

FEx Net 2023 Collated SAQs:

Emergent Psychiatric Presentations

- Answers

1. Agitation
2. Agitation
3. Agitation
4. Agitation
5. Agitation
6. Anorexia
7. Delusions
8. Eating Disorder
9. Eating Disorder
10. Eating Disorder
11. Eating Disorder
12. Eating Disorder
13. Mania
14. Mania
15. Mania
16. Psychosis
17. Psychosis
18. Psychosis
19. Psychosis
20. Psychosis
21. Suicidality
22. Suicidality
23. Suicidality

Question 1

1.

Past history of psychiatric disorder

Current presentation similar to previous psych presentations

Normal vitals

No acute drug intoxication / normal physical examination

Auditory hallucinations

Collateral history suggestive of slow onset deterioration

No medical symptoms / complaints

2.

Understands current condition

Understands treatment options

Understands possible outcomes of each treatment option

(some assessment of judgement)

3.

Verbal de-escalation

Oral sedation – eg diazepam 10mg po

Show of force

Physical restraint

Parenteral chemical restraint – eg droperidol 10mg IM

Question 2

A 25 year old female has been brought to your department by ambulance and police escort. She is agitated and violent, with contusions over her face and head.

The handover indicates her neighbours called the police for a domestic disturbance. Ambulance and police found evidence of drug paraphernalia around the house as well, as multiple empty alcohol containers. Medications in the patient's name include thyroxine, venlafaxine and pregabalin.

1. Other than alcohol/drug intoxication and psychosis, list 4 likely causes for this patient's presentation (4 Marks)

1. Trauma (head injury)
2. Non-intoxication toxidrome (serotonin toxicity)
3. Metabolic disturbance (thyroid storm, hypertensive encephalopathy)
4. Infective (meningo-encephalitis, febrile delirium)
5. Hypoxia
6. Drug withdrawal
7. Post ictal state

2. List 4 potential complications of emergency sedation (4 Marks)

1. Depression of airway reflexes
2. Depression of ventilation
3. Depression of cardiovascular system
4. Drug interactions/reactions (anaphylaxis, acute dystonic reaction, oculogyric crisis)

3. List 4 departmental design features that can help mitigate negative psychosocial states and violence in Emergency Departments (2 Marks)

1. Well lit + minimize hiding spaces
2. Positive distractions in waiting area (TV, play area for children, art works)
3. Clear sign posting + way-finding
4. Visible waiting area/CCTV
5. Duress alarms
6. Controlled/swipe card access to clinical areas
7. Separate access + non clinical/break areas for staff
8. Behavioural assessment rooms/safe assessment spaces

4. List 4 system-wide approaches to mitigation of violence in Emergency Departments in general (2 Marks)

1. Adequate staffing models
2. Hospital security
3. Staff training (de-escalation, violence recognition and prevention, reporting)
4. Violence response policy (Code Black/security response/police response)
5. Standardised reporting system/risk management
6. Supporting staff taking legal action

Question 3

1- List 6 key components of your assessment of this patient in the ED. (6 marks)

Mental state assessment including assessment for acute psychosis, depression
Assessment of suicide risk
Alcohol and drug use – current level of intoxication
Assess for physical injury
Assess for underlying medical condition that may be exacerbating behaviour
Exclude pregnancy
Social History including safety of child in the home
Prior notifications to Department of Child Safety (or equivalent) for this child

2- On attempting to take further history from the patient, she becomes aggressive and starts spitting at staff and throwing chairs around the treatment room.
You are unable to verbally deescalate the situation and decide to proceed with chemical restraint of the patient.

List the agents you would use to chemically restrain this patient in the ED. (including doses) (2 marks)

Droperidol
Midazolam
Diazepam
Haloperidol
Olanzapine IMI

3- After you have safely sedated this patient, her mother arrives and becomes angry that you have sedated her child. List the key components of your response to the mother's complaint. (4 marks)

Under Guardianship Act to maintain patient & staff safety
Necessary to allow further mental health assessment of the child
Reassurance of safety processes in place to ensure it was performed safely
Likely timeframe in which child will awake
Allow mother to remain with child whilst in the ED
Documentation of the above in the medical record.

Question 4

A 45 year old woman with a history of schizophrenia and medication non-compliance is brought in by an ambulance after being found trying to run into oncoming traffic. She is acting erratically and states she is being experimented on by the Government. She is becoming increasingly agitated.

List 3 clinical features suggestive of an organic cause for her presentation (3 marks)

- Fever
- Drug use
- Visual hallucinations
- Altered level of consciousness / cognition
- Altered vital signs – e.g. tachycardia / hypotension

List 5 features suggestive of acute psychosis (5 marks)

- Delusions
- Hallucinations
- Disorganised speech
- Grossly disorganised or catatonic behaviour
- Negative symptoms – flattened affect, alogia etc

Patient becoming increasingly agitated and attempting to leave the department. Verbal de-escalation fails and you decide to initiate chemical restraint.

