Psychiatry

Definitions

- **Formal thought disorder**
  - circumstantial speech - excessive detail, digressions, but eventually gets to the point
  - tangential speech - multiple digressions, never gets to the point
  - flight of ideas - rapid sequence of related concepts
  - loosening of association (knight’s move) - rapid sequence of unrelated concepts
  - neologisms - new words; metonyms - new meanings for words
  - thought blocking - sudden cessation esp. mid-sentence, no recall, then digress
  - perseveration - continuous repetition of word or phrase; echolalia - parrot speech

- **Overvalued idea** - preoccupied with plausible belief causing distress

- **Delusion** - fixed false belief not part of patient’s culture; may be *mood-congruent* or *bizarre*

  - primary (spontaneous) or secondary (related to existing mental illness)
  - grandiose - exaggerated self-importance e.g. god, messiah, superpowers
  - persecutory - others wish to dethrone / besmirch / harm / cheat the patient
  - reference - phenomena have intense personal significance
  - erotomaniac (de Clérambault’s) - high-status person is in love with patient
  - infidelity (Othello’s) - patient’s lover has been unfaithful
  - misidentification - Capgras (familiar is impostor), Fregoli (stranger is familiar)
  - nihilistic - the patient / others / the world is dead / non-existent
  - hypochondriacal (somatic) - concerning patient’s body e.g. organs rotting
  - infestation (Ekbom’s) - small but visible organisms, associated with formication
  - control - thought insertion, withdrawal, broadcasting

- **Hallucination** - perception in the absence of external sensory stimuli

  - auditory - elementary (noise), complex (thought narration / echo, command, dialogue)
  - visual - usually in organic brain disease, substance misuse, Charles-Bonnet
  - hypnagogic - occur just before sleep; hypnopompic - occur just after waking

- **Pseudo-hallucination** - perceptual experience subjectively arising from *within the mind*

- **Illusion** - misperception / distortion of external sensory stimuli

Rapid tranquilisation

- Reduction in agitation / aggression to allow psychiatric evaluation

  - lorazepam (PO / IM) - alone if non-psychotic, with olanzapine if psychotic
  - consider haloperidol (with antimuscarinic prochlorperazine if IV)

- Complications - LOC, airway obstruction, respiratory / cardiac arrest, seizure, EPSEs
Anxiety disorders

- Management - best results with **psychotherapy** (CBT); consider **sertraline** / **venlafaxine**
- **Generalised anxiety disorder** (GAD) - chronic **continuous** (non-situational) anxiety / worry
  - patient recognises anxiety is excessive but difficult to control; symptoms for > 6 months
  - also restlessness, easy fatigue, impaired concentration, irritability, muscle tension
- **Panic disorder** - chronic **episodic panic**; **agoraphobia, social phobia, anticipatory anxiety**
  - symptoms - palpitations, sweating, shaking, dyspnoea, choking, chest pain, nausea, dizziness, derealisation, depersonalisation, fear of loss of control / death

Post-traumatic stress disorder (PTSD)

- Follows ‘exceptionally threatening or catastrophic event likely to cause distress in anyone’
- Symptoms arising within 1 year of the trauma:
  - **re-experiencing** - flashbacks, nightmares, hallucinations, reminders
  - **rumination / avoidance** - constant rethinking or memory suppression
  - **hyper-arousal / emotional numbing** - vigilance, irritability or detachment, withdrawal
- Management - CBT, **EMDR**; consider paroxetine / mirtazapine / **SSRIs** / **TCAs**
- Complications - substance misuse, general medical / MSK problems

Attention deficit hyperactivity disorder (ADHD)

- Persistent frequent severe inattention, hyperactivity, impulsivity across multiple settings
  - affects up to 2.5% of children, usually diagnosed before aged 7 years
  - associated with ASD, learning difficulties, Tourette’s, ODD / CD, anxiety disorder
- Management - initially parent education programmes, behaviour modification therapy
  - if severe - consider **methylphenidate**, atomoxetine, dexamfetamine
- Complications - DSH, accidents, substance misuse, delinquency

