Psychiatric Liaison Services on the AMU

Chair: Dr Mark Holland
Dr Alys Cole-King
Clearing up Confusion: Delirium on the AMU

Dr Jim Bolton
St Helier Hospital Liaison Psychiatry Service
Questions we’re often asked

• “The patient is hallucinating. Is it schizophrenia?”
• “We can’t find a cause. Are you sure it’s delirium?”
• “Can we give them something to calm them down?”
• “The bloods are now normal, but patient is still confused. Are you sure it’s delirium?”
• “Will you take them away?”
What is delirium?

• Complex neuropsychiatric disorder
• Final common pathway of range of insults to the brain
There's a lot of it about...

- High rates in a general hospital
  - > 30% of inpatients
  - especially elderly, post-op., CNS disease, terminally ill

- Not recognised in 2/3 of inpatients
Clinical features

- Global impairment of cerebral function
- Conscious level - altered
- Cognition – global impairment
- Perception – e.g. illusions, hallucinations
- Mood – e.g. labile, low, irritable, frightened
- Thinking – e.g. delusions
- Activity - hyper- and hypo-activity
- Sleep-wake cycle - disturbed
- Fluctuating course
"The patient is hallucinating. Is it schizophrenia?"

- First onset unlikely during acute admission
- Especially if older
- Perceptual problems are common in delirium
- Visual hallucinations suggestive of organic disorder
- Similarly: “Do they need an antidepressant?”
  - mood symptoms common in delirium
Causes of delirium

- Myriad of potential causes
- A sufficiently severe insult to the brain
- Final common pathway of many causes, often in combination:
  - Underlying medical condition
  - Medical treatments
  - Alcohol & substance misuse / withdrawal
  - Unknown
Vulnerability to delirium

Age

Cerebral reserve
“We can’t find a cause. Are you sure it’s delirium?”

• Often due to multiple seemingly minor causes in a vulnerable individual
• Or no identified cause, but clinical picture is clear
• Causes often overlooked
  – alcohol withdrawal
  – newly prescribed medications
  – pain
Commonly implicated drugs

- Opioid analgesics
- Benzodiazepines
- Antiparkinsonian drugs
- Steroids
Pathophysiology

• Clinical manifestation of disruption of neuroendocrine homeostasis
• Common presentation of variety of different pathophysiological mechanisms...
• ...which impact on central metabolism, nerve conduction and blood brain barrier permeability
Key aspects of assessment

History
• Time course and pattern of confusion
• Drug or alcohol misuse

Examination
• Emphasis on identifying acute medical problems

Investigations
• On basis of history & examination
• Cerebral imaging if head trauma, or focal neurology
• EEG in selected cases
Key aspects of assessment

• Investigations
• Review drug chart – new or withdrawn drugs, altered dose?
• Informants – ward staff, family, carers
Differential diagnosis

• Dementia
  – Both states of global cognitive impairment
  – Dementia increases vulnerability to delirium
  – Corroborative history important
    • e.g. onset, duration and course of symptoms

• Depression
  – "pseudo-dementia"
Management - physical

- Treat the underlying cause(s)
- Minimise polypharmacy
- Withdraw contributory drugs if possible
- Monitor vital signs & intake
- Pain management
- Early mobilisation
Management - psychosocial

• Environment
  – bright lighting, familiar staff, calm environment, close to nursing station or side room
• Maintain sleep-wake cycle
• Re-orientation
  – e.g. window, clock, calendar
• Minimise sensory impairment
  – e.g. ear wax, hearing aids, spectacles
• Reassure & explain to family
  – important role in re-orientation
Drug treatments

• Avoid if possible (unless DTs)
  – May worsen confusion
  – Increased risk of falls

• Use when
  – patient poses a risk to themselves or others
  – Other measures ineffective

• Little evidence on which to base guidelines
Drug treatments

• Internationally – haloperidol and lorazepam most commonly recommended drugs
• NICE recommends haloperidol & olanzapine
Drug treatments

- Haloperidol
  - most frequently recommended
  - ideally check QTc prior to use
  - Extrapyramidal side effects

- Olanzapine
  - increased risk of stroke in older adults with dementia

- Lorazepam
  - no active metabolites
  - risk of paradoxical reaction
Drug treatments

• Short term (<1 week)
• Start with low dose
• Titrate cautiously according to symptoms
• Use antipsychotics with caution or not at all in Parkinson’s & dementia with Lewy bodies
• Alcohol withdrawal
  – Benzodiazepine withdrawal regimen
Prognosis

• May take several weeks to resolve
• Cognitive decline may persist
• Mortality 2X that of non-delirious patients with similar medical conditions
• Associated with
  – Functional decline
  – Poorer rehabilitation
  – Institutionalisation
  – Rehospitalisation
“Will you take them away?”

