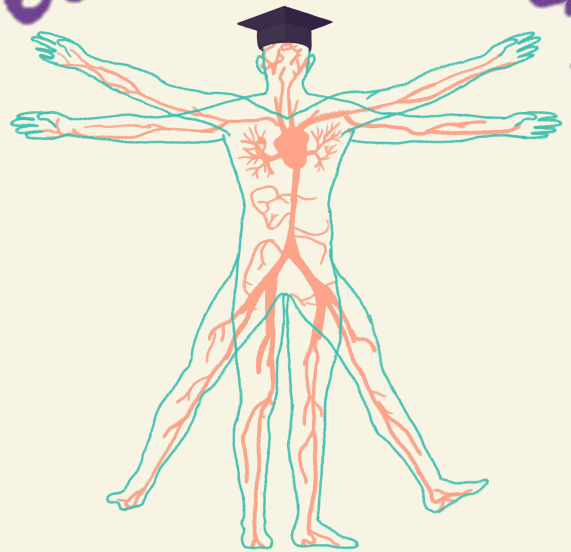
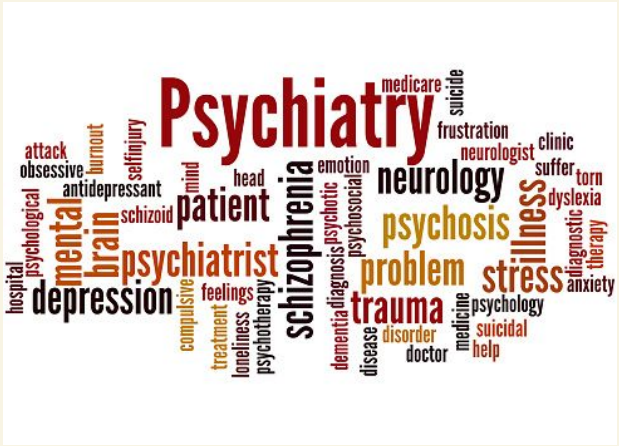
Peer Teaching



Society

2023/2024

Psychiatry



Phase 3A Revision Session

Shadha Shabani

November 2023

Aims and Objectives

ADHD
Mood disorders - depression
Autistic spectrum disorders
Bipolar disorders
Anxiety
OCD
Postpartum depression/psychosis
PTSD
Old-age psychiatry
Learning disabilities
Psychosis
Schizoaffective disorder
Schizophrenia
Other delusional disorders
Personality disorders
Phenomenology
Psychopharmacology
Counselling and psychological therapy
Hypnotics
ECT
Phobia
Psychiatric Emergencies
Substance misuse
Addictive behaviours
Drug Overdose
Alcoholism and withdrawal
Self-Harm, Suicide and risk
Mental health law
Wernicke's encephalopathy
Cognitive impairment
Dementia and Delirium

not covered in this presentation

- Psychiatric History and MSE
- Psychopharmacology
- Mental Health Act
- Common Presentations
- Risk Assessment
- Psychiatric Emergencies
- Example SBAs

History and Examination

Psychiatric History-Taking

- **History of Presenting Complaint**
  - Onset, duration, ?triggers, ICE
  - Screen for depression, psychosis, suicidal ideation, harm to self or others
- **Past Psychiatric History**
  - ?similar issues in past, any diagnoses, any previous admissions (sectioned/voluntary)
- **Past Medical History and Drug History**
  - Physical health and medications
- **Family History**
  - Mental health in family
  - Relationship with family

Psychiatric History-Taking

- **Personal History** - *predisposing factors*
  - Childhood milestones, unpleasant experiences eg abuse, education (enjoyment, qualifications, friends/bullies), employment chronology (relationship with coworkers), relationships (current and past), forensic (?offences)
- **Social History**
  - Accommodation, support network, finances, hobbies, alcohol/smoking/drug use
- **Premorbid History**
  - “Would people describe you differently now than you were before?”

Mental State Examination

Occurs throughout the assessment process- while taking the history, but present it separately

ASEPTIC

- Appearance and behaviour
- Speech - rate, tone, volume, quantity, flow
- Emotion (Mood and Affect)
- Perception
- Thoughts - form, content, possession
- Insight
- Cognition (Orientation to time, place, person)

Psychopharmacology

Overview

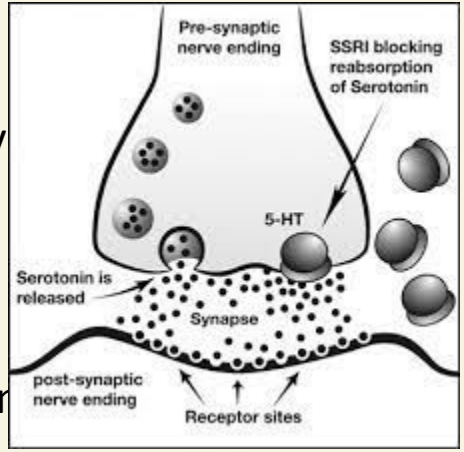
Drugs to know:

- Antidepressants
- Anxiolytics
- Hypnotics
- Antipsychotics
- Mood stabilisers
- Medication used in addictions
- Medication used in dementia
- Medication used in ADHD

Plus important interactions / any common or dangerous side effects

SSRIs

- Eg: **sertraline, fluoxetine, paroxetine, citalopram, escitalopram**
- Fluoxetine for under 18s
- Indicated for use in: **depression**, **anxiety**, **OCD**, bulimia nerv
- Mechanism: **inhibit the reuptake of serotonin** from presynaptic serotonin pumps
- Side effects: GI symptoms, anxiety/agitation, insomnia, sweating, sex (anorgasmia)
- Other side effects: associated with **increased suicidality**, car cause hyponatraemia, cytochrome-mediated interactions (fluoxetine)
- Withdrawal: dizziness, headache, tremor, agitation, GI issues ~ esp paroxetine and sertraline



SNRIs

- Eg **venlafaxine, duloxetine**
- Indicated for use in: **depression**, **anxiety**
- Mechanism: presynaptic blockade of both noradrenaline and serotonin reuptake pumps (in high doses also blocks dopamine reuptake); low effects on muscarinic, histaminergic and alpha-adrenergic receptors.
- Side effects: dizziness, dry mouth, constipation, hot flushes

NaSSAs

Noradrenergic and Specific Serotonergic Antidepressants

- Ie **Mirtazapine**
- Indicated for use in: **depression**, **anxiety** (off license)
- Mechanism: presynaptic alpha2 blockage -> increased noradrenaline and serotonin from presynaptic neurons; histamine antagonist
- Side effects: **sedation** and weight gain (blocking histamine), headache, postural hypotension, dizziness, tremor

Tricyclic Antidepressants

- Eg **amitriptyline**
- Indicated for use in: **depression**, **anxiety, OCD, chronic pain** (much lower dose), nocturnal enuresis
- **CI: IHD, arrhythmias, severe liver disease, overdose risk!!**
- Mechanism: blockade of both noradrenaline and serotonin reuptake pumps (also dopamine to a small extent). Muscarinic, histaminergic, alpha-adrenergic.
- Side effects - ***Triple A:***
    - **Anticholinergic** effects (muscarinic receptor block): dry mouth, constipation, blurred vision, urinary retention
    - **Antiadrenergic** effects: postural hypotension (dizziness and syncope)
    - **Antihistaminergic** effects: sedation and weight gain
    - Also **cardiac effects**: prolonged QT, heart block, arrhythmias, palpitations

MAOIs

Monoamine Oxidase Inhibitors

- Mechanism: inhibit enzyme Monoamine oxidase A & B
- Indicated for use in: **depression**
- Side effects: **overdose risk**, tyramine cheese reaction (hypertensive crisis)
- Not often used in clinical practice

Lithium

- Indicated for use in: **mania** (acute/prophylaxis), treatment-resistant depression, aggression and impulsivity, **mood stabilisation**
- Mechanism not clearly known
- Renally metabolised and excreted - *avoid NSAIDs, ACEi, diuretics*
- **MONITORING essential!!!**
- **Baselines** prior to starting: FBC, U&E, Ca2+, PO4*3-, thyroid, ECG, pregnancy
- **Weekly blood tests until stable levels, then 3-monthly** ~ renal & thyroid bloods too
- **Narrow therapeutic index:** range generally 0.5-1, 1.5-2= signs of toxicity, >2 signs of severe toxicity
- Side effects: polyuria, polydipsia, weight gain, oedema, fine tremor
- Serious side effects: coarse tremor, ECG changes (QT), arrhythmias, nystagmus dysarthria, brisk reflexes, impaired consciousness
- **TERATOGENIC** - causes Ebstein's anomaly (congenital malformation of tricuspid valve)

Sodium valproate

- Indicated for use as: **mood stabiliser, anticonvulsant**, migraine
- **HIGHLY TERATOGENIC** - avoid in pregnant women/women of childbearing age!
- Side effects: weight gain, dizziness, hair loss, n+v, tremor, deranged LFTs

Benzodiazepines

- Eg: **lorazepam** (short acting), **diazepam** (longer acting), **midazolam, chlordiazepoxide**
- Indicated for use in: **anxiety** (short term in extreme cases only), **mania**, **psychosis**, **alcohol withdrawal**, insomnia, **acute agitation/aggression**, epilepsy, acute back pain
- Mechanism: bind to GABA receptor -> neuronal inhibition
- Cautions: can be addictive if taken long term**, resp and CNS depressant effects** (so check if other CNS depressants being taken eg xs alcohol or antipsychotics)
- Avoid in neuro disease, severe resp disease

Z-drugs

- Eg: **zopiclone**
- Indicated for use in: initiating sleep (sleeping tablets)
- Mechanism: stimulate GABA receptor
- Can become dependent
- Again caution in resp and neuro disease

Antipsychotics

- Indicated for use in: **psychosis**, **mania**, depression, refractory anxiety, PTSD, behavioural challenges in dementia, tourettes, rapid tranquilisation

- Side effects: effects of anticholinergic, histamine blockage, alpha-adrenergic receptor blockage; can lower seizure threshold, ECG QT prolongation