Bipolar disorder

- Chronic episodic behavioural illness with **strong genetic links**
  - DSM-IV type I - severe manic episodes; type II - hypomania without psychosis
  - manic episodes last around 4 months; depressive episodes longer
  - ‘rapid cycling’ - more than 3 consecutive alternating episodes in a year
- **Mania** - elevated mood, high energy / speed of activity, reduced sleep, self-importance
  - grandiose ideas, pressure of speech, flight of ideas, recklessness, sexual disinhibition
  - if severe - delusions (grandiose, persecutory), hallucinations, lack of insight
- Management - in acute mania oral **olanzapine** / **quetiapine**, lorazepam if agitated
  - if already on the above - increase dose / substitute for **lithium** or **sodium valproate**
  - if bipolar type II - consider lamotrigine or carbamazepine
- Complications - **suicide** (up to 50% attempt at least once)
Depression

• Persistent low mood most days or anhedonia, associated with at least 2 weeks of:
  • fatigue, low energy, worthlessness, guilt, suicidal ideation, impaired concentration, psychomotor retardation, insomnia, early morning waking, decreased appetite / weight
  • if severe - nihilistic delusions, derealisation, depersonalisation
  • episodes last around 6 months; mild cases have spontaneous recovery
  • Risks - female sex, significant / chronic illness, mental ill health, major life events
  • Associations - anorexia, substance misuse, Parkinson’s, DM, Addison’s, hypothyroidism
  • Management - initially guided self-help, relaxation therapy, brief psychological interventions
    • SSRIs - if severe; review after 2 weeks for anxiety, agitation, suicidal ideation
    • mirtazapine - second-line, sedating
    • continue for 6 months after remission, reduce gradually over 4 weeks
    • consider CBT, IPT, family therapy, counselling
    • ECT in severe refractory cases
  • Complications - suicide, increased risk of mortality from CVD

Eating disorders

• Body dysmorphic disorder - preoccupation with imagined defect in appearance
  • associated with poor insight, delusions, suicidal ideation, depression, substance misuse
  • consider CBT, exposure and response prevention (ERP), SSRI

• Anorexia nervosa - BMI < 17.5, distorted body image, amenorrhoea / signs of starvation
  • SCOFF - make self sick, lost control over eating, lost one stone in 3m, feel fat, food
  • complications - hypokalaemia, hypotension, anaemia, cardiac failure, osteoporosis

• Bulimia nervosa - preoccupation with body weight / shape, binge / purge cycles
  • risks - obesity (inc. parental), dieting, FH of eating disorder, abuse
  • Russell’s sign - calluses on dorsal hand from self-induced vomiting

Medically unexplained symptoms

• Hypochondrial disorder - excessive / baseless concern over specific diagnosis e.g. ca.

• Münchhausen’s syndrome - lying (pseudologica fantastica), wandering (peregrination)
  • classically presents with bleeding, fits, cardiac-type pain, overdose, GI disorder, DSH

• Münchhausen’s by proxy - carer (esp. mother) fabricating illness in young child

• Somatisation - physical symptoms arising from underlying psychological problems
  • usually chronic pain, IBS, dyspnoea, headaches, dysuria, impotence

• BATHE - background (current activities), affect, troubles (most), handle, empathy
Personality disorder

- Pervasive enduring pattern of experience / behaviour differing from cultural expectations
  - creates significant distress or impairment in social functioning
  - may be associated with childhood abuse, neglect, bullying others, DSH
- DSM-IV PD clusters (cannot be diagnosed before aged 18):
  - A (eccentric) - paranoid, schizoid, schizotypal
  - B (emotional) - borderline, antisocial, histrionic, narcissistic
  - C (anxious) - dependent, avoidant, obsessive-compulsive
- Management - mainstay is psychotherapy
- Complications - mood disorder, substance misuse, suicide