• “No”

• But with which cases can psychiatry help?
  – Uncertain diagnosis
  – Advice on symptom management, especially drug treatment
Conclusions

• Delirium is common
• Increased risk of mortality and disability
• Often missed
• But it is preventable & treatable
• Management involves physical, psychological & social strategies
...and after it’s over?

- Reassure patient & family
- Written information
  – www.rcpsych.ac.uk
Suicide Prevention and Saving Lives in AMU

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Royal College of Psychiatrists Spokesperson on Suicide and Self harm and Consultant Liaison Psychiatrist

@AlysColeKing
EXCLUSIVE INVESTIGATION

1,200 KILLED BY MENTAL PATIENTS
Shock 10-year toll exposes care crisis

Mental Patient Fancy Dress Costume
£20.00

Select colour, size & quantity:
Colour: White
Size: Select size
Quantity:

ADD TO BASKET
Relationship self-harm to suicide

Suicidal thoughts

Self-harm

NSSI
Identification of suicide risk

Patients identified as high risk

Surface Level

Patients identified as low risk
Classification of suicidal thoughts (Cole-King 2010)

- Passive
- Active
- Dangerous
- Dangerous and imminent
Changing working practices

- Compassion
- Minimise Human Factors Errors
- Consistent Assessment Framework
- Wellbeing & Self Help
- Bite Sized Training
- Safety Plans & means restriction

& means restriction

Changing working practices
Response AMU self-harm

- Awareness
- Compassion
- Eradicate Stigma

- Governance:
  - Assessment
  - Triage
  - Referral
  - Documentation

- Self-harm/suicidal ideation bundle
SEPSIS BUNDLE

Blood Cultures X2 (prior to starting Abx)
Serum Lactate Level
Broad Spectrum Antibiotics (Give 1st dose of Abx ≤1 hour of onset severe sepsis/shock)
IV Fluid Bolus minimum 20mL/kg

1 HOUR

6 HOURS
Self-harm & suicidal behavior bundles

Compassion & hope

Triage

Referral MH services
Safety plan

Remove access to means
Self-help leaflets

U Can Cope

Feeling overwhelmed and staying safe

Feeling on the edge helping you get through it

www.connectingwithpeople.org/
References:

- Hines K, **Cole-King A** (2013) ‘Hey Kid are you OK..a story of a suicide attempt’ Advances in Psychiatric Treatment. 19:292-294
- **Cole-King A**, Lepping, P Suicide mitigation: time for a more realistic approach. 2010. BJGP 3-4
- 2009 4 RCPsych peer reviewed poster presentations of all clinical tools
Suicide Prevention and Saving Lives in AMU

www.connectingwithpeople.org/
Medically unexplained symptoms in the Acute Medical Unit
Plan

- Case presentation
- Key points
- Some facts
- Management
Some points from Case Presentation

• Early onset of unexplained symptoms
• Identification with illness
• Unhappy early childhood
• Numerous referrals to different specialists
• Once treatment is started, it is difficult to stop, even in the absence of diagnosable disease
• The presence of an organic condition complicates the clinical picture, but there are still clear ‘MUS’ presentations.
• Labelled as having organic disease, when it has actually been excluded.
• Repeated investigations
• Adult stress and difficulties in relationships
• Invalidity
• An absence of consideration of psychological factors
• Individual doctors try to stop certain treatments, but do not succeed.
• No involvement of GP
• No evidence of case conference or joined up management
• Referral to psychiatry is very late
Background
PHYSICAL symptoms are normal
Frequency of somatic symptoms in the Danish Population over a two week period (males)

Ekholm et al 2005
Frequency of somatic symptoms in the Danish Population over a two week period (females)
Incidence and aetiology of the 10 most common symptoms

Kroenke and Mangelsdorff, 1989
Most patients have multiple symptoms
(500 primary care patients presenting with a physical condition)

Kroenke et al, 1997
Symptom Clusters

Infectious diseases
- Dizziness
- Excessive fatigue
- Headaches

Gastroenterological
- Nausea
- Stomach cramps
- Heartburn
- Bloating

Reumatological
- Pains in joints
- Pains in lower back
- Numbness

Cardiological
- Chest pain
- Breathing difficulty
- Breathlessness
- Palpitations
Functional Somatic Syndromes

