Management of moderate depression

1. Prescribe an SSRI
2. If ineffective for at least 2-4 weeks → check adherence
3. Increase the dose
4. Change to a different SSRI
5. Try alternative class of antidepressant (*atypical antidepressants* → ***Mirtazapine***)

- Antidepressants should usually show effect in **1-2 week**, *if no effect after 2-4 weeks → check adherence*
- With good response to SSRIs → **Continue for at least 6 months after remission** as this reduces relapse
- Patients who had 2 or more depressive episodes in the recent past and who experienced significant functional impairment during episodes → **Continue for 2 years**
- When stopping SSRIs, the dose should be reduced **over a 4-week period**
- If the patient stopped medications abruptly and experiencing delusions → **Neuropsychiatric analysis**

Hospital management for depression

1. Admission to the psychiatric ward
2. investigations
3. Treatment with **SSRIs** or **SNRIs**
4. Augmentation with **lithium** with **CBT**
5. If nothing works → **ECT**

Reasons for hospital admission

- Serious risk suicide
- Serious risk of harming others
- Significant self-neglect
- Severe depressive or psychotic symptoms
- Lack or breakdown of social support
- Initiation of Electroconvulsive therapy (ECT)
- Treatment-resistant depression (where inpatient monitoring may be helpful)

- *High mood alone in the question (no mention of low mode at all)* → ***Hypomania***
- *Low mode alone in the question (no mention of high mode at all)* → ***Depression***
- *High mode and low mode (depression) (no matter time in between)* → ***Bipolar***
- *High mode with hallucinations and delusions* → ***Mania***
- *Mania and hypomania are distinguished by <u>hallucinations and delusions</u> in Mania*

Risk factors for suicide

- Previous suicide attempts
- Previous self-harm
- Depression and other mental health problems
- Alcohol and drug abuse
- Low socio-economic status

Bipolar affective disorder (Manic depression)

- Classically, periods of prolonged and profound **depression** alternate with periods of excessively elevated and irritable mood, known as **mania**

Features

- Decreased need for sleep
- Pressured speech
- Increased libido
- Reckless behavior without regard for consequences
- Grandiosity
- More talkative than usual

These symptoms of mania would alternate with depression

> **Cyclothymic disorder** → milder form of bipolar **lasting 2 years**, fluctuating from mild depressive and hypomanic symptoms

Treatment

- Mood stabilizers → **Lithium**- Despite problems with tolerability, lithium still remains the gold standard in the treatment of bipolar affective disorder

*Mood stabilizers **(LCVL)**: **Lithium, Carbamazepine, Valproic acid, Lamotrigine***

Points about lithium

- *Don NOT offer lithium to women who are planning a pregnancy or currently pregnant, unless antipsychotic medication has not been effective*
- *If a woman taking lithium becomes pregnant consider stopping the drug gradually over 4 weeks*
- *If a woman continues taking lithium during pregnancy, check plasma lithium levels every 4 weeks, then weekly from the 36th week and adjust the lithium dose to maintain plasma lithium levels at a therapeutic dose*

Tetralogy of lithium

- *Ebstein anomaly of the heart*
- *Floppy baby $*
- *Thyroid abnormalities*

Mania vs Hypomania

Mania	Hypomania
Abnormally elevated mood	A lesser degree of mania with persistent mild elevation of mood and increased activity and energy
Hallucinations or delusions	No hallucinations or delusions
Significant impairment of the patient's day-to-day functioning	No significant impairment of the patient's day-to-day functioning

