Welcome to the editorial of the Mind the GAP newsletter for the year 2013. In this issue’s editorial, I would like to present a brief summary of the West Midlands General Adult Higher Trainees’ Conference. This annual conference was held on 1st October 2013 at the Uffculme centre, Birmingham.

The day began with Dr Murphy, head of the School of Psychiatry opening the conference. This was the only talk that I missed whilst helping the organisers with registration process. Perhaps this may be a good reason for our colleagues to help by arriving promptly at registration time!

Dr Reed talked through series of cases about the associations between schizophrenia and violence, both historical and from his own experience. The cases demonstrated the importance of our skills to explore the delusions in our routine practice to make a link to the risk, if any. While it was clear at times that violence is unpredictable, the speaker emphasised “good clinical care” and self-reflection of “doing your best” as a vaccination to be immune to medico-legal implications.

Next in line was Prof Taylor, the editor of the Maudsley Guidelines. He talked on the research evidence of depot medications in addressing relapse prevention and ensuring compliance. Whilst the typical antipsychotic depots were sadly getting negative publicity for being difficult with dose titration and side-effects, one if not all typical depots had praise for being well tolerated and effective in reducing number of in-patient stays. The author made an effort not to be biased by the dominance of one pharmaceutical company in this field, but felt strongly about the scope for further research to find the best alternatives.

Dr Oates enlightened us with her in-depth knowledge in perinatal psychiatry with her session on psychosis and child birth. The talk helped us to differentiate postpartum psychosis from schizophrenia. There was discussion around the current national guidelines to screen all pregnant women for personal/family history of mental health conditions. There were also simple reminders like the most common cause of amenorrhoea being pregnancy rather than hyper-prolactinaemia and prenatal counselling/contraception advice being the best prophylaxis for perinatal psychiatric conditions. Dr Oates gave a take home message about the importance of affective psychosis and its link with relapse ranging beyond 50% in future pregnancies.

Post lunch there were five different parallel workshops on Early Intervention Service, Autistic Spectrum Disorder, Learning Disabilities, Older adults and Substance misuse. The workshops were facilitated by specialists in the respective fields and were well received with great interest and active participation.

The dynamic workshops were followed by a talk on principles and practice of rehabilitation for schizophrenia by Prof Craig. The speaker passionately talked about the interventions used by the Institute of Psychiatry towards patients’ recovery including occupational and recreational sports activities. This is perhaps a field which is yet to get its credit, as resource constraints within the NHS and lack of lobbying by private firms have not exposed its potential in putting our patients’ lives back on track.

The last programme on the agenda was “Patients’ Voice”. Dr Marriott, our fellow colleague, read extracts and poems from literature. These were taken from Memoirs of My Nervous Illness and Perceval’s Narrative both written by patients. These excerpts were able to help us gain insights into our patients’ lives and experiences of psychiatric care. This was a unique programme with touching experience which demonstrated the organisers’ commitment in not only enriching our knowledge but to acknowledge the patients who have always helped us learn.

The conference was brought to close with prize distribution for the best poster and closing remarks by Dr Chima. Overall the conference was a huge success which managed to attract a wide audience ranging from medical students to consultants, both locally and from beyond the Midlands. The organisers have set a trend of an excellent educational event at a competitive price which will be eagerly awaited by everyone in future.
Audit of Safety Awareness and Safety Provisions in Psychiatric Trainees in the West Midlands Deanery

Dr Humaira Arshad, ST5 Learning Disabilities Psychiatry

Introduction:

Safety of NHS staff is recognised as an important issue at a national level and a nationwide campaign was initiated to tackle violence and abuse against staff working in the NHS. (NHS Zero Tolerance Campaign, DOH 1999, National Audit on Violence, 2007).

Violence in the workplace is a cause for concern for junior doctors in general and psychiatric trainees in particular (Bhugra et al, 1999), more so since the shift from hospital psychiatry to community based psychiatry. Safety at workplace has been a concern for psychiatric trainees for some time, with various reports highlighting these issues. The BMA revealed that 60% of psychiatric trainees in the UK reported that they felt at risk of violence at workplace (BMA 2005).

In 2006 National Survey of Psychiatric Trainees in Ireland found that 16% of Psychiatric Trainees had experienced physical assault and 72% had felt threatened in workplace. In 2003 Survey of Specialist Registrars in South West England revealed that 67% had been assaulted in psychiatric training posts. A survey of Safety Provision in workplace among junior psychiatrists in Wales revealed gaps in safety training and facilities (Chubb, 1997).

Methods:

Questionnaires were sent out electronically to all trainees (Core and Specialist) in the West Midlands Deanery (WMD) in January 2012 and re-sent in February 2012 to increase the response rate.

The questionnaire was anonymous and confidential and was based on a series of questions on training issues, safety of clinic rooms and out of hours and community work. The aim of the questionnaire was to assess the level of awareness of safety amongst the trainees at the workplace.

