

## PSYCHIATRIC EMERGENCIES IN THE CASUALTY DEPARTMENT

DR PETER MUSCAT MD, LRCP, MRCS, MRC Psych.  
Consultant Psychiatrist,  
Head of University Department of Psychiatry

Psychiatric emergencies are difficult to define. The medical definition of psychiatric emergencies in situations in which, on account of an abnormal mental state or behaviour, the life of a patient, or someone else, is in jeopardy.

However this definition would exclude the commoner situations encountered in casualty which are characterised by severe dislocation in psychological or social functioning and often accompanied by their high nuisance value.

In order to remedy this limitation the concept of "crisis" is used to include those situations when there is a reduction in coping ability to external stress.

### EPIDEMIOLOGY

Only about twenty five per cent of "complaints" refer to psychiatric conditions in the conventional sense. This figure reflects the current social use of psychiatry. Sorrows and conflicts, many not caused by psychiatric illness, are brought to the Casualty Department and treatment demanded. This has expanded the boundaries of psychiatry and reflects the development of new views on mental health, the growth of a mental health industry in the welfare state and a loss of skills in handling emotions. Casualty departments cater for many who are not ill in the conventional sense. Perfunctory physical examinations and hurried discharges are not therefore sufficient; indeed they are counterproductive in that a population of "repeaters" may be created. On the other hand fifteen per cent of psychiatric emergencies may be accompanied by unknown severe physical disease.

### CLASSIFICATION

Psychiatric emergencies may have (i) organic  
(ii) functional  
(iii) social causes

The three are often found combined and are difficult to tease apart.

Instead of an aetiological approach, a syndrome-orientated one, is presented as it is more helpful in the prediction of management.

## ACUTE CONFUSIONAL STATE - ORGANIC (ACS)

"Clouding of the sensorium" is the primary psychological effect of acute brain insult. Hallucinations, paranoid ideations and emotional changes are often added. Delirium is the most florid state of acute confusional states.

ACS becomes an emergency when:-

- i) onset is acute
- ii) aetiology is unknown on admission
- iii) there is the threat of loss of behavioural control.

In most cases the degree of emergency is that of the causative illness, whether neurological, metabolic, endocrinological, cardiovascular or iatrogenic in cause. Sometimes increased motor activity or lack of patient cooperation add to the seriousness of the case.

When clouding, i.e. disorientation is absent, the cause may still be organic.

The following characteristics may be helpful identifying signs:

- abrupt personality change when there is good premorbid social functioning and family support.
- fluctuation in behaviour and mental state such as worsening in the evenings.
- catastrophic reactions; that is irritability, inability to recover from stress, lowered adaptive capacity, aggressive or violent behaviour in situations of ordinary stress may also be indicative of hidden organic pathology.

## MANAGEMENT

- Sedation must be withheld until clearly indicated, as this may mask or distort neurological signs.
- Nursing care is the most important first line of treatment; therefore a well illuminated side room is required as well as reassurance during lucid intervals by the same staff if possible.
- If sedation is required (e.g. patient becomes aggressive, suicidal or paranoid) phenothiazines are the drugs of choice. If hypotension, hypothermia or marked sedation are severe, Thioridazine or Haloperidol may be used instead of chlorpromazine. Benzodiazepines may aggravate confusion by reducing the level of arousal, but may be used in status epilepticus.

Once the decision to medicate is taken, adequate doses should be prescribed regularly and not prn which is disorientating and upsetting. Dystonia or pseudoparkinsonian side effects may be controlled with procyclidine (Kemadin) 10mg iv.



- Personality disorders of the explosive or aggressive type when under pressure may develop states of disorganisation, incoherence, terror or aggression. This sudden release, often sensitized by alcohol or drugs of so-called psychopathic tension may generate marked antisocial behaviour.

Management - The patient should be sedated in Casualty and then referred for psychiatric assessment and possible admission to the Psychiatric Unit, SLH or Mount Carmel Hospital.