List 2 options for parenteral administration (different classes) including dose / route / 1 side effect (4 marks)

Expect

Benzodiazepine: Midazolam / Lorazepam: Respiratory depression

Antipsychotic: Droperidol / Olanzapine / Haloperidol: Extrapyramidal side effects / Prolonged QT

Question 27

What is the diagnosis? (1 mark)

Urinary retention

Name 4 causes of this condition, each from a different category (4 marks)

Infective – e.g. UTI

Medication – e.g. anticholinergic

Neurological – e.g. cauda equina

Structural – e.g. BPH / haematuria / phimosis

Inefficient detrusor muscle (usually with above precipitant, or even fluid challenge etc)

In standard circumstances, how is this condition diagnosed? (2 marks)

Voiding difficulty +/- lower abdominal pain

Post-void residual volume > 300mL

You are unable to insert an indwelling catheter and decide to insert a suprapubic catheter. Outline the steps involved in performing the procedure (6 marks)

- Confirm and bladder position with bedside US
- Position supine / Prep and drape / sterile gloves
- Infiltrate local anaesthesia 2cm above pubic symphysis
 - insert needle until aspirate urine
 - direction ~perpendicular (more cephalad in children, more caudal in adults)
- Core steps
 - Needle to bladder / introduce wire / scalpel to skin / dilator / catheter / split away sheath
 - Scalpel incision / firm pressure into bladder with trocar, remove trocar / insert catheter / split away sheath
- Post-procedure: Attach collection bag / dress skin / cares and follow up organised

Question 5 (18 marks)

An acutely aggressive 24-year-old man is brought into your emergency department by ambulance and police after being found alone on a bridge.

a). Give a stepwise approach to managing this aggressive patient with specific examples. (5 marks)

verbal de-escalation
show of force
offer oral chemical restraint – 5-10mg PO diazepam, 5-10mg PO olanzapine
physical restraint
parenteral restraint – 10mg IM droperidol, 10mg IM or 2.5-5mg IV midazolam, 10mg IM olanzapine

b). Complete the following table for the components of a mental state examination. For each component give an example of what specifically should be assessed (8 marks)

Component	What to assess
Appearance + behaviour:	physical appearance (cleanliness, grooming), manner of relating to clinicians/family, activity level (slow/agitated)
Speech:	spontaneous/not, fluency, rate, volume, tone
Mood:	Predominant mood over last weeks, 0-10 scale
Affect:	observed emotional state: type, range, reactivity, appropriateness
Thoughts:	stream, form, content
Perception:	altered bodily experiences, passivity phenomenon, hallucinations
Cognition:	LOC, orientation, attention, memory, ability
Insight and judgement	Insight into perception disorders, (problem-solving)

c). List 10 risk factors that are associated with a high risk for suicide (5 marks)

Male gender
Marital status – separated, divorced, widowed
Unemployed/retired
Chronic illness/pain
Psychiatric diagnosis – depression, bipolar, schizophrenia, substance abuse
Social background – socially isolated, indigenous or refugee background
Suicidal ideation
Multiple previous attempts
Access to violent, lethal method
Clear plan
Act performed in isolation/precautions taken to avoid discovery
Final acts – wills, insurance, giving away property
Unwilling to seek help
Precipitant - stressor

Question 6

A severely emaciated 14-year-old girl presents to ED with her parents who are very concerned about her weight. She has a known diagnosis of Anorexia Nervosa.

1. List 4 overarching goals in the management of Anorexia Nervosa when admitting patients to the hospital for acute inpatient care.

(2 marks)

Medical stabilization of medical complications eg cardiac failure
Prevent or manage Refeeding syndrome
Weight restoration
Reversal of cognitive deficit due to starvation
Inpatient psychotherapy

2/4

2. List 6 clinical, bedside test or lab criteria that would require her to be admitted to the hospital under the Medical inpatient Team.

(6 marks)

BMI <12 (or rapid weight loss >1kg per week for many weeks)
HR < 40 or > 120
BP <80
Postural drop >20
Temp <35
ECG – arrhythmia, QTc prolonged, ST deviation or repolarization abn
BSL <2.5
Na <125
K <3
Mg<0.7
PO4 <0.8
eGFR <60
ALT >500
Albumin <30
Neutrophil <1
Pass mark 7/10

3. You decide this patient requires admission to a medical ward.

List 4 medical complications that may occur after this patient commences treatment.