Aims – To assess the level of awareness of safety amongst trainees. And to see whether the standards recommended by the Royal College were met in the WMD

Standard – The questionnaire was based on the recommendations in The Royal College Reports; RCPsych, Safety for Trainees in Psychiatry (1999); RCPsych, Safety for Psychiatrists (2006). This survey was conducted to investigate whether these suggested measures were correctly implemented in the West Midlands Deanery and to highlight any deficiency.

Results:

91 out of 218 trainees responded, giving a response rate of 41.7%.

79.2% had attended safety training on induction to their current post while 20% of the trainees did not receive any safety training on induction to their current posts.

Of those who had received safety training on induction only 20% had attended a refresher course.

40% of the trainees were not aware of the local safety guidance or procedures.

More than half of the responders were using clinic rooms with no panic button or internal inspection window to permit viewing when the room is occupied.

Nearly 2/3 of the clinic rooms are situated close to the main staff areas, but only 27% of the rooms had exit door that opened outward.

About 20% of the responders had stated that they did not feel safe in their clinic rooms due to the above reasons.
Discussion:

Majority of the responders stated that they inform other members of staff of their whereabouts while seeing patients in the community during normal working hours but only 68% informed other staff of their whereabouts during out of hours work. For out of hours work mobile phones and personal alarms did not appear to be readily available to more than half of the responders (53%). 48% of the responders were not aware of the lone worker policy while working in the community.

Only 1/3 of the responders had access to information about the risk assessments of the patients before they saw patients in the community. 93% of the responders had felt threatened or concerned for their safety at some point during their training.

The common reasons flagged up were the following:

1. Dealing with psychotic patients and those addicted to drugs on their own in A&E and outpatients.
2. Assessing/reviewing aggressive patients in clinic rooms with no panic buttons or alarm
3. Having no information about the risk assessments of the patients before assessing them

80% of the responders had experienced some form of verbal aggression while 1/4 of the responders had experienced physical aggression from the patients. Of those experiencing physical aggression, Police were called in 3 instances and one case was referred and dealt with by the court.

Conclusions:

Safety training was generally well attended by the trainees and appeared to meet their training needs. However some issues remain unaddressed, particularly with regards to provision of safe working environment. The employing trusts have the responsibility to ensure adequate safety of the work environment, but the trainees also need to inform themselves of health and safety policies and procedures. Trainees need to be encouraged to report unsafe working conditions to the management.

The shift to a more community based psychiatry poses additional challenge and therefore systems need to be in place to ensure trainees’ safety during normal and out of hours working, based on The Royal College of Psychiatrists’ recommendations.

Recommendations:

1. Additional workshops on safety guidance and lone worker policy in addition to the generic induction in the beginning of the post.
2. Better systems of communication about the risk assessments of the patients, particularly out of hours.
4. Increasing the awareness of trainees at induction to the relevant College Documents on safety and paper copies to be included in the induction packs.
5. Dissemination of the results of this audit to the relevant authorities for information and action.
6. Re-audit

Actions

1. The results have been included in the Deanery report.
2. A document has been created highlighting the criteria for safety provisions in a clinic room. This document has been forwarded to the School of Psychiatry to be forwarded to the Deanery for distribution to trainees in different trusts. The aim of this document is to increase trainee awareness about what constitutes a safe clinic room.

References

Department of Health (1999), NHS Zero Tolerance Zone. www.nhs.uk/zerotolerance/mental/
Index.htm
British Medical Association, Survey of Trainee Doctors working in Psychiatry, BMA Health and Economic Research Unit, 2005
Royal College of Psychiatrists. Safety for Trainees in Psychiatry (CR78), Royal College of Psychiatrists, 1999.

Correspondence: Humaira.Arshad@covwarkpt.nhs.uk
An Audit of baseline physical examination and investigations in people with First Episode Psychosis in North, East, South, West Birmingham & Solihull Early Intervention Service (EIS)

Abigail Kwok, 4th year medical student, University of Birmingham; Dr Veena Vishwanath, Foundation year doctor; Dr Lucy Howard, Foundation year doctor; Dr Sadira Teeluckdharry, consultant psychiatrist, EIS and Youthspace services; Dr Rowena Jones, consultant psychiatrist, South Early Intervention Service.

Introduction:
People with mental disorders and disabilities have a higher risk of poor physical health and premature mortality than the general population. It is estimated that those with severe mental illness have an almost 25–30 years shorter life expectancy. In schizophrenia, standardised mortality ratios are increased 3–4 times compared with controls; deaths mainly due to respiratory, circulatory, endocrine and digestive disorders. The risk of developing metabolic syndrome for those with Schizophrenia is 2–4 times greater than for the general population. The increased metabolic risk with treatment by second generation antipsychotics (in particular Olanzapine) was demonstrated in the CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) trial. The risk of sudden death in schizophrenia increases incrementally with each additional psychotropic medication taken by a patient.