- **Extrapyramidal side effects** (assoc with typical APs):
  - **Parkinsonian** symptoms: resting tremor, rigidity, bradykinesia
  - **Acute dystonia**: painful involuntary contraction of muscles - in neck/jaw/eyes
  - **Tardive dyskinesia**: rhythmic movements of tongue/face/limbs/trunk - after years
    - *avoid anticholinergic drugs!*

Antipsychotics

Typical antipsychotics

- Mechanism: antagonise D2 receptors involved in: mesolimbic (delusions and hallucinations), mesocortical (negative symptoms), substantia nigra (movement, blocking -> extrapyramidal side effects), tuberoinfundibular (prolactin secretion -> sexual function and libido), chemoreceptor trigger zone (n+v)

- Eg: **haloperidol, chlorpromazine, flupentixol**

Atypical antipsychotics

- Mechanism: block 5HT2 receptor -> metabolic side effects (eg weight gain, impaired glycaemic control, lipid elevation)

- Eg: **risperidone, olanzapine, quetiapine, aripiprazole, clozapine**

- **Clozapine:** use in **treatment-resistant schizophrenia**; lots of side effects inc hypersalivation, constipation, myocarditis, cardiomyopathy, **neutropenia** and **agranulocytosis**!

Oral Substation Therapies

Methadone

- Used as oral substitution therapy in addictions
- Opiate receptor agonist
- Risk of respiratory depression

Buprenorphine

- Oral substitution in opiate dependence
- Partial opiate receptor agonist
- Patient needs to be in state of withdrawal before starting or will cause withdrawal

AChE Inhibitors

Acetylcholinesterase Inhibitors

- Eg: **donepezil**, **rivastigmine**, galantamine
- Indicated for use in: **mild-moderate Alzheimer's disease**
- Baseline ECG and PR - risk of bradycardia
- Side effects: fatigue, GI issues, bradycardia

Methylphenidate

- Indicated for use in: **ADHD management**
- Mechanism: reuptake of dopamine and noradrenaline
- Modified (slow) release and fast release preparations
- Side effects: anxiety, inc BP, arrhythmias, appetite loss

Mental Health Law

Mental Health Act - 1983

A patient can be detained if:

They **have a mental disorder** that poses **significant risk to themselves or others**, and **treatment in the community is not possible** because of this

Mental Health Act - Sections

- Holding Powers - to stop patient leaving a ward, no MHA needed
  - **Section 5(4):** MH Nurse HP: can stop psychiatric patient leaving a ward up to 6hrs to allow for assessment by a doctor
  - **Section 5(2):** Doctor HP: can stop a patient leaving any ward up to 72hrs to allow for MHA to be organised

- Require MHA Assessment - 1 AHMP + 2 Section 12 Approved doctors
  - **Section 2:** 28 days ; for assessment (can treat)
  - **Section 3**: 6 months ; for treatment
    - Patient has right to appeal via tribunal

Mental Health Act - Sections

- Police Powers
  - **Section 136**: to take an individual to a place of safety - from a public place
  - **Section 135**: to enter someone's property and take them to a place of safety, needs magistrate approval

Mental Health Act - Sections

	Purpose	Duration	Professionals	Evidence
Section 2	Assessment	28 days	2 doctors (1 S12 approved) + 1 AMHP	1.Mental disorder present 2.For patient's safety or protection of others
Section 3	Treatment	6 months (can be renewed)	2 doctors (1 S12 approved) + 1 AMHP	1.Mental disorder present 2.Treatment in best interest 3.Treatment is available
Section 4	Emergency	72 hours	1 doctor, 1 AMHP	1.Mental disorder present 2.For patient's safety or protection of others 3.Not enough time for 2nd doctor to attend

Mental Health Act - Sections

	Purpose	Duration	Additional Info
Section 5(2)	Doctors' holding power	72 hours	-to wait if S2 or S3 are needed -FY2 and above
Section 5(4)	Nurses' holding power	6 hours	-to wait for medical assessment
Section 135	Police section	36 hours	-needs court order to access pt's home and remove them to a place of safety
Section 136	Police section	24 hours	-person suspected to have a mental disorder in a public place

Common Presentations

Core Problems

Addictive behaviours (drugs / alcohol / gambling)

Personality and identity (personality disorder types / gender)

Anxiety (panic / OCD / social anxiety)

Self-harm (risk assessment / personality / coping mechanisms)

Mood disorder (bipolar / depression / mania)

Cognitive impairment (dementia / brain injury / delirium)

Psychosis (schizophrenia / bipolar / schizoaffective / organic)

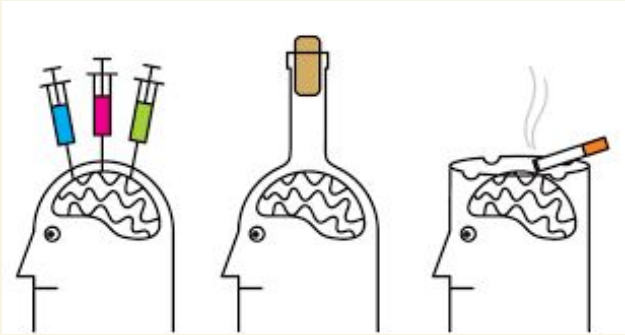
Learning disability (+ neurodevelopmental ASD / ADHD)