Schizophrenia

- Typically relapsing / remitting psychotic illness; prevalence around 1%, highest in inner city
  - associated with progressive structural brain abnormalities, defective neurotransmission
  - mostly affects aged 15 - 30 years; possible ‘prodrome’ of inattention, withdrawal
- Risks - FH, prematurity, low birthweight, intrauterine infection, social isolation, cannabis
- Symptoms - for at least 1 month, not explained by organic brain disease or substances
  - positive - delusions, auditory hallucinations, thought disorder, passivity phenomena
  - negative - blunted affect, poverty of speech, anhedonia, inertia, withdrawal, self-neglect
  - cognitive - memory / attention deficits, executive dysfunction, low social cues / etiquette
  - catatonic - rigidity, posturing, waxy flexibility, stupor, echopraxia, mannerisms, tics
- Management - olanzapine / quetiapine; consider depot
- Complications - homelessness, poverty, suicide, substance misuse

Substance misuse

- Pattern of substance use impairing functioning and / or compromising health
  - Dependence - desire, difficult to control, persisting misuse, priority, tolerance, withdrawal
- Complications - death, skin infection (inc. nec. fasc.), sepsis, IE, BBVs, TB, malnutrition

Opioids

- Opioids have both analgesic and euphoric effects; rapid dependence within 10 days
- Acute withdrawal - sweating, eye watering, rhinorrhoea, yawning, fever, cramps, nausea, tremor, goosebumps, insomnia, irritability, myalgia, tachycardia, HTN, dilated pupils
- Substitute prescribing - methadone and buprenorphine - to reduce use rather than quit
  - suitable if daily misuse, dependence, motivation to change, likelihood of compliance
  - induction (2-4wks) - methadone at 10-30mg PO solution od. / buprenorphine 8-16mg SL
  - supervision usually by community pharmacist for 3 months
**Detoxification** - takes 28 days as inpatient or up to 12wks in the community
- reduce methadone dose by 5mg / buprenorphine by 2mg every 1-2wks
- consider loperamide for diarrhoea, metoclopramide for nausea, mebeverine for cramps
- consider [naltrexone](https://www.nhs.uk/about-nhs/medical-products-and-drugs/naltrexone) post-detoxification for relapse prevention

**Smoking**
- Causes 100,000 UK deaths annually
- **Nicotine replacement therapy** (NRT) - patch, gum, nasal / buccal spray, SL, INH, lozenge
  - reduces withdrawal symptoms, controls weight gain
  - contra-indications - severe CVD, recent TIA / stroke; caution in PVD, DM, PUD
  - side-effects - nausea, dizziness, palpitations, dyspepsia, vivid dreams, skin irritation
- Begin bupropion / varenicline 1-2wks prior to intended stop smoking date
- **Bupropion** - atypical antidepressant, appetite suppressant, nicotine-receptor antagonist
  - contra-indications - pregnancy, epilepsy, anorexia, brain tumour, bipolar disorder
  - side-effects - dry mouth, insomnia, seizures (0.1%), anorexia, hallucinations, hepatitis
  - discontinue if abstinence not achieved at 9wks
- **Varenicline** - nicotinic ACh receptor partial agonist given as 12wk course
  - cautions - pregnancy, [history of psychiatric illness](https://www.nhs.uk/conditions/history-of-psychiatric-illness), CVD
  - side-effects - sleep disturbances, thirst, weight gain, AF, panic attacks, suicidal ideation