Current Guidelines:
Good psychiatric practice:
“Assess the physical health of their patients by taking a medical history, conducting a physical examination and by liaison with other health professionals”

NICE (physical health checks and investigations):
CG082 1.1.4.1 – Ensure that people with schizophrenia receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment.
CG082 1.2.4.2 Emphasis of cardiovascular risk when commencing anti-psychotic medication.
TA136 2.6 Current management for psychosis aims to promote functional recovery and reduce relapse rates; it includes standard physical, mental state, neurological and laboratory examinations.
CG038 – Lipid profile and plasma glucose monitored at start, and 3 months, more often if there is evidence of elevated levels.

Aims and Objectives:
The aims of the audit were to determine that:
- The existing practice in Birmingham and Solihull EIS, is in line with guidelines for keeping a full record of a physical health check once a patient was admitted, within an acceptable time frame.
- Appropriate monitoring of people treated with atypical antipsychotic medication.
- An organic cause of psychosis was ruled out if suspected, by use of computed tomography (CT) scanning.

The objectives were to implement the necessary changes, needed to ensure better systems are in place to monitor baseline physical health efficiently and physical health consequences of treatment by antipsychotic medication.
Standard: 100% for physical health assessments and baseline bloods within 3 months of entering the Early Intervention Service.

Data Collection:
This audit looked at all new patients to EIS from October 2012-March 2013 from the 5 teams across Birmingham (North, East, South, West and Solihull).

Patient IDs given by admin staff for each individual team, and RIO (an electronic online clinical record system) was used to look for evidence of baseline examination and investigations completed within 3 months of entering EIS, if not completed and recorded in the 3 months before taken on.

This includes looking at:
- Progress notes
- Physical health assessment (community, inpatient, core health monitoring)
- Document list view
- Intranet pathology report

Results:
Overall there are not enough examinations being done, however those that are done appear to be fairly complete, and each team is relatively consistent. There is variable completion of neurological examinations. Overall there are fewer baseline blood tests completed than physical measurements. Very few CT scans are being done.
Limitations:
The main problem encountered was poor recording of blood tests. The recording within progress notes is inconsistent and also physical health checks are not being recorded in the designated area.

Discussion:
What are the indicated blood tests? - There needs to be clearer guidance required on what and when - there are currently too many different sources of information and often these can conflict with each other, leaving some doctors confused as to the correct tests to order.

Completeness of neurological examinations? – There is no section of community physical health assessment for thorough neurological examination.

Patient Refusal may not allow the examination or investigations to take place – This therefore needs to be recorded as a log of an attempt to thoroughly examine and investigate the patient.

Very few CTs have been ordered – it is highly likely that clinical indication for an organic cause was low. It may possibly be a further line of enquiry further along the patient journey that has been reflected in low numbers in the early period of care.

Recommendations:
1. Trust guideline recommending physical health screen within 3 months of entering the service - Once client is taken on “start the clock” Part of MDT/Planning meetings
2. Re-audit including: ECG, MRI, Expand time frame to 3 months prior and post acceptance to EI. Only relevant blood tests performed, Alcohol use - Screening, Smoking - Screening
3. Get physical health link workers involved to develop and promote monitoring of physical health
4. RIO software improvement
Pop up reminders of due physical examination and investigation
Designated area for blood tests rather than using separate intranet Trend reports e.g. graphs – in order to get an idea of a trend over time rather than a snapshot view. Often it is too laborious to look through numerous separate blood tests on the intranet
5. Generally increase awareness of physical health monitoring through staff and patient education
6. A database of patients for physical health monitoring

References:

Correspondence: Dr Sadira Teeluckdharry; sadira.teeluckdharry@bsmhft.nhs.uk Abigail Kwok; AXK074@bham.ac.uk
Mania following Head Injury - A Case Report

Dr. Charlotte Marriott, ST5 Specialty Registrar, Dr. Laki Kranidiotis, Consultant Psychiatrist, Dr. Shraboni Bohra, Specialty Doctor, Worcestershire Health and Care NHS Trust

Abstract

Psychosis has long been recognized as a complication of head injury.

We present a case of a Severe Manic Episode with Psychosis following head injury, with evidence of diffuse axonal injury on MRI, in a young man without other risk factors for mental illness.

We present a 27-year-old man without previous psychiatric history. He sustained a head injury on 27/11/2009 during a road traffic accident (RTA), necessitating 2 months of ITU care and neurorehabilitation. He had a further RTA on 21/03/2013 but was not thought to have sustained a significant head injury at this time and CT scan was normal.

