Common Psychiatric Disorders at the End of Life

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My Background

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- Internal Medicine & Psychiatry board certified
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Presentation Outline

1. Review common psychiatric disorders encountered at end-of-life
2. Pharmacologic treatment
3. Non-pharmacologic approaches

Common Psychiatric Disorders

Delirium

Anxiety

Depression

Borderline Personality Disorder

Example Case #1

Mr. Jones is a 93 yo man with dementia who has been on hospice at home for a few months. His family asked that he be transferred to the hospice house because “we just can’t deal with him anymore”.

After arrival to the inpatient unit, you quickly notice that the patient is very agitated and repeatedly tries to get out of bed. He is pulling at his sheets, gown, and is mumbling incoherently. He also gets combative with personal care. He tends to get worse around evening shift change, and will sometimes sleep for a few hours at night.

Delirium

Defined as an acute change in level of consciousness

Two main types: Hyperactive and Hypoactive

Poor prognostic indicator

Signs/Symptoms

- Hyperactive:
  - Pulling at gown
  - Picking at sheets
  - “Sleep all day, party all night”
  - Responding to unseen others
- Hypoactive:
  - Staring spells
  - Appears scared

Causes of Delirium

Always look for reversible causes!

- Pain
- Constipation
- Urinary tract infection/retention
- Electrolyte abnormalities
- Medications

May be due to terminal illness

- Dementia
- Sepsis
- Cancer
- Hypoxia
- Hepatic encephalopathy

Delirium Treatment

Haldol is the standard of care

- Can be given PO/SL/IM/IV/SQ
- Best when scheduled

Risperidone, quetiapine, olanzapine are additional options

- Best for patients with Parkinson's and Lewy Body dementia

Chlorpromazine reserved for severe agitation

Avoid benzodiazepines in delirious patients

- May have paradoxical effect due to mechanism of action
- Can help if patient has anxiety component to delirium

Antipsychotics

Generic	Brand	Dosage Range	Sedation	EPS	ACH effects	Equivalence
Chlorpromazine	**Thorazine**	**50-1500mg**	**High**	**++**	**++++**	**100mg**
Quetiapine	Seroquel	100-750mg	High	+	+	50mg
Haloperidol	**Haldol**	**2-40mg**	**Low**	**+++++**	**+**	**2mg**
Olanzapine	**Zyprexa**	**5-20mg**	**Mid**	**+**	**+**	**2mg**
Risperidone	Risperdal	2-10mg	Low	+	+	2mg
Ziprasidone	Geodon	60-160mg	Low	+	++	10mg
Aripiprazole	Abilify	15-30mg	Low	+	+	2mg

JAMA Internal Medicine | Original Investigation

Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative Care
A Randomized Clinical Trial

Meera R. Agar, PhD; Peter G. Lawlor, MB; Stephen Quinn, PhD; Brian Draper, MD; Gideon A. Caplan, MBBS; Debra Rowett, BPharm; Christine Sanderson, MPH; Janet Hardy, MD; Brian Le, MBBS; Simon Eckermann, PhD; Nicola McCaffrey, PhD; Linda Devilee, MBus; Belinda Fazekas, BN; Mark Hill, PhD; David C Currow, PhD

Effect of Lorazepam With Haloperidol vs Haloperidol Alone on Agitated Delirium in Patients With Advanced Cancer Receiving Palliative Care
A Randomized Clinical Trial