(4 marks)

Refeeding syndrome associated complications –

Hypomagnesemia,
hypophosphatemia,
thiamine deficiency
Hypocalcemia
Hypokalemia

Hypoglycemia
Cardiac failure
Occult infection
Pass mark 2/4

References

1. **Queensland Health Guidelines for Eating Disorders (available on APEM website)**
2. http://www.rch.org.au/clinicalguide/guideline_index/Anorexia_Nervosa/
3. ***RANZCP Clinical Practice Guidelines for Eating Disorders. Australian & New Zealand Journal of Psychiatry*** 2014, Vol. 48(11) 1–62 (APEM website)

Question 7

A 21-year old male presents to the Emergency Department with concerns he is being chased by “bikies”. It is his first ED presentation. He is moderately agitated but alert and orientated.

His vital signs are

BP 115/70 mmHg

HR 80 bpm

Temp 36.9 C

a) List six (6) features of your history and examination which make you more likely to consider primary psychosis as your diagnosis. (6 marks)

- History

- Age of onset (Schizophrenia - 75% is 15-25 years old)
- Family history of schizophrenia
- Alcohol and/or drug intoxication/abuse
- Onset – subacute (acute e.g. drug induced)
- Impaired social/occupational functioning

- Examination

- Appearance and behaviour – restless/agitated, neglected/dishevelled, mannerisms or stereotypes
- Thought disorder – lack of logical thought processes, tangential, circumstantial
- Emotions – inappropriate affect, emotional blunting
- Hallucinations – predominantly auditory, occurs despite normal LOC
- Insight – lack of
- Judgment – impaired
- Delusions – most commonly multiple different types, rather than single

b) The Mental Health Team asks you if you have done a “medical clearance”. List two (2) reasons why it is important to perform a medical assessment of this patient? (2 marks)

- Determine if a medical illness is causing the presentation
- Determine if there is a concurrent acute medical illness requiring immediate/urgent treatment
- Determine if there is a chronic medical condition which requires management
- Determine if there are side-effects of the patient’s current treatment requiring immediate/urgent management

c) The patient is getting increasingly agitated. Attempts at de-escalation are unsuccessful. For safety measures you decide to use further restraint measures. Please fill in the table below (8 marks)

Type of restraint	Advantages	Disadvantages
Chemical	• Both sedating and anxiolytic • Antipsychotic treatment (in psychosis) • Multiple routes • Can de-escalate i.e. not require physical restraint • Less risk of physical injury	• Airway compromise/aspiration • Can require one-one monitoring • Decrease ability to carry out assessment due to sedation • Unexpected drug reactions • Slower time to control than physical restraint
Physical	• Self/staff/others protection • Safe(r) access to im/iv drug administration • Last resort option • Gains immediate control once team assembled	• Risk to both patient and staff (airway, injuries, sympathomimetic response) • Requires appropriate training • Min 5-6 people • Requires degree of chemical restraint too • Ongoing one-one monitoring

Question 8

1.

BMI <12 or <75% IBW

Systolic BP <80

HR <50 or >120

Postural Tachy >20bpm or Postural Hypotension >20mmHg

Temp <35.5 or >38

BGL <3

Sodium <125

K <3

Hypophosphataemia

Hypomagnesaemia

Neutropaenia <0.7

ECG abnormalities

2.

Hypophosphataemia

Hypokalaemia

Congestive Cardiac Failure

Peripheral Oedema

Rhabdomyolysis

Seizures

Haemolysis

Question 9

1. Her ECG is reproduced for review. What is the most likely diagnosis and provide supporting evidence. (5 marks) - 4/5

Answer:

Bradycardia - Rate 50

Long QT interval

T wave flattening and inversion

U waves

Characteristic of **hypokalaemia**

2. Describe 6 management steps for the above patient including any drugs required: - 5/6

Multi-disciplinary team approach including medical, psychiatric and social worker.

Treat shock with 20ml/kg normal saline, aim for Systolic > 90 and MAP >65 and Urine output 0.5 ml/kg/hr

Identify and treat hypoglycaemia with 50 ml of 50% Dextrose

Electrolyte correction: K and Mg IV supplement

Treat hypothermia with passive rewarming (Bear hugger)

IF HR remains low with hypotension: consider atropine 300 mcg boluses and start atropine infusion

Thiamine 100 mg TDS and multivitamin supplement.

Will require admission under Psych and Medicine in order to commence feeding once shock has been managed. Monitor for refeeding syndrome.

3. List the potential ethical and legal pitfalls that could be anticipated in the management of this patient: (2 marks) – 1/2

Patient might refuse the above treatment or lack insight into her condition, therefore **lacking capacity** to consent.

Under **duty of care** principle, this patient could be kept in hospital to receive the above treatment even if she is unable to consent.

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Patient may try to leave requiring escalation of restraint. (Verbal de-escalation with input from her NOK, family and Psych team , next step will be pharmacological restrain as last resource.)

4. List 7 common physical symptoms that a patient with anorexia nervosa may present with to the ED. For each list one potential underlying cause.