He presented with Mania with Psychotic Symptoms, including grandiose delusions, on 03/04/2013 and was admitted under Section 2, Mental Health Act, 1983 (MHA). He was refractory to treatment until semi-sodium valproate and quetiapine were introduced in combination. MRI showed multiple scattered focal areas of blooming artefact in the grey-white junction bilaterally with focal areas of blooming artefact in the bifrontal deep white matter and in the body of the corpus callosum. The ventricles, in particular the lateral and third ventricle, are more dilated than would be expected for age, raising suspicion of central brain volume loss. The overall appearance is of scattered foci of blood breakdown products, highly suggestive of chronic sequelae of diffuse axonal injury. He does not show evidence of frontal lobe deficits clinically and is now euthymic, although he has some residual grandiose delusions.

This is an interesting case of Mania with an organic aetiology, which was refractory to treatment, and has an unclear prognosis. He responded well to quetiapine, as the literature suggests.

Full Report

Introduction:

Traumatic brain injury (TBI) is a common cause of disability and has long been associated with psychiatric sequelae, most commonly personality change, depression, anxiety and psychosis\[^1\]. Bipolar affective disorder (BPAD) following TBI has been less frequently reported, although studies have shown that mania may occur in 4-9% of patients secondary to TBI \[^1,2\]. A Danish case-control study of 10242 patients with bipolar affective disorder showed that BPAD was associated with a 1.5 times increased risk of a history of head injury up to 5 years before the first psychiatric admission (IRR = 1.55; 95% CI 1.36-1.77)\[^3\].

Various brain lesions have been identified in bipolar affective disorder secondary to TBI, including left fronto-parietal haemorrhage\[^4\], bilateral temporal lesions\[^5\] and temporal basal polar lesions\[^1\]. A study of 66 patients with closed-head injury who were followed up at 3, 6 and 12 months showed that 9% of patients met criteria for mania at some point during follow-up and that temporal basal polar lesions were significantly associated with secondary mania. However, the severity of the brain injury, the degree of physical or cognitive impairment, level of social functioning, family history, personal history and past psychiatric history were not found to correlate with the appearance of secondary mania\[^1\].

In a review of functional imaging studies of patients with bipolar affective disorder without TBI it was identified that networks fundamental for cognitive and emotional processing, the limbic, sub-cortical and frontal regions, were involved\[^6\], as might be expected. Jorge R et al.[7] state that risk factors for mood disorder following TBI include prior psychiatric history, impaired social support and involvement of the prefrontal cortex and other limbic and paralimbic structures.

Although BPAD appears to be a fairly common occurrence secondary to TBI, treatment is not well described. However, the atypical anti-psychotic quetiapine has been recommended for its beneficial effects on post-traumatic mania, cognitive impairments and functional disability\[^8,9\].

We present a case of a severe manic episode with psychotic symptoms following head injury, with evidence of diffuse axonal injury on MRI, in a 27-year-old man without other risk factors for mental illness - he has no significant past psychiatric or medical history, was not on any medication, and does not use illicit substances or drink alcohol to excess. There is no family history of mental illness. He sustained a head injury on 27/11/2009 during a road traffic accident (RTA) on his motorbike, necessitating 2 months of ITU care and neurorehabilitation. He had a further motorbike accident on 21/03/2013 but was not thought to have sustained a significant head injury at this time and CT scan was reported as normal.
He presented with Mania with Psychotic Symptoms, including grandiose delusions, on 03/04/2013 and was admitted under Section 2, Mental Health Act, 1983 (MHA). His manic episode was very typical in presentation with elation, excess energy, irritability, excessive spending, pressure of speech, flight of ideas and decreased need for sleep. He had grandiose ideas of emulating Alan Sugar and Mark Zuckerberg and believed that he would become a millionaire as he was brimming over with ideas for new business ventures. He described his mind as “buzzing” and “clicking” but denied any perceptual disturbance. During admission olanzapine was started and titrated up to 20mg, to very little effect – in fact he became more unwell with grandiose and persecutory delusions becoming more prominent. Aripiprazole was similarly ineffective and subsequently also withdrawn. Semi-sodium valproate was initiated and led to a small improvement in his manic symptoms, but it was not until quetiapine was introduced in addition that he really started to recover from his delusions. During admission an MRI scan of his head was performed and showed multiple focal areas of blooming artefact on gradient echo imaging scattered in the grey-white junction in both cerebral hemispheres. There are also focal areas of blooming artefact in the bifrontal deep white matter, more on the right. There is a focal region of blooming artefact in the body of the corpus callosum just left of midline. The ventricles, in particular the lateral ventricles and third ventricle, are more dilated than would be expected for the patient's age raising the suspicion of central brain volume loss. There is no evidence of obstructing lesion. Overall appearance suggests scattered foci of blood breakdown products including at the body of the corpus callosum. This together with suggestion of an underlying central brain volume loss and previous history of head injury is highly suggestive of chronic sequelae of diffuse axonal injury.

