Physical Screening of the Mental Health Patient

A Simple Evidence-Based Approach

Sue Ieraci  November 2008
Perennial problem
lots of mythology

- The “missed” “medical” diagnosis
- Psych doctors can’t (won’t) examine patients physically
- “We can’t accept without medical clearance” (mythology vs law)
- “You people call us for anyone with a behavioural problem”
- “I’ll see them after they’re medically cleared”
- “Can go to the ward after medically cleared”
- “We’ve had lots of cases of missed medical problems – someone died once.”

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What is the purpose of “medical clearance”? 

- To determine whether the behavioural disturbance is caused by a “physical” (“medical”) illness or injury.
- To ensure that disposition is appropriate (i.e., the presentation is primarily psychiatric and the patient is physiologically stable).

What it’s NOT:

- NOT an “insurance exam”
- NOT a guarantee that the person has no intercurrent illness
- NOT a guarantee that there is no risk of subsequent illness

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Understanding delirium

- An alteration of conscious state caused by organic factors – end results of hypoxia, sepsis, hypotension

- Physiological abnormality resulting in altered brain function

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“The brain depends on the rest of the body for its nourishment and internal environment. If an inadequate supply of blood reaches the brain, or if that blood is deficient in oxygen or glucose, the brain cannot function properly.”

*Diagnostic and lab testing in Psychiatry*

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Acute psychosis

“Medical” causes:

- Drug intoxication (history + toxidrome)
- Organ failure (Hx + physiological abnormality)
- Sepsis (physiological abnormality)
- Intracranial SOL (neurological signs)
- Endocrine emergency (physiological signs)

So

What “medical” cause gives you acute psychosis without physiological signs?
Search for local data

- Anecdotal cases only
- No data collection
- Only one single MET call to the MHU in the past year for a patient admitted within 24 hrs from ED – patient stayed on the MHU.

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Any help in the literature?

- Searches often reveal someone’s guidelines rather than real evidence (and often repeat the myths)

- There are many audits that look at what was done, but few of them correlate their findings with clinical outcome

- In a US series of 100 scheduled MH inpatients, 3 had hyperthyroidism and MDC, another 3 were hyperthyroid and had schizophrenia

- Josephson and McKenzie analysed 18 case reports of “mania” following thyroid hormone replacement for hypothyroidism – and found that 15 of the 18 were psychotic prior to the treatment.
“Mania resulting from brain tumour”

- Single case report in Sept 2000 of 76 yr old female presenting with reports of “personality change.” (Ma, UCLA Dept of Med)
- Recently diagnosed breast cancer
- Secondary lesion on CT

“A careful search for the underlying cause of psychosis, including mania, after age 45 is generally warranted.”

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Do brain tumours present with psychosis?

Macintyre in Am J Psych 98: The problem of brain tumour in psychiatric diagnosis

- Brain tumour is found at autopsy in from 3.5 per cent to 13.5 per cent in state hospital deaths

- “Brain tumour may occur in a patient with a major psychosis in which instance it is not necessarily the cause of psychotic symptoms but will undoubtedly aggravate them”

- Various single case reports

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What about blood tests?

- **Korn et al J Emerg Med 2000:**
  Of 80 patients with strictly psychiatric complaints and without significant medical history, only two had abnormal blood tests which did not alter treatment.

  “Patients with a primary psychiatric complaint coupled with a documented past psychiatric history, negative physical findings, and stable vital signs who deny current medical problems may be referred to psychiatric services without the use of ancillary testing in the ED.”

- **Olshaker et al Acad Emerg Med 1997:**
  If their 345 psych admissions had had no blood tests, they would have missed only two SYMPTOMATIC patients with hypokalaemia.
  History alone had 94% sensitivity for identifying acute medical conditions.
A structured approach

1. FLOWCHART

ATS 3, 4 or 5

Exacerbation of known mental health condition

Physiological observations and conscious state normal

Age less than 65

No further “physical” or tests prior to psychiatry referral

New presentation

Ingestion or injury

Abnormal Obs

Delirious

Physical symptoms

Age >65

Initial ED evaluation

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Flowchart detail

ATS CAT 1 or 2:
- Immediate threat of dangerous violence
- Immediate threat to self or others
- Requires or has required restraint
- Severe agitation or aggression
- Any other Cat 1-2 medical features

Triage to Emergency Department
Acute Assessment & Stabilisation

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INITIAL SCREEN

Reason for presenting:
Exacerbation of known mental health condition, wanting mental health assessment or admission

Physiological obs: Temp, pulse, BP, resp rate, SaO2
Consciousness

If different history or any abnormal observations:

SECONDARY SCREEN:
physical symptoms as main presenting complaint
age > 65
delirium screen:
drowsiness
acute onset
fluctuating state
inattention
drug ingestion

all OK:
direct to MH team assessment

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2. Documentation

BANKSTOWN HOSPITAL Emergency Department
PHYSICAL HEALTH REVIEW FOR MENTAL HEALTH PATIENTS

Brief description of presenting problem:

<table>
<thead>
<tr>
<th>Physiological Observations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate</td>
</tr>
</tbody>
</table>

Any acute physical health problems (including ingestion or drug side-effects) ?

__________________________________________________________________________________________________________________________________

Is the patient excessively drowsy or confused?(distinguish confusion from psychosis)

__________________________________________________________________________________________________________________________________

Can you find any evidence of physical cause for the acute presentation?

__________________________________________________________________________________________________________________________________

Are there any issues that the psychiatry team should follow-up?

__________________________________________________________________________________________________________________________________

ED doctor’s name printed           Signed           Date and time

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Advantages of system

1. Logical and “evidence”-based
2. Ensures physiological obs are done (almost always)

1. Brief and standardised
2. Makes intention of “screen” clear

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Reception by MH staff

- Managers like it, sometimes complain when form not completed
- Registrars reluctantly accept that it serves its purpose
- MHU nurses expect to see it
- No-one can disagree with any of its specific content
- There are still anecdotes.....“the Lithium level wasn’t done – what if they were toxic?”
  (and asymptomatic??)

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SUMMARY

- To affect behaviour, a systemic illness has to affect brain oxygenation, perfusion or glucose

- Systemic illness or drug intoxication affecting brain behaviour is highly unlikely to be occult

- ED processes that do not add value to patient care, or that delay patients getting to definitive care, should be eliminated

- An evidence-based and standardised approach helps in rationalising processes
Two psychiatrists are out in the woods when one of them collapses.

He doesn't seem to be breathing and his eyes are glazed.

The other guy whips out his phone and calls the emergency services. He gasps: "My friend is dead! What can I do?"

The operator says: "Calm down, I can help. First, let's make sure he's dead."

There is a silence, then a shot is heard.

Back on the phone, the guy says: "OK, now what?"