MANAGEMENT OF THE ACUTELY DISTURBED PATIENT

ACUTE CONFUSIONAL STATES

AKA Acute Organic Psychosyndrome
Toxic Confusional State
Delirium

10% of all medical/surgical in-patients have had delirium. 17% of elderly medical inpatients.

ICD-10 criteria for delirium:

(i) Impairment for consciousness and attention.
(ii) Global disturbance of cognition (impaired orientation, memory, comprehension, perception, thinking).
(iii) Psychomotor disturbances (hypo-hyperactivity).
(iv) Disturbance of sleep-wake cycle.
(v) Emotional disturbances (anxiety, fear, depression, apathy, perplexity).

Aetiology:

1.	Hypoxia	heart failure, MI, respiratory problems.
2.	Infection	general, e.g. chest, UTI cerebral, e.g. meningitis, encephalitis
3.	Metabolic Disorder	electrolyte disturbance, uraemia hepatic encephalopathy hypoglycaemia, porphyria
4.	Vitamin Deficiency	Thiamine (Wernickes encephalopathy) B12 deficiency
5.	Endocrine Disease	Myxoedema, thyrotoxicosis, Cushings Diabetes, Addisons, Parathyroid disease
6.	Trauma	Head injury.
7.	Epilepsy	Epileptic status, psychomotor seizure Post-ictal states.
8.	Space occupying lesions	tumours, primary or metastases subdural haematoma, cerebral abscess
9.	Vascular disease	TIA, Multi-infarct dementia, SAH

10.	Drug intoxication	Anticholingergics, Corticosteroids Digoxin, Isoniazid, L-Dopa Hypnotics, Barbiturates Almost all psychotropics in the elderly.

11. Withdrawal of drugs/alcohol

Despite the many varied causes, the end clinical picture is surprisingly similar.

Think of ACS when		Sudden onset and resolution (although can be subacute). Impairment of consciousness which often fluctuates (worse at night). Global impairment of cognitive functioning. Visual hallucinations (not very common in functional disorders).
Greater risk with	-	Increasing age anxiety sensory under/over stimulation brain damage of any kind, including dementia (acute on chronic confusion).

Aetiology is undetermined in 5-20% of elderly delirious

Most common causes	-	drug toxicity (often prescribed) CVA UTI Diabetes IHD n.b. constipation in elderly
Significant mortality	-	25% of elderly hospitalised delirious patients die.

CHRONIC CONFUSIONAL STATES

AKA Chronic Organic Psychosyndromes
Dementia

Generalised impairment of intellect, memory and personality with no impairment of consciousness. Note that people with underlying dementia are more prone to acute confusional states - acute on chronic confusion.

Aetiology:

1.	Degenerative	-	Alzheimer's disease, Pick's disease Huntington's chorea, Parkinson's disease Creutzfeld-Jacob disease Normal pressure hydrocephalus
2.	Space occupying lesion	-	Tumour, Subdural haematoma
3.	Infection	-	Encephalitis, Neurosyphilis Cerebral sarcoidosis, AIDS
4.	Metabolic	-	Sustained uraemia, Liver failure Non-metastic effects of tumours
5.	Vitamin Deficiency	-	Sustained lack of B12, folic acid, Thiamine (Korsakoff's psychosis)
6.	Trauma	-	Severe single head injury
7.	Vascular	-	Multi-infarct dementia Occlusion of carotid arteries
8.	Toxic	-	Alcoholic dementia Lead poisoning
9.	Anoxia	-	Anaemia, Post-anaesthesia, Carbon monoxide, post arrest, resp failure

Most common causes of dementias are irreversible, but important not to miss the reversible causes.

Depending on the aetiology, clinical picture can vary, but all dementias can present with disturbed behaviour.

FUNCTIONAL PSYCHIATRIC CONDITIONS

1. Schizophrenia, usually acute episode

2. Manic

3. Depression with suicidal behaviour

4. "Neurotic" disorders

5. Personality disorder

NOTE: A number of physical disorders can cause psychiatric symptoms which are very similar or identical to those seen in functional disorders –

ORGANIC MENTAL DISORDERS

E.G. Organic delusional disorder
Organic mood disorder
Organic anxiety disorder
Organic personality disorder

Patients with functional disorders are more likely to be seen by psychiatrists first. However, they may turn up in the General Hospital setting because:

(i) Psychiatric patients often self-present to Emergency Department

(ii) Psychiatric patients do get physical illnesses requiring General Hospital treatment.

ACUTE ALCOHOL AND DRUG INTOXICATION

1. Alcohol intoxication	-	probably the most common cause of disturbed behaviour in the ED
2. Drug intoxication	-	often require Hospital admission for physical complications
More likely to cause psychic disturbance	-	Cocaine Cannabis Barbiturates Benzodiazepenes Volatile substance

Nowadays most present with polydrug use.

Management of the acutely disturbed patient

1. Ask yourself "why is this patient acutely disturbed at this point?" Important to answer this as this will influence your management of the situation.

2. General points

   - Be able to get out of the room in which interview/assessment takes place, e.g. in ED patient should not be nearer door.

   - Potential weapons and missiles should be removed.

   - It is inadvisable to sit face to face with an aggressive patient in a confronting or eyeball to eyeball position.

   - Don't intimidate patient, e.g. standing over him if interviewing in the ED

   - Encourage patient to sit. If patient pacing may be advisable to terminate interview.

   - Note that many paranoid and agitated people feel more comfortable with a wall behind them.

   - Have colleagues present with you or readily accessible. Do not interview in an isolated room where no one can hear you if problems arise.