Schizophrenia

1. **Auditory hallucinations**
   - Third-person auditory hallucinations → voices are heard referring to the patient as 'he' or 'she', rather than 'you'
   - **Thought echo** → an auditory hallucination in which the content is the individual's current thoughts
     - Hearing thoughts after being produced → *Echo de la pensée*
     - Hearing thoughts at the same time or before as thought being produced → *Gedankenlautwerden*
   - Voices commenting on the patient's behavior
2. **Thought disorder**
   - **Thought insertion** → The delusional belief that thoughts are being placed in the patient's head from outside
   - **Thought withdrawal** → The delusional belief that thoughts have been 'taken out' of his/her mind
   - **Thought broadcasting** → The delusional belief that one's thoughts are accessible directly to others
   - **Thought blocking** → a sudden break in the chain of thought
3. **Passivity phenomena**
   - Bodily sensations being controlled by external influence
4. **Delusional perceptions**
   - A two-stage process where first a normal object is perceived then secondly there is a sudden intense delusional insight into the object's meaning for the patient e.g. 'The traffic light is green therefore I am the King'

Management

1. Antipsychotics
   - 1st → **olanzapine** or **risperidone**
   - If rapid tranquillization is needed → **Diazepam**

Tardive dyskinesia

- *Continuous involuntary movements of the tongue and lower face*
- *Caused by long-term use of antipsychotic drugs*
- *Often reported by family members as patients are often unaware of these movements*

Atypical antipsychotics have lower risk of TD:

1. ***Risperidone** (tabs, injections) → better for incompliant patient (Depot, long-acting injections)*
2. ***Olanzapine** (tabs)*

Tardive dyskinesia can be treated by → ***Tetrabenazine***

- Drug-induced parkinsonism → **1 week** after starting anti-psychotic
- Akathisia → **1 month** after starting antipsychotics
- Tardive dyskinesia → **months-years** after starting antipsychotics

Paranoid personality disorder

- Hypersensitivity and an unforgiving attitude when insulted
- Unwarranted tendency to question the loyalty of friends
- Reluctance to confide in others
- Preoccupation with constitutional beliefs and hidden meaning
- Unwarranted tendency to perceive attacks on their character

Postpartum blues vs Postnatal depression vs Postpartum psychosis

	Postpartum Blues	Postnatal Depression	Postpartum Psychosis
Onset	Starts at two or three days after birth and lasts 1–2 days	Peaks at 3 to 4 weeks postpartum	Peaks at 2 weeks postpartum
Mother cares for baby	Yes	Yes Occasional thoughts of harming baby	Thoughts of harming baby
Symptoms	Mostly crying	Symptoms of depression: Feels that she is not capable of looking after her child Feels as if she will not be a good mother Tearful, Anxiety Worries about baby's health	Psychotic symptoms E.g. hears voices saying baby is evil Insomnia Disorientation Thoughts of suicide
Management	Reassurance and explanation	Antidepressants or cognitive behavioural therapy (CBT)	Admit to specialist mother and baby unit if available Antidepressant, mood stabilizers (i.e. carbamazepine), and electroconvulsive therapy (ECT)

In postpartum depression, 1st line SSRI → ***Sertraline***
Postpartum psychosis usually starts with postpartum depression
Postpartum psychosis = Puerperal psychosis

Generalized anxiety disorder (GAD)

- ‘Excessive worry’ and feelings of apprehension about <u>everyday</u> events, with symptoms of muscle and psychic tension, causing significant distress and functional impairment

Symptoms of GAD

- Restlessness
- Concentration difficulties or ‘mind going blank’
- Irritability
- Muscle tension
- Sleep disturbance
- Palpitations/tachycardia
- Sweating
- Trembling or shaking
- Breathing difficulties as choking sensation
- Chest pain or discomfort
- Fear of losing control, ‘going crazy’, passing out or dying

- If symptoms on/off (attacks lasting 20-30min) → ***Panic attacks***
- If continuous (for 6 months) → ***GAD***

GAD present most days for <u>at least 6 months</u> + <u>3 or more somatic symptoms</u>

Management of GAD

- **CBT** or applied relaxation or drug treatment
- 1st line → ***Sertraline*** (SSRI)
- Alternative SSRIs → *escitalopram* or *paroxetine*