(12 marks) – 8/12

Answer:

Chest pain - Cardiomyopathy, arrhythmias secondary to electrolytes

Palpitations - brady/tachycardia, arrhythmias

Constipation – dehydration, hypocalcaemia

Abdo pain - pancreatitis post binge, secondary to ileus

Collapse or syncope – hypoglycaemia, hypocalcaemia, anaemia

Fractures – secondary to osteopenia

Weakness – electrolyte abn hypokalaemia, hypocalcaemia, hypoglycaemia, peripheral neuropathy, hypothyroidism

Passmark = 18/25 (adjust to /10)

(7.2/10)

Question 10

A 16 year old girl is brought in by her parents due to concern about her weight and mental health.
She weighs 38kg.

**I. List four (4) features on history that may suggest an eating disorder .
(4 marks)**

- Intense fear of gaining weight
- Preoccupation with body image / body dysmorphia
- Change in eating habits – intense dieting
- Excessive or compulsive exercise
- Significant weight fluctuations
- Obsessive food rituals
- Induced purging after meals/laxative use
- Deceptive/ secretive behaviour around food

**II. List four (4) medical complications that may occur due to an eating disorder.
(4 Marks)**

- Cardiac – hypotension, heart failure, arrhythmias, cardiomyopathy
- Haematological – anaemia, leukopaenia, thrombocytopaenia
- Musculoskeletal – osteopenia/osteoporosis leading to fractures
- Gastrointestinal – gastritis, PUD, oesophagitis
- Gynaecological – amenorrhoea, infertility
- Neurological – peripheral neuropathy

**III. What principles of risk assessment need to be considered when deciding her treatment?
(4 marks)**

- Presence of immediate life threats – arrhythmias, signs of heart failure, hypotension
- Patient's capacity to consent/refuse treatment
- Likely compliance with treatment
- Active suicide risk
- Family/social/community support

Question 11

Kelvin Huang

A 16 year old woman is brought to the emergency department by her parents who are concerned about her recent loss of weight. She is known to have an eating disorder and currently has a BMI of 15.

List ten (10) significant physiological complications of Anorexia (5 marks)

Cardiovascular

- Hypotension**
- Bradycardia**
- Sudden Cardiac Death**

CCF

GI

- Hepatitis**

Constipation

CNS

- Impaired Cognition**
- Delirium**

Electrolyte

- Hypokalaemia**

Hypoglycaemia

Hypoalbuminaemia

Hypercholesterolaemia

Haematological

Anaemia

Marrow Suppression

Clotting abnormality

Musculoskeletal

Muscle Catabolism

Osteoporosis

An arterial blood gas is performed and shown below

pH	7.53
pCO ₂	51

Na	131
K	2.2
Cl	75
Base Excess	25.3
HCO ₃	48

What are the significant abnormalities shown? (3 marks)

