LIAISON PSYCHIATRY

- Two days after admission for a hernia operation, a 52-year-old accountant clambers around the ward, convinced that the FBI are tracking him, walking carefully but clumsily, to avoid the snakes that he can see wriggling on the floor.

- A 19 year-old man with bilateral chest pains due to empyema, asks whether he can have help with his heroin problem.

- 17 year-old girl weighing 31 kg is refusing nasogastric tube feeding for anorexia nervosa.

- A 40 year-old unemployed divorced man, discovered by chance in a lonely wood has been admitted with carbon monoxide poisoning . . . . .

These scenarios are relatively common in general hospitals. All doctors, not just psychiatrists, need to be able to recognise and treat common conditions such as depression, anxiety disorders, delirium and substance misuse. In a few hospitals there is dedicated psychiatric input to ensure the optimum psychiatric/psychological care of patients admitted with ‘physical’ illness. The majority of hospitals in the UK have no psychiatric liaison service and therefore it is essential for you to have some knowledge about how you would cope with these potential stressful situations. You need to be able to recognise and assess these disorders, and to initiate treatment when appropriate.

Presentations in the general hospital where psychiatric input may be needed include:

Deliberate self harm; Delirium; Depression; Somatoform disorders; acute stress reactions - perhaps related to the physical presentation; Agitation/aggression; Alcohol and drug abuse; Capacity issues; Anxiety disorders; Dementia and depressive pseudo-dementia; Psychiatric manifestations of physical illness; Terminal care; Eating disorders; Sleep disorders; Factitious disorders; Pain . . .

……to name but a few!

DELIRIUM:

Diagnostic Criteria:

- **Disturbance of consciousness** - reduced awareness of environment with decreased ability to focus, sustain or shift attention.

- **Change in cognition** - memory deficit, disorientation, language disturbance or development of perceptual disturbances.

- **Acute onset** (hours to days) with **fluctuation** in severity.
Evidence from history, examination or lab findings that disturbance is caused by direct physiological consequences of a general medical condition.

Other common features include problems with sleep, psychomotor agitation or retardation, emotional lability, tremor, myoclonus, heightened reflexes and muscle tone.

Main differential diagnosis is dementia (usually alert, more insidious, non fluctuating).

Prevalence: 10-30% of the hospitalised medically ill; 25% of cancer patients; 30-40% of patients with AIDS; 50% of patients post operatively; 80% who are terminally ill will experience delirium.

Duration: Delirium typically resolves in 2 weeks but may last 30 days or more especially in the elderly. The morbidity and mortality is high with about 25% dying within 6 months.

Aetiology:

Many medical conditions can result in delirium, chiefly associated with:

- Electrolyte imbalance
- Acid/base disturbance
- Hypoglycaemia
- Other metabolic disturbances
- Hypoxia
- Pyrexia
- Substance abuse/withdrawal
- Drug reactions
- Head injury

This may be secondary to:

- CNS trauma (e.g. head trauma, seizures, post-ictal, vascular disease, degenerative disorders, stroke)
- Metabolic causes: renal, hepatic failure, anaemia, hypoxia, hypoglycaemia, thiamine deficiency, endocrinopathy, fluid/electrolyte imbalance, and acid base imbalance.
- Cardio-Pulmonary Disorders (MI, CCF, arrhythmias, shock, respiratory failure).
- Systemic Illness (neoplasm, infection, severe trauma, sensory deprivation, temperature dysregulation, post-op).
- Many substances can cause delirium through intoxication or withdrawal. These include alcohol, amphetamines, cannabis, cocaine, LSD, opioids.
Assessment and Treatment

A coordinated approach is necessary:

1. Thorough history and physical examination to ascertain underlying cause.

2. Check recent medication / drug chart for toxic states.

3. If the differential diagnosis is unclear, screen the following as appropriate:
   - FBC
   - Glucose,
   - U and Es,
   - Calcium magnesium, potassium, ammonia,
   - LFTs,
   - B12 and folate,
   - Blood cultures,
   - Serum blood levels
   - Blood gases,
   - urinalysis
   - ECG, chest X-ray
   - CT or MRI
   - EEG
   - LP especially if there is suspected encephalitis.

