

PSYCHIATRIC EMERGENCIES

Acknowledgements: Most of the information included in this chapter was obtained from the Handbook of Psychiatry, 2005, Mental Health Information Centre of SA, Department of Psychiatry, University of Stellenbosch.

Chapter by Professors Dana Niehaus, Soraya Seedat, Willie Pienaar and Dr Sandra Brink.

THE AGGRESSIVE RESTLESS PATIENT

Predicting aggressive behaviour remains a difficult science. However, the clinician should be aware of the most commonly encountered risk factors for aggressive behaviour. The two most common risk factors are a history of aggression and recent alcohol intake. The proper and safe management of an aggressive, restless patient can minimise the distress experienced by staff, individuals and families.

The following conditions can present with aggression: Mental retardation, behaviour disorders, delirium, dementia, psychotic disorders, intermittent explosive disorder, personality disorders (paranoid, antisocial, borderline and narcissistic), V-code diagnoses, and adjustment disorders characterised by behavioural disturbances.

Bear in mind, however, that delirium is not an indication for certification. Patients with psychiatric disorders should be certified, in accordance with the relevant articles in the law. Here the family plays a role, since they can apply for certification. This process ought to be discussed with them. In extreme cases, where the usual certification procedure cannot be followed, emergency certification can be performed as a last resort. You should be thoroughly acquainted with the procedures that need to be followed in both of these circumstances.

DRUG-INDUCED SIDE EFFECTS

Akathisia:

The use of antipsychotic medication (and particularly high potency drugs), and in some cases serotonin antidepressants, can lead to this side-effect. The symptoms are described as a subjective feeling of restlessness that can often be observed objectively. The person may, for example, keep changing their position, shift their weight from side to side or keep moving about. It can easily be confused with restlessness due to illness, and lead to an incorrect increase in the dose of antipsychotic medication. Akathisia usually starts between day 6 and 60 after treatment initiation and is associated with an increased risk for suicide. Intervention by the patient's psychiatrist or treating doctor is indicated.

Acute dystonia:

Acute dystonia is a side-effect of antipsychotic medication (usually the high potency drugs) and comprises sustained muscle contraction. In addition to the discomfort of muscle spasms and the distress of an oculogyric crises (where the downward gaze is impossible due to contraction of the eye muscles), laryngeal muscle contraction may lead to respiratory distress.

Neuroleptic malignant syndrome (NMS):

NMS is a potentially lethal side-effect of antipsychotic medication (typical, atypical and even in rare cases clozapine). However, it is more common with the typical and more specifically the high-potency drugs. The prevalence ranges from 0.02 to 2.4% and the mortality rate is approximately 20%.

The most common symptoms are excessive sweating (due to increased body temperature), labile blood pressure, tachycardia, muscle rigidity, dystonic reactions, and in severe cases, with catatonic symptoms.

The first sign is usually a deterioration of the psychosis and often delirium. NMS can occur at any time during the treatment with antipsychotic medication. Patients that receive antipsychotic medication for the first time, are treated with high-potency drugs, have a history of NMS, or are young, black or male, are at an increased risk for NMS.

Discuss treatment options with a specialist. Management is mainly supportive. Immediately discontinue the antipsychotic medication and admit the patient to a medical emergency unit. Monitor the fluid balance and kidney function. Anticholinergic drugs are sometimes given for the muscle rigidity, while benzodiazepines also help to relax the muscles. Keep the patient's body temperature within normal limits.

Lithium toxicity:

Lithium toxicity is a serious medical emergency that can lead to death. To avoid this side-effect, patients on lithium must be evaluated regularly for signs of toxicity and increased plasma levels. Plasma levels higher than 1.2 is associated with toxicity. The physical signs of toxicity are divided into gastrointestinal (anorexia, nausea and diarrhoea) and central nervous system effects (muscle weakness, sedation, ataxia, tremor and muscle contractions). At higher plasma levels disorientation and convulsions occur. Coma and death can follow. Lithium toxicity necessitates the immediate discontinuation of lithium and supportive therapy (sometimes dialysis is needed). Although lithium can be re-instituted once the levels have normalised, it would be wise to first discuss the case with a specialist.

Serotonin syndrome:

The serotonin syndrome stems from an overstimulation of the serotonin system. This syndrome has been reported with the simultaneous use (or overdose) of SSRI's, MAOI's, TAD's with a serotonin effect, and St John's Wort. Symptoms include: agitation, restlessness, excessive sweating, diarrhoea, increased reflexes, poor coordination, confusion, myoclonus and tremor. Onset is usually within hours of the

initiation of medication or change in dose. Management depends on the immediate discontinuation of the drug(s) and supportive therapy. Discuss your treatment options with a specialist.