Primary Metabolic Alkalosis with secondary respiratory alkalosis

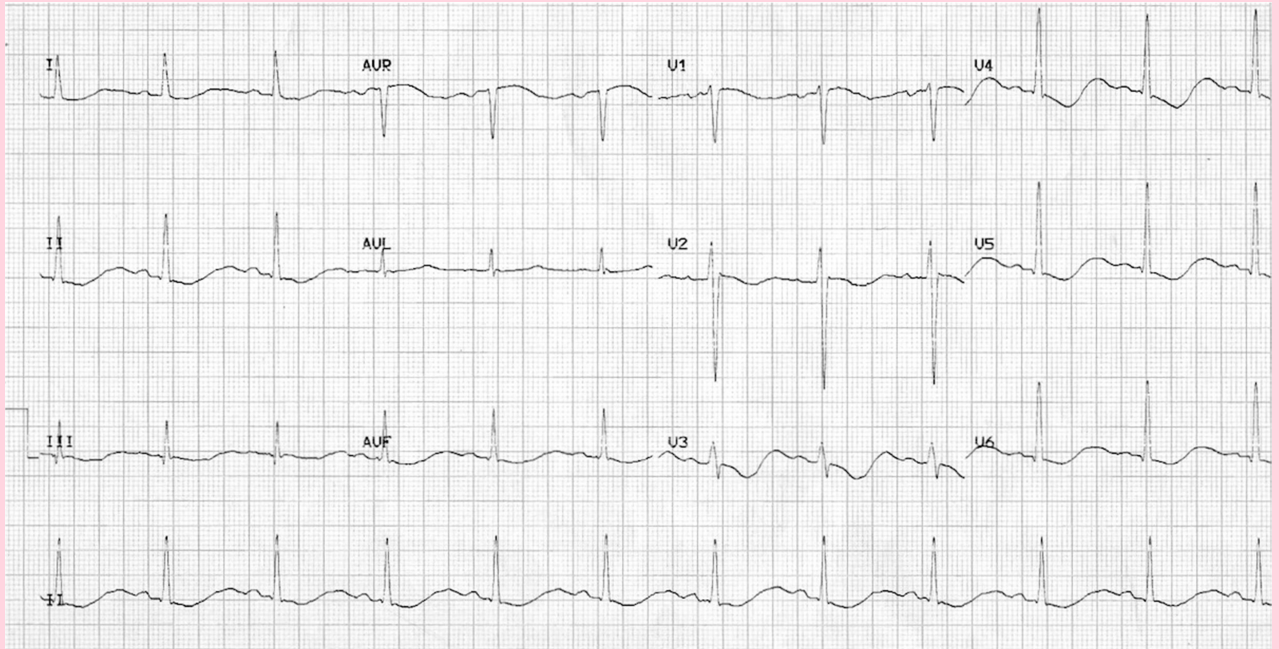
Mild hyponatraemia

Severe hypokalaemia

What is the likely underlying cause? (2 marks)

Prolonged vomiting causing hydrogen ion loss causing metabolic alkalosis
Malnutrition and poor intake causing hypokalaemia

An ECG is performed and shown below



What are the significant findings shown on ECG? (3 Marks)

ST depression with T wave inversion and U waves
Significantly Prolonged QU interval
Consistent with severe hypokalaemia

What significant arrhythmia is this patient at risk of? (1 Mark)

Ventricular arrhythmias VT, VF, Torsades de Pointes

The patient is admitted nutritional rescue.

What are the major electrolyte abnormalities associated with refeeding syndrome? (3 Marks)

Hypokalaemia
Hypomagnesaemia
Hypophosphataemia

What vitamin is also deficient must be supplemented ? (1 Mark)

Thiamine B1

Question 12

A 17 yr old girl is brought to the emergency department by her parents as they are concerned she isn't eating enough. On examination she is extremely pale and thin. Her weight is 42 kg and her height is 173 cm.

(1) What are 4 of the diagnostic criteria for anorexia nervosa ? (4 marks)

- (i) BMI < 17.5 (or body weight < 85 % expected)
- (ii) Weight loss is self induced
- (iii) One or more of :
 - Body image distortion (delusional belief of being overweight, even when dramatically thin).
 - Self induced vomiting or purging
 - Excessive exercise
 - Associated endocrine disorders (eg amenorrhoea for >3 consecutive months for post-menarche females)

(2) Give 4 **medical** indications for admission for patients with severe eating disorders (4 marks)

- (i) Heart rate < 40
- (ii) BP <90/60
- (iii) Symptomatic hypoglycaemia
- (iv) $K^+ < 3$
- (v) Dehydration
- (vi) Other cardiovascular abnormalities
- (vii) Temp < 36

(3) Give 2 long term complications of eating disorders (2 marks)

(any 2 of the below)

- (i) Osteoporosis
- (ii) Short stature
- (iii) Abnormalities of cognition (loss of grey matter during starvation may persist)

- (iv) Higher miscarriage rate
- (v) Renal calculi
- (vi) Stress fractures

Question 13

1

Past Hx mania / bipolar AD

Pressured speech

Flight of ideas

Thought derailment

Spending money

Sexual promiscuity

Delusions of grandeur

(many others)

2

TFTs – thyrotoxicosis can present with similar mental state

CT head – in first presentation of major mental health disorder

Serum Na – where excessive water consumption, cause for delirium

LP – to look to encephalitis if febrile, meningism

BSL – hypoglycaemia as cause for delirium, hyperglycaemia if diabetic with intercurrent illness

Urine drug screen – looking for amphetamine use as a precipitant for behavioural disturbance

(probably many others)

Question 14

What are the clinical features of mania? (4 marks)

- Inflated self-esteem / grandiosity
- Decreased sleep
- More talkative
- Flight of ideas
- Distractability
- Increased goal-directed activity
- Excessive involvement in pleasurable activities with high risk of bad outcome

What are the main clinical features of a large acute lithium overdose (2 marks)

Mainly GI toxicity (heavy metal): <25g mild-mod GI, >25g mod-severe GI +/- neurotoxicity (rare)

What are the main clinical features of a chronic lithium toxicity? (4 marks)

Mostly neurotoxicity / progressive based on symptoms

- Grade 1 = tremor, agitation, hyper-reflexia, ataxia
- Grade 2 = stupor, rigidity, hypotension
- Grade 3 = coma, seizures, myoclonus

Name 3 factors predispose a patient to chronic lithium toxicity? (3 marks)

- Impaired renal function
- Diabetes insipidus
- Sodium depletion
- Dehydration
- Drug interactions [NSAIDs / ACEi / thiazides]

What is the modality and name 3 indications for enhanced elimination in lithium toxicity. (3 marks)

