“Just Clear Them”
The Approach to Medical “Clearance”

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My Disclosures

• None!
Psychiatric Patients

• Patients present to the Emergency Department with Psychiatric Complaints
• Psychiatric teams want ER Physicians to “Medically Clear” before they begin an assessment
<table>
<thead>
<tr>
<th>Patient</th>
<th>56 year old male;</th>
<th>77 year old male</th>
<th>21 year old male</th>
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</thead>
<tbody>
<tr>
<td>Details</td>
<td>Recently divorced, lost his job, started on SSRI for depression. Depressed and tearful. History of HTN; takes Diltiazem 240mg OD. Otherwise healthy. States took a handful of his blood pressure pills before coming to the ER.</td>
<td>77 year old male presents with new onset severe depression and fatigue. Taking SSRI for 3 months without effect; no other meds. History of bowel CA treated with surgical resection 7 years ago. Otherwise healthy. Tearful.</td>
<td>21 year old male. Reclusive for years. Quit school at age 16 and spends all his time in the basement playing with baseball cards. Followed by Psychiatrist. Non Compliant. Family wants help. Parents have supported him for years. Paranoid that Major League Baseball is taking over the world.</td>
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Exemplary patient experiences, always.
Just Clear Him

Same presentation
Alert
Oriented
Cooperative

Same Vitals
37.2
76
134/80
RR 14
96%

Exemplary patient experiences, always.
Can I send the patient to Psych?

Are they Medically Clear?
Psychiatric wards

• Specialized unit geared for mental health issues. No IV. Oral medications only; no cardiac monitoring

• Manage ongoing Medical issues (little to no medical treatment in psychiatric beds)

• 40% or more of patients admitted to a psychiatric unit have ongoing medical conditions that need ongoing care

• Can still get ongoing care for chronic conditions

Exemplary patient experiences, always.
Objectives

- What is “Medical Clearance”
- How can we safely assess medical stability
- What tests if any are needed as part of “Medical Clearance”
  - Blood work
  - urine Tox screens
  - Alcohol levels
  - Cranial CT
- Take Home Messages
Medical Clearance

- No currently accepted, standardized process of medical clearance
- Patients seeking medical care present with a large number of concurrent psychiatric, medical and social needs
- Documenting “Medically Clear” is inaccurate and misleading if not based on an adequate Hx, Px ± lab investigations
- We do Not “Medically Clear”
- We determine:
  - Currently medically stability/No obvious medical contraindications for admission to Psychiatric ward
  - Assess if the presentation represents a psychiatric presentation of an organic condition

Exemplary patient experiences, always.
Assessing Stability

• VITAL SIGNS!
• Review of medical history
• Brief review of symptoms
• Mental status examination
• Physical examination…
• Tests?
Red Flags for Organic

- Abnormal Vital signs
- HIV
- Drug abuse
- History of Cancer
- First Presentation?
- Homeless?
- Elderly
- Evidence of a toxidrome
Examination

Violent psychotic patient
• can be a limited examination, sedate, review vitals, determine evidence of head injury.

Competent cooperative patient
• Physical documenting neurological status, cardiac, resp, ? Thyroid

Neither – takes a lot of time

Exemplary patient experiences, always.
Testing

- Are routine Labs necessary in patients with psychiatric symptoms?
- Does the results of a urine drug screen affect management?
- Does an elevated alcohol level preclude the initiation of a psychiatric evaluation?
- Should brain imaging be obtained acutely?
Testing & Medical Clearance

Korn, JEM, 18(2), 2000

- Retrospective study, 212 ED pts referred to psych
- All underwent blood/urine screen incl tox, BHCG, and CXR
- 80 (38%) pts had isolated psych Sx with known prev psych Hx, negative Px
- All had negative lab screen
Testing & Medical Clearance

Janiak and Atteberry  JEM, 2012;43: 866-870

- Retrospective study, 502 consecutive admissions to Psychiatry
- All underwent blood/urine screen incl tox, BHCG, TSH, T4, Folate
- Only 1 had lab tests that changed management
  - 46 yo. Bipolar , hypertension, chf, crf obesity, Multiple cardiac meds/diuretics, dig
  - Tachycardia and febrile
  - Elevated AG, CR, hypo k
Limitations

• All retrospective
• No study has looked at all patients presenting with psychiatric symptoms (may have been admitted to medical floor)
• Needs prospective trial enrolling all patients in the ED on presentation prior to final diagnosis and discharge
Laboratory testing: Recommendations

- Lab screening may be warranted in high risk patients:
  - Substance abuse
  - Homeless
  - Elderly
  - Previous history of cancer, HIV, significant medical conditions
  - No previous known psych Hx?
  - Abnormal physical findings/Vitals

