CONSULTATION LIAISON PSYCHIATRY

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Faculty Disclosures

- Paid clinical/teaching faculty in the depts. of Internal Medicine and Family Medicine at UTCOM–Chattanooga
- No pharmaceutical company funding, but I still come across old drug company pens or sticky note pads in my office....
Learning Objectives

1. Recognize the legal ramifications of providing both formal and informal consultation to medical colleagues
2. Describe the differential diagnostic categories when assessing a delirious patient and propose the most likely etiology
3. Identify psychotropic drugs more and less likely to prolong the QTc interval
Who requested psychiatric consultation?

- Admitting physician
- Another consulting MD/NP/PA
- Nursing staff
- Case manager
- Patient
- Family
- Therapist
- Court system
Specific question(s) to be addressed?

- Decision-making capacity
- Differential diagnosis of a psych problem
- Recommend psychiatric management of a particular problem
- Affirm or change psychotropic med regimen
- Where should this patient/loved one go??
- HELP me protect my staff, milieu, sanity....
- Get this patient off my hospital unit!!!
Consultation as a form of education

- From a second-year resident: “I don’t know much about psychiatric medications.”
- “How do you know if the patient is bipolar?”
- “Does this woman really need to be on six different psych meds?”
- “There’s a woman I need you to see….unless I try to kill her first!”
Consultation as a form of education

– How many of you have 24/7 readily available psychiatric or mental health consultants?
– Every physician needs to be competent to manage basic psychiatric emergencies and more common problems!
– The better you provide a rationale for your DDx and treatment plan, the less likely you are to need to consult to the same MD for the same issue in the future.
Most consultations are formally requested by a medical colleague

Does MD have to approve request from ancillary staff or family?

Pitfalls of “curbside” consultation
  ◦ Time (could be a pro or a con)
  ◦ Reimbursement
  ◦ Legal liability?
Avoiding Liability

- Refuse to help colleagues informally?
- Ask to formally evaluate the patient if you have concerns
- State this is your hypothetical opinion only
- Ask specifically NOT to be quoted in the chart
- Consult your malpractice carrier, e.g. SVMIC, if you are unsure
- Stop practicing medicine?!
Decision-Making Capacity

- Not the same as competency, which is a legal definition determined by the courts
- For what type of decision?
  - Medical
  - Financial
  - Testamentary
  - Housing
- Is deficiency at a particular state in time or an enduring condition unlikely to ever change?
Criteria to Assess Capacity

- Awareness of the specific problem
- Appreciation that this problem applies to them
- Articulate the various treatment options, pros and cons, and alternatives
- Ability to clearly, consistently communicate a choice
- NOT whether the patient agrees with MD recs
How urgent is the consult request?

- A 48yo man is admitted to trauma surgery service after a TBI from a car wreck
- He becomes agitated on hospital day 3, has no further surgery planned, and demands to leave the hospital right away
- He has removed his cardiac monitor, IV and asks where his clothes are to leave
- “I need to go take care of some business…”
Discharge Against Medical Advice

- Rarely will a psychiatric consultant be available to assess emergently the patient who demands AMA discharge
- Evaluate: vital signs, orientation, presence of any psychotic thinking, abnormal perceptions, suicidal or violent thoughts, reasons to leave....
- Review notes from ancillary staff about the patient’s behavior!
- Confer with available family and friends
- Is there greater liability to detain the patient involuntarily or to allow him/her to leave?
Delirium Differential Diagnosis

- Infection
- Withdrawal
- Acute Metabolic
- Trauma
- CNS disturbance
- Hypoxia

- Deficiencies
- Endocrine abnormality
- Acute Vascular
- Toxins (usually meds we prescribe)
- Heavy Metals
A 48yo man is admitted to a rehabilitation hospital after a TBI sustained in a car wreck.

You are asked to evaluate him because of long-standing bipolar disorder.

“Please suggest treatment alternatives to Lithium.”

Pertinent labs, only offered when you ask the nurse by phone: [Lithium]=3.0; [Cr]=3.0
Lithium Side Effects

- Early signs of toxicity: worsened tremor, nausea, diarrhea, polydypsia/polyuria
- Later signs: ataxia, confusion, sedation, slurred speech, cardiac arrhythmias, seizures
- Lab abnormalities associated with therapeutic doses: elevated TSH, Creatinine, PTH, Calcium, WBC
A 63yo woman with depression, anxiety, early-onset dementia, and fibromyalgia is admitted for altered mental status.

Psychiatry is asked to comment on her meds, confusion, and dementia management

Prescribers include a MHC, pain management, rheumatologist, and PCP
Home meds include:
- Hydroxyzine 25 mg tid prn anxiety
- Amitriptyline 50 mg qhs for fibro/sleep
- Cyclobenzaprine 10 mg tid prn muscle tension
- Oxybutynin 10 mg for overactive bladder
- Tylenol PM 2 tabs prn insomnia (not listed)
- Duloxetine 120 mg qam for depr/fibromyalgia
- Donepezil 5 mg qhs for dementia

Anticholinergic Toxicity?
Common Anticholinergic Meds

- NOT just limited to the usual suspects, e.g. tricyclic antidepressants, H1 antihistamines
- Antibiotics: Amp, Gent, Vanc, Clindamycin...
- Cardiac Meds: Captopril, Digoxin, Diltiazem, Furosemide, Hydralazine, Nifedipine
- Steroids
- Miscellaneous: Colchicine, Warfarin, Eyedrops
Conditions Worsened by Anticholinergic Meds