Liaison (+ eating disorders / perinatal / medically unexplained symptoms / somatisation)

Addictive Behaviours

- Eg pathological gambling/gaming/substance misuse etc - ***repeated*** *behaviours that* ***dominate*** *the patient's life to the* ***detriment*** *of social, occupational, material and family values and commitments*

- Features of substance misuse:
  - Acute intoxication, hazardous use (puts individual at risk), use despite harmful effects to physical/mental health, tolerance to substance, withdrawal, dependence, residual disorder, compulsion to take, prioritising over commitments
  - 3 or more symptoms from ICD-10 Criteria for >1 month



Substance Misuse management

Assessment / Ix:

- MSE, physical Ex (?IVDU/?withdrawal)
- Bloods, urine toxicology, CXR, ECG, Echo

Management:

- CBT
- Opioid dependence:
  - Detox regimes (Methadone/Buprenorphine/Dihydrocodeine), Lofexidine (relieve withdrawals), Naltrexone (prevent relapse), Naloxone (Tx of overdose)
- Smoking:
  - NRT (stop smoking cigarettes), Champix/Varenicline (reduce cravings), Bupropion/Zyban (reduce pleasure)

Alcohol Abuse management

Pathophysiology:

- up-regulation of NMDA receptors + down-regulation of GABA receptors -> cessation causes CNS-hyperexcitability

Intoxication Sx:

- slurred speech, ataxia, impaired judgement ; severe Sx: coma, hypoglycaemia

Withdrawal Sx:

- **malaise, tremor, nausea (within 6hrs) -> seizures (36hrs) -> delirium tremens (72hrs)**

Assessment and Ix:

- AUDIT, CAGE, SADQ, FAST ; CT head, ECG, bloods

Management:

- CBT, AA; **chlordiazepoxide (treat withdrawal) + IV thiamine/pabrinex;** disulifram (induces bad sx when drinking), naltrezone (dec pleasure), acamprosate (dec cravings)

Personality Disorders

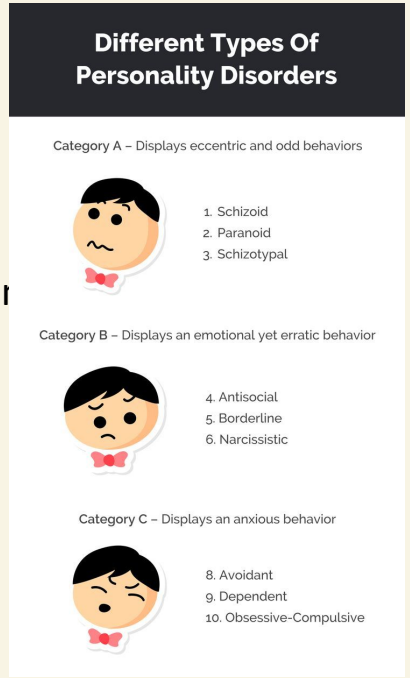
Definition: An enduring long-term pattern of inner experience and behaviour that deviates markedly from cultural expectations (of the individual) and leads to significant distress or impairment to self or others.

- Patterns manifest in: **cognition, interpersonal functioning, impulse control, affectivity**.
- **Enduring** nature, cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Patterns are **inflexible** and **pervasive** across personal and social situation and present in adolescence/early adulthood.

Risk factors:

- Socioeconomic status, positive family history, poor parenting, attachment issues in childhood, childhood abuse/neglect/deprivation.

Categorised by DSM-V into **clusters** - according to predominant features



Personality Disorders

Personality disorders	Description
Cluster A	
Paranoid	Sensitive, suspicious, unforgiving of others, spouse fidelity questioned, perceives attack, jealous, criticism not liked, distrust of others, preoccupied with conspiratorial explanations and self-referential
Schizoid	Emotionally cold, detached affect, lack of interest in others, indifferent to praise/criticism, tasks done alone, sexual drive low
Schizotypal	Interpersonal discomfort with peculiar ideas, perceptions, appearance, eccentric behaviour, speech and beliefs are odd, inability to maintain friendships, lack of companionship, emotionally cold
Cluster B	
Antisocial	Callous lack of concern for others, disregard to rules and responsibility, irritability, aggression, incapacity to maintain relationships and evidence of childhood conduct disorder
Emotionally unstable personality disorder	1. Impulsive type: violent, impulsive and poor response to criticism 2. Borderline type: Self-image and chronic feelings of emptiness, intense and unstable relationships, self-harm and suicidal attempts profound
Histrionic	Self-dramatisation, shallow affect, egocentricity, craving attention and excitement and manipulative behaviour
Narcissistic	Grandiosity, lack of empathy and need for admiration
Cluster C	
Avoidant	Tension, self-consciousness, fear of negative evaluation by others, timid, social inhibition and insecure
Dependant	Reassurance required, expressing disagreement is difficult, lack of self-confidence, abandonment fears, needs others to assume responsibility, companionship sought and exaggerated fears
Obsessive-compulsive disorders (ICD refer to as 'Anankastic')	Doubt, indecisiveness, caution, pedantry, rigidity, perfectionism and preoccupation with orderliness and control