- Chronic fatigue syndrome
- Irritable bowel syndrome
- Functional dyspepsia
- Chronic pelvic pain
- Multiple chemical sensitivity syndrome (20th Century Disease)
- Fibromyalgia
- Temporomandibular joint pain
- Globus
Diversity of Opinion

• “The existence of specific somatic syndromes is largely an artefact of medical specialisation”

  - Simon Wessely
  - Lancet 1999

• Existence of various diagnostic criteria for different conditions and study of those conditions in isolation of other ‘somatic symptom groups’
Unexplained symptoms and psychiatric co-morbidity

Kroenke et al, 1994
MUS is a spectrum disorder

- Normal human experience
  - Mild symptoms, usually remit quickly
    - N.B 3 or more
  - Contact with healthcare system
- Moderate symptoms, persist over months
- Severe and chronic
- Increasing likelihood of psychological distress
MUS is a spectrum disorder

Normal human experience

Contact with healthcare system

Mild symptoms, usually remit quickly - N.B 3 or more

Moderate symptoms, persist over months

Severe and chronic

Increasing likelihood of psychological distress
Examples

• 48 male Confusion-right sided weakness
• 55 male Unable to walk –weakness in both legs
• 19 female loss of vision right eye
• 36 females bizarre agitated behaviour-”fits”
• 41 female multiple abdominal symptoms
• 38 male complex feeding problems post gastrectomy
Examples

• 24 male unexplained abdo pain and seizures
• 25 male seizures
• 19 female asthma attacks
• 57 female left sided weakness
• 27 man unexplained vomiting
• 45 female diabetic foot ulcer-not healing
Understanding the problem

• Medically unexplained symptoms plus
• Good evidence of an associated psychological problem or difficulty
  – Co-morbid anxiety or depression
  – Childhood vulnerability factors
  – Previous history of unexplained complaints
  – Opiate dependency
  – Factitious (deliberate falsification of symptoms linked to emotional problems)
  – Malingering (deliberate falsification of symptoms for financial gain or other non psychological motive)
Management Strategies: NEAD

- Clear explanation of nature of ‘episodes’
- Not epilepsy
- Most likely related to stress
- Avoid using words like seizures or attacks
- Use ‘episodes’ or ‘faints’
- Review all anti-epileptic medication with a view to discontinuation
- Psychological explanation based upon biopsychosocial model
- Limit length of hospital admission
- Simple advice re managing ‘episodes’
- Involve family
- Check medical notes are consistent
- GP is involved in management
- Out-patient psychological treatment
Management: Acute pain

• Clear explanation that pain is disproportionate to underlying physical health problem
• Review analgesic medication
• Look for evidence of opiate dependency
• If suspected, plan reducing regime.
• Assess and treat depression, if present
• Assessment of factors which may be exacerbating presentations other than dependency
• Involve GP and family in management
Management: Weakness
A biopsychosocial model for FBD (Drossman et al, Gut 1999: 45 (Suppl) II25-II30)
The Brain
Antidepressants

• Good evidence for antidepressants from several systematic reviews
Review: Efficacy of antidepressants and psychological therapies in irritable bowel syndrome: systematic review and meta-analysis.

Comparison: 01 antidepressants

Outcome: 01 global IBS symptoms or abdominal pain unimproved or persistent after therapy