Panic disorders

- **Several sudden** onset episodes (>2 panic attacks)
- A panic attack peaks around 10min then gradually resolves over the next 20min

Features of panic attacks

- Palpitations, tremors, sweating, shaking, tachycardia and shortness of breath that develop rapidly
- Patient might feel he’s going to die from cardiac or respiratory problems
- Dizziness, circumoral paresthesia, carpopedal spasm
- Can occur with no obvious trigger and awaken the patient from sleep (nocturnal panic attacks)

- *In a panic ATTACK, **simple breathing exercises** and **reassurance** is all what’s needed*
- *Numbness and circumoral paresthesia occur due to hyperventilation and wash of CO2 → respiratory alkalosis → high pH enhances binding between Ca and protein → decreased ionized Ca*

Management of panic disorder

- When you’re panicking, avoid using FaceBook → ***Fluoxetine*** and

- **CBT** or applied relaxation or drug treatment
- 1st line → **SSRIs** (do NOT use fluoxetine)
- if SSRIs contraindicated or no response after 12 weeks → *imipramine* or *clomipramine*
- In an acute sitting → **Beta-blockers** and **Rebreathing into paper bags**
- DO NOT use benzodiazepine for panic attacks

Acute stress disorder

- *Lasts hours-days*

Social anxiety disorder (Social phobia)

- Persistent fear and anxiety around people or in certain situations, sufferers fear being criticized. They tend to worry excessively before, during and after the encounter

Anxiety-provoking situations

- Meeting people (especially strangers)
- Talking in meetings
- Talking to authority figures
- Eating or drinking while being observed
- Going to school
- Going shopping
- Being seen in public

There are two forms of the condition:

1. ***Generalized social anxiety*** *which affects most, if not all areas of life. this is the more common type (70%)*
2. ***Performance social anxiety*** *which can be seen in certain situations such as public speaking*

Agoraphobia → *Fear of open places or being in situations escape might be difficult or help wouldn't be available if things go wrong*

- *Public transport*
- *Shopping centers*
- *Leaving home*

Autism spectrum disorders

- Can be recognized at any age
- Usually present in times of stress or sudden life change

Features

1. Severe difficulties communicating and forming relationships
2. Difficulties in language
3. Repetitive and obsessive behavior

Asperger $

- *Autism spectrum disorder except language is normal + normal or high IQ*

Post-traumatic stress disorder (PTSD)

- Develops following a traumatic event, usually after 6 months since the event

Features

- **Re-experiencing**: Flashbacks, nightmares
- **Avoidance**: Avoiding people, situations or circumstances resembling or associated with the event
- **Hyperarousal**: Hypervigilance for threat, exaggerated startle response, sleep problems, irritability and difficulty concentrating
- **Emotional numbing**: Lack of ability to experience feelings
- Depersonalization can be one of the symptoms

Management

- **Trauma-focused cognitive behavioral therapy (TF-CBT)** and **eye movement desensitization and reprocessing (EMDR)** → *first-line*
- **SSRI's** → *second line*. e.g. **P**aroxetine or **S**ertraline are licensed for **P**T**S**D
- Other unlicensed possibilities include: **fluoxetine**, citalopram, escitalopram, and fluvoxamine

If you find all these names of SSRI's difficult to remember. Just remember these 3 → Paroxetine, sertraline, and fluoxetine

Obsessive-compulsive disorder (OCD)

- Chronic condition, often associated with marked anxiety and depression, characterized by "obsession"
- Characterized by recurrent unreasonable obsessions concerning contamination, guilt, aggression and sex
- Compulsions are peculiar behaviors that reduces anxiety, commonly hand-washing, organizing, checking, counting and praying

Management

- **Low intensity CBT**, including **exposure and response prevention (ERP)**
- If low intensity CBT is inadequate → **more intensive CBT + SSRIs**
- **SSRIs** → escitalopram, fluoxetine, sertraline or paroxetine
- If patient is suicidal or severely incapacitated → **ECT**