Personality Disorders

Investigations

- Psychiatric history + MSE
- Personality diagnostic questionnaire (PDQ-IV)
- Minnesota multiphasic personality inventory

Management

- Risk assessment
- **No specific pharmacological Tx** - can treat depression/anxiety, and use mood stabilisers/antipsychotics
- **Psychotherapies** eg CBT, DBT, MBT, psychodynamic therapy

Anxiety Disorders

<u>Anxiety</u>: a subjective, unpleasant sense of unease and worry of sth bad happening.

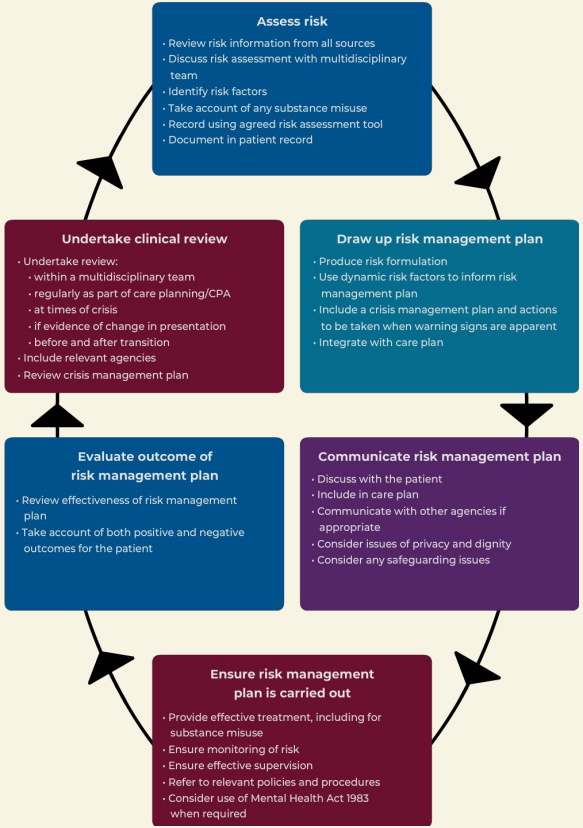
- **Generalised Anxiety Disorder**: numerous day-day worries -> **SSRI, CBT**
- **Social Anxiety:** fear of being ridiculed in social situations -> **SSRI, CBT**
- **Specific phobias:** irrational fear of particular things -> **CBT/desensitisation**
- **OCD**: obsessions (recurrent unpleasant intrusive thoughts/images) + compulsions (an action to alleviate the anxiety), insight of irrational fears -> **SSRI, exposure response prevention**
- **Panic attacks:** short lived episodes approx 20mins; severe anxiety, palpitations, rapid breathing, existential fears -> **SSRI**, **BB eg propranolol**
- **Panic disorder:** unpredictable repeated panic attacks (within 1 month), no specific psychiatric cause -> **CBT +/- SSRI**
- **PTSD**: onset 1 month following a catastrophic event to self/others; reliving, hyperarousal, nightmares, intrusive thoughts/images, flashbacks, avoidance of triggers -> **SSRI, CBT, EMDR**

Risk Assessment - harm to self/others

Ways of assessing risk:

- **Risk assessment tools** eg DRAM, FACE
- **Clinical Assessment** - psychiatric history + MSE
- **Static risk factors** - *do not change*
- **Dynamic risk factors** - *may change*

Consideration of: history, environment, mental state, info from other sources (eg criminal records/carers), MDT, **how serious and how immediate** the risk is



Risk Assessment - harm to self/others

Static risk factors

- History of self-harm/ overdoses
- Seriousness of previous suicidality
- Previous hospitalisation
- History of mental disorder
- History of substance use disorder (overdose or suicide)
- Personality disorder/traits
- Childhood adversity
- Family history of suicide
- Age, gender and marital status

Dynamic risk factors

- Suicidal ideation, communication, and intent
- Hopelessness
- Psych Sx – ?command hallucinations
- Treatment adherence
- Substance use
- Psychiatric admission and discharge - risk when discharged
- Psychosocial stress
- Problem-solving deficits

Depression

Depression:

1. **2 Core symptoms:**
   - Persistently low mood, low energy, loss of enjoyment (anhedonia) - present most days for at least 2 weeks, and not due to grief/substance use
2. **Associated symptoms**
   - sleep disturbance, poor concentration, libido loss, worthlessness, hopelessness, change in weight/appetite, inappropriate guilt, psychomotor agitation/retardation, fatigue, suicidality

- Severity according to **PHQ-9, functioning, ?suicidality**
- **Psychosis** can occur in severe depression (delusions re poverty, guilt, death)

Depression

DDx:

- Hypothyroidism, neuro disorders (parkinson's, MS, dementia), adverse drug effects
- Substance misuse, grief reaction, anxiety disorders, BPD, PMDD