David Hui, MD, MSc[1]; Susan Frisbee-Hume, MS[1]; Annie Wilson, MSN[1]; et al

» Author Affiliations | Article Information

JAMA. 2017;318(11):1047-1056. doi:10.1001/jama.2017.11468

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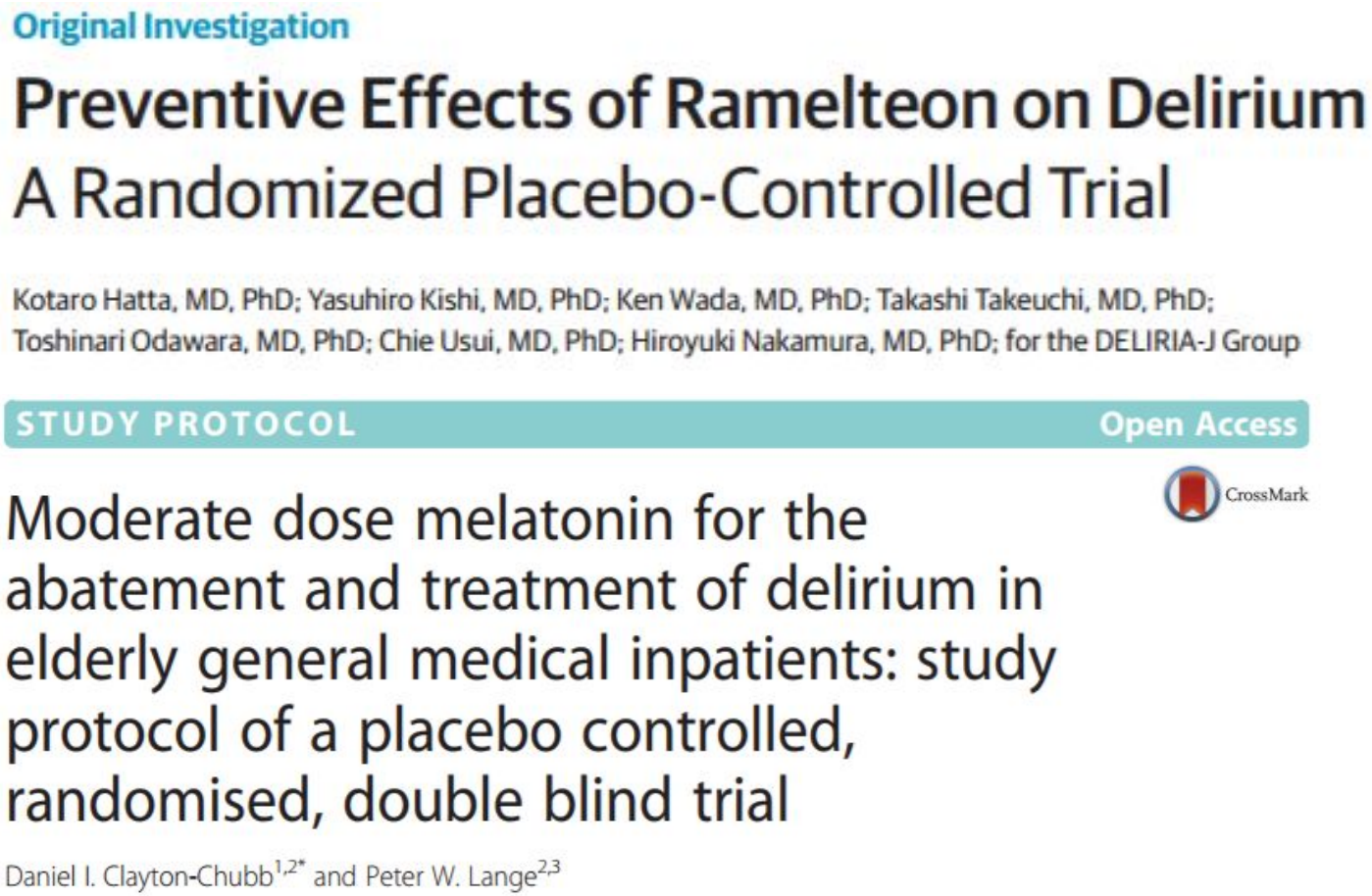

Original Investigation

Preventive Effects of Ramelteon on Delirium
A Randomized Placebo-Controlled Trial

Kotaro Hatta, MD, PhD; Yasuhiro Kishi, MD, PhD; Ken Wada, MD, PhD; Takashi Takeuchi, MD, PhD; Toshinari Odawara, MD, PhD; Chie Usui, MD, PhD; Hiroyuki Nakamura, MD, PhD; for the DELIRIA-J Group