   - Don't dismiss patient as "Dykebar base", nuisance, etc. Especially important to remember that acutely confused elderly people are not being disruptive deliberately, but because they are unwell. If dismissive attitude or annoyance with patient demonstrated disturbed behaviour more likely.

   - Gather as much information as possible about disturbed behaviour from others, e.g. nurses in the ED or on ward, relatives, Police, etc., who may have brought patient in.

   - Introduce yourself to patients. Tell them what you are doing - even more important if someone is confused!

   - Recognise signs of increasing agitation, anger. Observe body language.

   - Don't be afraid of terminating an interview if you feel you are losing control of the situation.

SPECIFIC CONDITIONS

1. **Acute Confusional States:**

   - Main priority is to treat the underlying cause.

   - Therefore, obtain good history (use relatives) and do appropriate physical investigations.

   - Nurse in well-lit room, avoid under/over stimulation from the environment.

   - Patient should be given repeated explanations of his condition. Disorientation and misinterpretation of the environment can be reduced by a calm and consistent approach.

   - MEDICATION - see later.

   - **N.B**. Treat patients likely to develop alcohol withdrawal **before** they develop symptoms. Uncomplicated withdrawal develops within 24 hours of abstinence. DT's usually developed 1-4 days after drinking. Start patients likely to have alcohol withdrawal on the CIWA regimen and consider the need for IV or oral thiamine.

2. **Chronic Confusional States:**

   - Usually no treatment for the underlying cause, but do not miss those rare cases in which there is a reversible cause.

   - Note in those with Alzheimer's disease (reduction in cholinergic neurones) the anticholinergic effects of antipsychotics can increase the level of confusion and agitation.

   - Be careful in using antipsychotic medication in patients suspected of having Lewy Body dementia as such patients are often very sensitive to the Parkinsonian side-effects associated.

   - MEDICATION - see later.

3. **Functional Psychiatric Conditions:**

   - Important to involve psychiatrists at an early stage, even if simply for 'phone advice initially.

   - MEDICATION - see later.

- USE OF MENTAL HEALTH ACT - see previous

4. **Acute alcohol and drug intoxication**

Alcohol — Someone who is simply drunk does not require psychiatric admission. Advise to return when sober. If need be, call the Police to remove. However, beware of certain pitfalls in the drunk patient.

a) More likely than non drunk to have sustained head injury.

b) Disinhibiting effects of alcohol may make them more likely to self harm or behave in a disturbed manner. If threatening self harm or if they have past psychiatric history, contact the psychiatrist for advice.

- **DO NOT** detain someone under the influence of alcohol before discussing with on-call psychiatrist.

Drugs — Those with acute drug intoxication may require admission if concerns regarding physical state.

As drug induced psychiatric states are usually short-lived, try and avoid sedating. However, this may be necessary

MEDICATION: Sedation of the acutely disturbed patient

Despite the many different causes of acutely disturbed behaviour, the modern treatment of acutely disturbed behaviour relies on two main groups of drugs or a combination of both
- antipsychotic
- benzodiazepenes

N.B. No psychotropic medication is without side-effects and interactions with other drugs must be considered. Weigh-up the possible harmful effects of treating the patient against the risks of leaving him untreated.

If rapid tranquillisation is considered necessary, prior to formal diagnosis and where there is any uncertainty about previous medical history (including history of cardiovascular disease, uncertainty regarding current medication, or possibility of current illicit drug/alcohol intoxication), **lorazepam** should be considered as the first-line drug of choice. Where there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol in combination with lorazepam is sometimes used.

BENZODIAZEPINE

useful in the disturbed patient where antipsychotics are not recommended, e.g.

- Where fitting has occurred.
- Alcohol complicating the picture.
- Severe dystonia in the past.
- Cardiac disease.

Lorazepam - Useful if liver disease as it is not metabolised by the liver. 1-2mg im. Time to peak plasma concentration 60-90 mins Beware risk of loss of consciousness, respiratory depression, cardiovascular collapse (if using clozapine in combination with benzo)

ANTIPSYCHOTICS

AKA Neuroleptics or major tranquillisers

In the acute situation being used for their sedating actions and not antipsychotic action (takes up to one week for this).

Have to vary the dose according to age of patient and physical status, e.g. elderly require much smaller doses.

Also vary the dose according to route of administration (less with parenteral).

Haloperidol oral IM or IV. (best to avoid IV). 15-60mins to peak plasma concentration

Dose varies greatly according to age and response

IM dose 2.5-5mg. allow 30 mins to assess effect

Side effects associated with antipsychotics:

1. Loss of consciousness, excessive sedation

2. Cardiovascular & respiratory complications and collapse

3. EPSE, e.g.acute muscular rigidity (dystonia). Treat with 5-10mg I.M. Procyclidine.
   Subjective experience of restlessness (akathesia)
   Involuntary movements (dyskinesia)

4. Reduction in seizure threshold.

5. Neuroleptic malignant syndrome - rare. Idiosyncratic

- Increased temperature and muscle tone
- High B.P. + pulse.
- Autonomic instability
- Delirium
- Increased WCC + CK

This is a medical emergency. Stop drug and contact physicians.

There are many other antipsychotics in use. Most of the others cannot be given I.M. (depots are not for use in the acute situation). Main differences are in side-effect profile.

If in doubt about which one to use or which dose, then consult psychiatrist.

Carrying out rapid tranquillisation

The patient should be able to respond to communication throughout the period of rapid tranquillisation. The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user or to others

Extra care should to be taken when implementing rapid tranquillisation in the following circumstances:

- the presence of congenital prolonged QTc syndromes
- the concurrent prescription or use of other medication that lengthens QTc intervals both directly and indirectly
- The presence of certain disorders affecting metabolism, such as hypo- and hyperthermia, stress and extreme emotions and physical exertion