Modality

Haemodialysis

Indications

Established neurotoxicity

Serum Li > 2.5

Renal impairment

Candidate Name: _____

Question 15

1

Past Hx mania / bipolar AD

Pressured speech

Flight of ideas

Thought derailment

Spending money

Sexual promiscuity

Delusions of grandeur

(many others)

2

TFTs – thyrotoxicosis can present with similar mental state

CT head – in first presentation of major mental health disorder

Serum Na – where excessive water consumption, cause for delirium

LP – to look to encephalitis if febrile, meningism

BSL – hypoglycaemia as cause for delirium, hyperglycaemia if diabetic with intercurrent illness

Urine drug screen – looking for amphetamine use as a precipitant for behavioural disturbance

(probably many others)

Question 16

Pass mark: 8

A 40 year old known schizophrenic patient presents to your ED by ambulance on an involuntary order. He had been behaving erratically at a train station. Whilst waiting to be seen he absconds from the ED and is unable to be located by ED staff.

Questions:

1-List 5 immediate steps in managing this situation (5 marks)

Security to search premises

Attempt to contact patient by his listed mobile phone.

Notify police that patient has absconded & request welfare check at listed address

Notify NOK that patient has absconded & ask them to bring him back to ED if they have contact with him.

Notify psychiatric unit that patient on involuntary order has absconded

Document attempts to locate patient in chart

2-List 4 features that would make this patient at high risk of self harm. (4 marks)

Recent cessation of medications

Active auditory hallucinations or delusions

Recent suicidal ideation

Past suicidal ideation or attempts

Recent depressive symptoms

Concurrent drug abuse

Lack of social supports

Loss to follow up with psychiatric care

High number of psychiatric hospitalisations

Access to firearms/means for suicide

3- A few hours later the patient is returned to the ED by police. On arrival he is behaving aggressively and is resisting being moved into a treatment cubicle. (3 Marks)

List 3 options for chemical restraint, including doses:

Droperidol 10mg IMI, repeat 15 mins later if required

Midazolam 2.5-10mg

Haloperidol 5mg IV, titrated to a maximum of 10mg over 15 minutes.

Question 17

A 29 year old lady presents to ED on a Friday night, with bizarre behaviour following a recent admission under the medical team with cellulitis.

She has a history of depression and self-harm. She is accompanied by her husband, who states that she has not slept since discharge.

She is currently taking antibiotics and an SSRI. Her husband states that she started to hallucinate while she was an inpatient but didn't mention it to medical staff as she wanted to go home.

You are concerned that she has an acute presentation of psychosis.

1. What features of her mental state exam indicate psychosis.

List 4 features:

(4 Marks)

Positive symptoms – Hallucinations, delusions, disorganised speech, disorganised behaviour, catatonic

Negative symptoms – Blunted affect, emotional withdrawal, anhedonia, attention impairment.

Functional decline

Appearance

Lack of insight

2. Missed medical diagnoses in psychiatric patients are reported in up to 45% of patients. What are the main pitfalls in the “medical clearance process”.

List 4 pitfalls:

(2 Marks)

History – difficult to get from patient, failure to seek collateral, limited by location of review.

Exam – Location of patient, failure to do full examination, no vitals or MMSE, no Neuro exam.

Patient cooperation.

Acceptance of “medical clearance” or over reliance on investigations, failure of ongoing review.

3. She is calm and responsive to your assessment and request for further investigations. She is referred to the mental health team for review. What features of her presentation suggest she should remain for inpatient assessment?

List 2 features:

(2 Marks)

1st presentation

History of depression and self harm – high risk of harm

Carer fatigue

Weekend therefore delay to follow up

4. She suddenly becomes more agitated in the department whilst waiting for the mental health team review. She is pacing in her cubicle and threatening harm to herself. Her husband has left the department.

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How do you manage this situation?

**List 4 steps
(4 Marks)**

Patient – verbal de-escalation

Area – move to resus/monitored bed

Staff – security, nursing

Teams – include mental health

Equipment – to provide safe chemical sedation or physical restraint

Drugs – oral/iv/im options- with suggested doses

Pass mark: 8/12

Question 18

Questions:

1-Outline your 5 immediate steps in managing this situation (5 marks) – 4/5

Security to search premises

Attempt to contact patient by his listed mobile phone.

Notify police that patient has absconded & request welfare check at listed address

Notify NOK that patient has absconded & ask them to bring him back to ED if they have contact with him.

Notify psychiatric unit that patient on involuntary order has absconded

Document attempts to locate patient in chart

2-List 6 features that would make this patient at high risk of self harm.

