Psychiatric Publishing Inc. Washington.

A psychiatric emergency is acute behavioural disturbance requiring urgent intervention, manifesting with mood, thought disorder or behavioral signs and symptoms. Psychiatric emergencies can have a variety of presentations and occur in a variety of settings. The emergency may present as threatened or acute violence towards others, behaviors like self harming, destructive, hallucinating, disinhibition, disorientation or confused emotional upset, psychological distress, verbal abuse, acute excitement. Nearly 10% of psychiatric admissions are primarily caused by a medical problem and 50% of people admitted to psychiatric services have a medical problem that needs to be addressed.

A psychiatric emergency can be conceptualized under following broad categories:

- Acute onset of illness in a person with no past background of a psychiatric illness
- Acute exacerbation of a chronic psychiatric illness or an acute relapse in a psychiatric illness of recurring nature
- Psychiatric symptoms resulting from an underlying medical illness or use of a psychoactive substance or prescription drug
- Behavioral symptoms occurring related to use of psychoactive substances

### **Evaluation of a psychiatric emergency**

1. Risk Assessment: to harm self and others, as patients presenting with a psychiatric emergency are often emotionally and behaviorally disturbed and are likely to endanger themselves or others.
2. Setting priorities according to how ill a patient is and how quickly the problem must be assessed in order to maximize chances of recovery.

### **Assessment of a psychiatric emergency**

Assessment of risk to self and others:.

Immediate risk to harm self can be determined by presence of the following:

- History of recent attempt at self harm.
  - Verbalization of suicidal ideation or attempt.
  - Hearing voices giving instruction to harm self
  - State of altered or clouding of consciousness
  - Abuse of alcohol or other psychoactive substance
- Immediate risk to others can be determined by assessing the following:
- Violence towards others or property in the recent past
  - The individual appears angry e.g., exhibits loud voice, clenching fists, angry verbal content or facial expression of anger

- History of being involved in physical conflict as evident by facial scars, stitches, ecchymoses on physical examination.
- Past history of violence
- Impairment from alcohol or other substance of abuse
- Confusion

### 1. Physical examination

- Sudden (hours to days) appearance of psychiatric symptoms in a previously well functioning person.
- History of altered consciousness along with psychiatric symptoms.
- History of recently diagnosed medical illness and psychiatric manifestations appearing along with the physical symptoms
- Psychiatric symptoms appearing after starting a new medication or change in dosage in the existing medication
- Personality change or marked lability of mood.
- Absence of past or family history of psychiatric disorder.
- Vital monitoring is mandatory.

**Psychiatric assessment.** The following features are a pointer towards presence of physical illness:

- Clouding of consciousness
- Disorientation
- Impairment in attention and concentration

- Memory impairment
- Visual hallucinations and illusions
- Language abnormalities
- Reversed sleep wake cycle

Some key steps with psychiatric symptoms in an emergency situation include:

- Physician should always introduce self and address the patient with respect
- Interview should begin with nonspecific, less intrusive questions. Specific details about illness should be enquired once patient shows some comfort.
- Questions should be open ended. Avoid asking questions with yes or no.
- Physician should be flexible in approach to patient.
- If the patient is acutely disturbed, interview should be structured with straight forward questions.
- It is important not to correct the perceptual disturbances and odd beliefs in a patient in emergency assessment and argue with the patient there.
- Do not use logic to convince the patient that he or she is wrong.

### Common Psychiatric Emergencies

#### Suicide

Suicide can be defined as intentional self inflicted death. There are three terms frequently used while discussing suicide: suicidal ideation or

intent, suicidal attempt or attempted suicide, and completed suicide. Suicide, as such, means completed suicide. The term "suicidal intent" or "suicidal ideation" is self explanatory and refers to recurrent ideation about causing death to self. The prevalence of suicidal ideation, attempted suicide and completed suicide in general population is in ratio of 100:10:1 (WHO, 2001).

**Risk factors.** Past suicidal attempt, Sex, Age, Marital Status, Mental disorder, Alcohol and drug abuse, etc.

#### **Clinical assessment of suicidal risk.**

- Whether the patient often feels sad and dejected?
- Whether the patient has lost all hopes in his life and finds the future completely dark?
- Whether he/she has ever thought that it would be better to be dead rather than being alive due to the constant miseries of life?
- Whether he/she has ever thought of causing death to self?
- Whether the patient has ever attempted suicide in the past?
- If yes, how he/she thought, he/she would attempt suicide?