STUDY PROTOCOL Open Access

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Moderate dose melatonin for the abatement and treatment of delirium in elderly general medical inpatients: study protocol of a placebo controlled, randomised, double blind trial

Daniel I. Clayton-Chubb[1,2*] and Peter W. Lange[2,3]

Stay Tuned…

Psychosomatics 2015:56:615–625

Review Article

Valproic Acid for Treatment of Hyperactive or Mixed Delirium: Rationale and Literature Review

Yelizaveta Sher, M.D., Anne Catherine Miller Cramer, M.D., Andrea Ament, M.D., Sermsak Lolak, M.D., José R. Maldonado, M.D.

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Valproic Acid for Treatment of Hyperactive or Mixed Delirium in ICU

Non-pharmacologic Treatment of Delirium

Orientation techniques
- Pictures of family in room
- Visits from family
- Visits from pets
- Familiar music
- Blankets and clothes from home
- Clock in room

Sleep hygiene
- Lights on during day, off at night

Monitor stimulation
- Soothing television shows

Example Case #2

Ms. Smith is an 83 yo woman with severe COPD and pulmonary hypertension. She was discharged home with hospice after her oxygen and pulmonary medications were optimized.

One morning Ms. Smith becomes acutely dyspneic and starts to panic. You are asked to visit the patient in her home. She states that she cannot catch her breath and states that she feels like she is about to die. Her family becomes anxious and states “you have to do something! We were told hospice would keep her comfortable! If you aren’t going to do anything we are going to call 911!”

Anxiety

Occurs frequently in dying patients, especially patients with CHF and COPD

- Fear of suffocating to death

Often related to dying process

- Will I be in pain?
- Will my family be okay?
- Where will I go after I die?

Signs/symptoms include:

- Sweating, palpitations, chest pain, difficulty breathing, tremor, nausea, abdominal pain, sense of impending doom, chest pain, “out of body experience”

May escalate to panic attack

Treatment of Anxiety

Talk to patients about their anxiety and what they are worried about

- Ask how they have coped with difficult situations in the past
- Get help from social work, spiritual care, music therapy, massage therapy
- Talk to patient about fears of symptoms not being controlled at the end of life

Treatment of Anxiety

May need treatment with SSRI/SNRI, tricyclic antidepressant, or benzodiazepine depending on prognosis

- SSRI/SNRI take weeks to reach full effect
- TCA have anticholinergic effects, risk with overdose
- Benzodiazepines work quickly, may develop tolerance

Benzodiazepines

Generic	Brand	Dosage Range	Rapidity of Absorption	Half-life (hours)	Equivalence
Alprazolam	Xanax	0.25-4mg	+++	6-20	0.5-1mg
Lorazepam	**Ativan**	**2-6mg**	**+++**	**10-15**	**1-2mg**
Diazepam	Valium	5-40mg	+++++	20-50	5-10mg
Temazepam	Restoril	15-30mg	+++++	10-20	10-20mg
Clonazepam	**Klonopin**	**0.5-4mg**	**+**	**80**	**0.25-0.5mg**

Example Case #3

Ms. Smith is a 49 yo woman with metastatic breast cancer. She was admitted to home hospice for pain and symptom management.

Although Ms. Smith's pain has improved, the staff has noted on their visits that she appears withdrawn and does not engage with her children and husband. She states that she feels hopeless about the future and "I wish I would just die already". She also endorses poor sleep and a poor appetite. She states that she stays up all night worried about the future and what will happen to her family when she dies.