He remained in hospital for more than 2 months, under Section 2 and subsequently Section 3 of the Mental Health Act, 1983. He was refractory to treatment until the introduction of quetiapine, but eventually made a full recovery and is now doing well in the community under the care of the Early Intervention in Psychosis Team, and has gained insight into his illness and delusional beliefs. His prognosis is uncertain.

Discussion

This case is interesting, not only because of the history of at least one very significant head injury preceding onset of manic symptoms, but also because of the very clear evidence of brain damage on MRI scan. MRI showed evidence of diffuse axonal injury, which is described as damage to axons caused by shearing rotational and linear forces, exerted by acceleration and deceleration forces in impact or inertial injuries, leading to changes in parasagittal white matter, corpus callosum, brainstem long tracts and grey-white matter interface in the hemispheres. Damage to bifrontal areas is consistent with reports from the literature as discussed in the introduction, but damage to temporal regions was not seen in this case.

This patient has not suffered any long term physical or cognitive sequelae of his traumatic brain injury, despite the severity of it, and in the absence of other risk factors for bipolar affective disorder it seems that the TBI is implicated, although it is impossible to say whether or not it is directly causative. He presented with a very typical manic episode with psychotic symptoms, rather than with symptoms suggestive of a frontal lobe syndrome (such as tactlessness, aggression and impulsivity), and although he was quite refractory to treatment initially, made a full recovery on the combination of semi-sodium valproate and quetiapine. Quetiapine is the medication recommended for mania secondary to TBI as discussed in the introduction and it is interesting to note that it was the most effective treatment in this case.

References


Conflict of Interest: Dr Marriott is a member of the editorial board. This article has been peer reviewed without her involvement.

Correspondence: charlottemarriott@doctors.org.uk
Late onset Huntington’s disease – A case report

Dr Udayaraj Balakrishna Speciality Trainee year 4 Old Age Psychiatry
Dr David Rice, Consultant Old Age Psychiatry
Shelton Hospital South Staffordshire and Shropshire NHS Foundation Trust

Introduction

Huntington’s disease (HD) is an autosomal dominant neurodegenerative disorder with an onset between 3rd to 5th decades of life. Currently the estimates are that about 6-7 per 100,000 people have Huntington’s disease in the UK. HD is characterized by a triad of motor, cognitive and psychiatric symptoms. The early symptoms of HD include behavioural and personality changes which could be attributed to various causes, but the motor symptoms are generally prominent and can occur at any stage of HD. Here we discuss the case of a 70 year old female who initially presented to the psychiatric team with mental health problems and worsening movement disorder, which was later diagnosed as late onset Huntington’s disease.

Case Report

The patient, a 70 year old female was admitted to an acute psychiatric unit detained on Section 2 of the Mental Health Act, due to her deteriorating mental state, unmanageable behavioural problems and worsening movement disorder; the latter symptom was diagnosed as probable Tardive Dyskinesia.

Her first referral to psychiatric services had been 2 years previously when she was diagnosed as having Obsessive Compulsive Disorder and Agoraphobia. She initially benefited from treatment with a combination of an SSRI antidepressant and psychological therapy. It had also been noted that she had mild dystonia. During subsequent relapses, she was also prescribed Lithium carbonate and oral antipsychotic medication. During this period her psychiatric symptoms subsided, but she reported developing various difficulties with her movements. On further enquiry her husband reported that his wife had some problems with her gait and had been complaining of back stiffness prior to being prescribed treatment for her mental state. The only other significant history was that her mother had been diagnosed with Parkinson’s disease.

During the psychiatric admission her movement disorder worsened. She was fidgety, clumsy while walking, had dysarthria and involuntary facial movements. She was unable to sit still, constantly moving her upper body and legs. This was initially attributed to the side effects of oral antipsychotic medication which were discontinued. This had minimal benefit on her movement disorder. Her behavioural problems escalated, she became more irritable, argumentative and demanding staffs’ attention. She was also emotionally labile with pressure of speech, was distracted and had concrete thinking.

She was seen by a neurologist and a general physician who both, based on the history, examination and her normal CT scan report, reported that the most likely diagnosis was Tardive Dyskinesia.

She was prescribed various anticholinergic medications including Tetrabenazine for her movement disorder and Carbamazepine for her behavioural disturbance. Her behaviour improved marginally over few weeks but there was little improvement in the abnormal movements. On further review a diagnosis of Huntington’s disease was considered, although thought unlikely due to the absence of a family history of the disorder. However, after consultation with the neurologist and the regional Clinical Genetics service, and with the consent of the patient, a blood sample was sent for diagnostic testing and a positive result for Huntington’s disease was returned, with a CAG trinucleotide repeat of 44.

Subsequently the patient received support and counselling from the Clinical Genetics service as well as from local Mental Health Services. There was some improvement in her mental state and behaviour and she was discharged home with support from a care package.