Anorexia nervosa

- Most common cause of admissions to child and adolescent psychiatric wards. It is most commonly seen in **young women** (13-17 years) in which there is marked distortion of body image, pathological desire for thinness, and self-induced weight loss by a variety of methods

Features

- BMI **<17.5kg/m²** or < 85% of that expected
- Rapid weight loss
- Self-induced weight loss → reduce food intake, vomiting, purging, excessive exercise
- Intense fear of being obese
- Disturbance of weight perception
- Endocrine disorders that cause amenorrhea, reduced sexual interest/impotence, raised GH levels, raised cortisol, altered TFTs, abnormal insulin secretion
- Bradycardia
- Hypotension
- Fatigue
- Muscle weakness
- Intolerance to cold

Management

- BMI <15 OR rapid weight loss OR evidence of systemic failure (electrolyte disturbance as hypoglycemia or bradycardia)
  - Refer to eating disorder unit (**EDU**), medical unit (**MU**)
- Moderate (BMI 15-17.5) + NO evidence of systemic failure
  - Refer to the **local community mental health team** or **EDU** if available
- Mild anorexia (BMI >17)
  - Building a trusting relationship + self-help books and a food diary

If BP< 90/60 → Medical unit

Reasons for admission in a psychiatric illness

1. Lack of insight
2. Danger to self
3. Refusal of voluntary admission → mandatory admission under the mental health act

Bulimia nervosa

- **Binge eating** followed by **compensatory weight loss behaviors** (self-induced vomiting, fasting, intensive exercise, abuse of medications such as laxatives, diuretics, thyroxine or amphetamines)
- They don't usually have to be thin; some have BMI above 17.5 kg/m^2

Examination

- **Salivary glands** (especially the parotid) may be swollen
- **Russell's sign** may be present (calluses form on the back of the hand, caused by repeated abrasion against teeth during inducement of vomiting)
- There may be **erosion of dental enamel** due to repeated vomiting

Alcohol drinking questionnaires

AUDIT
A-Amnesia
U-Units
D-Doing less work
I-Injured yourself or others
T-Termination

CAGE
C-Cut down thoughts
A-Annoyed by friends or family asking you to cut down
G-Guilt or remorse after drinking
E-Eye opener drinker

Neuroleptic malignant $

- Rare but life-threatening reaction to **anti-dopaminergic medications (e.g. clozapine, metoclopramide, haloperidol)**
- Onset is usually within a few weeks of starting the anti-dopaminergic medication but can occur at any time

Features

- High fever
- Confusion or alerted consciousness
- Variable blood pressure
- Extrapyramidal symptoms (e.g. Rigidity, tremors)
- Tachycardia

Management

- Stop offending medication
- Rapid cooling
- Dopaminergic agents → **Bromocriptine**

Serotonin syndrome

- Life threatening iatrogenic disorder that's characterized by triad of **autonomic**, **cognitive** and **somatic** effects
- Precipitated shortly after use of **SSRIs**

Autonomic effects

- Pyrexia
- Tachycardia
- Nausea
- Diarrhea

Cognitive effects

- Confusion
- Agitation
- Hallucinations

Somatic effects

- Tremors
- Muscle spasms

Cocaine overdose

- Arrhythmias
- Both tachycardia and bradycardia may occur
- Hypertension
- Seizures
- **Mydriasis**
- Hypertonia
- Hyperreflexia
- Agitation
- Psychosis
- Effects include necrosis of nasal septum

- **Cocaine withdrawal** → depression
- **Heroin withdrawal** → increasing body secretions (sweating, runny nose), muscle aches, agitation, and sleep disturbance
- **Benzo withdrawal** → features of a panic attack

Heroin

- Intense pleasure and pain relief
- Relaxation, drowsiness and clumsiness
- **Miosis**
- Confusion
- Slurred and slow speech
- Slow breathing and heartbeat
- Dry mouth
- Reduced appetite and vomiting
- Decreased sex drive