Depression

Difficult to assess at the end of life

Symptoms frequently overlap with symptoms of serious illness

- Low mood
- Decreased energy
- Decreased appetite
- Sleep disturbance

Distinguished by psychological symptoms

- Feelings of hopelessness and/or worthlessness
- Social withdrawal
- Suicidal ideation

Causes of Depression

Terminal illness

Medications
- Steroids
- Opioids
- Benzodiazepines

Illnesses misdiagnosed as depression
- Hypoactive delirium
- Anticipatory grief

Treatment of Depression

Talk to the patient

- Ask if they are feeling depressed
- Ask if they are having thoughts of suicide or wanting to hurt themselves
  - If yes follow your organization's policy

Offer the patient non-pharmacologic therapies

- Music, pets, social work, spiritual care visits

Treatment of Depression

If patient's prognosis is weeks, SSRI/SNRI may be prescribed

- Selection of SSRI/SNRI based on targeting specific symptoms and minimizing side effects

If patient's prognosis is days-weeks, then a stimulant may be ordered

- Example: methylphenidate 5mg po BID

Antidepressants

Class	Drug (Brand)	Indication	Dosing Range	Sedation	ACH	Insomnia	Orthostasis	GI	Weight gain
SSRI	**Citalopram (Celexa)**	**MDD**	**20-40mg**	**0**	**0**	**+**	**+**	**+**	**+**
	Escitalopram (Lexapro)	MDD, GAD	10-20mg	0	0	+	+	+	+
	Fluoxetine (Prozac)	MDD, OCD, Panic	10-80mg	0	0	++	+	+	+
	Paroxetine (Paxil)	MDD, OCD, GAD, PTSD	10-50mg	+	+	+	++	+	++
	Sertraline (Zoloft)	**MDD, Panic, PTSD**	**25-200mg**	**0**	**0**	**++**	**+**	**++**	**+**
SNRI	Duloxetine (Cymbalta)	MDD, Fibromyalgia GAD	20-60mg	0	0	+	0	++	+
	Venlafaxine (Effexor)	**MDD, GAD, Panic**	**37.5-225mg**	**0**	**+**	**+**	**0**	**++**	**+**

Adapted with permission from Kristen Clark, MD

Other medications

Class	Drug (Brand)	Indication	Dosing Range	Sedation	ACH	Insomnia	Orthostasis	GI	Weight Gain
Serotonin Modulator	Trazodone (Desyrel)	MDD	50-300mg	++++	+	0	++	++	0
Atypical	Bupropion (Wellbutrin)	MDD	100-150mg TID (IR) 150-200mg BID (SR) 150-450mg (XR)	0	0	++	0	+	0
	Mirtazepine (Remeron)	**MDD**	**7.5-45mg**	**++++**	**+**	**0**	**0**	**0**	**++++**

Adapted with permission from Kristen Clark, MD

Example Case #4

Mr. Jenkins is a 26 yo man who is a paraplegic from a gunshot wound sustained years ago. He is brought to the inpatient unit for uncontrolled pain, wound care, and caregiver breakdown.

Although Mr. Jenkins was admitted for acute care, he often refuses to take his medications or to allow the nurses to do his dressing changes. He presses his call bell button every 15 minutes. He has also been belligerent with staff members to the point they have threatened to quit. He tells you “you’re the best *fill in the blank* and the only one who really understands me”. Your social worker has attempted to call his family, only to have his calls not returned.

Borderline Personality Disorder

Characterized by emotional dysregulation

- "I hate you, don't leave me!"
- Splitting behaviors
- Burned bridges with friends and family

Elicit strong emotions from staff

- Increased time discussing patient on daily rounds, IDG
- Time intensive patients
  - Frequent visits
  - Easily angered when requests are not fulfilled
- Staff feel urge to help, but recognize they are being manipulated by patient

Borderline Personality Management

There is NO PILL to treat personality disorder

Boundaries work best for patient AND staff

- Set schedule for patient and stick to it
- Minimize number of providers involved in care to reduce risk of splitting
- Communicate plan of care to have a unified front

Validate and pivot

- Acknowledge that patient has true disease and physical and emotional symptoms
- Focus on current problem and address directly
- Redirect their behavior to things they can change and have control over

Summary

Psychiatric disorders are common at the end of life

Selection of pharmacologic treatment is influenced by prognosis

Non-pharmacologic treatment should always be considered

Patients with borderline personality disorder do best with a structured plan of care

Questions?

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