Discussion

Huntington’s disease is a neurological disorder with Autosomal Dominant inheritance and the presentation is most common during middle age. It can present with a wide variety of psychiatric and motor symptoms. The psychiatric symptoms can manifest at any stage of the illness, but usually in the later stages of the illness. The most characteristic and prominent symptoms of HD are those of movement disorder, in the absence of which, there is a risk of overlooking the possibility of this diagnosis.

The confirmatory investigation for HD is genetic testing; a positive result confirms the presence of a defective gene for Huntingtin protein with the presence of 39 or more CAG trinucleotide repeats. Studies have shown an inverse correlation between the number of repeats and the age of onset of the disease. Twenty-five percent of patients affected by HD are of late onset and inherit the defective gene from their mother rather than their father.
Conclusion

HD can present at any age and with a myriad of symptoms. It is important to rule out all possible causes of movement disorders in older adults before a diagnostic test for HD is considered, as a positive result has important ethical and psychological implications for the patient and their family. Confirmation of the diagnosis, and thus explaining and understanding the cause for the movement disorder can be therapeutically important for the patient.

References


Insula and obsessive-compulsive disorder. [Can J Psychiatry. 1995]


Comorbidities of obsessive and compulsive symptoms in Huntington's disease. [J Nerv Ment Dis. 2010]


Obsessive-Compulsive Disorder Symptoms in Huntington's Disease: A Case Report. [Rev Colomb Psiquiatr. 2008]


Review Children with obsessive-compulsive disorder: are they just "little adults"? [J Clin Invest. 2009]


Correspondence: drudayrb@hotmail.com

Inviting articles for the next edition.....

We welcome articles and contributions for the next edition of MIND THE GAP newsletter (West Midlands Higher Trainees newsletter).

Articles are peer reviewed and it can be a case report, audit, research, about a course/conference you have attended, a book that you have reviewed and anything interesting/related to Psychiatry - preferably General Adult Psychiatry. Portfolio certificates are provided on request.

If you need any further information please contact us on our email list given at the bottom of page 13. Please send your articles in Word format (up to 1500 words) and you can also include pictures/Graphs/Charts etc.

Online access of the current edition and previous editions of the newsletter are available via the college website. Please copy & paste http://www.rcpsych.ac.uk/workinpsychiatry/divisions/westmidlands/traineesection.aspx in the web browser.
Treatment of Tuberculosis: Managing methadone prescribing and the Interactions with initiation and down-titration of Rifampicin – A case report

1 P. Duffield, Senior Nurse, Birmingham & Solihull Mental Health NHS Foundation Trust, Birmingham Heartlands Hospital, UK

2 M. A. Ramji, Consultant Psychiatrist, Erewash Recovery Team, Derbyshire Healthcare NHS Foundation Trust, UK

Introduction

The interactions between rifampicin and methadone are not well researched and there is limited guidance on its management. This complex case forged multi-agency multi-disciplinary working in order to achieve a successful outcome and is therefore highlighted in order to share good practice.

A 43-year old Caucasian gentleman was admitted to the infectious diseases ward with primary pulmonary tuberculosis (TB), diarrhoea, alcohol dependency and poor nutritional status. Although not requiring active treatment, he was positive for Hepatitis C. When diagnosed with TB, he was on a methadone programme, being prescribed 140ml methadone daily, reduced from 180ml daily. He was prescribed rifampicin as treatment for his TB (initially in the community), resulting in rapid onset opiate withdrawal symptoms.¹

Prior to admission and continuing in hospital, his methadone prescription was gradually increased to 310ml daily over a period of 12 weeks; rifampicin dosing was increased twice during the period in hospital. A chlordiazepoxide regime along with intravenous vitamin B compound for management of alcohol withdrawal was also required initially. He remained in hospital due to continuous positive sputum samples reflecting the severity of his TB. His electrocardiogram (ECG) was monitored every four weeks whilst in hospital for signs of QTc prolongation,² a possible side-effect of high dose methadone treatment, but his ECG remained unremarkable throughout.

Prior to increasing the methadone dose each time, his methadone plasma level was monitored. Evidence suggests increased metabolism of methadone by rifampicin, an inducer of cytochrome P450 (CYP) 3A4, resulting in increased methadone dosage requirements in patients prescribed rifampicin.³ The methadone plasma level remained constant at 0.7mg/litre (therapeutic range is between 0.05 – 1mg/litre).³ He remained an inpatient for 5 months, followed by a treatment regimen of rifampicin combined with antibiotics for an extended period in the community. He received regular community follow-up through outpatient appointments with TB nurses and Respiratory physicians.

After fifteen months of rifampicin in the community as 300mg daily along with Rifnah⁴ 300/150 (rifampicin and isoniazid combined) two tablets daily, a plan was made to stop rifampicin and adjust the methadone dosing accordingly. Initially attempts were made for an admission under the substance misuse services. As this could not be arranged, the gentleman was re-admitted to the infectious diseases ward. On admission, the patient’s daily methadone dose was 340ml.

