

Diagnosing and managing psychosis in primary care

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How should psychosis be diagnosed?



PSYCHOSIS IS BROADLY DEFINED AS THE PRESENCE OF DELUSIONS AND HALLUCINATIONS

and can be organic or functional in nature. The former is secondary to an underlying medical condition, such as delirium or dementia, the latter to a psychiatric disorder, such as schizophrenia or bipolar disorder.

Functional psychosis is relatively common in the general population, with epidemiological studies estimating its prevalence to be approximately 0.2-0.7%.¹ However, this

What are the common causes and triggers?

figure varies depending on a number of factors including the definition used and the age group. By some definitions up to a third of people have experienced psychotic symptoms in their lifetime. Prevalence in the elderly increases to 4.8%² and is even higher in nursing home populations.^{3,4}

The identification and treatment of psychosis is important as it is associated with a 10% lifetime risk of

What are the management options?

suicide⁵ and significant social exclusion.⁶ Delays in recognition can ultimately lead to a worse prognosis.⁷

DIAGNOSIS

Psychosis can be recognised by:

- taking a thorough history
- examining the patient's mental state
- obtaining a collateral history

First episode psychosis is a rare presentation in general practice, at least in younger patients, which can be difficult to identify initially. Prodromal symptoms are often nonspecific in nature, appear gradually over a



Box 1

Symptoms of psychosis

Symptoms	Schizophrenia	Bipolar disorder	Organic psychosis (delirium/dementia)
Hallucinations			
Auditory	■■■	■■	■■
Visual	■	■	■■■
Delusions			
Persecutory	■■■	■	■■■
Grandiose	■	■■■	■
Reference	■■■	■■	■
Passivity			
Thought insertion/withdrawal	■■■	■■	■
Thought broadcast	■■■	■■	■
■■■ Strong indicator ■■ Moderate indicator ■ Some indication			

Box 2

Psychiatric differential diagnosis

Non-affective psychosis	Affective psychosis	Organic psychosis	Diagnoses that mimic psychosis
Schizophrenia	Bipolar affective disorder	Dementia	Autistic spectrum disorder
Delusional disorder	Psychotic depression	Drug-induced psychosis	Personality disorder (schizotypal, paranoid or borderline)
Schizoaffective disorder		Other medical causes, delirium	OCD

period of months and can be difficult to distinguish from depression or problems of normal adolescence. In those patients with an established psychiatric diagnosis, such as schizophrenia, psychosis may be easier to identify, particularly if there is a clearly documented relapse pattern.

History

The history should enable a distinction to be made between bipolar disorder, schizophrenia and other causes, although this may not always be possible, as subjective histories can be misleading, and the patient may be too unwell to give an accurate account.

Early symptoms often include low mood, declining educational or occupational functioning, poor motivation, changes in sleep, perceptual changes, suspiciousness and a mistrust of others. Patients presenting with more overt symptoms such as paranoid or persecutory delusions (see box 1, above) or hallucinations are more easily identifiable but are less likely to present directly to primary care.

Mental state examination

The patient's appearance, e.g. unkempt or inappropriately attired, may reflect their predominant mental state. While motor symptoms such as

catatonia are rare there may be signs of agitation, hostility or distractibility. Speech may be disorganised and difficult to follow or there may be evidence of decreased speech. Mood may be depressed or elated or may be labile i.e. change rapidly.

'Insight varies during the course of a psychotic illness but should be explored as it has implications for management'

Patients may describe abnormal thoughts - overvalued ideas, delusions - and these should be explored. Enquiry into thoughts of suicide should be routine. Disturbances of thought such as insertion or withdrawal may be present along with perceptual abnormalities i.e. illusions or hallucinations.

Cognitive function may be impaired but gross abnormalities in younger people suggest an underlying organic cause or learning difficulties. Insight

varies during the course of a psychotic illness but should be explored as it has implications for management.

Third party history

Where possible another perspective on the patient's illness can be very useful particularly in cases where the patient is experiencing a first psychotic episode. Family or friends may have noticed unusual behaviour such as responding to unseen or unheard stimuli and may be able to identify prodromal features.

COMMON CAUSES AND TRIGGERS

Psychosis is a syndrome rather than a diagnosis and has multiple causes, which may be functional or organic (see box 2, left).