- Acute management of opiates (heroin) overdose → **Naloxone IV**
- Chronic management/detoxification/addiction/withdrawal symptoms → **Methadone**
- Naloxone has a short half-life so coma and respiratory depression often recur when naloxone wears off, observation is essential and repeated doses might be needed

- *2nd line in detoxification → Buprenorphine*
- *3rd line or for shorter detoxification period → Lofexidine*
- *Used as an adjuvant to prevent relapses → Naltrexone*
- *Naloxone has a short half-life → coma and respiratory depression often recur after its effect wears off*

Ecstasy (MDMA)

- Uncontrolled body movements
- Dehydration or extreme thirst
- Hyperthermia
- HTN
- Insomnia
- Tachycardia
- Spots of color/floating colors/flashing colors when their eyes are open
- Increased RR

LSD (Lysergic acid diethylamide)

- Visual hallucinations when eyes closed → ***LSD***
- Visual hallucinations when eyes open → ***Ecstasy***

- **Mydriasis**
- Flushing and sweating
- Diarrhea
- Paresthesia
- Hyperactive reflexes
- Delusions and hallucinations
- Intensified senses
- Smelling colors and seeing sound
- Testing things that aren't there

Can be treated with benzodiazepines

Lithium poisoning

Causes

- Therapeutic overdosage → *common*
- Drug interactions with either a diuretic or NSAIDs → *common*
- Deliberate self-harm (less common)

Mild

- Nausea
- Altered taste
- Diarrhea
- Blurred vision
- Polyuria
- Fine resting tremors

Moderate

- Increasing confusion
- Increased deep tendon reflexes
- Myoclonic twitches and jerks
- Increasing restlessness followed by stupor

Severe

- Coma
- Convulsions
- Cardiac arrythmias
- Cerebellar signs

With lithium

- *Therapeutic dose → fine tremors*
- *OD → N, drowsiness & coarse tremors*

Na Valproate

- *Therapeutic dose → fine tremors*
- *OD → N, drowsiness but NO tremors*

Before commencing on lithium	After commencing on lithium
• **Kidney function tests** • **TFTs**, *thyroid disturbance can mimic mania or depression* • ECG, BP, pulse, FBC, U&E and PT if sexually active	• Serum lithium every 3 months • TFTs and renal function tests every 6 months

- *Lithium should be checked a week after starting. Following that, lithium levels are checked every 3 months*
- *Lithium levels should also be checked 12h after taking the last lithium dose*