Discussion

Whilst we were aware of articles relating to commencing rifampicin for patients prescribed methadone,⁵ a literature search uncovered no such information relating to stopping rifampicin. Verbal discussion with two nationally respected Consultant Psychiatrists in the substance misuse field and the local GP lead all suggested halving of the methadone dose within a few days of stopping the rifampicin and to give prn doses of methadone to manage any opiate withdrawal symptoms.⁶ When preparing for admission, this proposal evoked significant anxiety in the patient and he suggested he would decline admission if this approach was carried through.

At admission we met with the patient on the ward with the knowledge and support of the respiratory team. He had remained abstinent from alcohol since his discharge from hospital seventeen months earlier. Whilst at home his ECGs remained unremarkable and his hepatitis C RNA continued to be stable and therefore did not require active treatment. He admitted lapses in his heroin use on three occasions in the five weeks prior to admission; he had injected intravenously each time. He had however been stable on his prescribed methadone, confirmed by both oral swab and urine testing at his community drug service. He quoted anxiety related to coming off rifampicin too quickly and the likelihood of opiate withdrawal symptoms as the reason for his lapse.

During this second admission, methadone was administered four times a day; 85ml each time. The patient preferred to split the daily dose as this was in line with how he took his methadone at home and we agreed this regime would make opiate withdrawal symptom management easier.

The Respiratory Consultant stopped rifampicin on the second day of the second admission. Its action on liver enzymes is believed to continue for between two and four weeks after stopping treatment.⁷ It was agreed that we would not make the first reduction in methadone until 72 hours after stopping the rifampicin. Methadone was reduced by 40ml on day six of the admission split across the four daily doses. Nursing staff were briefed to monitor the gentleman using the Clinical Opiate Withdrawal Scale (COWS)⁸ at
each methadone administration. 10ml methadone up to three times daily was written up but only to be given if the COWS score was 18 or higher. It was felt unnecessary to monitor methadone plasma levels during the methadone reduction regime.

After five days at 300ml daily, there was no evidence of either over sedation or significant symptoms of opiate withdrawal, the highest COWS score in the five days being 13. In discussion with the patient, the ward team and community drug service, it was agreed that methadone would be reduced by 20ml daily every four days (5ml off each of the four daily doses). We continued to observe for over sedation and opiate withdrawal using COWS at each of the daily administrations of methadone. The option of prn methadone was continued.

The reduction regime continued as planned without any significant events and the highest COWS score during the reduction was 11. The plan for discharge was agreed during the second week of admission: Community drug services would take over methadone prescribing post discharge and once the daily dose had been reduced to 180ml, effectively half the admission dose and close to the dose he had been receiving prior to starting rifampicin.

During his stay in hospital we continued to monitor his ECG pattern intermittently which remained unremarkable. HIV, hepatitis A and B screens were also done, all negative and hepatitis C RNA was also repeated. He was insistent that on all three recent occasions when he had injected heroin, he had done so alone using aseptic technique and sterile equipment.

He achieved 180ml methadone daily after thirty four days in hospital. He was discharged the day after commencing that dose. Post discharge, follow up was arranged with his community drug worker, prescribing doctor, TB nurses and Respiratory Consultant. He has continued to reduce his methadone prescription; the daily dose was 85ml ten weeks after discharge with his goal being complete abstinence.

**Summary**

TB is increasingly prevalent in the United Kingdom. Patients with similar characteristics to those described here are likely to be at increased risk of exposure to the condition and its effects are likely to be more serious due to the comorbidities. It is therefore helpful if clinicians’ awareness is raised as to the problems of interaction between methadone and rifampicin not only when commencing rifampicin but also when it is being stopped.

This case demonstrates the advantage of achieving concordance with patients and management in a multidisciplinary team. It is possible that an alternative more rapid methadone reduction could in theory have been achieved but all the clinicians involved in this patient’s case were of the opinion that had such a course of action been taken the patient would have had struggled to achieve the desired outcome and increased the risk of heroin use.

This case demonstrates the value of a variety of disciplines working together with clear and effective channels of communication. We were able to provide holistic care for this patient with well defined clinical roles and responsibilities. It is to the immense credit of the Respiratory Consultant and her team that they were willing to accommodate admission for this patient, enabling him to successfully stop rifampicin and remain stable on methadone.

**References**


Kouimtsides C. Consultant Psychiatrist. Personal Communication. 02 February 2012.


**Acknowledgements:** We wish to acknowledge Karen Wright, librarian for Birmingham and Solihull Mental Health NHS Foundation Trust who kindly assisted in the research for this case study.