**Alcohol**
- Safe limits - 21 units (men) / 14 units (women); 1 unit is half-pint, small glass wine, 1 spirit
- **CAGE** - felt the need to cut down, annoyed at others’ judgements, guilt, eye-opener
- Acute withdrawal (6-12hrs) - agitation, tremor, tachycardia, HTN, sweating, nausea, craving
  - **alcoholic hallucinosis** (12-24hrs) - visual, auditory, tactile
  - **grand mal seizures** (24-48hrs)
  - **delerium tremens** (48-72hrs) - hyperadrenergic state, hallucinations (esp. Lilliputian)
- **Wernicke-Korsakoff syndrome** - caused by thiamine deficiency; affects 2% alcoholics
  - causes degenerative neuronal loss in cerebral cortex, hypothalamus, cerebellum
  - **Wernicke’s encephalopathy** - confusion, ataxia, ophthalmoplegia / diplopia / ptosis
  - associated with [confabulation](https://www.nhs.uk/conditions/confabulation), anterograde and retrograde amnesia, disorientation
- Management (acute withdrawal) - **chlor Diazepoxide** 20mg qds. reducing for 5-7 days
  - **Pabrinex** (vit. B complex) - 2 ampoules IV / IM od. for 3-5 days (low Mg may impair)
  - for DTs - glucose, diazepam, Pabrinex, magnesium
- Management (relapse prevention) - **acamprosate** may reduce cravings; continue for 1 year
  - **naltrexone** - reduces pleasurable effects, may prevent binges
  - **disulfiram** (Antabuse) - causes acetaldehyde accumulation / severe alcohol reaction
- Complications - stroke, cerebellar degeneration, ALD, pancreatitis, PUD, GI ca., HTN, arrhythmias, immunosuppression, hypoglycaemia, hyperlipidaemia, anaemia, osteoporosis
Overdose

- Management - consider activated charcoal (caution if drowsy; not for alcohols, metals)
  - Paracetamol - causes up to 150 deaths annually; > 150mg/kg or 12g total potentially fatal
    - peak plasma concentration 1hr post-ingestion; glucuronide conjugation, renal excretion
  - NAPQI build-up causes necrosis of liver and renal tubules (ALT > 1000 IU/L)
  - symptoms - initial nausea, vomiting; after 24hrs RUQ pain, jaundice suggests necrosis
  - alcohol - acutely may be protective (inhibits enzymes); chronically hastens progression
  - monitor glucose (low), PT / INR (prolonged), ABG (metabolic acidosis), U&Es (AKI)
  - consider activated charcoal if > 150mg/kg ingested within 1hr
  - give NAC if levels > 100mg/L at 4hrs or > 3mg/L at 24hrs; up to 100% effective at < 8hrs
  - give NAC with 5% glucose (normal saline otherwise) in 3 IV infusions:
    - 150mg/kg in 200ml over 1hr; 50mg/kg in 500ml over 4hrs; 100mg/kg in 1L over 16hrs
  - Opiates - drowsiness, respiratory depression, hypotension, nausea, pinpoint pupils, ALI
    - give naloxone 0.4 - 2mg IV / IM; repeat if no response after 2mins
  - Aspirin - nausea, hyperventilation, tinnitus, deafness, sweating, confusion, seizures
    - treat with rehydration, sodium bicarbonate (alkalinise urine), haemodialysis if severe
  - TCAs - dry mouth, hypotension, coma, convulsion, respiratory failure, arrhythmias
    - consider benzodiazepines if delirium / convulsions, sodium bicarbonate if arrhythmias
  - Benzodiazepines - drowsiness, ataxia, dysarthria, nystagmus, coma
    - consider flumazenil only if not mixed overdose and not benzodiazepine-dependent

Deliberate self-harm (DSH)

- Includes mechanical self-injury, overdose, harmful substance misuse
- Risks - psychiatric disorders, domestic violence, poverty, stress, abuse, bullying
- Management - ideally structured psychological intervention
- Complications - suicide (up to 100-fold increased risk)

Suicide

- Risks - male sex, age (40s), unemployment, mental illness, substance misuse, chronic illness / pain, significant adverse life events, social isolation, institutionalisation, divorce
- Intent e.g. Beck’s / Pierce suicide intention scales
  - advance planning - premeditation, affairs in order, suicide note
  - precautions to avoid detection - concealment, timing, isolation
  - lethality - specific desire to die, violent methods, expectation of success
  - reflection - disappointed, regretful, guilty, called for help
- Always assess for depressive or psychotic symptoms and substance misuse