Psychiatry Review (from First Aid + some lectures notes)

1st lecture

Delirium

"Waxing and waning" level of consciousness** with acute onset; rapid ↓ in attention span and level of arousal. Characterized by disorganized thinking, hallucinations (often visual), illusions, misperceptions, disturbance in sleep-wake cycle, cognitive dysfunction.
Usually 2° to other illness (eg, CNS disease, infection, trauma, substance abuse/withdrawal, metabolic/electrolyte disturbances, hemorrhage, urinary/fecal retention).
Most common presentation of altered mental status in inpatient setting. Commonly, diffuse slowing EEG.*
Treatment is aimed at identifying and addressing underlying condition. Haloperidol may be used as needed. Use benzodiazepines for alcohol withdrawal.

Delirium = changes in sensorium.
May be caused by medications (eg, anticholinergics), especially in the elderly.
Reversible.

It is a medical emergency: The patient can present with an infection , electrolyte imbalance

Dementia

↓ in intellectual function without affecting level of consciousness. Characterized by memory deficits, apraxia, aphasia, agnosia, loss of abstract thought, behavioral/personality changes, impaired judgment. A patient with dementia can develop delirium (eg, patient with Alzheimer disease who develops pneumonia is at ↑ risk for delirium).
Irreversible causes: Alzheimer disease, Lewy body dementia, Huntington disease, Pick disease, cerebral infarct, Creutzfeldt-Jakob disease, chronic substance abuse (due to neurotoxicity of drugs).
Reversible causes: hypothyroidism, depression, vitamin B_{12} deficiency, normal pressure hydrocephalus, neurosyphilis.
↑ incidence with age. EEG usually normal.

"Dememtia" is characterized by memory loss.
Usually irreversible.
In elderly patients, depression and hypothyroidism may present like dementia (pseudodementia). Screen for depression and measure TSH, B_{12} levels.

**Important difference between Delirium and Dementia

- Memory loss + normal level of consciousness

*Another difference between the two disorders.

Psychosis

Distorted perception of reality characterized by delusions, hallucinations, and/or disorganized thinking. Can occur in patients with medical illness, psychiatric illness, or both.

Delusions

Unique, false beliefs that persist despite the facts (eg, thinking aliens are communicating with you).

Hallucinations

Perceptions in the absence of external stimuli (eg, seeing a light that is not actually present).
Contrast with illusions, misperceptions of real external stimuli. Types include:

- Visual—more commonly a feature of medical illness (eg, drug intoxication) than psychiatric illness.
- Auditory—more commonly a feature of psychiatric illness (eg, schizophrenia) than medical illness.
- Olfactory—often occur as an aura of temporal lobe epilepsy (eg, burning rubber) and in brain tumors.
- Gustatory—rare, but seen in epilepsy.

Delirium tremens

الدكتور شرحها بالمثال حق الشايب اللي ظهرت عليه اعراض غريبة بعد الجراحة

Life-threatening alcohol withdrawal syndrome that peaks 2–4 days after last drink.
Characterized by autonomic hyperactivity (eg, tachycardia, tremors, anxiety, seizures). Classically occurs in hospital setting (eg, 2–4 days postsurgery) in alcoholics not able to drink as inpatients.
Treatment: benzodiazepines.
Alcoholic hallucinosis is a distinct condition characterized by visual hallucinations 12–48 hours after last drink. Treatment: benzodiazepines (eg, chlordiazepoxide, lorazepam, diazepam).

2nd lecture

Major depressive disorder

May be self-limited disorder, with major depressive episodes usually **lasting 6–12 months**. Episodes characterized by at least 5 of the following 9 symptoms for 2 or more weeks (symptoms must include patient-reported depressed mood or anhedonia). Treatment: CBT and SSRIs are first line. SNRIs, mirtazapine, bupropion can also be considered. Electroconvulsive therapy (ECT) in select patients.

SIG E CAPS:

- Depressed mood
- Sleep disturbance
- Loss of Interest (anhedonia)
- Guilt or feelings of worthlessness
- Energy loss and fatigue
- Concentration problems
- Appetite/weight changes
- Psychomotor retardation or agitation
- Suicidal ideations

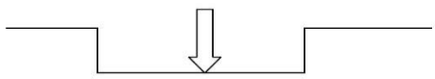
Persistent depressive disorder (dysthymia)—depression, often milder, **lasting at least 2 years.**

➢ **Mood**
Is the sustained and pervasive feeling tone (example: when someone feels unhappy for a period of time (ex. the last month)) that influences a person's behavior and perception of the world (ex. In depression the triad of how a person looks in a negative way نظرة تشاؤمية to 1-himself 2-others 3- future). It is internally experienced. Mood can be normal, depressed, or elevated.

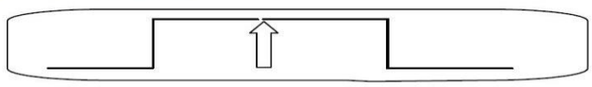
➢ **Affect** (what appears from you now)
is the person's present transient emotional state. It represents the external expression of mood.

