THE CONFUSING PICTURE OF PSYCHOTIC DISORDERS

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EVALUATION AND TREATMENT WHILE USE OF MULTIPLE ADDICTIVE SUBSTANCES IS SURGING
SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS
Diagnostic Criteria for Schizophrenia

A. *Characteristic symptoms*: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. delusions
2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. negative symptoms, i.e., affective flattening, alogia, or avolition
B. Social/occupational dysfunction

C. Duration: Continuous signs of the disturbance persist

for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A.
Diagnostic Criteria for Brief Psychotic Disorder

A. Presence of one (or more) of the following symptoms:
   (1) delusions
   (2) hallucinations
   (3) disorganized speech (e.g., frequent derailment or incoherence)
   (4) grossly disorganized or catatonic behavior

B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.
Diagnostic Criteria for Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.

B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode during the duration of the illness.

C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness

Bipolar type; Depressive type; specify if with catatonia
DELUSIONAL DISORDER

A. The presence of one (or more) delusions with a duration of one month or longer
B. Criterion A for schizophrenia has never been met
C. Functional impairment is related to delusional theme; non-bizarre behavior
D. Mood symptoms relatively brief in relation to the delusion(s)

Specify type: Erotomanic, Grandiose, Jealous, Persecutory, Somatic, Mixed, Unspecified
SPECIFIERS FOR DELUSIONAL DISORDER, SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDER

- 1st episode, currently in acute episode
- 1st episode, currently in partial remission
- 1st episode, currently in full remission
- Multiple episodes, currently in acute episode, partial remission or in full remission
- Continuous
- Unspecified
CURRENT SEVERITY:

Each primary symptom must be rated for severity within the last 7 days from 0 (not present) to 4 (present and severe)
OTHER SPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER

• Persistent auditory hallucinations
• Delusions with significant overlapping mood episodes
• Attenuated psychosis syndrome
• Delusional symptoms in partner of individual with delusional disorder
UNSPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER
MOOD DISORDERS
Major Depressive Disorder

At least five for a two week period

1. Depressed mood
2. Anhedonia
3. Weight loss/gain (anorexia/hyperphagia)
4. Insomnia/hypersomnia
5. Psychomotor disturbance
6. Diminished energy
7. Diminished self-esteem/guilt
8. Impaired concentration
9. Recurrent thoughts of suicide
• Partial/full remission

• Mild: few, if any sx, in excess of required. Minor impairment. Distressing but manageable

• Moderate: number and intensity of sx between mild and severe

• Severe: number of sx is substantially in excess of those required. Marked impairment. Seriously distressing and unmanageable
MDD SPECIFIERS

• With:
  ➢ Anxious distress
  ➢ Mixed features
  ➢ Melancholic features
  ➢ Atypical features
  ➢ Mood congruent psychotic features
  ➢ Mood incongruent psychotic features
  ➢ Catatonia
  ➢ Peripartum onset
  ➢ Seasonal pattern (recurrent only)
BIPOLAR AND RELATED DISORDERS
**Manic Episode**

A. distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

   (1) inflated self-esteem or grandiosity

   (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (e.g., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
Hypomanic Episode

A. Distinct period of persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting throughout at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing.

(5) distractibility (e.g., attention to easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
WHAT IS IT?

At least one manic episode. Major depression is not required, though the vast majority experience these episodes.
BIPOLAR I SPECIFIERS

CURRENT OR MOST RECENT EPISODE: MANIC, HYPOMANIC, DEPRESSED OR UNSPECIFIED
MILD, MODERATE OR SEVERE
PARTIAL OR FULL REMISSION
With:

- Anxious distress
- Mixed features
- Rapid cycling
- Melancholic features
- Atypical features
- Mood congruent psychotic features
- Mood incongruent psychotic features
- Catatonia
- Peripartum onset
- Seasonal pattern (recurrent only)
WHAT IS IT?

Must meet the criteria for a current or past hypomanic episode and the criteria for a current or past major depressive episode. There must never have been a manic episode.
Specify if current episode is: hypomanic or depressed
Mild, moderate or severe
Partial or full remission
BIPOLAR II SPECIFIERS CONT’D

With:
- anxious distress
- mixed features
- rapid cycling (4 mood episodes in the last 12 months)
- melancholic features
- atypical features
- mood congruent psychotic features
- mood incongruent psychotic features
- Catatonia
- peripartum onset (during pregnancy or in the 4 weeks following delivery)
- seasonal pattern (recurrent only)
• Short duration hypomanic episodes (2-3 days) and major depressive episodes
• Hypomanic episodes with insufficient symptoms and major depressive episodes
• Hypomanic episodes without prior major depressive episode
• Short duration cyclothymia
UNSPECIFIED BIPOLAR AND RELATED DISORDER
POSTTRAUMATIC STRESS DISORDER
WITH OR WITHOUT PSYCHOTIC FEATURES?????
THE CO-OCCURRING PICTURE
CANNABIS

