Managing Psychiatric Emergencies
In the Terminally Ill

Psychiatric Emergencies

Unnoticed or unmanaged symptoms precipitate a crisis

Most Common Psychiatric Emergencies in the Hospice/Palliative Care Setting

- Delirium
- Depression
- Anxiety
- Suicidal Ideation
Delirium

15-20% hospitalized Cancer Patients
Up to 75% of terminally ill Cancer patients

Delirium - what does it look like?

- Patient appears disorganized
- Sleep-wake cycle disturbed
- Disorientation (3P’s)
- Perceptual disturbance (illusions)
- Waxing and waning level of consciousness
- Trouble maintaining/shifting attention

Don’t confuse Delirium with Dementia

<table>
<thead>
<tr>
<th>Delirium</th>
<th>Dementia</th>
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</thead>
<tbody>
<tr>
<td>Onset – rapid</td>
<td>Onset – progressive</td>
</tr>
<tr>
<td>Symptoms – fluctuating level and severity</td>
<td>Symptoms – consistent progressive worsening</td>
</tr>
<tr>
<td>Reversible</td>
<td>Irreversible</td>
</tr>
<tr>
<td>Less memory impairment</td>
<td>More memory impairment</td>
</tr>
<tr>
<td>Emergency</td>
<td>Non-emergent</td>
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Measures / Scales / etc.

- Mini-Mental Status Exam
  - assess cognitive functioning
  - does not distinguish between dementia and delirium
  - quick and easy.

- Memorial Delirium Assessment Scale
  - correlates well with other cognitive tests
  - can be used over time in medically ill

Delirium - Causes

- Drugs
  - hypnotics, narcotics (titration, IV), steroids, chemotherapeutic agents, infection control agents

- Organ failure
  - liver, kidneys, lungs; treatment effects

- Metabolic changes
  - thyroid, adrenal failure; electrolyte imbalance

- Infection

- Nutritional state

Delirium Management

1. What is the etiology?
   - Attempt to correct it as quickly and safely as possible

2. Meanwhile...
   - Provide a quiet, safe environment
   - Orient patient repeatedly
   - Consider 1:1 staffing
   - Antipsychotic (often Haldol – PO, IM, IV, SC)
Accept sadness about illness, NOT depression...

**Depression**

- Sleep Changes
- Interest Decreases
- Guilt
- Energy Decreases
- Concentration Wanes
- Appetite Changes
- Psychomotor Disturbance
- Suicidality

Looks like a CA patient - not specific
Depression is under diagnosed in the terminally ill

- 20-25% of terminally ill are depressed
- % ↑ with pain, advancing illness, and greater disability
- ↑ with positive family or personal history

Endicott Substitution Criteria

<table>
<thead>
<tr>
<th>Physical Somatic Symptom</th>
<th>Psychological Symptom Substitute</th>
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</thead>
<tbody>
<tr>
<td>1. Change in sleep/weight</td>
<td>1. Depressed appearance, tearfulness</td>
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<tr>
<td>2. Sleep disturbance</td>
<td>2. Social withdrawal, decreased talkativeness</td>
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<tr>
<td>3. Fatigue, Loss of energy</td>
<td>3. Brooding, self-pity, pessimism</td>
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<tr>
<td>4. Diminished concentration, Indecisiveness</td>
<td>4. Lack of reactivity</td>
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</tbody>
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Rule out contributing / causing abnormalities:

- Metabolic Abnormalities
- Endocrinologic Abnormalities
- Medication Effects

Uncontrolled PAIN
Treat what you Find
When in doubt, assess carefully, consult, then treat

- Better pain control can alleviate depression and suicidal ideation
- Metabolic corrections/improvements may alleviate symptoms of depression
- Lowering or discontinuing putative drugs may improve depressive symptoms

Managing Depression

- Psychotherapy
- Tend to the Spirit
- Somatic Treatments
  - SSRI’s
  - TCA’s
  - Psychostimulants

Suicide in the Terminally Ill

Hopelessness links Depression with Suicidal Intention
Delirious Patient is more likely to Suicide Impulsively
Isolation, Abandonment & Unmanaged Pain Yield Hopelessness
Advanced Illness PAIN Depression Delirium
Suicide Risk Checklist

- Uncontrolled Pain
- Depressive Presentation
- Hopelessness
- Delirium

Mayan Goddess of Suicide

Schedule of Attitudes Toward Hastened Death

High reliability correlates with

- PAIN * and physical symptoms
- Clinician ratings of depression and psychological distress
  (Beck’s, Hamilton’s depression scales)


* best indicator

Evaluation of the Suicidal CA or AIDS Patient

- Establish rapport with an empathic approach
- Obtain the Patient’s understanding of illness and present symptoms
- Assess mental status (internal control)
- Assess vulnerability variables, pain control.
- Assess support system (external control)

Evaluation of the Suicidal CA or AIDS Patient con’t...

