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
Postoperative delirium
Postoperative delirium
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
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

Cerebral reserve

Age
Vulnerability to delirium

Cerebral reserve vs Age
Vulnerability to delirium

Cerebral reserve

Age
No one is immune
“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
“Can we give them something to calm them down?”
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
“The bloods are now normal, but patient is still confused. Is it delirium?”
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?”
“Will you take them away?”

• “No”

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

• Functional neuroimaging – multiple areas of disordered cerebral function
• EEG – diffuse slowing of cortical activity
• Neurotransmitters
  – e.g. cholinergic deficiency, dopaminergic excess
• Cytokines
  – e.g. interleukins, TNF-alpha, interferon
• Chronic hypercortisolism secondary to stress
Assessment

• **Investigations**

• Physical investigations on basis of history & examination
  – blood tests
    • FBC, CRP, U&Es, LFTs, TFTs, calcium, B12, folate
  – urinalysis, ECG, CXR
  – oxygen saturation
  – cerebral imaging if head trauma, or new focal neurological signs
  – EEG in selected cases
Assessment

History
• Time course and pattern of confusion
• Past history of confusion
• Past & current medical history
• History of drug or alcohol misuse

Examination
• General, neurological, mental state, cognitive
• Emphasis on identifying acute medical problems
# Delirium vs. dementia

<table>
<thead>
<tr>
<th>Features</th>
<th>Delirium</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>Sudden</td>
<td>Insidious</td>
</tr>
<tr>
<td>Course</td>
<td>Fluctuating</td>
<td>Persistent</td>
</tr>
<tr>
<td>Duration</td>
<td>Days / weeks</td>
<td>Months / years</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Impaired</td>
<td>Clear</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Common</td>
<td>Often absent</td>
</tr>
<tr>
<td></td>
<td>- esp. visual</td>
<td></td>
</tr>
<tr>
<td>Delusions</td>
<td>Fleeting</td>
<td>Often absent</td>
</tr>
<tr>
<td>Cognitive testing</td>
<td>Impaired</td>
<td>Impaired</td>
</tr>
</tbody>
</table>
 Assessing capacity in delirium

• Decision specific
  – Capacity to do what?
  – May have capacity to make some decisions, but not others

• Likely to fluctuate with delirium
  – May have capacity during more lucid intervals

• Can the decision wait?
  – e.g. long-term care decisions
Why is delirium often missed

• Lack of awareness of the diagnosis
• Mild symptoms at outset
• Fluctuating course
• Hypoactive delirium more easily missed
Prevention (NICE)

• Delirium can be prevented in 1/3 of those at risk

• Highlighted risk factors
  – Age 65 years or over
  – Cognitive impairment (past or present)
  – Severe illness
  – Current hip fracture
Prevention (NICE)

- Consistent staffing
- Avoid moving if possible
- Within 24 hours of admission, assess for common potential causes of delirium
- … and address these through multidisciplinary care
- Regular reassessment
Suicide Prevention
and
Saving Lives in AMU

Dr Alys Cole-King MB, BCh, DGM, MSc, FRCPsych
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
- NSSI
- Self-harm
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

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

& 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

1 HOUR

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

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:

- 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

Professor Else Guthrie
Plan

- This is a practical talk
- Case Illustration
- Some Facts and Figures
- Management of common scenarios
Case History

• 36 year old woman reported that her problems began in utero with maternal rubella.
• She reported that she was blind and deaf as an infant, but recovered.
• Insulin dependent diabetes diagnosed at 2 yrs- numerous lengthy admissions before 5 yrs.
• Both parents physically fit but mother suffered from depression and father drank excessively. The marriage was unhappy.
Case History

• As patient got older she admitted to inducing hypoglycaemia in order to punish her parents.
• Attended an ordinary school until 9 yrs followed by a school for handicapped children.
• Reported fits since she was 2 yrs but said doctors never believed her mother’s description of this.
• Has been taking phenobarbitone since a child despite frequent attempts by doctors to stop it.
Case History

- Left school at 15 and worked in a handicraft shop until she retired on invalidity pension at 30 yrs.
- Married at 25 yrs having previously been sterilised. The marriage ended after several years.
- Said that there was ‘no love only fear’ in the marriage.
- Has never experienced sexual desire or enjoyment and had pain on intercourse.
Case History