**Management.** Management of a suicidal patient is summarised in the following steps:

The patient should preferably be referred to a psychiatrist or a hospital.

- a. The patient should never be left alone or without constant observation.
- b. No dangerous or potentially dangerous objects, such as sharp edged weapons, knives, firearms, ropes or drugs should be available in easy access to the patient.
- c. The family should always be taken into confidence and be actively involved in the management.
- d. Hospitalisation is preferred.
- e. Antidepressants or electroconvulsive therapy (ECT) are definitely the treatment for many patients, but it is not advisable to begin with antidepressants in the emergency room.
- f. In patients suffering from depression, the antidepressants like Selective Serotonin Reuptake Inhibitors (SSRIs) e.g. fluoxetine, sertraline, paroxetine, have been reported to increase suicidal risk in the first 2-3 weeks of treatment initiation. Therefore, one needs to be careful in first few weeks of treatment with SSRIs.

#### **Prevention**

- Careful prescribing of psychotropic drugs by the clinicians.
- Greater use of counselling by the general practitioners and looking into the psychological causes for symptoms.
- Media can play an important role by highlighting the need for professional help.

- Easily available support services, suicide prevention clinics in hospitals and voluntary agencies can play an important role here.

### Violent and Agitated Patient

Violent and agitated patients are not very uncommon emergencies in medical setup for which an urgent psychiatric referral needs to be sought. The disturbance needs to be controlled urgently.

**Etiology.** Violent behaviour can be due to a variety of causes, which could include a new onset psychiatric illness, exacerbation or relapse of a pre existing psychiatric disorder, iatrogenic causes,

Mania, Acute psychosis, Schizophrenia, Depression, Substance dependence.

**Management.** The assessment of the violent patient should be done as quickly as possible as this could be a threat for the safety of the patient and others as well. History should be relevant and adequate.

### Pharmacological management

- Inj. Lorazepan 2mg IV/IM slow or Inj. Diazepam 10mg IV/IM slow
- Inj. Haloperidol 10mg IV./IM slow with or without Inj. Promethazine 50mg IV/IM
- Inj. Olanzapine 5-10 mg IV/IM

### Delirium

Delirium is a transient disorder of brain function manifested by global cognitive impairment, alteration of consciousness and behavioral disturbances.

**Table 2. Assessment of a patient of delirium in emergency**

#### History

- Try to get detailed history from the caregiver, friends, medical records and other health care providers
- Review drug charts
- Review the vital sign charts
- Review anesthesia record, if a post operative patient

#### Physical examination

- Detailed physical examination including neurological assessment

#### Detailed psychiatric assessment

- Level of consciousness
- Higher mental functions
- Behaviour, affect, thought disturbances, perception, etc

**Careful review of medications and correlation with behavioral changes Laboratory investigations**

- Blood chemistries (electrolytes, glucose, renal, liver and thyroid (function; HTV, DRL)
- Hemogram
- Drug levels (digoxin, theophylline, phenobarbital, etc.)
- Urinalysis
- Electrocardiogram
- Chest X-ray

**Laboratory - order as needed**

- Electroencephalogram,
- Lumbar puncture
- CT or MRI
- Neuropsychological testing

**Course.** Symptoms of delirium usually resolve in 3-5 days but can continue upto 6-8 weeks.

**Treatment**

- a. Identification and management of the cause: The clinician must identify the specific etiology and manage accordingly. Detailed physical and psychiatric assessment should be done and Vital signs should be monitored periodically.
- b. Symptomatic management: The patient's room should have clues as to orientation like a calendar and wall clock, adequate light in the room at night as it can decrease frightening illusions.

**Alcohol Related Emergencies**

It is maladaptive behavior after the recent consumption of alcohol. Blood serum alcohol levels range from 10-20 mg/dl in patients who have pathological intoxication to 400- 500 mg/dl or more in patients who are obtunded or near death.

The physical signs include dysarthria, incoordination, ataxia, nystagmus and a flushed face.

**Management**

- It is important to protect the acutely intoxicated person from harming self. It is best to use physical restraints to control a patient as sedation may mask an evolving medical problem.
- Identify associated medical problems that require immediate attention by thorough

physical examination and relevant investigations.

- If the patient is uncontrollable, small doses of benzodiazepines may be used.