(6 marks) - 4/6

Recent cessation of medications

Active auditory hallucinations or delusions

Recent suicidal ideation

Past suicidal ideation or attempts

Recent depressive symptoms

Concurrent drug abuse

Lack of social supports

Loss to follow up with psychiatric care

High number of psychiatric hospitalisations

Access to firearms/means for suicide

3- A few hours later the patient is returned to the ED by police. On arrival he is behaving aggressively and is resisting being moved into a treatment cubicle.

List 3 options for chemical restraint, including doses and endpoints of treatment.

(7 marks) 5/7

Droperidol 10mg IMI, repeat 15 mins later if required

Midazolam 2.5-10mg

Haloperidol 5mg IV, titrated to a maximum of 10mg over 15 minutes.

Endpoint: Titrated to effect of sedation but still spontaneously breathing & maintaining own airway

Passmark = 13/18 (adjust to /10)

(7.2/10)

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Question 19

1. What issues need to be addressed in your assessment of this patient? (3 marks)

Safety of patient and staff
Additional resources required – mental health, security
Capacity of the patient to decline treatment
Differentiating organic vs psychiatric cause for behavioural disturbance

1. List 5 potential organic mimics of psychiatric conditions that may be present in this patient. (5 marks)

Anticholinergic toxicity
Serotonin syndrome
Stimulant toxicity
Head injury
Drug withdrawal
Encephalitis
Neuroleptic malignant syndrome
Temporal lobe epilepsy

2. List 5 major features of acute delirium (5 marks)

Acute onset
Fluctuating course
Clouded consciousness
Deranged vitals signs
Visual hallucinations

3. List the steps you would take in managing this patient's aggression (5 marks)

Appropriate location – resus/dedicated mental health assessment room
Security presence at the bedside
Attempt verbal de-escalation
Offer oral medication/sedatives – diazepam 5-20mg orally, olanzapine wafer 10mg
If above measures fail – physical restraint followed promptly by chemical sedation with Droperidol 10mg IMI

Question 20

1. What features of her mental state exam indicate psychosis, list 4: (4 Marks)

Positive symptoms – Hallucinations, delusions, disorganised speech, disorganised behaviour, catatonic
Negative symptoms – Blunted affect, emotional withdrawal, anhedonia, attention impairment.
Functional decline
Appearance
Lack of insight

2. Missed medical diagnoses in psychiatric patients are reported in up to 45% of patients. What are the main pitfalls in the “medical clearance process” List For (4)

(4 Marks)

History – difficult to get from patient , failure to seek collateral, limited by location of review.
Exam – Locations of patient, failure to do full examination, no vitals or MMSE, no Neuro exam.
Patient cooperation.
Acceptance of “medical clearance” or over reliance on investigations, failure of ongoing review.

3. She has remained calm and responsive to your assessment and investigations. She is referred to the mental health team for review and they decide she is not a danger to herself, so can be followed up in the community. What features of her presentation would lead to you challenge that decision. List 3

(3 Marks)

1st presentation
History of depression and self harm – high risk of harm
Carer fatigue
Weekend therefore delay to follow up

4. She suddenly becomes more angry in the department while waiting for a mental health bed, her husband had left, she is pacing and threatening harm to herself. How do you manage this situation? List 5 steps

(5 Marks)

Patient – verbal and chemical de-escalation
Area – move to resus/monitored bed
Staff – security, nursing
Teams – mental health
Equipment – if sedated
Drugs – oral/iv

Pass mark: 10/16

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Question 21

A 78 year old man is brought to your ED by ambulance after a carer found him drowsy in bed this morning at 0900. The patient admitted to taking 10 X 10mg temazepam capsules and a glass of whisky at 2200 the night before with the intent of 'having a long sleep'.

He denies ingestion of any other substances and detailed further assessment does not suggest ingestion of any other agent.

He has a past history of hypertension, hypercholesterolaemia and an uncomplicated cholecystectomy 12 years ago. He had a left sided MCA infarct 8 months ago and can only walk with the aid of a frame. He is widowed and lives alone on a small farm on the outskirts of town.

a) List 5 risk factors he has for a subsequent successful suicide attempt in the following month? (5 marks)

Non disclosed attempt

Male gender

Age > 75 years

Chronic disability/medical illness

Potential social isolation (lives alone, social isolation)

Examiners comments

Better scoring candidates answered the question based on the facts presented in the stem.

Lower scoring candidates made assumptions about the patient and their circumstances that may not have been true. These candidates also tended to state multiple examples of the same concept on separate lines, making it hard for them to gain marks. A few of these candidates also appeared to think that the current attempt means that he has had a previous attempt, despite there being no mention of a previous attempt in the question stem.

There is a significant difference between alcohol use and alcohol abuse - one glass of whisky is not evidence of alcohol abuse.

Just because you live on a farm does not mean you automatically have access to firearms and high lethality poisons.

Temazepam in the dose used is probably not a high lethality medication, even in a 78 year old with co-morbidities.