• At 18, following several admissions for keto-acidosis, she was referred to a diabetic clinic where complaints ‘neither typical of hypo or hyperglycaemia’ were noted.
• Abdominal pains at 19 led to appendicectomy and loin pain was diagnosed as lumbar strain.
• Since age 23 she has complained of paraesthesia in her hands and feet.
• A bilateral carpal tunnel decompression at 26 failed to alleviate this and she was referred to a Raynaud’s unit.
• It was noted her symptoms were not consistent with a peripheral neuropathy.
Case History

• At 27 years she was investigated for ‘visual deterioration’ and diplopia but no cause was found.
• From 27 to 30 yrs, she suffered from intermittent aphonia which she later said was due ‘to the stress of my husband hitting me’.
• At 29 yrs she was investigated for abdominal pain.
• Tests suggested a gallstone and cholecystectomy was performed after 4 months of continuous pain.
• Findings were normal at operation and her pain persisted.
Case History

• Her pain was then attributed to sacro-ileitis for which she received a variety of treatments including physiotherapy.

• After 10 months it was noted that ‘every type of technique and grade of technique aggravated her condition’.

• She was then referred to a rheumatologist and investigated for low back pain.

• Tests were normal and she was treated with steroid injections, a corset and a raised shoe.
Case History

• At 31 years she was referred to the pain clinic with neck and thoracic pain.
• Transcutaneous nerve stimulation, acupuncture, a soft collar and relaxation exercises had no effect.
• During the same period she was referred to an orthopaedic surgeon with numbness in her hands.
• Nerve conduction studies were normal and her symptoms were described as functional.
• The same year she saw a gynaecologist about pelvic pain and inter-menstrual bleeding.
Case History

• Dilatation and curettage were normal. At follow-up she reported haematuria and after a normal IVP, was admitted for laparoscopy and cystoscopy which were also normal.
• Her pain persisted and she had an abdominal hysterectomy at 33.
• Post operative cytology was normal.
• Following this she reported urinary incontinence, and despite normal urodynamic tests, requested surgery, which was refused.
Case History

• The gynaecologist then arranged for her to see a neurologist because of numb feet.
• Nerve conduction studies were normal but despite this, a ‘mild form of neuropathy’ was diagnosed.
• This diagnosis was subsequently revised and she had myelography to rule out lumbar canal stenosis—which it did.
• Her gait then became abnormal and she was admitted.
• Nerve conduction studies were again normal and she was seen by an orthopaedic surgeon because she claimed her problem was scoliosis.
Case History

- The surgeon found no evidence of this and tried unsuccessfully to dissuade her from wearing a raised shoe.
- On discharge she was referred back to the gynaecologist with urinary incontinence and frequency.
- At 34 yrs she saw a chest physician for dyspnoea.
- Lung function tests and an echocardiogram were normal and a diagnosis of asthma was made on the history.
- Started on anti-spasmodic and steroid inhalers.
- Although the diagnosis was subsequently changed to hyperventilation syndrome- she remained on this medication.
Case History

• A few months later she was referred from the chest clinic to a cardiologist with dyspnoea on exertion and palpitations.
• A treadmill test, thallium scan and 24 hour ECG tape were normal.
• At 35 she had more eye tests but they could not account for her visual symptoms.
• She was told that she might have a retinal disturbance and she has since worn dark glasses.
• A few months later she was again referred to a neurologist with tremor and numbness of her hands, diarrhoea and incontinence.
Case History

• She was concerned that she had multiple sclerosis and visual evoked responses were performed to reassure her.
• These were normal but a history of MS was often recorded in subsequent notes.
• Other entries in her notes described her as a known diabetic neuropath despite the lack of evidence for this.
• The same year she was seen in dermatology, oral medicine and the ENT departments because of pain in her throat which she said was associated with blood blisters.
• She also had persistent nausea which led to a negative barium meal.
Case History