- **Intoxication**: frank psychosis (rare), acute psychosis more common when eaten, paranoid ideation, GAD, panic attacks (rare)
  
  K2 (Spice): Delta 9 v CBD effect

- **Chronic use**: memory impairment, learning skills impairment, 8 point IQ drop, amotivational syndrome
ALCOHOL

Intoxication: mania (stimulant effect) at low doses; depressant effects at higher doses.

Withdrawal:
- Acute: mild (anxiety, insomnia); severe (agitation, mania, delirium, psychosis)
- Sub-chronic: depression
- Chronic: MDD, psychosis, dementia
SEDATIVES

Intoxication (use): depressant, amnesia, ataxia and falling (old), rarely paradoxical agitation (young/old),

Withdrawal:

✓ Acute: mild (anxiety, insomnia); severe (agitation, mania, delirium, psychosis)
✓ Sub-chronic & chronic: depression, anxiety
STIMULANTS

• **Intoxication**: anxiety, panic attacks, mania, psychosis
• **Withdrawal**: *prolonged* depression, insomnia, psychosis
EVALUATION OF CO-OCCURRING DISORDERS
URINE DRUG SCREENING
<table>
<thead>
<tr>
<th>Substance</th>
<th>Blood</th>
<th>Saliva</th>
<th>Sweat</th>
<th>Urine</th>
<th>Hair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>12 hrs</td>
<td>6-12 hrs</td>
<td>unknown</td>
<td>6-24 hrs (5 days with EtG)</td>
<td>n/a</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>12 hrs</td>
<td>3 days</td>
<td>unknown</td>
<td>1-4 days</td>
<td>up to 90 days</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>1-21 days</td>
<td>unknown</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>1-42 days</td>
<td>unknown</td>
</tr>
<tr>
<td>Cannabis (single use)</td>
<td>2-3 days</td>
<td>12-24 hrs</td>
<td>unknown</td>
<td>2-3 days</td>
<td>up to 90 days</td>
</tr>
<tr>
<td>Cannabis (habitual use)</td>
<td>2 weeks</td>
<td>12-24 hrs</td>
<td>unknown</td>
<td>15-30 days</td>
<td>up to 90 days</td>
</tr>
<tr>
<td>Cocaine</td>
<td>unknown</td>
<td>1 day</td>
<td>unknown</td>
<td>4-5 days</td>
<td>up to 90 days</td>
</tr>
<tr>
<td>Codeine/Morphine</td>
<td>unknown</td>
<td>12-36 hrs</td>
<td>unknown</td>
<td>2-4 days</td>
<td>up to 90 days</td>
</tr>
<tr>
<td>Heroin</td>
<td>unknown</td>
<td>unknown</td>
<td>unknown</td>
<td>2-4 days</td>
<td>up to 90 days</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>1-3 days</td>
<td>unknown</td>
<td>unknown</td>
<td>3-5 days</td>
<td>up to 90 days</td>
</tr>
<tr>
<td>PCP</td>
<td>1-3 days</td>
<td>3 days</td>
<td>unknown</td>
<td>3-7 days</td>
<td>up to 90 days</td>
</tr>
</tbody>
</table>

*Shortest Detectability - Longest Detectability*
FENTANYL SCREENING VS. CONFIRMATION TESTING

• POC test immediate
• Fentanyl is mixed in many drugs: individuals might not know they have been taking it
• Fentanyl complicates the detox/MAT process
SCREENING VS. CONFIRMATION TESTING

THERE IS A DIFFERENCE!
There is a Difference and it is VERY IMPORTANT

- Screening can yield up to a 50% false negative rate.
- Screening can yield up to a 41% false positive rate for oxycodone, 22% for opiates, 21% for marijuana and 11% for benzodiazepines.
The Difference Cont’d

Reasons for false negatives:
• Higher cutoff levels
• Unable to effectively identify some substances (e.g. Lorazepam, Klonopin and Xanax)

Reasons for false positives:
• Cross-reactivity
CONFIRMATION TESTING

• Either GC-MS or LC-MS/MS are the only reliable testing methods upon which one can be assured of the right decision.