Episodes (discrete periods of abnormal mood; low, high, or mixed mood)

1.Major depressive episode (MDE):
≥ 2 weeks of low mood/loss of interest + other features



2.Manic episode:
≥ 1 week of elevated, expansive, or irritable mood + other features

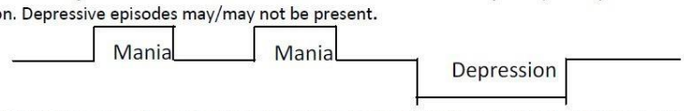


3.Mixed episode:
≥ 1 week of both depressed and manic mood + other features

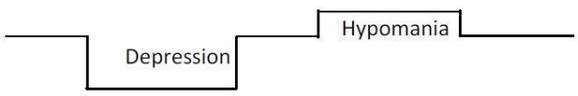
4.Hypomanic episode:
≥ 4 days less severe elevated mood + other features

Disorders (longitudinal view / diagnostic term)

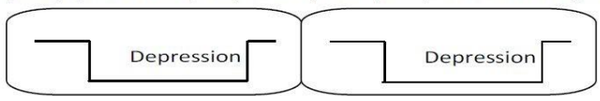
1.Bipolar I disorder: patient has met the criteria for a full manic or mixed episode, usually sufficiently severe to require hospitalization. Depressive episodes may/may not be present.



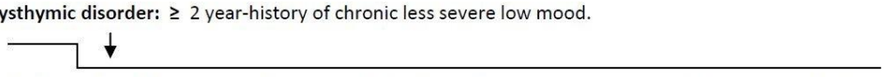
2.Bipolar II disorder: patient has at least one major depressive episode and at least one hypomanic episode, but ***NO*** manic episode.



3.Major depressive disorder (MDD): patient has major depressive episodes (MDEs) but no manic or hypomanic episodes.



4.Dysthymic disorder: ≥ 2 year-history of chronic less severe low mood.



5.Cyclothymic disorder: Less severe bipolar mood disorder with continuous mood swings; alternating periods of hypomania and moderate depression.

Postpartum mood disturbances

Onset within 4 weeks of delivery.

Postpartum depression	10–15% incidence rate. Characterized by depressed affect, anxiety, and poor concentration. Treatment: CBT and SSRIs are first line.
Postpartum psychosis	0.1–0.2% incidence rate. Characterized by mood-congruent delusions, hallucinations, and thoughts of harming the baby or self. Risk factors include history of bipolar or psychotic disorder, first pregnancy, family history, recent discontinuation of psychotropic medication. Treatment: hospitalization and initiation of atypical antipsychotic; if insufficient, ECT may be used.

cont. 2nd lecture

DYSTHYMIC DISORDER (*Persistent Depressive Disorder)*

Diagnostic Criteria

- ≥ 2 years history of chronic low mood.
- No remission periods more than two months.
- During low mood there should be ≥ 2 out of the following:

2. low energy or fatigue.
3. low self-esteem.
4. feeling of hopelessness.
5. insomnia (or hypersomnia).
6. poor appetite (or overeating).
7. poor concentration or difficulty in making decisions.

- Not better accounted for by any other psychiatric or medical diseases (e.g. major depression, hypothyroidism).
- It leads to impairment in functioning or significant distress.

Differential Diagnosis

This is essentially identical to that of major depression. However, two disorders require consideration:

1. Chronic Fatigue Syndrome / Neurasthenia

• Disabling chronic fatigue of uncertain etiology associated with variable extent of somatic and / or psychological symptoms.

2. Recurrent Brief Depressive Disorder:

Brief (less than two weeks) periods during which depressive features are present with greater severity than that of dysthymic disorder. The course is episodic and recurrent.

3rd lecture

Schizophrenia

Chronic mental disorder with periods of psychosis, disturbed behavior and thought, and decline in functioning **lasting > 6 months**. Associated with ↑ dopaminergic activity, ↓ dendritic branching.

Diagnosis requires at least 2 of the following, and at least 1 of these should include 1–3 (first 4 are "positive symptoms"):

1. Delusions
2. Hallucinations—often auditory
3. Disorganized speech
4. Disorganized or catatonic behavior
5. Negative symptoms (affective flattening, avolition, anhedonia, asociality, alogia)

Lifetime prevalence—1.5% (males = females, African Americans = Caucasians). Presents earlier in men (late teens to early 20s vs late 20s to early 30s in women). Patients are at ↑ risk for suicide.

important

- **Brief psychotic disorder**—lasting < 1 month, usually stress related.
- **Schizophreniform disorder**—lasting 1–6 months.
- **Schizoaffective disorder**—> 2 weeks of hallucinations or delusions without major mood episode (major depression or mania), plus periods of concurrent major mood episode with schizophrenic symptoms.

Genetics is the most common cause

Delusional disorder

Fixed, persistent, false belief system **lasting > 1 month**. Functioning otherwise not impaired (eg, a woman who genuinely believes she is married to a celebrity when, in fact, she is not).

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