- Angina
- CHF
- Cardiac conduction disorders
- Constipation
- Diabetes
- Narrow–angle glaucoma
- Prostatic hypertrophy
The Confused Engineer

- 68–yo retired engineer is admitted for dyspnea and severe anemia (H/H=6/18), eventually diagnosed as autoimmune hemolytic anemia
- Psychiatry is consulted for agitation, which required IM Geodon 20 mg and restraints
- Patient exhibits mild tremor, pressured speech, grandiose thinking, and complains of his lack of sleep during hospital stay
Depressed after wife died 5 years ago, but no psychiatric meds or therapy.
Drinking more (6 beers/day?) since then
WBC=20K with left shift, but afebrile and on steroids
[Na+] = 120; BMP o/w WNL. TSH = 1.7
Hepatitis panels negative. Sl. Elevated LFTs.
SaO2 drops to <90% at times if off nasal O2
Differential Diagnosis?
Steroid–Induced Psychosis

- Steroids may cause anxiety, insomnia, hypomania, or depression at lower doses
- Typically seen at Prednisone dose=40+ mg
- MOST patients do NOT develop mania or psychosis despite high steroid doses!
- Med/Psych emergency, with erratic behavior and patients lacking judgment, yet too sick to safely stop steroids or leave the hospital
Taper steroids as clinically feasible
Move to quieter room to facilitate sleep
Sitter or family member present
Stop other activating meds, caffeine, etc.
Atypical antipsychotics
Benzodiazepines
Anticonvulsants, e.g. Valproic Acid (PO or IV)
Obstructive Sleep Apnea Screening

- Snoring
- Tired/sleepy daytime
- Observed apneic spells
- Pressure: HTN

- BMI >35
- Age >50
- Neck >16” (40 cm) for women; >17” (42) men
- Gender=male

- Mnemonic=STOP BANG

- If 3+ are positive, high likelihood of OSA!
Psychogenic Non–Epileptic Seizures

- Variously called “faking it,” malingering, attention–seeking, non–epileptic seizures, psychogenic non–epileptic episodes (PNEE)
- Manifestation of underlying psychological conflict, expressed as neurological signs/sx
- Conversion Disorder = DSM–IV term
- Functional Neurological Symptom Disorder = DSM–5 term
30% of patients may not respond to AEDs
Reconsider dx of epilepsy and refer to an epilepsy center for video EEG (gold standard)
20–25% of patients referred for VEEG for intractable epilepsy have PNES
Only 20% of patients fully remit after the dx of PNES is presented. The rest continue to be symptomatic, but may utilize fewer resources
Conversion Disorder (PNES)

- 38-yr MWF from rural AL is admitted to her third hospital in ten days for intractable seizures, refractory to BZDs
- Neurological workup includes negative head CT and contrasted MRI
- Bedside EEG shows NO epileptiform activity during two shaking spells witnessed by family
- Patient denies any major psychosocial stress or loss during interview alone
Further History

- Seen later with sister and teen daughter in the room, they reveal the death of a favorite aunt one month ago.
- Patient is deemed “just like all of us.” Mom, 2 siblings, and daughter all on SSRIs for anxiety.
- Patient later discusses her caregiver burden since husband started a nightshift job recently.
- She later reveals childhood sexual abuse hx. “I have been a bad sleeper ever since then.”
Management of PNES

- Complicated!!!
- Ideally, present dx to patient and family together with the neurologist. Assure that a “typical spell ” was recorded
- 1/5–1/3 of video EEG patients have PNES
- More challenging given the patient/family’s reluctance to accept a “non-medical” diagnosis. They may flee elsewhere
- Paradigms from Brown U. by Curt LaFrance, MD and John Barry, MD at Stanford
- Focus on individual and group cognitive–behavioral therapy
- Medications, e.g. antidepressants, may play an adjunctive role. Not solo/first–line!
Barriers to Effective PNES Care

- Rural settings
- Inability of the patient to drive >6 months after “seizure” events
- Poor mental health coverage
- Lack of trained CBT providers
- Care is NOT integrated between PCP, neurology, psychiatry, and therapist
Various formulas to calculate QTc: Hodges, Bazett
Risk of torsades de pointes/ fatal arrhythmia
Should we worry if QTc > 450 msec or just > 500?
Ideally, correct electrolytes, etc first
MANY drugs, not just psychotropics, may prolong QTc
Leucht, Lancet 2013; 382:951
Beach, Psychosomatics, 2013; 54: 1–13
What psych med is safe??

- 50yo man with schizo-affective disorder and alcoholism, admitted for angina
- Allergic to Quetiapine and Haloperidol
- Risperidone 2 mg qhs ordered, anticipating use of IM long-acting form q 2 weeks
- Cardiac cath unremarkable, but QTc=580 msec and pt agitated/restrained after cath
- QTc=526 msec 3 days after Risperidone (only given x 3 days) stopped
“Relatively ” safer meds in long QTc syndrome

- Antipsychotics
  - Aripiprazole (Abilify)
  - ? Newer agents, but perhaps just undocumented

- Anti-manic
  - Valproic Acid/Divalproex (Depakote)
  - Lamotrigine (Lamictal)

- Anti-depressants
  - Bupropion (Wellbutrin)
  - Mirtazapine (Remeron)

- Benzodiazepines
Not every depressed patient needs medication! SSRI/SNRI risks include: hyponatremia, increased bleeding, QTc prolong’n (Citalopram), increased levels of 2D6 substrates (Fluoxetine, Paroxetine)

Medication is not necessarily first-line choice for acute/post-traumatic stress disorder

Identify the underlying cause of psychotic sx, especially in delirium, rather than just start antipsychotic Rx.
Questions???