• There are no false negatives or false positives for drugs tested.
Drug Combinations

<table>
<thead>
<tr>
<th>Type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYNFN W two or more</td>
<td>14</td>
</tr>
<tr>
<td>SYNFN W three or more</td>
<td>11</td>
</tr>
<tr>
<td>SYNFN W AMP</td>
<td>8</td>
</tr>
<tr>
<td>SYNFN W THC</td>
<td>8</td>
</tr>
<tr>
<td>SYNFN W COC</td>
<td>8</td>
</tr>
<tr>
<td>SYNFN W BENZ</td>
<td>7</td>
</tr>
<tr>
<td>SYNFN W OPI</td>
<td>4</td>
</tr>
<tr>
<td>SYNFN W COC and OPI</td>
<td>3</td>
</tr>
<tr>
<td>SYNFN W BUP</td>
<td>3</td>
</tr>
<tr>
<td>SYNFN W ETG</td>
<td>4</td>
</tr>
<tr>
<td>SYNFN W COC and MTD</td>
<td>0</td>
</tr>
<tr>
<td>SYNFN W COC and OXY</td>
<td>1</td>
</tr>
</tbody>
</table>
KEY FACTORS IN EVALUATING DUAL DISORDERS

1. Comprehensive history
2. Phase specific symptoms:
   a) Intoxication
   b) Use
   c) Withdrawal
   d) Post acute withdrawal

Focus on duration/sxs of each phase and timing as it relates to potential psych sxs.
VERY IMPORTANT:
WHAT ARE THE SXS DURING TIMES OF ABSTINENCE AND HOW LONG HAS THE INDIVIDUAL BEEN ABSTINENT.
REMEMBER ACUTE VERSUS POST ACUTE WITHDRAWAL SXS AND DURATION.
DON’T GIVE DEFINITIVE DX WHILE INTOXICATED OR WITHDRAWING. HOW LONG SHOULD ONE WAIT?

HISTORY IS CRITICAL: 1) FAMILY HISTORY; 2) LOOK FOR “WINDOWS” OF CLEAN TIME; 3) BEWARE OF “WHITE KNUCKLES”.

PSYCHOLOGICAL TESTING ONLY AT APPROPRIATE TIME.

REMEMBER - A DIAGNOSIS CAN HAVE PERMANENT RAMIFICATIONS!
Stabilize the basic withdrawal: comfort and safety

I. Alcohol withdrawal: prn/symptom-based vs. protocol driven
   - Common: Librium vs Valium vs Ativan

II. Benzo withdrawal: long half-life vs. short half-life drugs

III. Combination of alcohol and benzos

IV. Amphetamines/methamphetamines

V. Cocaine

VI. Opioids: pills, heroin, fentanyl, kratom, tianeptine
   - Comfort meds, buprenorphine taper vs induction
SCREENING TOOLS
### Alcohol Concentration-Effect Relationship

<table>
<thead>
<tr>
<th>BAC [%]</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.02-0.03</td>
<td>Mood elevation. Slight muscle relaxation.</td>
</tr>
<tr>
<td>0.05-0.06</td>
<td>Relaxation and Warmth. Increased reaction time. Decreased fine muscle coordination.</td>
</tr>
<tr>
<td>0.08-0.09</td>
<td>Impaired balance, speech, vision, hearing, muscle coordination. Euphoria.</td>
</tr>
<tr>
<td>0.14-0.15</td>
<td>Gross impairment of physical and mental control.</td>
</tr>
<tr>
<td>0.20-0.30</td>
<td>Severely intoxicated. Very little control of mind or body.</td>
</tr>
<tr>
<td>0.40-0.50</td>
<td>Unconscious. Deep coma. Death from respiratory depression</td>
</tr>
</tbody>
</table>
Alcohol Withdrawal Assessment Scoring Guidelines (CWA - A)

**Substance Withdrawal**: Rate on scale 0-7

0 - None
1 - Mildness with no withdrawal
2
3
4 - Intermittent nausea
5
6 - Diarrhea or dehydrated
7 - Withdrawal symptoms

**Adaptation**: Rate on scale 0-7

0 - Normal activity
1 - Somewhat limited activity
2
3 - Moderate changes in activity
4 - Severe changes in activity
5 - Severe changes in activity, but can be left alone
6 - Severe changes in activity, but cannot be left alone
7 - Severe changes in activity, and death is imminent

**Eye Signs**: Rate on scale 0-5

0 - No symptoms
1 - Weakness, slowed pupil reflexes
2
3
4 - Severe eye reflexes
5 - Severe eye reflexes with death

**Psychiatric Symptoms**: Ask, "Have you experienced any fright, fear, anxiety, restlessness, and irritability, or a feeling of being warned or tormented by your own mind?"