Assessment / Ix:

- Psychiatric Hx + MSE + risk assessment
- Questionnaires: **PHQ-9**, HADS, BDI-II
- **Bloods**: FBC, U&E, LFT, TFT, Ca2+, B12/folate, glucose, CRP/ESR
- Other tests: urine toxicology, thyroid antibodies,24hr urinary free cortisol

Mx - **psychological therapies (IAPT) and/or antidepressants**:

- Mild: guided self help, IPT, group-based low intensity CBT
- Moderate: high intensity CBT +/- SSRI
- Severe: high intensity CBT + SSRI

NICE: Do not routinely prescribe antidepressants first line! Follow up if prescribed

Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total Score: 1-4 Minimal depression; 5-9 Mild depression; 10-14 Moderate depression; 15-19 Moderately severe depression; 20-27 Severe depression

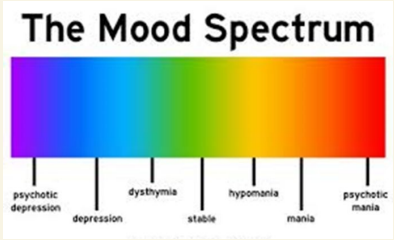
Other Affective Disorders

Seasonal Affective Disorder:

- Recurs annually around same time (often winter) with remission in between.
- Mx: light therapy, SSRI

Dysthymic disorder:

- 2-5yr persistent subthreshold depressive Sx
- Mx: SSRI, CBT



Postnatal depression:

- Peaks 3-4wks postpartum, may occur anytime during first year.
- DDx: “baby blues” = occurs 2-3days after birth and resolves within 2 weeks
- Mx: CBT, SSRI (if breastfeeding: sertraline/paroxetine preferred)

Bipolar Disorder

<u>Bipolar:</u> episodes of **depression + mania(T1)/hypomania(T2)**

Diagnosis requires **at least 1 episode** of mania or hypomania.

- **Mania**:
  - >1wk, totally impaired functioning +/- psychosis
  - Elevated mood, energy, irritability, disinhibited, grandiosity, flight of ideas, dec sleep, pressured speech
- **Hypomania**:
  - 4+ days, somewhat impaired daily functioning
  - Similar Sx but less severe and no psychosis

Cyclothymic disorder: recurrent depressive and hypomanic states, lasting >2yrs, does not meet diagnostic threshold for a major affective episode

Bipolar Disorder

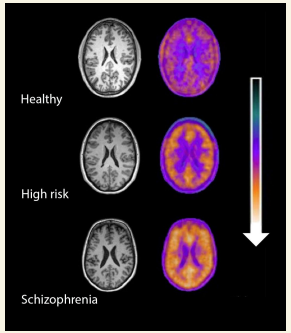
Mx:

- Psychoeducation
- Psychotherapy - **IPT, CBT**
- Social support eg family, support groups

- Pharmacological:
  - Maintenance: **lithium**
  - Mood stabilisers: lithium, sodium valproate, carbamazepine
  - Depressive episode: **SSRIs**
  - Psychotic symptoms: **antipsychotics**
  - Acute mania: **quetiapine + lithium + benzodiazepines**

Schizophrenia

Complex chronic psychotic condition - essentially an *impairment of perception and thinking*



<u>First Rank Symptoms:</u>

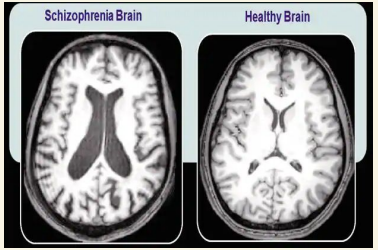
- Delusional perceptions, auditory hallucinations, thought disorders (insertion, broadcasting or withdrawal), passivity phenomenon

Positive Symptoms:

- First Rank Sx, thought form disorder, incongruent affect

Negative Symptoms:

- Affective blunting, alogia, apathy, anhedonia, attentional impairment



RFs: FHx, traumatic childhood events, childhood cannabis use, birth trauma, maternal poor health, urban living, emigrating to more developed country

- **Poor prognosis**: FHx, abuse Hx, substance misuse, teenage onset, low IQ, male.
  Better prognosis: high IQ, sudden onset, strong support network, obvious precipitating factor eg traumatic life event, +ve Sx predominate.

Schizophrenia

Paranoid schizophrenia:

- Prominent paranoid delusions and auditory hallucinations

Hebephrenic (disorganised) schizophrenia:

- Disordered thought/affect, v chaotic and disorganised, delusions/hallucinations less prominent

Simple schizophrenia:

- Characterised by negative symptoms

Mx:

- Consider **psychological therapies** eg CBT/family therapy
- Pt needs significant degree of **social support**
- **Antipsychotics**:
  - **Atypical** trialled first
  - If 2 antipsychotics tried without success -> “treatment-resistant” -> **clozapine**
  - **Depots** if compliance an issue

Eating Disorders

Bulimia:

- **Episodes of compulsive uncontrollable bingeing** (xs amount of food in <2hrs) **followed by compensatory behaviour to prevent weight gain**
  - Compensation may be via purging (vomiting/laxative/diuretic), xs exercising, or fasting
  - Driven by feelings of shame/guilt about binge
- May have normal BMI, periods usually present
- **Body dysmorphia**
- Physical Sx: low/normal BMI, hypotension, **dental erosion**, **parotid gland swelling**, **Russell's sign** (scarring on fingers from induced vomiting)
- Cx: metabolic alkalosis, Mallory-Weiss Tear, dehydration, GORD/ Barrett's oesophagus, constipation, cardiac arrhythmias, prolonged QT on ECG
- Mx: **SSRIs**, **CBT**, **IPT**, **psychoeducation** (re vomiting and laxative use)

Eating Disorders

Anorexia Nervosa:

- Bodyweight <15% of expected / **BMI <17.5**
- **Dread of gaining weight**, feel overweight (overvalued intrusive idea)
- Preoccupation with a target weight/food/calories
- **Deliberate self induced weight loss** - eg via vomiting/exercise/laxatives
- **Poor insight**
- Physical Sx: low BMI, **hypoT**, **bradycardia**, enlarged salivary glands, **lanugo hair** (fine hair covering skin), **amenorrhoea**; **prolonged QT on ECG**
- Biochem: **hypokalaemia**, low sex hormones, inc GH, inc cortisol, hypercholesterolaemia
- Mx: to return to healthy weight & psychological therapies for underlying thought processes
- Cx: **refeeding syndrome** (rapidly inc insulin -> K+, PO4*3-, Mg into cells - can be fatal
  Sx: oedema, confusion, tachycardia, delirium seizures, hyperglycaemia; Tx w PO4*3-)
- Risk of ventricular fibrillation (potentially fatal **arrhythmia**)

Refeeding syndrome:
Hypophosphatemia
Hypomagnesaemia
Hypokalaemia
Thiamine deficiency
Salt + water retention

Psychiatric Emergencies

Neuroleptic Malignant Syndrome

- **Adverse reaction to antipsychotics** (dopamine receptor agonist) **or abrupt dopaminergic withdrawal** (levodopa)

- Sx: altered mental state, confused, fever, tachycardic, HTN/hypotension, muscular hypoactivity and severe (lead pipe) rigidity

- Ix: bloods, CT/MRI head, infection screen
  - Inc WCC, CK, LFTs ; Low Fe
- Mx: medical emergency - **stop causative drug + supportive management**
- Cx: PE, Renal Failure, Shock

Serotonin Syndrome

- **High synaptic concentration of serotonin**
- Caused by SSRI/SNRI, opioids, MAOi, Lithium, TCA

- Sx: confused, hallucinations, tremor, hyperreflexia, HTN, tachycardia, hyperthermia, sweating, shivers
    - DDx: NMS (high WCC in NMS, normal in SS)

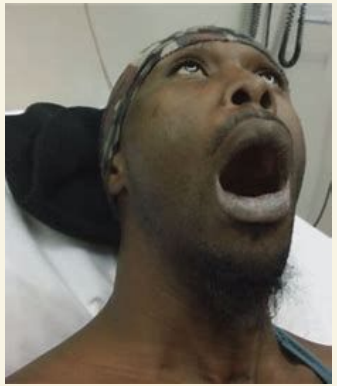
- Mx: medical emergency - **stop causative drugs + supportive treatment**
- If SSRI overdose -> activated charcoal

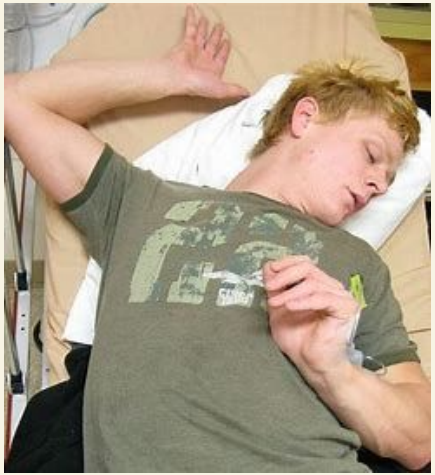
Acute Dystonic Syndrome

- **Caused by typical antipsychotics - EPSEs**
- Sx - extremely painful contraction in the:
  - eyes - oculogyric crisis
  - neck - antero/latero/retro/torticollis
  - Jaw

  Arm held in dystonic posture, neck spasm to side, mouth open, upward eye gaze, pain and distress

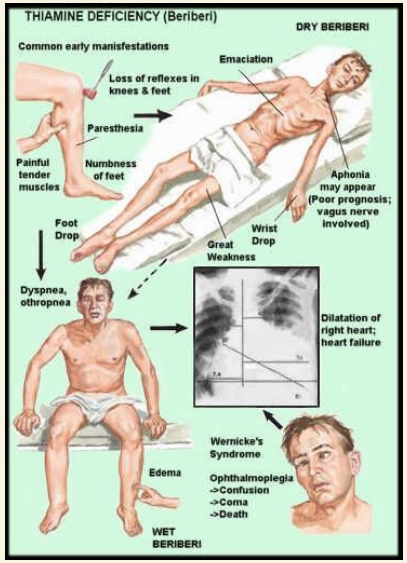
- Mx: **IM Procyclidine 5-10mg**





Alcohol Withdrawal Complications

Wernicke's Encephalopathy



Due to acute thiamine deficiency

Sx: delirium, nystagmus, hypothermia, ataxia

Mx: Pabrinex (IV thiamine)