• Whilst attending the cardiology clinic she had further investigations for dizzy spells.
• A high serum phenobarbitone level led to the diagnosis of toxicity in a ‘lady with cardiac disease’.
• Her gait deteriorated and she was admitted for a lumbar puncture.
• This and further electrophysiological studies were normal and a diagnosis of Briquet’s syndrome was made.
• Shortly after this, she was admitted to her local coronary care unit with chest pain, but tests were normal.
• A few months later she was admitted under the cardiologists because of further chest pains.
Case History

- Coronary angiography was normal but she continued taking anti-anginal drugs.
- The pain was diagnosed as gastrointestinal in origin and ranitidine prescribed.
- At the age of 37 yrs she was referred to a psychiatrist.
Some points

- Early onset of unexplained symptoms
- Identification with illness
- Unhappy early childhood
- Illness in 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.
Some points

• 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
Facts and Figures
Unexplained 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)

Age in years

Total
67+
45-66
25-44
16-24

percent

0 10 20 30 40 50 60 70 80 90 100
Incidence and aetiology of the 10 most common symptoms

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

Kroenke et al, 1997
Relationship between physical and psychological symptoms

No of psych symps

Number of physical symptoms
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
MUS is a spectrum disorder

Normal human experience

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

Moderate symptoms, persist over months

Severe and chronic

Increasing likelihood of psychological distress

Contact with healthcare system

AMU
Effective treatments

• Good RCTs and systematic reviews for both antidepressants and brief psychological treatments.
• N.B. Refer to patients with moderate symptoms
• No efficacy/effectiveness studies for acute medical ‘MUS’ population
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>
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<tbody>
<tr>
<td>01 tricyclic antidepressants</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Heefner 197853</td>
<td>10/22</td>
<td>12/22</td>
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<td>5.94</td>
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<td>Myren 198259</td>
<td>5/30</td>
<td>10/31</td>
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<td>2.66</td>
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<td>Nigam 198436</td>
<td>14/21</td>
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<td>14.74</td>
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<td>Boerner 198856</td>
<td>16/42</td>
<td>19/41</td>
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<td>7.63</td>
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<td>Bergmann 199161</td>
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<td>14/16</td>
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<td>3.82</td>
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<td>Vij 199158</td>
<td>14/25</td>
<td>20/25</td>
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<td>10.67</td>
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<td>Drossman 200337</td>
<td>60/115</td>
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<td>Talley 200851</td>
<td>0/18</td>
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<td>Vahedi 200860</td>
<td>8/27</td>
<td>16/27</td>
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<td>5.02</td>
<td>0.50 (0.26 to 0.98)</td>
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<tr>
<td>Subtotal (95% CI)</td>
<td>319</td>
<td>256</td>
<td></td>
<td>67.56</td>
<td>0.68 (0.56 to 0.85)</td>
</tr>
</tbody>
</table>

Total events: 132 (treatment), 153 (control)

Test for heterogeneity: $\chi^2 = 10.94$, df = 8 (p = 0.21), $I^2 = 26.9\%$

Test for overall effect: $Z = 3.86$ (p = 0.0001)

| 02 selective serotonin re-uptake inhibitors |
|-----------------------|--------------|-------------|---------------------|----------|---------------------|
| Kuiken 200354         | 9/19         | 12/21       |                     | 5.85     | 0.83 (0.45 to 1.51) |
| Tabas 200455          | 25/44        | 36/46       |                     | 14.90    | 0.73 (0.54 to 1.01) |
| Vahedi 200552         | 6/22         | 19/22       |                     | 4.52     | 0.32 (0.16 to 0.67) |
| Tack 200657           | 5/11         | 11/12       |                     | 4.90     | 0.50 (0.25 to 1.04) |
| Talley 200851         | 5/17         | 5/16        |                     | 2.27     | 0.94 (0.33 to 2.60) |
| Subtotal (95% CI)     | 113          | 117         |                     | 32.44    | 0.62 (0.45 to 0.85) |

Total events: 50 (treatment), 83 (control)

Test for heterogeneity: $\chi^2 = 6.46$, df = 4 (p = 0.17), $I^2 = 38.1\%$

Test for overall effect: $Z = 2.74$ (p = 0.006)

Total (95% CI) 432 373

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>
Examples of people with MUS admitted to acute medical unit in last few months

• 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 male - Unexplained vomiting
- 45 female - Diabetic foot ulcer-not healing
3 common scenarios