### **Alcohol Withdrawal**

Individuals who are dependent on alcohol can present with acute withdrawal syndrome in medical emergencies and sometimes develop withdrawal syndrome when they are admitted to a hospital for a medical or surgical problem.

**Clinical picture.** History of stopping or reduction in drinking after an intake of alcohol for a long duration going up to many years. Tremors of hands, tachycardia, sweating, elevated blood pressure, nausea or vomiting, malaise or weakness, anxiety, restlessness, sleeplessness, headache and bodyaches and transient hallucinations or illusions are often seen.

**Management.** Adequate hydration and nutrition has to be maintained. Benzodiazepines can relieve the withdrawal symptoms. Chlordiazepoxide 40-100 mg/day or diazepam 10-30 mg/day in 2-3 divided doses can be used. The benzodiazepines should preferably be tapered off in about a week. Lorazepam is another alternative benzodiazepine. The patients also need thiamine supplementation, which may need to be given parenterally in dose of 100 mg per day. Later it can be changed to oral route.

### **Delirium Tremens**

Delirium tremens is the delirium occurring after reduction or cessation of heavy alcohol intake in a

person with alcohol dependence. It usually occurs after 48-72 hours of stopping or reduction of alcohol intake, but can occur up to one week after stopping the alcohol.

### **Neuroleptic Malignant Syndrome**

Neuroleptic malignant syndrome (NMS) is a potentially fatal complication of the neuroleptic (antipsychotics like haloperidol, risperidone, olanzapine and quetiapine.) therapy. The syndrome is characterized by muscular rigidity, hyperpyrexia and autonomic instability and carries a mortality risk upto 10%. One year prevalence in patients exposed to neuroleptics ranges from 0.02 -2.4 %.

**Management.** Stopping the antipsychotics, Supportive measures like oral and intravenous hydration, ice packs and cooling blankets, and oxygen, if necessary. One should continue or initiate the anticholinergic medications and consider the use of amantadine, bromocriptine, and dantrolene.

### **Acute Dystonia**

Acute dystonia is an acute side effect of neuroleptics, occurring in up to 10% of cases. It is characterised by sudden onset of abnormal positioning or tonic spasm of the muscles of head and neck, jaw muscles, limbs or the trunk. It occurs within few days of starting or increasing the dose of antipsychotics.

**Etiology.** It is an extrapyramidal side effect and is more commonly seen with the high potency antipsychotics.

**Assessment.** It may involve the neck (tortocollis or retrocollis), eye muscles (oculogyric crisis), jaw (forced opening or trismus), tongue (protrusion or twisting) or the entire body (opisthotonus).

**Management.** Immediate management is aimed at relieving the symptom. This can be achieved by administering promethazine Hcl 50 mg IM or IV or diazepam 10 mg or lorazepam 2mg . Symptoms are usually relieved within 5-15 minutes. Prophylactic antiparkinsonian agents like trihexyphenidyl 4-8mg /day should be started.

### **Panic Attack**

Panic attacks are seen in panic disorder and are characterized by episodes of intense anxiety, usually lasting less than 30 minutes. These are quite common with prevalence of 1.5-2.0% and get confused with acute respiratory distress or anginal attacks.

**Symptoms** include palpitations, sweating, dizziness, shortness of breath, trembling or shaking, choking, etc

**Management.** Management of panic attacks in emergency settings is mainly by detailed assessment and reassurance, since by the time the patient reaches the doctor, the attack has already subsided. In case of continuing symptoms and frequent attacks, benzodiazepines such as alprazolam or clonazepam can be given in dose of 0.25-0.5 and 0.5 -1 .Omg respectively orally and the dose can be repeated after 4-6 hours

Long term treatment (SSRIs) like sertraline (50-200mg/day), fluoxetine (20-60mg/day) or

paroxetine (20-50mg/day). The treatment is started at the lowest dose. Treatment may need to be given for a period varying from 1-2 years.

### **Psychiatric Emergencies in Disaster Survivors**

Disaster survivors are people who have survived a sudden, unexpected, overwhelming stress that is beyond normally expected level. Typical stresses include earthquakes, floods, fires, air crashes, mud slides, building collapses. The common emotions in disasters include fear, panic, anger, frustration, numbness, confusion, helplessness, and guilt.