- Obtain history of prior emotional problems or psychiatric disorders
- Obtain Family History
- Record prior threats, attempts.
- Assess suicidal thinking, intent, plans
- Evaluate the need for 1:1
- Formulate a treatment plan, immediate and long term

Breitbart W. Cancer pain and suicide. Advances in pain research and therapy. 16, 399-412, 1990.

Anxiety
the most common psychiatric presentation in End-of-Life Care

Sources of Anxiety

“Reactive” related to the stresses of the illness and its RX

“Symptomatic” derives from a medical problem

“Previous” panic, chronic anxiety in the past now exacerbated

Reactive Anxiety

- Related to the stresses of the illness and its treatment
- Intense feeling state that can impair the individual’s functioning
- Render him/her unable or unwilling to comply with treatment
Reactive Anxiety Responds to:

- Reassurance
- Support
- Understanding this patient's particular fears and concerns
- Medication

Symptomatic Anxiety

- Agitated, anxious patient in pain
- "over the edge"
- Treat pain aggressively (Q24)
- Heralds an acute medical event... Ex. agitated, anxious pt with resp distress? PE

Drugs: steroids, EPS

"I feel like I am jumping out of my skin" SSRI's. Correct underlying issue.

Withdrawal: etoh, narcotics, benzo's

Acute MSE change within 10 days of admission – look for withdrawal.

Identifying an Anxiety State

- Questions for querying patients about anxiety symptoms
- Compendium of complaints endorsed by anxious patients
- HX: PTSD, Generalized, "Free-flowing"

Managing Anxiety

Drugs
- Benzodiazepines
- Choice
  - severity of symptoms
  - desired duration
  - rapidity of onset needed
  - route available
  - interactions

No Drugs
- Inform the patient
- Be Supportive & Patient
- Cognitive approach if possible
- Behavioral approaches:
  - guided imagery
  - meditation
  - biofeedback
- Progressively visualize success re problem issue (blood draw)

Incidence of Psychiatric Problems

- Depression
  - 25-77 %
- Delirium
  - 25-40% early,
  - up to 80% with advanced disease
- Anxiety
  - most common
- Suicidal Ideation
  - see Slides 18 - 21

Risk Factors for Psychiatric Problems

- Unmanaged pain doubles the likelihood
- Disease related
  - pancreatic cancer \(\rightarrow\) depression
  - central nervous system tumor \(\rightarrow\) delirium
- Metabolic, endocrine, nutritional, abnormalities increase risk of depression and delirium
- Treatment related factors
Risk Factors con't

- Previous Psychiatric History
- Personal History
- Family Issues
- Social Supports

Drug-Drug Interactions

Oxidative Drug Metabolism in Humans

- ACTIVE DRUG
- Sometimes called an oxidation reaction
- Enzyme System: Adds Oxygen to active drug compound
- Also called a hydroxylation reaction
- ACTIVE DRUG

As a result, the drug compound changes shape and is not easily recognized by:

- GI epithelium
- Drug Levels increase
- Drug Levels increase

- LIVER
- Oxidation
Cytochrome P450 System

This system is called **Cytochrome P-450**

1. First, it attaches to the drug.
2. Then, it picks up oxygen from iron.
3. Next, it uses the energy to pick up an oxygen (O2) molecule.
4. Finally, it releases O2 to the drug, changing its shape and losing energy.

Result: Drug 3-D shape is distorted.

Result: Drug levels increase.

P-450 now depleted of energy.

Drugs are metabolized.

Drug levels increase.

Drugs are metabolized.

Drug levels increase.

Drug-Drug Interactions

Example:
- Drug A inhibits the P450 system.
- Drug B is metabolized by the P450 system (by adding O2 and changing its shape).
- Therefore, Drug A interacts with Drug B.

Practical Result Example:
If a patient is on theophylline (Drug B), and you add imipramine (Drug A), the theophylline levels would rise.

Why?
Because imipramine inhibits the (P450) system which is responsible for the metabolism of theophylline.

What’s the Researcher’s Approach to Drug-Drug Interactions?

Define, through reaction analysis, the P450 relationships of as many drugs as possible.

What’s the Practitioner’s Approach to Drug-Drug Interactions?

LOOK IT UP
Primary References

