Old Age Psychiatry in a General Hospital

Delirium, Dementia or something else?

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Structure of Case Presentation

Interactive

- History, MSE, Examination
- Questions to / from the floor
- Preferred Diagnosis & Differential Investigations
- Agreed a Treatment Plan
- Outcome
- Introduction to the 4AT
My Hospitals; South West London

Springfield University Hospital Founded in 1840

St George’s founded 1733 once in Hyde Park Corner now in Tooting has 1300 Beds Serves a population of 1.3 millions
Liaison Psychiatry
St George’s: My team

2 Consultant Psychiatrists
1 Registrar
1 SHO
1.5 Foundation Trainees
7 Senior Specialist Nurse
12 Mental Health Nurses
Students-nursing, medical, ambulance & Physician associates
Learning Objectives

Awareness of the 3xDs
Introduction to the 4AT & The Butterfly Scheme

Delirium
Dementia
Depression
The Clinical Case

Dr Ali PhD

83yr old male
Middle Eastern
Retired Pharmacist
Married
3 Children; Geneticist, Businessman & GP
25/10 GP referral: OA CMHT

5 week history: “Increasing agitation, anxiety and flat affect”
2 weeks: “Thinks wife is poisoning him”

-Depression ?
Re-started Lofepramine 70mg BD
02/10 OA CMHT Assessment

- Precipitous return from Middle East 5 weeks earlier - Victim of fraud
- Unprovoked DVT x2, PE & new AF
- Diagnosed 3rd Episode of depression

Previous 2 episodes:

1) 1981 After coming to UK aged 44yrs (& post-revolution)

2) 1998 Retirement, aged 63yrs ~Lofepramine
CMHT starts Treatment

- Lofepramine -> Mirtazapine 15mg increased to 30mg,
- Then reduced when appeared to wife as more psychotic
- Diazepam 2mg BD
- Risperidone liquid 0.25mg TDS
CMHT cont.

- Poor compliance
- Bowels not open for 1 week, “blocked up”
- Refused Investigations for raised PSA
- Self-restricts fluids
- Believes is incontinent (?delusions)
- Denies wife trying to poison him
02/11 CMHT cont.

- Weight Loss progressing-10kg/3mths
- Constipation
- Dehydration
- Fluctuating confusion
- Refusing Medication
- ~Psychiatric Admission
02/11 Psych Admission

- MHA Assessment
- Section 2
- Admission Springfield Hospital
- Refusing Medication
- V poor oral intake
- Section 3
- ECT x4, 6 seconds asystole
- 19/11 Transferred to St George’s
SGH Admission

On Examination:

- Almost mute
- Refusing food/drink
- Dry lips, Cachectic
- Confused
- Frightened
4-AT

- **Alertness** 4/4
- **AMT4** (Age, DoB, Place, Year) 1/2
- **Attention** (Mths backwards) 1/2
- **Acute Changes or Fluctuating Course** Yes/No 4/4

Total: 10
Informant History

No Family History of Severe Mental Illness
Privileged Childhood
Wealthy
PhD in Pharmacy
Retired University Lecturer
Informant Hx. cont

Refused GP investigations for enlarged prostate
Generally well until returned from Middle East
“Unprovoked” DVTs
PE
Paroxysmal AF - on anticoagulant
Informant Hx. cont

- No Hx of recreational drug use
- Ex-smoker of tobacco
- No alcohol use
- Lives with wife
- Previously Independent in ADLs
- Recently returned from Middle East
Timeline

In the Middle East: traumatic experience

Referral to MH services

Completely Independent
Looking after wife
Sees grandchildren frequently
Only 2 past episodes of depression

Weak, bedbound
Refusing to eat/drink
Paranoid

Here we meet!
Questions

Clarification of History, Mental State or Physical Examination
Teams Involved

- MDT Approach +++
- Geriatricians, Cardiology, Neurology, Psychiatry, Dietetics (& dietetic MDT), Physio, OT
- & Family Involvement-
- Butterfly Scheme & REACH
Preferred Diagnosis

&

Important Differentials

The ThreeDs
Investigations

• **Bloods**
  - Uraemia (14), CRP 17

• **CXR**
  - NAD

• **CT-Brain**
  - “a couple of left striatal-capsular lacunar infarcts
  - A few areas of patchy deep white-matter low attenuation (non-specific) but most likely related to small vessel ischaemic changes

• **MRI**
  - Generalised reduction in cerebral volume
  - Appearances in keeping with neuro-degenerative processes possibly Alzheimer's, some mid-brain atrophy.
Thoughts

- Likely diagnosis?
- Psychiatric advice to treating physicians?
Treatment & MDT Approach

- **Geriatrics** - ?ceiling of care/Palliation (Neurology)
- **Dietetics/Nutrition** - NGT, NGT + Bridel/Mittens, PEG, supplements
- **Cardiology** - Pacemaker
- **Psychiatry** - Essential to treat possible recoverable conditions
- **Psych Meds via PEG if necessary, under the MHA**
Liaison Psychiatry

- Careful History & 4-AT
- Refute diagnosis of dementia
- & Advocate for active treatment

Psych Meds via NGT:
- 1. Sertraline (depression)
- 2. Diazepam (agitation)
- 3. Risperidone (paranoia)
- 4. Trazodone (augmentation)
Progress

Once receiving adequate nutrition and Psych Meds - response within 10 days
Able to collaborate around recovery plan
Outcome

Discharged home
Mental State
-no longer paranoid, moderately depressed mood, anxious
-eating and drinking well
-no obvious cognitive deficits
Conclusion

What was the diagnosis?

Recurrent Depressive Disorder with Psychotic Symptoms
ICD-10 F33.
Follow-up

HTT and CMHT
Memory Clinic
Cardiology
Urology
Thanks for listening and time for Coffee!