**Correspondence:** abbasramji@doctors.org.uk
An audit of prescription card compliance with guidelines

A completed audit cycle by Dr Salwan Jajawi, speciality Registrar and Dr Ganapathy, consultant psychiatrist

Aim of the project:

To measure the level of compliance of medicine prescription cards with the Birmingham and Solihull NHS MH Trust prescribing guidelines and to identify areas where improvements are required and put measures in place to improve the quality of the prescription cards if needed. It is expected that the team achieve 100% of the recommended standards.

Method:

Initially the audit department approved the project and provided further guidance and information. An audit tool was devised which included all standards expected from medicine prescription cards according to the Trust standards. All current patients under the care of Crisis resolution and home treatment team (CRHT) were included in the audit from early March 2012. Re-Audit of the results took place 6 months after the initial audit to provide a satisfactory period to improve areas of concerns.

Summary of Results:

Significant areas of improvement needed were identified in the first audit. The results showed medicine prescription cards only met 65% of several standards required. It showed areas of concern including drug allergy status, unit number and prescription date were not recorded. The concerns identified were discussed with the team and recommendations were devised and implemented. The recommendations following first audit were:

1. Pharmacy was informed and involved to monitor future compliance regularly.
2. Findings were presented in team meetings to present the audit findings and communicate areas of concern.
3. Re-audit of the results.

Following Re-Audit, significant improvement was noticed in areas of concern and the team achieved above 95% in all standards required for medicine prescription. Audit results were distributed in the trust to enhance patient care.

Conclusion & Key learning points:

1. Completed audit cycle showed significant areas of change to current practice were implemented and helped improve key areas in patient care. Identification of areas of concern is vital to improve patient care.
2. Education and proper communication between staff members were key to implement key changes in order to help improve areas of concern.
3. Re-audit helped to identify areas of improvement implemented.

References and guidelines:

Birmingham and Solihull NHS MHT Prescribing guidelines
Birmingham and Solihull NHS MHT audit department guides and information

Correspondence: salwanjaj@yahoo.com
Upcoming Events

The programme, fees and call for posters and papers will be available in January. Please log on to http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses.aspx

For further information, please contact Laurence Johnson - email: ljohnson@rcpsych.ac.uk or 020 3701 2618

RCPsych Faculty & Section Annual Meetings

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Venue</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Faculty Institute Day</td>
<td>13 February 2013</td>
<td>Royal College of Psychiatry, 21 Prescot Street, London E1 8BB</td>
<td>Caroline Simms, email: <a href="mailto:csimms@rcpsych.ac.uk">csimms@rcpsych.ac.uk</a>; Catherine Ayres, email: <a href="mailto:cayres@rcpsych.ac.uk">cayres@rcpsych.ac.uk</a></td>
</tr>
<tr>
<td>Forensic Psychiatry Faculty Annual Conference</td>
<td>05-07 March 2013</td>
<td>Europa Hotel, Great Victoria Street, Belfast BT2 7AP</td>
<td>Book online now <a href="http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/facultysectionconferences/forensicconference2014.aspx">http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/facultysectionconferences/forensicconference2014.aspx</a></td>
</tr>
<tr>
<td>Old Age Psychiatry Faculty Annual Conference</td>
<td>12-14 March 2013</td>
<td>Royal York Hotel, Station Road, York, YO24 1AA</td>
<td>Catherine Ayres, telephone 020 3701 2605, or email <a href="mailto:cayres@rcpsych.ac.uk">cayres@rcpsych.ac.uk</a></td>
</tr>
<tr>
<td>Medical Psychotherapy Faculty Annual Conference</td>
<td>02-04 April 2013</td>
<td>The Rougemont Hotel, Queen Street, Exeter, Devon, EX4 3SP</td>
<td>Book online now <a href="http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/facultysectionconferences/medicalpsychotherapy2014.aspx">http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/facultysectionconferences/medicalpsychotherapy2014.aspx</a></td>
</tr>
<tr>
<td>Faculty Psychiatry Intellectual Disability Spring Conference</td>
<td>4 April 2013</td>
<td>Royal College of Psychiatry, 21 Prescot Street, London E1 8BB</td>
<td>Booking available soon <a href="http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/facultysectionconferences.aspx">http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/facultysectionconferences.aspx</a></td>
</tr>
</tbody>
</table>

Forthcoming General Adult Psychiatry peer group meetings 2014

(All meetings are full day events held at The Uffculme Centre, Birmingham)

13th March 2014
12th May 2014
9th July 2014
9th September 2014

The views expressed in the articles are the views of the authors and do not necessarily reflect those of the editors of the newsletter. This newsletter is intended to inform and promote the positive work of the West Midlands General Adult Psychiatry higher trainees. It is also hoped that it provides a platform for junior trainees, trainees in other specialties, SAS doctors and Consultants. Portfolio certificates are provided on request.

Contributions should be sent to the editorial board:

docdoniparthi@yahoo.co.uk; charlottemarriott@doctors.org.uk; caladakatti@yahoo.co.uk; rejijayan@doctors.org.uk; vanathikennedy@googlemail.com