- Catatonic excitement responds to high doses of intramuscular haloperidol (30-50mg). As it has a long half life, two injections daily are usually sufficient. Electroconvulsive therapy (ECT) is indicated in patients nearing exhaustion and who are not responsive to drugs.
- Mania and Paranoid excitement respond to large doses of neuroleptics but ECT may also be indicated.
- Hysterical and psychopathic excitements respond well to benzodiazepines and supportive psychotherapy.

## 2) Stupor

There are both neurological and psychiatric stupors. Twenty per cent of these are organic.

Therefore psychiatric stupor should only be diagnosed if tests for the function of the cerebral hemispheres and brain stem are normal and caloric tests produce nystagmus and not tonic deviation of the eyes.

An EEG should also be carried out.

Psychiatric stupor is of three main types

- (i) catatonic
- (ii) depressive
- (iii) hysterical

## Management

Functional stupor compromises life by interfering with eating, drinking and defaecation. Those resulting from psychotic illness respond well to ECT. Hysterical stupors respond to any treatment but determined efforts should be made to identify their meaning and secondary gain. Patients only abandon this symptom if provided with an alternative means of coping.

### 3) Panic Attacks

These are characterised by a sudden increase in free floating anxiety with or without signs of autonomic overstimulation. There may or may not be accompanying fears of death or impending disasters including themselves or others. Such panic attacks are common in patients with agrophobia, anxiety states and obsessional illnesses.

Panic attacks are also seen in organic states such as SLE, thyrotoxicosis, phaeochromocytoma, hypoglycaemic states, carcinoid syndrome, acute intermittant porphyria or acute schizophrenia.

#### Management

This should be of the underlying disease. Situational panic attacks settle down in the casualty room as do many other psychiatric disorders. This does not mean that they are 'hysterical' or 'unimportant'.

Panic attacks are often prolonged by the hyperventilation paraesthesia and tetanic response which feed the patient's fears.

If all relevant medical investigations are found to be negative, benzodiazepines eg diazepam 10mg iv may be administered and psychiatric referral organized - not necessarily as an emergency.

### iv) Hysterical Fugues

This is a dissociation produced by a stressful situation and consists of a 'motivated' or 'psychogenic' loss of memory. Organic states accounting - for amnesia must be ruled out.

#### Management

Admission to St Luke's Psychiatric Unit or Mount Carmel Hospital is advisable in order to organize management and protect the patient from potentiated danger.

### v) Destructive Behaviour Against Others

Anyone who during a crisis breaks the television set, attacks another person without motive, or demonstrates some other sort of destructive behaviour is likely to be brought to the Casualty Department. The incident must be assessed in terms of its circumstances, the patient's premorbid personality and contributing factors such as alcohol, drugs, mental illness and organic confusion. It must be decided whether aggression is alien to the aggressor, when organic or serious psychotic causes may be important, or if it is a feature of his subculture or personality disorder.

## Voluntary Organisations

Al-anon

Alcoholic Anonymous

Angel Fish Club

Cana - Marital Counselling

Caritas - Drug abuse/prevention. Treatment programmes.

Dar il-Wens

Dar il-Kaptan

Dar tal-Providenza

Down's Syndrome Association

Eden Foundation

Fond Ghaj-Ri

Friends of Attard

Frate Francesco

HANDS - HIV/AIDS A need demanding support

Malta Hospice Movement

Maria Bugeja Cancer Support

Merhba Bik

MIRA - Moviment Impenn Ghar-Rihabilitazzjoni tal-Alkoholici

Moviment Kuragg u Tama ghar-Romol

Muscular Dystrophy Group

OASI - Organizazzjoni Anti Droga u Solidarjeta Indipendenti

Parents Association for the Handicapped

Physically Handicapped Rehabilitation Fund

Razzett tal-Hbiberija

Richmond Fellowship Foundation Malta

Schizophrenia Association

Thursday Club for Psychiatric Patients

Welcome Home

YANA - You are Not Alone