- Very mild anxiety
- Mild anxiety
- Moderate anxiety
- Severe anxiety
- Continuous anxiety

**Vomiting**: Ask, "Does the patient vomit or feel nauseous?"

- None
- Slight nausea
- Moderate nausea
- Severe nausea
- Constant nausea

**Breathing**: Ask, "Does patient exhibit rapid, shallow, or labored breathing?"

- None
- Slight
- Moderate
- Severe
- Continuous

**Hiccups (Staccato)**: Ask, "Does patient exhibit hiccups?"

- None
- Slight
- Moderate
- Severe
- Continuous

**Other Symptoms**: Ask, "Does the patient exhibit any other symptoms that might indicate withdrawal?"

- None
- Slight
- Moderate
- Severe
- Continuous

Procedures:
1. Assign an oxidation of the 10 criteria of the CWA scale. Each criterion is rated on a scale of 0-7, except for "Oxidation and Staccato of symptoms" which is rated on a scale of 0-4. Add up the score for all ten criteria. This is the total CWA A score for the patient at that time.
2. Psychiatric medication should be started for any patient with a total CWA A score of 5 or greater (i.e., severe withdrawal indications). If started on psychiatric medication, additional PNS medication should be given over a total CWA A score of 13 or greater.
4. The CWA A Scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is equally important. Early intervention for CWA A score of 5 or greater provides the best means to prevent the progression of withdrawal.
**APPENDIX 1**

**Clinical Opiate Withdrawal Scale**

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Date and Time: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for this assessment:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Restlessness</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>restless</td>
</tr>
<tr>
<td>1</td>
<td>restless still, but is able to do so</td>
</tr>
<tr>
<td>2</td>
<td>frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>3</td>
<td>restless even 5-10 seconds</td>
</tr>
<tr>
<td>4</td>
<td>restless over 15-30 seconds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pupil size</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>normal size for room lighting</td>
</tr>
<tr>
<td>1</td>
<td>pupils possibly larger than normal for room lighting</td>
</tr>
<tr>
<td>2</td>
<td>pupils moderately dilated</td>
</tr>
<tr>
<td>3</td>
<td>pupils so dilated that only the rim of the iris is visible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Bone or Joint aches</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>not present</td>
</tr>
<tr>
<td>1</td>
<td>mild diffuse discomfort</td>
</tr>
<tr>
<td>2</td>
<td>patient reports severe diffuse aching of joints/muscles</td>
</tr>
<tr>
<td>3</td>
<td>patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Runny nose or tearing</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>not present</td>
</tr>
<tr>
<td>1</td>
<td>nasal stuffiness or unusually moist eyes</td>
</tr>
<tr>
<td>2</td>
<td>nose running or tearing</td>
</tr>
<tr>
<td>3</td>
<td>nose constantly running or tears streaming down cheeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>GI Upset</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>no GI symptoms</td>
</tr>
<tr>
<td>1</td>
<td>stomach cramps</td>
</tr>
<tr>
<td>2</td>
<td>nausea or loose stool</td>
</tr>
<tr>
<td>3</td>
<td>vomiting or diarrhea</td>
</tr>
<tr>
<td>4</td>
<td>multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sweating</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>no sweating</td>
</tr>
<tr>
<td>1</td>
<td>patient can be felt, but not observed</td>
</tr>
<tr>
<td>2</td>
<td>slight sweating observable</td>
</tr>
<tr>
<td>3</td>
<td>gross sweating or muscle twitching</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Tremor</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>no tremor</td>
</tr>
<tr>
<td>1</td>
<td>tremor observable</td>
</tr>
<tr>
<td>2</td>
<td>slight tremor observable</td>
</tr>
<tr>
<td>3</td>
<td>gross tremor or muscle twitching</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Anxiety or Irritability</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>none</td>
</tr>
<tr>
<td>1</td>
<td>patient reports increasing irritability or annoyance</td>
</tr>
<tr>
<td>2</td>
<td>patient obviously irritable or annoyed</td>
</tr>
<tr>
<td>3</td>
<td>patient so irritable or annoyed that participation in the assessment is difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Gooseflesh</strong></th>
<th>Observations during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation:</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>skin is smooth</td>
</tr>
<tr>
<td>1</td>
<td>pruritus of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>2</td>
<td>prominent gooseflesh</td>
</tr>
</tbody>
</table>

| **Initials of person completing assessment:** | |
|---------------------------------------------| |

**Total Score:**

The total score is the sum of all 11 items.