Notes

- Low mood, anhedonia, guilt, can't concentrate (for at least 2 weeks) → ***Mild depression***
- Mild depression + poor sleep + poor libido + easy fatigue → ***Moderate depression***
- Moderate depression + suicidal thoughts → ***Severe depression***
- Severe depression + hallucinations + delusions → ***Psychotic depression***
- Increase in fatigue, appetite, weight and sleep with low mood but remains reactive, leaden paralysis (feeling of heaviness in the limbs) may occur → ***Atypical depression***
- Persistent depressive state, milder than MDD and persists more than 2 years → ***Dysthymia***
- Milder form of bipolar lasting 2 years, fluctuating from mild depressive and hypomanic symptoms → ***Cyclothymic disorder***
- The individual is unable to cope with particular stress or major life event, they must occur within 1-3 months of a particular psychosocial stressor, and shouldn't persist longer than 6 months after the stressor is removed → ***Adjustment disorder***
- Lack of interest in social relationships + tendency towards a solitary lifestyle → ***Schizoid personality disorder***
- Mood swings, marked impulsivity, unstable relationships, fear of abandonment and inappropriate anger, usually attention seekers and may have multiple self-inflicted scars → ***Borderline personality disorder (Emotionally unstable personality disorder) (EUPD)***
- Mild degree of mania where there's elevated mood but no significant impairment of daily activities → ***Hypomania***
- Antihypertensive drugs when administered with lithium can cause psoriasis → ***ACEIs***
- Antihypertensive drug causes hypokalemia + high lithium level → ***Thiazide diuretics***
- Other causes of lithium toxicity → ***Metronidazole, Dehydration, renal failure***
- Inability to resist impulses to deliberately start fires, in order to relieve tension or for instant gratification → ***Pyromania***
- Delusional belief that a famous person is secretly in love with them → ***Erotomania (De Clerambaut $)***
- Impulsive urge to pull out one's hair leading to noticeable hair loss → ***Trichotillomania***
- Inability to refrain from stealing → ***Kleptomania***
- False belief that significant remarks, events or objects in one's environment have personal meaning or significance (e.g. someone constantly gives him messages through the newspaper) → ***Delusion of reference***
- Delusional belief that one's life is being interfered in a harmful way → ***Persecutory delusion***
- Fantastical beliefs that one's famous, wealthy or powerful → ***Grandiose delusions***
- False belief that one's thoughts, feelings, impulses or behavior is being controlled → ***Delusion of control***
- Delusional belief that patient died or the world has ended and nothing matter → ***Nihilistic delusions***
- Nihilistic delusions + psychotic depression → ***Cotard's $***
- Feeling guilty or remorse with no valid reason, one believes they deserve punishment → ***Delusions of guilt***
- When the person believes that different people are in fact a single person that changes appearances or in disguise → ***Fregoli delusion (delusion of doubles)***
- Patient believe that a person known to them has been replaced by a double → ***Capgras $***
- Feigning physical or mental illness, most frequently in prison inmates, they produce "approximate answers" or sometimes wrong however still hold some relevance to them → ***Ganser $ [Gangster]***
- Perceptual distortions of the size and shape of objects and altered body images, they might feel their body is expanding or getting smaller → ***Todd's $***
- Delusional jealousy, marked by suspecting a faithful partner of infidelity like cheating, adultery or having an affair, patient may attempt monitoring his partner → ***Othello $***
- Delusional parasitosis/infestation where they believe their skin/body is infected with parasites → ***Ekbom's $***