In a significant minority of cases the delirium is multi factorial. An example of this would be the alcoholic patients with delirium tremens who may also have e.g. hypoglycaemia, hypomagnesia and head trauma.

Treat the underlying cause and correct metabolic disturbances as indicated.

Maintain orientation - nurse in a well-lit side room with minimal staff changes. Reassure and reorientate as necessary.

Drug Treatment

Use anti psychotics if necessary to maintain patient safety. There is most experience with typicals e.g. haloperidol, although some of the newer atypical anti psychotics may also be used e.g. risperidone. The maxim is start low, go slow.

Benzodiazepines are the treatment of choice with alcohol withdrawal and can also be used if there are seizures. They may also be used in conjunction with antipsychotics to enable a lower dose of anti psychotic to be used. If there is hepatic damage lorazepam is the preferred benzodiazepine, as it is not metabolised by the liver. Vitamins may also be necessary especially in alcohol withdrawal.

DEPRESSION

This is common in physical illness but is often missed; 20-45% of patients with cancer have a depressive illness, approximately 30% post-stroke, 15-30% of patients’
post-MI, 35% of patients with chronic pain and 40% of patients with Parkinson’s disease also have depression.

Important points to consider include:

- Is the patient clinically depressed?
- Is there an organic cause (e.g. medication) that can be eliminated, treated or reversed?
- Would treatment of the medical condition alleviate the depression?

Depression is often dismissed as appropriate e.g. if someone has terminal cancer. **IT IS NEVER APPROPRIATE.** Not only does it greatly increase morbidity and undermine physical health, but it can also increase mortality. The more seriously the underlying illness more likely the depression will occur. Patients who have illness localised to the central nervous system are at much greater risk.

It is not always easy to diagnose depression in those who are physically ill, because some of the biological symptoms such as weight loss and sleep disturbance may be associated with the physical illness.

It is important to establish whether the patient has:

(a) depressed mood
(b) anhedonia
- If they do then treatment with anti-depressant medication may well be helpful.

**Differential diagnosis** of depression in the medically ill includes: an organic mental syndrome, anger, and organic causes of depression. The latter is similar to the organic causes of delirium and may include vascular, infective, neoplastic, degenerative, intracerebral, congenital, traumatic, infectious, vitamin deficiencies, endocrine, metal poisoning, anoxia, and depressive pseudodementia.

It is important to separate clinical depression, which responds to anti-depressant treatment with despondency secondary to physical illness. Physical illness may bring on dread, bitterness and despair. Work and relationships may be jeopardised, and there may be disappointment with what has and has not been accomplished. Management of this despondency is by encouraging the patient to express their concerns (but not forcing them), and normalising their experience. One should try to protect the patient’s self esteem and restore to life the real person behind the patient with serious physical illness.

Think about what psychological support is available - eg MacMillan nurses are very skilled at helping people to look at their fears about their illness and death. Social and practical help may also be needed and can restore some independence, which boosts self-esteem.

**PSYCHOSIS:**

Psychotic symptoms are actually fairly common within the general hospital. There is a wide variation in the clinical profile and most are only picked up when they become especially florid. It is important to ensure that both patients and staff are safe and that these symptoms are demystified. Try to obtain a well-ordered differential diagnosis, which helps to transform insanity, with its disturbing connotations, to a more
comprehensible disorder of brain function. In assessing someone with new onset psychotic symptoms, both medical conditions and toxic states should be screened for. The mini mental state examination is useful. Deficits in attention, or short-term memory suggest delirium or dementia rather than a primary psychotic illness. It is important to establish whether the symptoms relate to mood, substance misuse, medication and medical illness.

**Treatment**

In terms of medication symptoms usually improve with anti-psychotics regardless of the cause. If an organic psychosis is likely one must weigh up the duration, and severity of the symptoms verses the side effects of the medication. It is important to ensure that medication is not given long term in this case. Avoid sending people home on unnecessary medication. In those people who have a psychotic illness such as schizophrenia, the natural exacerbation of their symptoms related to stress usually improve without having to alter medications. High potency anti-psychotics e.g. haloperidol are the best of the typical anti-psychotics. Of the newer drugs risperidone does not cause anticholinergic side effects.