Social isolation only scored one point, no matter how many examples of it were used.

b) List 5 additional risk factors for subsequent suicide that you be seeking when your assess him? (5 marks)

Hopelessness

Suicidal ideation

Established plan

Access to high risk means (e.g. beta blockers, firearms, high lethality substances (farmer))

PHx Suicide attempt

PHx Depression

Alcohol/substance abuse

Question 22

Answers:

1. List six factors of history used to assess his risk of suicide:

(6 marks) 4/6

Anything from this list:

- Active psychiatric illness - major depression, severe anxiety, active psychosis
- Loss - relationship, family, work, health (ie serious illness)
- Support network or absence thereof, social isolation
- Demographics - age, sex, cultural background
- Plans - lethality & violence of ideas, access to lethal means, degree of planning, suicide note
- Previous attempts
- Intoxication and substance abuse
- Hope - hopelessness vs plans for the future
- Insight and judgement, degree of impulsivity

Also SADPERSONS score:

- **S:** Male sex
- **A:** Age
- **D:** Depression
- **P:** Previous attempt
- **E:** Excess alcohol or substance use
- **R:** Rational thinking loss
- **S:** Social supports lacking
- **O:** Organized plan
- **N:** No spouse
- **S:** Sickness

2. List four features most useful in differentiating an organic cause from a psychiatric cause of his presentation

(4 marks) 2/4

Suggestions:

- Abnormal vital signs, including fever
- Age of first onset
- Drug and alcohol use
- Features of delirium - fluctuating symptoms, disorientation, visual hallucinations, decreased level of consciousness
- Neurological features
- Identifiable intercurrent medical illness
- (Aim is for candidates to say what they feel are *most* useful. Experienced candidates should be able to define this easily. Examiners should allow discretion, but use their own experience to decide if answers are reasonable.)

3. What pharmacological options do you have to calm him down? For each option, list the dose and route of administration.

(6 marks) 4/6

Suggestions:

- Oral preferred as least restrictive or invasive method for management
 - Oral diazepam - well tolerated, easy to dose & administer, doesn't mask symptoms
 - Oral olanzapine - easy to administer, well tolerated
- IM agents more invasive, probably only used if requires detention, or patient prefers
 - Droperidol 10mg - predictable, well tolerated
 - Consider midazolam or haloperidol, but candidate needs to have good reasons for using these agents and this route in this situation

4. List three factors which influence your decision on whether he can leave.

(3 marks) 2/3

Suggestions:

- Suicide/self harm risk stratification (as above)
- Capacity
- Current or prior MHA orders in effect
- Mental State Examination
- Support person to ensure safety
- Follow-up in place

Passmark: 12/19 Adjust to ../10 please

Question 23 (12 marks)

You are the duty Consultant in a tertiary ED. An intern is about to assess a 24 year old man who has been brought to the ED by his brother with suicidal ideation following the break-up of a long term relationship. He has a past history of an anxiety disorder and depression, with several similar presentations. He is on a regular antidepressant. He has no other medical problems.

The intern asks for advice on how to proceed with the assessment.

i) List SIX (6) factors which suggest the patient is at HIGH risk of suicide. (6 marks)

4 of 6 to pass

- High intent/ continual or specific thoughts
- Definite plan
- Hopelessness
- Severe depression
- Psychosis/ command hallucinations/ delusions about dying
- Past attempts/ high lethality attempts
- Impulsivity/ changeability/ lack of rapport
- Intoxication/ substance abuse/ dependence
- Male gender
- Recent psychiatric hospitalisation
- Access to means
- Lack of supportive relationships/ social isolation
- Conflicting information/ unable to verify information

The patient is referred to the psychiatry registrar for a mental health assessment. The registrar asks if the patient is “medically cleared?” The intern asks you if they need to take bloods on the patient.

ii. List THREE (3) low risk criteria which must be fulfilled to enable the patient to be “medically cleared” without investigations. (3 marks)

2 of 3 to pass

- Age 16-65 years
- No acute physical health problems (including trauma, ingestion or drug side-effects)
- No altered level of consciousness
- No evidence of physical cause for the acute presentation /normal vitals and examination
- Not the first or significantly different psychiatric presentation

The patient feels better after discussing his concerns, denies further suicidal ideation, and asks if he may leave before mental health review to have follow-up with his GP. The intern asks you if the patient should be “detained”.

iii. List THREE (3) criteria which must be satisfied before a patient can be placed on an involuntary treatment order under the relevant mental health act. (3 marks)

Bold plus 1 other to pass

- **Patient has a mental illness (essential ie 0 marks if not in)**
- Without the treatment there is risk to the health and safety (harm) of the patient, or the safety of others (harm)
- Patient does not have decision making capacity/ refuses treatment
- Treatment will be appropriate and effective
- There is no less restrictive means