- A situation where two people with a close relationship share a delusional belief, this arises as a result of a psychotic illness in one individual, delusion resolves in the second person on separation, the first should be assessed and treated → ***Folie à deux (madness of two)***
- Persistent belief in the presence of an underlying serious disease (e.g. cancer or HIV), patient refuses to accept reassurance or negative test results → ***Hypochondriasis (illness anxiety disorder)***
- Multiple symptoms, multiple investigations, never reassured → ***Somatization disorder***
- Feigning symptoms NOT for secondary gain but medical attention → ***Munchausen's $ (factitious disorder)***
- Feigning illness in a child to gain medical attention, a form of child abuse that subjects the child to unnecessary medical procedures, hospitalization or treatments → ***Munchausen's $ by proxy***
- Feigning symptoms for secondary gain (e.g. for compensation, to avoid military service or to obtain an opiate prescription) → ***Malingering***
- Motor or sensory dysfunction which initially appears to have a neurological or other physical cause but is later attributed to a psychological cause, patient doesn't consciously feign the symptoms or seek material gain. Memory loss, seizures, loss of speech and paralysis can occur → ***Conversion (dissociative) disorders (functional neurological symptom disorder)***
- Continuous antisocial or criminal acts and inability to conform to social rules, impulsivity, disregard for the rights of others, aggressiveness and lack of remorse, they will typically be manipulative, deceitful and reckless → ***Antisocial Personality disorder (Antisocial behavioral disorder)***
- A young patient <18y with similar features as Antisocial Personality disorder → ***Conduct disorder*** → ***Tx: juvenile detention***
- Young children with negative, defiant behavior WITHOUT serious violation of social norms, more common with interaction with adults → ***Oppositional defiant disorder*** → ***Tx: parenting***
- Inattention + hyperactivity + impulsiveness → ***Attention deficit hyperactivity disorder (ADHD)***
- An incompliant patient in need for antipsychotics → ***Depot haloperidol***
- An incompliant patient + tardive dyskinesia → ***Depot risperidone***
- Pinpoint pupils, confusion, agitation and copious secretions → ***Organophosphate poisoning***
- To avoid anxiety before a certain event → ***Beta-blocker***
- If the patient is having an attack → ***Rebreathe into paper bags***, if very severe → ***Benzodiazepines***
- For long-time management and to prevent further attacks → ***CBT*** or ***SSRIs***
- SSRIs are the first line medical management in → ***GAD, OCD, PTSD and Panic disorders***
- In GAD, 1st line SSRIs → ***Sertraline***
- In panic attacks → ***All except Fluoxetine***
- In OCD → ***All except Citalopram***
- Drugs that interact with SSRIs → ***NSAIDs, Aspirin, Heparin, Warfarin, Triptan*** *[TWHAN]*
- Preferred SSRIs with MI patients → ***Sertraline*** then, ***Citalopram***
- Preferred SSRIs with no relevant medical history → ***Citalopram*** then, ***Fluoxetine***
- Preferred SSRI in young kids → ***Fluoxetine***
- For rapid tranquillization in an aggressive NOT-psychotic patient → ***oral lorazepam***, then ***IM***
- For rapid tranquillization in a psychotic patient → 1st ***Lorazepam IM, haloperidol IM***
- For rapid tranquilization in a psychotic episode in elderly → ***Haloperidol IM***
- 1st line for status epilepticus → ***IV Lorazepam***
- Binge eating followed by compensatory weight loss behaviors → ***Bulimia nervosa***
- Low weight, food restriction, fear of gaining weight and strong desire to be thin → ***Anorexia nervosa***
- Ability to recognize one's own mental illness (OCD, phobias)→ ***Insight***
- A very fast and accelerated speech without a pause, hard to follow, cannot be interrupted, seen in mania → ***Pressure of speech***
- Thought and words leap from topic to another with frequent shifts abruptly → ***flight of ideas***

- Irrational fear of confined spaces → ***Claustrophobia***
- Fear of spiders → ***Arachnophobia***
- Fear of heights → ***Acrophobia***
- Hallucinations hours after heavy drinking (12-24h) → ***Alcohol hallucinosis***
- Hallucinations/tremors/disorientation/diaphoresis in a chronic alcoholic following a day of abstinence → ***Delirium termens***
- Transient false perception experienced when the person is on the verge of falling asleep → ***Hypnagogic hallucinations [go to sleep]***
- Transient false perception experienced while waking up → ***Hypnopompic hallucinations***
- A psychotic feature of bipolar disorder where a person's belief or action does not match their mood (e.g. laughing at a funeral, believing to have superpowers while depressed) → ***Mood incongruence***
- A psychotic feature of bipolar where the belief or action is consistent with the mood → ***Mood congruence***
- Encourage women with a mental health problem to breastfeed unless they're taking → ***Carbamazepine***, ***clozapine*** or ***lithium***
- Everything is decreased + miosis → ***Heroin***
- Everything is increased + mydriasis → ***Cocaine***
- Colors when eyes open + increased thirst + uncontrolled body movements + hyperthermia, tachycardia, tachypnea, insomnia → ***Ecstasy***
- Colors when eyes closed + heightened senses + flushing, sweating → ***LSD***
- Antidote for benzodiazepines (e.g. drowsiness after benzo) → ***Flumazenil***
- Blood findings that support chronic alcoholism → **High GGT, high MCV**
- First line in delirium termens → ***Lorazepam, diazepam***
- If de-escalation techniques failed in delirium → ***Olanzapine, haloperidol***
- **Antidepressants** may precipitate **mania** and should be ceased if patients have manic episodes