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From Straps and Needles to Care and Compassion: How to Optimally Manage and De-escalate Agitated BD and SCZ Patients Therapeutically and Non-Pharmacologically

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

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Dr. Zeller:
Hi everybody. My name is Dr. Scott Zeller. I'm a emergency psychiatry physician, and an Assistant Professor at the University of California Riverside School of Medicine. I've also been the Chair of the National Council on Psychiatric Emergencies and the American Association for Emergency Psychiatry, and have published several books on agitation. And I'm thrilled to be talking to you about agitation today. And I'm being joined by two really great experts in the field. The first is Dr. Sharlena Wilson, and maybe Dr. Wilson, you can introduce yourself.

Dr. Wilson:
Sure. Hi, my name is Sharlena Wilson. I'm also a psychiatric physician. Currently, I'm the Vice Chair of the Department of Psychiatry at Providence Little Company of Mary Medical Center in San Pedro. And my main focus is emergency psychiatry in crisis settings.

Dr. Zeller:
And Dr. Gooch, if you would be so kind to introduce yourself.

Dr. Gooch:
Definitely, thank you. I'm Dr. Michael Gooch. I'm an emergency medicine nurse practitioner. I currently practice in flight transport, as well as in a community emergency department here in the Nashville, Tennessee area. And I'm also an Assistant Professor of Nursing at Vanderbilt University.

Dr. Zeller:
That's great. So today, we're going to be talking about the perils and the pitfalls of making a diagnosis when somebody is presenting to an emergency setting with symptoms of agitation. And this is an actually very, very interesting topic, because so often, emergency departments are facing people who are coming in who are loud, who are disruptive, who are aggressive, who may be combative. And the initial thought is, this is somebody who's doing criminal behavior, or this is somebody we need to corral and contain.

And what they might not immediately recognize is that some of these symptoms are ubiquitous, and are not just due to bad behavior or a psychiatric diagnosis, but also can be emblematic or paradigmatic of some medical conditions. So let's talk about how we get a differential diagnosis working and when we're immediately presented with somebody who is showing symptoms of agitation, what is our goal when we're trying to do something? Which often needs to be made in a matter of moments, because sometimes this is a seriously life or death situation. And making the wrong decision can have some bad outcomes.

So if somebody comes into an emergency department, let's say, and they're loud, they're screaming, they're maybe being brought in by

police or paramedics, and have to be either, you know, restrained by hand or restrained by physical means, such as they're on a gurney and they've got restraints to arms, legs, midsection, and they're calling you all sorts of names and all things like that. Thinking as a medical clinician, as both of you are, what is the first thing you think of besides safety, of course, which is paramount? But as a clinician, and from a differential diagnosis standpoint, what's the first kind of things you're thinking about, as you try to differentiate what's going on and how you can help this individual? Dr. Gooch, let's start with you.

Dr. Gooch:
I think the first two things I want to think about, like I said, besides safety, is this something tox? Or is this something endocrine? And have to think about what are those differentials that might make this appear to be a mental illness that actually could be metabolic or could be something that's totally not even related to their mental well-being, and try to run through those differentials real quickly. Sometimes the history we can get from EMS or from law enforcement, or sometimes even the patient if they're able to give us a little bit, to give us an idea about how quickly this transitioned from normal to agitated. And that sometimes is really helpful.

Dr. Zeller:
Dr. Wilson, what can you add to that?

Dr. Wilson:
I completely agree. I think it can be very easy to automatically assume that this is a psychiatric problem. But it is important to first rule out any medical problems and, you know, in order to do that, getting as much history as you can. And part of that is getting history even from the patient themselves if they're able to. And so, part of that approach is trying to reassure and calm the patient, get as much history as possible. And also, like Dr. Gooch said, getting history from anyone else you can, from EMS, from any family members that might have come in with the patient, to really try to elucidate what the cause of the agitation is.

Dr. Zeller:
Excellent points, both of you. Thank you so much. And while we're thinking about this in this differential, let's identify, for our audience some of the things that cause agitation that are nonpsychiatric. Because one of the problems with it is that, as you both identified, maybe they're metabolic, or maybe they're due to some kind of other situations such as a CVA or an embolism, or, you know, the other kinds of things that we might think of such as poisoning or head trauma and things like that. These can be life-threatening conditions. And if we make the wrong turn, and just assume this is somebody who is, quote unquote, just psych, we might actually be really, really missing the boat and putting our patient in serious jeopardy. So what would be some pearls we can share with our audience about how we can make sure that we're not just confining - consigning this patient to being a psychiatric condition, and that we should actually be taking a deeper look? What do you say, let's start with you, Dr. Wilson?

Dr. Wilson:
Well I would say one of the major things when we're looking at differential is delirium. Because delirium can also present with agitation. And delirium itself, you know, is a huge kind of umbrella diagnosis that can have many causes, but that's something you definitely want to be on the lookout for. And one of the major things about delirium is the level of consciousness that's waxing and waning. They're kind of going in and out. And they're very, very confused and very disoriented. So if you see those symptoms, you definitely want to be thinking about delirium, especially if you don't have a psych history.

And I would say another thing that I want to always look at is vital signs and physical exam. It can be difficult to get a good physical exam on somebody when they're agitated, admittedly so. But we want to try our best to see if there are any symptoms that can clue us in that something else is going on. Specifically, vitals, anytime anyone is agitated, they're probably going to be a little tachycardic, and their blood pressure might be a little high. But if you're seeing strange things like a weird 02 sat, or just things that don't quite look right, that might clue you in something in medical is going on, then you definitely should kind of go down that path and try to figure out if there's something that you might be missing.

Dr. Zeller:
Excellent, excellent. Discussion. Dr. Gooch. We're kind of running short on time. But do you have some pearls you'd like to add on that?

Dr. Gooch:
Sure. And some great points that Dr. Wilson mentioned, vital signs, especially temperature, is really important. Definitely, this is a medication or action, some type of toxicological scenario, hyperthermia, may be very common. And two of the things I like to keep in mind, is this hypoglycemia, or is it hypoxia? And I've definitely seen patients who are both who can be really agitated, sometimes really combative, and become safety issues for themselves as well as us. And that's something we can usually quickly assess quickly on that patient. And as she mentioned that history, and you know, if this is no history of mental illness, likely this person has an acute onset of an acute psychiatric emergency with no history there. So definitely those H's are really important history, hypoglycemia, and hypoxia.

Dr. Zeller:
Excellent, excellent points, both of you. The one thing I might add is looking for things like diaphoresis with this on the skin, looking at the pupils, those often being - can be indicative of substance abuse or other kinds of psychiatric emergencies. You look into that whole picture. It's really important for us to rule out medical causes that mimic psychiatric symptoms, because unfortunately, like you were mentioning, Dr. Gooch, about the hypoglycemia, that can be life threatening. Head trauma can be life threatening. You know, poisoning can be life threatening. All these things need to be evaluated and decisions need to be made while you're trying to determine the cause of the agitation. And that's going to lead you to the next step, which is treatment.

And that's where we'll wrap it up for here. And thank you both for joining us for this amazing discussion.

Dr. Gooch:
Thank you.

Announcer:
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