Score 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.
TOOLS FOR MANAGEMENT OF ACUTE-ONSET PSYCHOSIS DURING WITHDRAWAL/INTOXICATION

• Reduce stimulation
• Empathic support
• Do not challenge symptoms: they are real to the patient
• Low dose, high potency antipsychotics: FGA vs SGA
  ➢ E.G.: risperidone vs haloperidol vs olanzapine
• Other FGA and SGA good for maintenance but not as effective for this scenario
• Relatively little literature
Side effects of SGA and FGA:

**EPS:** benztropine

**Akathisia:** try propranolol

**Acute dystonic reaction (oculogyric crisis, opisthotonos, torticollis, dysarthria):** IM Benadryl (25 or 50mg) or benztropine (1mg)
SCENARIO-DRIVEN TEACHING
SCENARIO # 1

49 yo male with no known psych history and comes in with no meds. Drinking one liter to one gallon vodka per day. BAC is 0.387. Walking and talking as if not intoxicated. CIWA = 0. V/S WNL. Two hours later, BAC 0.30. Talks about seeing people that others don’t see, oriented only to person, clouding of sensorium, tremors and diaphoresis.
ALCOHOL WITHDRAWAL DELIRIUM A MEDICAL EMERGENCY CALL 911
SCENARIO # 2

SCENARIO # 2 TX

• Do not treat b/p independent of withdrawal

• Do not treat psychotic symptoms yet! Greatest risk of withdrawal seizures is approx. 24hrs! FGA and SGA reduce seizure threshold. Might not need to!

• Begin Librium protocol and give Ativan (1-2mg). Don’t worry, cross tolerance!

• Repeat Ativan every 1-2 hours until vitals are WNL and CIWA below 10

• Push fluids, thiamine, multivit, nutrition as tolerated

• If psychosis continues and adequate blood level of benzo: risperidone or haloperidol. If agitation severe: IM with 2mg Ativan. If patient compliant give po. May repeat q30min (IM) or q1hour or more frequently if needed po.

• Check for cogwheel rigidity. If present may add benztropine 0.5-1mg bid. Beware acute dystonic reaction.
SCENARIO # 2 TX cont’d

- Set dose of for next day antipsychotic based upon amount given to stabilize
- Can begin a rapid wean after approx. Day 3 of the protocol as tolerated
BENZODIAZEPINES

- Xanax most common, seeing diazepam more frequently than expected
- Klonopin 1:1. High end vs. Low end. Beware if also diazepam
- Phenobarbital?
- CIWA-driven (and v/s) as per alcohol
- Can have delirium like alcohol
- Psychosis during withdrawal treat like alcohol with scenario # 2.
SCENARIO # 3

60 yo black, homeless, male with a 40-year h/o cocaine use disorder. Prior Baker Acts for bipolar disorder and/or schizophrenia and treated with multiple mood stabilizers, FGA’s and SGA’s as well as SSRI’s. Never stayed on his meds (couldn’t afford). Last Baker Act was 3 years ago. Prison for 5 years 10 years ago secondary to burglary; no psych treatment. Used cocaine in the parking lot. UDS + cocaine and fentanyl; doesn’t know anything about fentanyl.

Agitated, paranoid delusion of police hiding in the parking lot, diaphoretic, tremulous, hypervocal, flight of ideas, tachycardic with b/p 160/90.

Unlikely diagnoses? Likely diagnosis? Why?
SCENARIO # 3 cont’d

• Reduce stimulation
• Empathic, non-challenging, non-judgmental responses
• Suffering due to paranoia/agitation: try Ativan first. Why?
• COWS q2h while awake
• Supportive hydration, nutrition, etc.
• Residential tx
SCENARIO # 4


What is obvious from presentation?

What history do i want to know?

What did i do?
SCENARIO # 5

32 yo Hispanic male seen in outpatient clinic. Long h/o bipolar disorder with psychotic features. On longterm treatment with haloperidol 20mg bid. Here for continuation of treatment and refill of medication. Long h/o cocaine use disorder of $50-$100/day. H/o multiple, short duration manic sxss followed by major depressive sxss. Psychotic sxss only during manic phase. During interview, MSE only positive for depressed mood and affect. UDS negative. Involuntary chest wall movement noted. Very motivated. Called the prior treating physician.

Probable diagnoses?

Treatment plan?

Outcome………….
36 yo Caucasian female presents with long h/o methamphetamine use disorder. Daily use. H&P WNL. V/S WNL. MSE WNL except complex delusional system involving ex-bf and police (he was a LEO). Plans to find her and set her up. Was seeing dust particles coming from the vent; they would merge and become little animals. Very animated and engaging. High intelligence. Felt safe in the treatment center.

Differential diagnoses?

Treatment plan?

Outcome............
SCENARIO # 7


What are my priorities?

Treatment timeline?
QUESTIONS AND THANK YOU!