In terms of non-pharmacological management, emphasise that being in hospital is very stressful. The patients with psychotic illnesses may have difficulty in expressing their fears. As a doctor you should anticipate the unspoken fears. Patients may be easily overwhelmed and over-stimulated in a busy chaotic environment. Look for ways to reduce the stimulation - for instance nurse in a side room if possible.

**ANXIETY**

This is indistinguishable from fear except for cause and is an expected and normal transient response to stress (indeed it may be a necessary, adaptive response). Pathological anxiety is distinguished by its (a) autonomy (b) intensity (c) duration (d) behaviour.

Anxiety is very common. Some patients will come in with anxiety disorders and some will develop as a consequence of hospitalisation, medical illness or treatment. This is perhaps not surprising giving the stress of being in hospital where patients face internal and external dangers e.g. uncomfortable procedures, forced intimacy with strangers, an atmosphere of illness, pain and death, as well as separation from loved ones.

Some degree of anxiety is normal in the hospital setting. If anxiety leads to a sustained change in behaviour or becomes overwhelming the patient is likely to have some form of anxiety disorder. The management includes explaining procedures and diagnosis carefully and in straightforward terms, so that fear of the unknown is addressed and eliminated if possible. Contact with specialist nurses can help to demystify the condition. More specialised therapy may be indicated.

Anxiolytics (benzodiazepines) are rarely appropriate unless for the very short term (3 days maximum) - but may be helpful for example for the very anxious pre-operative patient.
If drug therapy is necessary longer-term tricyclic or SSRI antidepressants are appropriate.

THE ‘DIFFICULT’ PATIENT
This is behaviour rather than a diagnosis, but can cause huge problems on the ward. The patient often has abnormally intense affects and is unable to neutralise them. Their cognitive resources are distorted and primitive and these patients generally have an absence of higher defences, although primitive ones such as splitting and projective identification are very much present. These patients tend to dissociate easily and can distort reality. They see the world in black and white terms e.g. as good and evil. They try to manage negative effects with splitting (the nurses have been absolutely wonderful but the doctors just don’t care at all) and projection (the consultant wants to hurt me).
Normal people are able to tolerate ambivalence whereas patients with so called borderline personality disorders are unable to and shift from one feeling state to the opposite. Quite often in an acute ward situation such a patient will take an unwanted aspect of their self and project it totally on to the other person. The recipient will often respond and heighten the tension on the ward.

In dealing with these patients it is important to be aware but not to be too confrontational. These patients are extremely vulnerable to care-givers ordinary imperfections. Staff who are psychologically naïve may regress to a helpless or vengeful position, which only serves to foster the dysfunctional relationship. Careful explanation of these factors to staff may help to improve the milieu.

MENTAL HEALTH ACT IN THE GENERAL HOSPITAL
The Mental Health Act is usually used in psychiatric hospital settings or in the community and is monitored by the Mental Health Review Tribunal and the Mental Health Act Commission. In the general hospital there may be frequent occasions where people are, for example, transiently psychotic and the Mental Health Act is not used. Remember that the Mental Health Act is an enabling Act and should not always be used just because it can be.
The Mental Health Act only refers to mental illness rather than physical illness and treatments. As such, if a person lacks capacity and needs physical treatment, this should be done under common law without resorting to the Mental Health Act.
However there are certainly grey areas and as you will know the separation of mind from body is a very arbitrary and not necessarily a helpful one.

Capacity: This is a legal term and can only be ascertained by a registered medical practitioner. The patients should (a) understand in simple language what the medical treatment is (b) understand the risks, benefits and alternatives (c) understand the consequences of not receiving
the proposed treatment (d) retain the information for a long enough time to make a decision (e) believe the information (f) weigh the information in the balance to make a free choice.

The principle of necessity is the doctrine that in some situations it is appropriate to act to restrain people believed to be suffering from mental disorder who are exhibiting behaviour that suggests they are a risk to themselves or others. This should be the minimum intervention for the shortest time possible.

Bolam Test: When clinical decisions are made an individual clinician’s competence will be judged against what is considered reasonable and proper by a body of responsible doctors at that time.

All actions, whether or not the patient is detained under the Mental Health Act should be considered to be in the patient’s best interests. Thus if an individual who lacks capacity is admitted needing treatment to preserve life or function, it would normally be considered to be in the patient's best interest to administer the treatment.