The functional causes are broadly subdivided into affective i.e. associated with a severe mood disorder - both depression and mania, and non-affective psychoses e.g. schizophrenia.

In affective psychosis, the mood disorder usually predates the onset of the psychotic symptoms. If the patient presents with severe mood symptoms and psychosis concurrently, a diagnosis of schizoaffective disorder is used.

Almost all patients with schizophrenia will have psychotic symptoms as part of their illness. This compares with 50% of those with bipolar disorder⁸ and 15% of those with depression in community settings.⁹

Common triggers for functional psychosis include:

- major life events
- childbirth
- poor concordance with prescribed medication in those who have already received treatment

In the elderly, depression is the second most common cause of psychosis accounting for 20% of those presenting with symptoms.¹⁰ The most common cause of psychosis in the elderly is dementia and it occurs frequently in all forms, although is almost pathognomonic in dementia with Lewy bodies.^{1,12}

There is a minor area of overlap between functional psychosis and organic psychosis.

Substance misuse can not only trigger a functional psychosis, e.g. schizophrenia triggered by cannabis, but also cause a transient organic psychotic illness in its own right such as a 'trip' on hallucinogenic drugs, alcoholic psychosis or alcohol withdrawal (delirium tremens).

Postnatal psychosis, as opposed to postnatal depression, occasionally presents with clouding of consciousness.

INITIAL MANAGEMENT

Although the presence of psychotic symptoms usually necessitates referral to psychiatric services, there is a role for primary care in initial management especially where there is some uncertainty as to the presence of an underlying organic cause.

Occasionally patients can be unpredictable and present a risk to themselves or staff and it is important to ensure that the situation is safe before proceeding with more

detailed examination.

In extreme circumstances it may be necessary to contact the police or request a Mental Health Act assessment. In the majority of cases, however, referral to local psychiatric services by the usual route will suffice. All patients presenting with a first episode of psychosis for which no organic cause can be found should be referred to the local early intervention service.¹³

If a patient is acutely disturbed, but poses no immediate risk, rapid tranquilisation in the form of oral lorazepam may be appropriate (see box 3, below). This will avoid

masking symptoms if an opportunity for early and definite diagnosis by a specialist is available, but will provide immediate relief of agitation and anxiety. Commencement of antipsychotic medication is best done in consultation with psychiatric services for a patient presenting with a first episode.

For patients, who present with a relapse of a known illness, recommencing medication may be more straightforward. Psychotic symptoms in elderly and demented patients require special consideration (see box 4, below).

REFERRAL

All patients presenting with a first episode of psychosis for which no organic cause can be found should be referred to the local early intervention service.¹³ In the acute phase, crisis resolution and home treatment teams should be used to support patients and their carers. Acute day hospitals may also provide an alternative to admission.

In patients with a known diagnosis referral should be considered if there is:

- poor response to treatment
- non-adherence to medication
- intolerable side effects from medication
- comorbid substance misuse
- risk to self or others

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Box 3

Initial management

- Rule out organic causes and perform baseline tests for commencing antipsychotics:
 - physical examination including full neurological examination
 - urine drug screen
 - U&Es, LFTs, FBC, glucose, lipid profile and prolactin
 - brain scan may rarely reveal underlying lesion
 - ECG for those with cardiac disease/hypertension
- Assessment of cognitive function in the elderly
- Offer an oral antipsychotic
- Refer to psychiatric services

If very disturbed consider:

- Rapid tranquilisation
- Referral for a Mental Health Act assessment
- Calling the police

Box 4

Evidence-based treatment options

Condition	Source	Treatment
Behavioural disturbance	NICE (2005) ¹⁴	● Consider oral lorazepam and an oral antipsychotic
Schizophrenia	NICE (2009) ¹³	● Offer oral antipsychotic, chosen with the patient by reviewing the side effect profiles of available drugs ● A trial of antipsychotic at a therapeutic dose is 4-6 weeks ● If the patient does not respond to 2 different antipsychotics (including a second-generation antipsychotic) clozapine should be considered
Mania	BAP (2009) ¹⁵	● Atypical antipsychotics or valproate for severe mania (avoid valproate in women of childbearing age) ● Lithium or carbamazepine for milder mania ● Adjunctive benzodiazepines for insomnia ● Taper and discontinue antidepressants
Psychotic depression	NICE (2009) ^{16,17}	● Treat with an antidepressant first ● Consider addition of antipsychotic to antidepressant ● Consider ECT for severe, life-threatening depression and when a rapid response is required, or when other treatments have failed
Alzheimer-type dementia	NICE (2011) ¹⁸	● Optimise social care of the patient and consider treatment with acetylcholinesterase inhibitors ● Low-dose trazodone can be considered ● Consider antipsychotics only when severe non-cognitive symptoms present ● Risks and benefits must be discussed and cardiovascular risk factors minimised