• Pain
• Attacks
• Weakness/paralysis
To meet any psychiatric disorder under either ICD-10 or DSM-V, in addition to physical symptoms, there has to be evidence of psychological co-morbidity or associated psychological issues.
Understanding the problem using a biopsychosocial model

- Co-morbid anxiety or depression
- Childhood vulnerability factors
- Previous history of unexplained complaints
- Opiate dependency
- Maintaining factors
- Factitious (deliberate falsification of symptoms linked to emotional problems)
- Malingering (deliberate falsification of symptoms for financial gain or other non psychological motive)
Bio-psycho-social model

- Childhood adversity
- Exposure to physical illness as a child
- Genetic/physiological factors

Current stress

- Iatrogenic
- Family response
- Environmental

- Investigate
Some points

• 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.

• Unusual for MUS to begin in late life
• Explanations and models important
• Common
• Avoid referral if possible
• Avoid starting treatments
• MUS common in organic conditions
• Check medical notes thoroughly
Some points

• 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

• Avoid repeated investigations
• Stress may be overt

• Avoid provision of aids-be positive re future
• Enquire about psychological factors-involve liaison psychiatry early

• If more than one consultant involved-try to work as team

• Involve GP
• Consider case conference

• Refer early
The role of liaison psychiatry

- Refer early (i.e. as medical investigations are continuing)
- Normalise referral
- Assess and treat co-morbid psych problems
- Help develop a credible working model which involves a psychological component
- Work with staff to reduce unnecessary meds
- Develop a management plan which involves patient, family and GP.
- Access to community psychological services
Models are important: an example

Computer hard ware and software

Weakness or loss of function in a limb can be likened to either a problem in the nerves/brain (i.e. hardware) or a problems with the way the brain co-ordinates control of the nerves and limbs (i.e. the software).

Stress (via hormones or other chemical agents can interfere with the way software works leading to crashes)
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.
- Ensure patient understands the rationale and the harm continued use of opiates will cause
- Assess and treat depression, if present
- Assessment of factors which may be exacerbating presentations other than dependency
- Involve GP and family in management
- Agree pain relief regime in the community (set firm limits)
- GP will need support to manage patient
- Agree best professional to do this

- N.B Avoid under treating someone in acute pain!
Prognostic Factors

- Positive
- Negative
Services are limited

- Brief out-patient treatment from psychological services but long waiting lists
- One specialist in –patient unit for UK
<table>
<thead>
<tr>
<th>Patient concern</th>
<th>Physician response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t have any problems apart from my pain.</td>
<td>You have mentioned how fed up you have felt and the way your life has changed since your pain started and you have become quite disabled. It may be possible to help you with these things, even though you still have the pain.</td>
</tr>
<tr>
<td>Patient concern</td>
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<tr>
<td>There must be something you can give me for the pain, doctor. If you can just get rid of the pain, everything will be fine.</td>
<td>You have already had a lot of different drugs and other physical treatments and none of them has made any lasting difference. I’ve made a list of the number of different drugs you’ve had over the last two years. You’ve had 10 different drugs and none have helped. It’s important to face that now and try to explore a completely different approach.</td>
</tr>
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<tr>
<td>How can you be sure? The doctor told my aunt her pain was all in the mind and she was dead from cancer within the week.</td>
<td>A physical illness can never be completely ruled out, but you have had all the appropriate tests and they’re all normal. If you had a serious disease, like cancer, for the last two years, it would certainly have shown up by now. I’m aware of your concerns and I will keep an open mind. If your condition suggests that you need further investigations, I will certainly carry those out. I want you also however to keep an open mind and look at all the possibilities.</td>
</tr>
<tr>
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<tr>
<td>I want an operation. I ‘d be prepared to have an operation, if it would take my pain away. I’d even have my whole bowel removed, if it would make me better.</td>
<td>Well, I’m afraid, that operation would not make you better. An operation would involve removing a part of your bowel, but the tests have not shown that there is a part of your bowel that is damaged. In fact surgery is only likely to make your pain worse. As people with chronic pain often get problems with adhesions and other complications following surgery. I’m afraid an operation would make you worse.</td>
</tr>
</tbody>
</table>