Korsakoff's Psychosis

- Due to untreated WE
- Sx: irreversible ST memory loss, confabulation, time disorientation
- Mx: Pabrinex

Delirium Tremens

- **72 hrs after alcohol cessation**
- Sx: cognitive impairment, Lilliputian hallucination, paranoid delusions tremor, fever, tachycardia, sweating, dehydration

- Mx: **IV Pabrinex + Lorazepam** (both 1st line), can give haloperidol if psychotic features

Lithium Toxicity

- Common side effects: Nausea, diarrhoea, dry mouth, metallic taste, thirsty, mild tremor
- Rare side effects: Renal dysfunction, hypo/hyperthyroidism, foetal abnormality (pregnancy)

Lithium Toxicity (narrow TI, levels 0.4-1.0mEq/L)

- Polyuria / incontinence / nausea
- Drowsy, confusion, blackouts, faints, blurred vision
- Shaking / muscle twitches, spasms in face, tongue & neck
- ***TOXICCC*** **- coarse tremor, oliguric renal failure, ataxia, inc reflexes, convulsions, dec consciousness, coma**

- Ix: U&E, TFTs, Lithium levels

- Mx: Medical Emergency - **stop lithium, high fluid + IV NaCl, haemodialysis if severe**

Misc

Descriptive Psychopathology

- Formal thought disorder: disorganised thinking evidenced in speech; seen in psychosis and schizophrenia
  - **Circumstantiality**: moves onto diff topics w a followable train of thought, but eventually returns to original topic
  - **Derailment**: conversation moves randomly from one topic to another
  - **Poverty of speech**: lack of spontaneous speech
  - **Perseveration**: repetition of words/ideas when another changes topic
  - **Thought blocking**: suddenly halts in thought process and c/n continue
- **Delusions**: irrational beliefs held in spite of evidence to the contrary; eg nihilistic delusions (in depressed Px), grandiose (mania), persecutory (psychosis)
- **Compulsions**: repetitive stereotypes behaviours in response to obsessions
- **Flight of ideas**: stream of accelerated thoughts jumping rapidly topic to topic
- **Word salad**: severe formal thought disorder where Px uses words nonsensically; word salad= salad of words mixed up nonsensically
- **Neologisms**: coining of new words only understood by Px; neologue= new word
- **Pressure of speech**: inc quantity and speed of speech; common in mania
- **Logoclonia**: repeating last syllable of a word; logo-clone ie last syllable cloned
- **Obsessions**: repetitive irrational irresistible intrusive thoughts/behaviours
- **Monomania**: preoccupation w single subject to pathological degree
- **Echopraxia**: Px imitates another person's movements automatically; echo copying praxia movements
- **Stupor**: Px fully conscious but unable to speak or move; severe form of dep ret
- **Depressive retardation:** psychomotor retardation assoc w low mood
- **Conversion disorder:** Sx w/o underlying cause ; **La belle indifference:** assoc w conversion disorder, inappropriate lack of concern over Sx they are experiencing
- **Hypochondriasis**: xs concern of serious illness w/o evidence, want Ix d/t worries
- **Munchausen's**: intentionally fake Sx for attention and play patient role
- **Malingering**: intentionally fake Sx for benefits eg universal credit/avoid work etc

SBA Examples

Case 1

Tony is a 40-year-old male who has recently presented to the crisis team with suicidal ideation. Upon further questioning Tony also reports having low mood, lack of energy, waking up early in the morning, and a lack of concentration. Tony says that these symptoms are there most of the time, however he does have good days and bad days. There is no previous psychiatric history.

What is the most appropriate drug to start Tony on?

A. Duloxetine
B. Mirtazapine
C. Venlafaxine
D. Sertraline
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She has recently completed a course of cognitive behaviour therapy but is still struggling with persistent symptoms of loss of interest and enjoyment. She would like to try an antidepressant and is commenced on sertraline.

When is the earliest that she should she next be seen by her GP?

A. One week
B. Two weeks
C. Four weeks
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E. No routine follow-up required

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Case 3

You are working on the community mental health team. You review a 35-year-old woman with schizophrenia. She is not experiencing any hallucinations or delusions. However, she reports that she no longer enjoys the things she used to and has become very socially withdrawn. She is currently taking risperidone and previously was taking aripiprazole. The consultant thinks the patient is experiencing worsened social withdrawal, anhedonia and alogia.

What psychotropic medication could you consider switching for risperidone to help with these symptoms?

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What best fits her diagnosis?

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B. Avoidant personality disorder
C. Borderline personality disorder
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Case 5

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A. Thought broadcasting
B. Visual hallucinations
C. Thought withdrawal
D. Delusional perceptions
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THANK
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