### **Management**

- Be empathic and supportive.
- Make the patient as comfortable as possible.
- If the facts may be overwhelming for ? patient, delay telling the facts, but do not intentionally tell a patient something that is not true.
- Involve the victims to mobilize supports and a plan of action.
- Remind the victims how well they have coped up with problems in the past.
- Encourage the patients to talk about their feelings and how they experienced the disaster.

Medications are usually not needed; though severe anxiety may be relieved with a brief course of short-acting benzodiazepines - for example, alprazolam 0.25 to 0.75 mg/day, lorazepam, 2 to 3 mg/day in divided doses.



## Rape and Sexual Abuse

Rape is the forceful coercion of an unwilling victim to engage in a sexual act, usually sexual intercourse although anal intercourse and fellatio can also be acts of rape. In addition to rape, other forms of sexual abuse include genital manipulation with foreign objects, infliction of pain and forced sexual activity.

**Assessment.** Typical reactions in both rape and sexual abuse victims include shame, humiliation, anxiety, confusion and outrage.

- If possible, a female clinician should evaluate the patient, since the victim may find it easier to talk with a woman than with a man.
- The evaluation should take place in private.
- When rape or sexual abuse has not been acknowledged openly, be alert to the fact that many victims are hesitant to discuss the assault and avoid the topic
- Do not write "rape" as a diagnosis on the chart, since rape is a legal determination.
- The medical record may be used as evidence in criminal proceedings; therefore, meticulous objective documentation of all aspects of the evaluation is essential.
- Take photographs of the evidence, if possible.

- With the patient's written consent, collect evidence, such as semen and pubic hair, which may be required in later investigations.

**Management.** Rape and sexual abuse victims are often confused during the period after the assault. Be reassuring, supportive, and nonjudgmental.

- Educate the patient about the availability of medical and legal services.
- Immediately refer the patient for the treatment of injuries sustained in the assault.
- If pregnancy is a possible consequence, consider giving progesterone or diethylstilbestrol by mouth for five days to prevent implantation.
- Provide treatment, including a course of antibiotics, for possible sexually transmitted diseases.
- Test for human immunodeficiency virus (HIV) at an appropriate time.
- Assess the availability of supportive friends and relatives.

Usually, no drug treatment is indicated. Short-term treatment with a benzodiazepines such as alprazolam 0.5 to 1 mg/day, lorazepam 2-6 mg/day in 2-3 divided doses.

## Cannabis Intoxication

Cannabis a common drug of abuse in India, taken in the form of bhang, ganja and hashish. The most common methods of cannabis administration are

orally and smoking. The drug's effects develop 20 to 30 minutes after smoking and a little later after oral intake. Features include euphoria, heightened sexual arousal, and decreased social interaction. Physical findings include fine tremor, a slight decrease in body temperature, reduced muscle strength, decreased balance, motor incoordination, dry mouth, bloodshot eyes, nausea and vomiting.

**Management** is mainly supportive. Symptoms usually clear off spontaneously from few hours to 1-2 days, as the drug washes out of the body. The patient and the family needs to be reassured. If the patient's anxiety and panic become severe, benzodiazepines can be given.

### Summary

- Patients presenting with behavioural disturbances are not uncommon in medical emergency settings and in medical and surgical inpatient
- Common psychiatric emergencies include suicidal behaviour or attempt, violence and agitated behaviour, acute anxiety attacks, delirium, drug related problems, neuroleptic malignant syndrome
- The patient is in need of help and realizes it. The violent patient should not be feared upon, but seen sympathetically.
- Physical examination is an essence along with psychiatric assessment.
- Initial management can be provided by the primary clinician and a psychiatric referral can be sought then.

### References

1. Hales RE and Yudofsky SG (Eds) (2004) Textbook of Clinical Psychiatry. American Psychiatric Publishing Inc. Washington.
2. Levenson JL (Ed) (2005) Textbook of Psychosomatic Medicine. American Psychiatric Publishing Inc. Washington.
3. Slaby AE, Dubin WR and Baron DA (2005) Other Psychiatric Emergencies. In: Comprehensive Textbook of Psychiatry, 8th ed (Eds. B J Sadock and VA Sadock). Lippincott Williams and Wilkins. Philadelphia
4. Sudak HS (2005) Suicide. In: Comprehensive Textbook of Psychiatry, 8th ed (Eds. BJ Sadock and VA Sadock). Lippincott Williams and Wilkins: Philadelphia.
5. World Health Organisation (2001) Suicide Prevention: Emerging from Darkness. WHO, SEARO: New Delhi