JISC update April - May 2018

Bulbar palsy, NMS and antipsychotics

Ten weeks after starting a depot antipsychotic a patient presented to hospital with what appeared to be sepsis. He was intubated and it was noted that he tolerated the tube with no sedation; had marked muscle rigidity, fever, autonomic instability and modest CK rise and so was commenced on treatment for Neuroleptic Malignant Syndrome; first with dantrolene and later bromocriptine. Tone improved but there was a continued bulbar palsy with no swallow or cough – necessitating ongoing intubation. Retrospectively it is noted that there were sporadic comments about dysphagia for fluids in the weeks prior to acute presentation.

Question: Is bulbar palsy seen as a feature of neuroleptic malignant syndrome? Is bulbar palsy seen as an extrapyramidal side effect?

Response one: Reports that catatonia is a possibility – that it can overlap with NMS in its presentation; he had 2 recent cases that dropped their oxygen saturations with this problem. He advises that lorazepam or ECT may help.

Response two: Ran a search "neuroleptic malignant syndrome" AND "bulbar palsy" with no associations found.

Respondent three: Had researched the association between quetiapine (and other antipsychotics) and dysphagia; and he suggests possible mechanisms of antipsychotic-related dysphagia:

• Rigidity and bradykinesia impairing oral phase of swallowing;

• Depression of bulbar centres with inhibition of cough, gag and swallow reflex;

• Dopaminergic and cholinergic blockade producing central and peripheral effects on swallowing, and potential impairment of oesophageal motility and gag reflex;

• Manifestation of tardive dyskinesia which is rare with quetiapine, and rarely causes dysphagia.

How to safely manage patients who want to leave the hospital

A Liaison colleague asks: 'I am wondering how Acute hospital Trusts across the UK manage the issue of patients detained under the mental health act who try to leave/abscond from ward areas within an acute hospital'. She wonders what happens in the interim period, where someone is actively trying to leave a ward area; and for whom de-escalation techniques have not worked. She wonders if Acute hospital trusts provide their clinical staff with clinical holding/restraint training; or do Trust's rely on common law in such an instance with regard to reasonable force?

This liaison service looked at the cost of training enough staff on the wards - ensuring that there is enough trained nursing staff on duty to safely restrain a patient in the hospital 24/7. Costs were considerable. The frequency of incidents requiring restraint was rare; so even if the staff were trained they are not exposed to enough situations to develop their expertise. This service tends to use agency mental health nursing assistants, works very closely with security, whose manager is on the trust safeguarding committee, and they go in over the weekend to support ward staff if this is needed.

It is difficult to engage acute trusts in this at a policy and training level. This service had negotiated joint training in "personal security and medication holds" for their team, some ED staff and security staff which is backed up with written policy. They hope this will create an atmosphere where staff feel safe in restraining patients when it is necessary.

What is the best way to accurately recording MHAct activity in the hospital?

The Devon recipe is to engender a close and supportive relationship with the DGH site office; to deliver training to the site office on MHA and MCA on a regular basis to make sure changing DGH staff stay informed. She recommends attending daily DGH site brief meetings so they can flag things up in the moment. (This last part is the most useful)
The site office will then have and be able to supply any information on MHA activity that you need and you can cross match it against the one that your MH Trust owns and collects. 'You can then ponder the gaps and decide that yes, the forms are devilish tricky and the junior doctors may need more advice/training'.

In a Scottish service it is the medical records department who process the forms and collect the data for us; and this has worked well.

Does anyone have a protocol when patients are not eating?

This clinician would like to create a protocol/pathway for patients who present to the acute hospital (including A&E) and who are not eating or drinking as a result of mental illness (severe depression or psychosis as opposed to eating disorders).

A North London Liaison Psychiatrist suggests creating a protocol or pathway for psychiatric inpatients that are not eating or drinking sufficiently to maintain weight. He advises against too rapidly using IV fluids and nasogastric feeding when 1:1 nursing, dietician assessment on the psychiatric ward, and assertively offering food, fluids and supplements may be sufficient.

An experienced eating disorder clinician advises looking at the MARSIPAN guidelines.
In Worthing Hospital we are extremely grateful for and often use the MARSIPAN guidelines – it helps the medics consider the risks in a measured confident and comprehensive way.

Dr Jackie Gordon
Worthing