**Editorial**

# Psychiatric Patients in Medical Emergency

The American Psychiatric Association defines a psychiatric emergency as "a situation that includes an acute disturbance in thought, behavior, mood, or social relationship, which requires immediate intervention as defined by the patient, family, or social unit." These presentations include such symptoms as anxiety, depression, aggression, personality changes, delusions, and hallucinations; all of these can be caused or aggravated by medical disorders. Patients with predominantly psychiatric complaints represent 2% to 12% of emergency department visits.[1] Patients who do not have predominantly psychiatric complaints also visit emergency department (ED) frequently. The emergency physician spends relatively little time during residency training learning how to evaluate and manage psychiatric patients. The busy emergency physician is expected to evaluate and treat these patients rapidly and comprehensively.

It has been seen that patients who frequently visit ED have more psychiatric illnesses than random users. In a study of frequent users of emergency medical service in rural areas 93% of frequent users had at least one psychiatric diagnosis on structured clinical interview. Random users had 50% of similar complaints. The most common diagnoses among frequent users were major depression, generalized anxiety disorder, adjustment disorder, somatoform pain disorder, substance abuse and dependence, and dysthymia. The treating emergency department physician mentioned a psychiatric diagnosis for only 9% of frequent users. [2] Co morbid psychiatric disorders need to be treated so that burden on ED can be lessened.

Depressive symptoms are seen with many physical illnesses that present to ED. Negative cognitions of depressive disorder would affect patient's coping with illness, compliance and satisfaction with treatment. These factors will affect quality of life and outcome of medical illness. Depression is often ignored in ED setting. In a multi center study of major depressive disorder (MDD) among emergency department patients prevalence of MDD ranged from 23.0 – 35.0%. These patients had a diagnosis of asthma or arthritis/rheumatism. On multivariate analysis anxiety, back pain, and chronic fatigue was independently associated with MDD.[3] Similar results were reported when a prospective study was done on adult patients in urban emergency department. 32% patients screened positive for depression, which was more likely in patients with psychiatric history, substance abuse history or a suicide attempt.[4]

Patients with bipolar disorder do not reveal history of manic symptoms unless specifically asked for. In such cases a diagnosis of recurrent depressive disorder is frequently made. Bipolar patients present to ED with alcohol use complications or after road traffic accident. In a study to find out prevalence of bipolar disorder among ED patients, nearly 7% screened positive for bipolar disorder.[5] Bipolar disorders remain under recognized in primary care and even in psychiatric care. In a study psychiatrists and primary care physicians failed to detect bipolar disorder among 53% and 78% of patients respectively, who screened positive for bipolar disorder.[6] This study highlights that bipolar disorder remains under diagnosed and inappropriately treated.

Emergency care providers routinely care for patients with hazardous and harmful drinking. 10% to 46% visits to ED are known to be associated with alcohol. ED patients were 1.5 to 3 times more likely

to report heavy drinking, consequences of drinking, or taking treatment of alcohol problem than primary care patient.[7] Alcohol related diseases and injuries pose a significant burden on hospital ED. A rate of 28.7 per 1000 US population attributable to alcohol related causes in ED was reported.[8] In patients seeking ED care alcohol misuse was seen to be associated with depression in 51.0%. Even patients with minor injuries presenting to ED had high rate of psychiatric disorders. Alcohol use disorder was seen in 16% and drugs were seen in 7% of patients. Current mood disorder was present in 47% of patients.[9] Patients with alcohol use disorder can be motivated in ED to take treatment for alcohol use if it is diagnosed.

Chest pain is a common presentation to ED. In a study on anxiety and depressive disorders in patients presenting with chest pain 23% of patients had diagnosable psychiatric condition.[10] Patients with schizophrenia present to ED twice more than patients without mental illness. Patients with respiratory problems and those with any co morbid condition reported significantly more use of ED.[11]

Psychiatric patients present to emergency department very often, and are often under diagnosed. There is a need to improve recognition of various psychiatric disorders in ED. Adequate training of emergency medical officers in psychiatry is imperative. Few screening questionnaires can also be used in ED setting by nursing staff or social workers. It is important to subsequently refer these patients to mental health services.

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References:


1. Shepherd WS. Medical clearance of psychiatric patients. Emerg Med Clin N Am 2003; 18 (2) :185 - 198
2. Mehl-Madrona LE. Prevalence of psychiatric diagnoses among frequent users of rural emergency medical services. *Can J Rural Med* 2008;13:22-30.
3. Castilla-Puentes RC, Secin R, Grau A, et al. A multicenter study of major depressive disorder among emergency department patients in Latin- American countries. *Depress Anxiety* 2007;1-6.
4. Boudreaux ED, Cagande C, Kilgannon H,et.al. A prospective study of depression among adult patients in an urban emergency department. *Prim Care Companion J Clin Psychiatry* 2006; 8(2):66-70.
5. Boudreaux ED, Cagande C, Kilgannon H,et. al. Bipolar disorder screening among adult patients in an urban emergency department setting. *Prim Care Companion J Clin Psychiatry* 2006; 8(6):348-351.
6. Frye MA, Calabrese JR, Reed ML, et al. Use of health care services among persons who screen positive for bipolar disorder. *Psychiatr Serv* 2002; 56:1529-33.
7. D'Onofrio G, Becker B, Woolard RH. Impact of alcohol, tobacco, and other drug use and abuse in emergency department. *Emerg Med Clin N Am.* 2006; 24: 925-967.
8. McDonald AJ 3rd, Wang N, Camargo CA Jr. US emergency department visits for alcohol related diseases and injuries between 1992 and 2000. *Arch Intern med* 2004; 164:531-7.
9. Richmond TS, Hollander JE, Ackerson TH, et al. Psychaitric disorders in patients presenting to the emergency department for minor injury. *Nurs Res* 2007; 56: 275-82.
10. Srinivasan K, Joseph W. A study of lifetime prevalence of anxiety and depressive disorders in patients presenting with chest pain to emergency medicine. *Gen Hosp Psychiatry* 2004; 26(6): 470-4.
11. Goldberg RW, Gmyrek AL. Use of medical emergency departments by veterans with schizophrenia. *Psychiatr Serv* 2007;58: 566a-567