- CBC, Lytes, CR, Glucose, ASA, Acet, LFTs/INR, ASA/Acet, beta, Osmol, ETOH ?, anion gap,
Laboratory testing: Recommendations

Lab evaluation of all patients prior to psych referral is time consuming, expensive and unnecessary (low yield)

Use medical history, prior psychiatric diagnoses and physical examination to guide testing
Do you really need that Drug Screen

- Developed for work place management and contractual patients
- Only tells that the drugs have been taken in the past
- No correlation to presence and clinical findings
- Labels our patients
- Will point you in the wrong direction!!!
- Liar, Liar Pants on Fire is not an acceptable diag
UTOX

• Routine urine toxicologic screens in alert, awake, cooperative patients do not affect ED management

• Urine toxicologic screens for the use of the receiving psychiatric facility or service should not delay patient evaluation or transfer.
Critical Issue

• Does an elevated alcohol level preclude the initiation of a psychiatric evaluation in alert, cooperative patients with normal vital signs and a noncontributory history and physical examination?
Alcohol

• The patient’s **cognitive abilities, rather than a specific blood alcohol level, should be the basis on which clinicians begin the psychiatric assessment.**

• Needs appropriate cognition, normal vital signs, and a noncontributory history and physical examination

• Consider using a period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves
To CT or not CT

• Should brain imaging be obtained acutely:
  – Patients with new onset psychosis without focal neurological deficit
  – Intoxicated patients
New Onset Psychosis

• CT of the brain has historically been “an important part” of the evaluation
• Mass lesions and psychiatric conditions
  – Can present with psychosis, delirium, dementia, encephalopathy
CT

- 7 studies CT and MRI first episode of psychosis
- Rates of abnormal findings varies 3%-66.1%
- Influenced management or altered diagnosis 0-5%
- Can be incidental or unrelated
- No difference in positive findings compared to control groups (11.1% vs 11.8%); Summer et al How frequent are radiological abnormalities in patients with psychosis? A review of 1379 MRI scans. Schizophr Bull 2014
- No good studies
- All retrospective and subject to bias.
Confounders

• We do not have an accurate rate of abnormal neurological findings based on the current literature.

• Underestimate
  – Poor retrospective studies. May not have included patients who received final alternative diagnosis.

• Overestimate
  – poor neurological examination cooperation; Lower threshold to CT. (may have focal
Recommendations

• Use individual assessment of risk to guide CT in the ED for patients with new onset of psychosis without focal neurological deficit.

• Consider history
  – Malignancy, HIV, drug use, trauma, Vitals

• Not everyone needs a CT
Altered Mental Status and ETOH

Exemplary patient experiences, always.
Altered Mental Status and ETOH

• Clinical presentation:
  – ICH: confusion, memory impairment, loss of consciousness, headache, dizziness, nausea/vomiting, delayed verbal expression, slurred or incoherent speech, motor incoordination
  – Intoxication: confusion, memory impairment, loss of consciousness, headache, dizziness, nausea/vomiting, delayed verbal expression, slurred or incoherent speech, motor incoordination
Altered Mental Status and ETOH

• 50% of patients presenting with traumatic brain injury also present with acute drug or alcohol intoxication

• Signs and symptoms seen in acute ethanol intoxication can confound a diagnosis of ICH

• Decision rules exclude intoxication

• Easily, rapidly and definitively resolved with a CT!

• So let’s CT them all?
CT

- Radiation
- Cost
- Valuable resources (someone waits longer)
- Similar rates of intracranial injury intoxicated vs general population
- Low yield (1.9%)
Delayed CT

• Defer CT:
  – Low clinical suspicion of intracranial injury
  – Scan only if failure to show clinical improvement
  – Spares radiation, cost, ED resources

• Risk
  – Delay diagnosis and treatment
Delayed CT

  - 5943 patients
  - 7.8% received a CT; rest observed clinically
  - 0-3 hours
    - 0 patients scanned in less than three hours had significant intracranial finding
  - >3 hours
    - 1 patient had a finding that required non emergent neurosurgical intervention
- Deferred CT while monitoring mental status appears to be safe.
- Issues- Retrospective; lack of follow up
Recommendations

• Not all Intoxicated patients with altered mental status need a CT
• Consider the circumstances and Physical exam
• Consider delayed CT
Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department

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Approved by the ACEP Board of Directors September 23, 2004
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Back to our Cases

- 56 year old male;
- Handful of Extended Release Ca Channel Blocker
- Needs monitoring for up to 24 hours

- 77 year old
- Cancer Red Flag
- CT Shows Multiple cerebral mets

- 21 year old male
- Paranoid Schizophrenia
- No work up necessary
Final recommendation

• People need a thought process more than they need a test
Patient Care Reinvented.
Exemplary patient experiences, always.