<table>
<thead>
<tr>
<th>Study or sub-category</th>
<th>Treatment n/N</th>
<th>Control n/N</th>
<th>RR (random) 95% CI</th>
<th>Weight %</th>
<th>RR (random) 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 tricyclic antidepressants</td>
<td></td>
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</tr>
<tr>
<td>Heefner 1978[^53]</td>
<td>10/22</td>
<td>12/22</td>
<td></td>
<td>5.94</td>
<td>0.83 (0.46 to 1.50)</td>
</tr>
<tr>
<td>Myren 1982[^59]</td>
<td>5/30</td>
<td>10/31</td>
<td></td>
<td>2.66</td>
<td>0.52 (0.20 to 1.35)</td>
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<tr>
<td>Nigam 1984[^36]</td>
<td>14/21</td>
<td>21/21</td>
<td></td>
<td>14.74</td>
<td>0.67 (0.49 to 0.92)</td>
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<tr>
<td>Boerner 1988[^56]</td>
<td>16/42</td>
<td>19/41</td>
<td></td>
<td>7.63</td>
<td>0.82 (0.50 to 1.37)</td>
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<tr>
<td>Bergmann 1991[^61]</td>
<td>5/19</td>
<td>14/16</td>
<td></td>
<td>3.82</td>
<td>0.30 (0.14 to 0.70)</td>
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<tr>
<td>Vij 1991[^58]</td>
<td>14/25</td>
<td>20/25</td>
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<td>10.67</td>
<td>0.70 (0.47 to 1.04)</td>
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<td>Drossman 2003[^37]</td>
<td>60/115</td>
<td>36/57</td>
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<td>16.77</td>
<td>0.83 (0.63 to 1.09)</td>
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<tr>
<td>Talley 2008[^51]</td>
<td>0/18</td>
<td>5/16</td>
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<td>0.33</td>
<td>0.08 (0.00 to 0.88)</td>
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<tr>
<td>Vahedi 2008[^60]</td>
<td>8/27</td>
<td>16/27</td>
<td></td>
<td>5.02</td>
<td>0.50 (0.26 to 0.94)</td>
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<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td>319</td>
<td>256</td>
<td></td>
<td>67.56</td>
<td>0.68 (0.56 to 0.84)</td>
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<tr>
<td><strong>Total events:</strong> 132 (treatment), 153 (control)</td>
<td></td>
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<tr>
<td><strong>Test for heterogeneity:</strong> $\chi^2 = 10.94$, df = 8 ($p = 0.21$), $I^2 = 26.9%$</td>
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<tr>
<td><strong>Test for overall effect:</strong> $Z = 3.86$ ($p = 0.0001$)</td>
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</table>

<table>
<thead>
<tr>
<th>02 selective serotonin re-uptake inhibitors</th>
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</thead>
<tbody>
<tr>
<td>Kuiken 2003[^54]</td>
<td>9/19</td>
<td>12/21</td>
<td></td>
<td>5.85</td>
<td>0.83 (0.45 to 1.52)</td>
</tr>
<tr>
<td>Tabas 2004[^55]</td>
<td>25/44</td>
<td>36/46</td>
<td></td>
<td>14.90</td>
<td>0.73 (0.54 to 1.01)</td>
</tr>
<tr>
<td>Vahedi 2005[^52]</td>
<td>6/22</td>
<td>19/22</td>
<td></td>
<td>4.52</td>
<td>0.32 (0.16 to 0.69)</td>
</tr>
<tr>
<td>Tack 2006[^57]</td>
<td>5/11</td>
<td>11/12</td>
<td></td>
<td>4.90</td>
<td>0.50 (0.25 to 1.01)</td>
</tr>
<tr>
<td>Talley 2008[^51]</td>
<td>5/17</td>
<td>5/16</td>
<td></td>
<td>2.27</td>
<td>0.94 (0.33 to 2.66)</td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td>113</td>
<td>117</td>
<td></td>
<td>32.44</td>
<td>0.62 (0.45 to 0.84)</td>
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<tr>
<td><strong>Total events:</strong> 50 (treatment), 83 (control)</td>
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<tr>
<td><strong>Test for heterogeneity:</strong> $\chi^2 = 6.46$, df = 4 ($p = 0.17$), $I^2 = 38.1%$</td>
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<tr>
<td><strong>Test for overall effect:</strong> $Z = 2.74$ ($p = 0.006$)</td>
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</tbody>
</table>

| 03 Total (95% CI)                           | 432          | 373         |                     | 100.00   | 0.66 (0.57 to 0.76) |

| Total events:** 182 (treatment), 236 (control) | | | | | |
| **Test for heterogeneity:** $\chi^2 = 17.66$, df = 13 ($p = 0.17$), $I^2 = 26.4\%$ | | | | | |
| **Test for overall effect:** $Z = 4.95$ ($p < 0.00001$) | | | | | |
Some Specific therapies that have been shown to treat MUS

<table>
<thead>
<tr>
<th>Strong evidence</th>
<th>Moderate Evidence</th>
<th>Weak Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioural therapy</td>
<td>Exercise</td>
<td>antidepressants</td>
</tr>
<tr>
<td>Consultation letter to primary care physician</td>
<td>Non-CBT psychotherapies (psychodynamic-interpersonal therapy)</td>
<td>Training of primary care physicians in MUS care</td>
</tr>
</tbody>
</table>