key points

SELECTED BY

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Psychosis is broadly defined as the presence of delusions and hallucinations. It can be organic or functional. The former is secondary to an underlying medical condition, such as delirium or dementia, the latter to a psychiatric disorder, such as schizophrenia or bipolar disorder. The identification and treatment of psychosis is vital as it is associated with a 10% lifetime risk of suicide and significant social exclusion.

Psychosis can be recognised by taking a thorough history, examining the patient's mental state and obtaining a collateral history. The history should enable a distinction to be made between bipolar disorder, schizophrenia and other causes, although this is not always possible. Early symptoms often include low mood, declining educational or occupational functioning, poor motivation, changes in sleep, perceptual changes, suspiciousness and mistrust.

The patient's appearance, e.g. unkempt or inappropriately attired, may reflect their predominant mental state. There may be signs of agitation, hostility or distractibility. Speech may be disorganised and difficult to follow or there may be evidence of decreased speech. Mood may be depressed or elated or change rapidly. Patients may describe abnormal thoughts and enquiry into thoughts of suicide should be routine. Disturbances of thought such as insertion or withdrawal may be present along with perceptual abnormalities i.e. illusions, hallucinations. Insight varies during the course of a psychotic illness but should be explored as it has implications for management.

Psychosis is a syndrome rather than a diagnosis and has multiple causes, which may be functional or organic. The functional causes are broadly sub-divided into affective i.e. associated with a severe mood disorder and non-affective psychoses e.g. schizophrenia. If the patient presents with severe mood symptoms and psychosis concurrently, a diagnosis of schizoaffective disorder is used. In the elderly, depression is the second most common cause of psychosis accounting for 20% of those presenting with symptoms. Substance misuse can not only trigger a functional psychosis, but can also cause a transient organic psychotic illness in its own right.

Although the presence of psychotic symptoms usually necessitates referral to psychiatric services, there is a role for primary care in initial management especially where there is uncertainty about an underlying organic cause. In extreme circumstances it may be necessary to contact the police or request a Mental Health Act assessment. Rapid tranquilisation with oral lorazepam may be appropriate. Antipsychotic medication is best started in consultation with psychiatric services for a first episode.

All patients presenting with first episode psychosis for which no organic cause can be found should be referred to the local early intervention service. In patients with a known diagnosis consider referral if there is: poor response or non-adherence to treatment; intolerable side effects; comorbid substance misuse; risk to self or others.

TREATMENT

The treatment options depend to a large extent on the underlying cause of the psychosis. In the acute phase treatment with rapid tranquilisation may also be necessary.

Evidence-based treatments recommended by different guidelines are listed in box 4, p 19.

CONCLUSION

Psychosis disrupts family life, is socially embarrassing and potentially dangerous, and can be a complication of many possible underlying diseases. The GP is ideally placed to detect underlying organic causes, treat those that are common and do not need hospitalisation, and make sure that the patient is seen by the appropriate specialist, if necessary.

Psychotic patients tend to pose a challenge to both family and doctor, because concordance cannot be assumed. Good clinical skills are necessary to achieve successful resolution with the appropriate treatment.

Patients with long-lasting psychotic conditions have the further complication that their illness behaviour faced with organic disease is not normal and often requires assertive enquiry and regular follow-up using signs and investigations if necessary, because the spontaneous history given can be misleading and incomplete.

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Useful information

RETHINK

www.rethink.org

SANE

www.sane.org.uk

MDF: The Bipolar Organisation

www.mdf.org.uk

Royal College of Psychiatrists

www.rcpsych.ac.uk

Institute of Psychiatry

www.mentalhealthcare.org.uk

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