Clinical characteristics of the Psychiatric Emergency Room of Ain Shams University Hospital (Early results of an Epidemiological study)

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Abstract This study was conducted to assess the clinical characteristics of cases presented to the Emergency Room (E.R.) at Ain Shams University Hospital in order to highlight the determinants of decision-making within the E.R. It covered a period of 6 months from February to July 1992. Each patient who came to the E.R. during the first 10 days of the month was examined.
The commonest presentation included disturbed behavior, mainly in the form of excitement and aggressive tendencies. The main diagnoses were schizophrenia, conversion disorder, substance use disorder and major depression.
The decision to hospitalize depended mainly upon the diagnosis and the presence of recent violence. Males were more in number and younger in age in admitted cases. Disposition increased with previous psychiatric history, previous history of hospitalisation and the non-availability of senior psychiatrist.

Introduction Emergency psychiatry is considered an important sub-specialty for teaching general psychiatry. Moreover, the urban psychiatric emergency service has become a major point of entry to in-patients treatment for the severely mentally-ill.

For the troubled individual, the decisions made during the emergency room visit determine the choice of a subsequent treatment plan and often influence the course of the probable illness. The potentially dramatic impact of the visit on the patient's life and the expanding role of the psychiatric emergency ward in the delivery of mental health make the process of emergency psychiatric intervention an important service, training and research area (Gerson & Bassuk, 1980).

Mascon et al. (1988) concluded that a simplistic dichotomy to hospitalize or not to hospitalize characterizes the early studies of ER decision-making. Modern psychiatric disposition, by contrast, involves a much wider range of alternatives with varying degrees of restriction (24 hours observation, supervised residential programs and a wide array of out-patient referral possibilities).

The following work will provide a descriptive experience of the E.R. covering a 6 month-period as a trial to highlight the determinants of decision-making within the E.R. This will allow to define the characteristics of patients liable for admission and for out-patient clinic, type of treatment, referral to other specialities and so on.

Subjects And Methods

The setting

The study was conducted at Ain Shams University Hospital in Cairo, Egypt. The Hospital is a general hospital affiliated to a medical school. It covers a catchment area of the east and north of Cairo and the adjacent rural areas. The psychiatric department lies in a new building constructed to act as a mental hospital but within the general hospital serving the purpose of liaison.

The total number of beds is approximatly 75. The emergency room provides daily care, following the time of out-patient clinics. So, it works from 3 p.m. to the next morning except on Friday (the official holiday) where it covers the 24 hours.

The E.R. includes a team formed of a psychiatrist, a nurse and occasionally a social worker or a psychologist. The psychiatrist is a resident able to evaluate and treat all psychiatric emergencies. A senior psychiatrist is always available and is contacted mainly for difficult cases.

Methods The presented study covered a period of 6 months from February to July 1992. Each patient who came to the E.R. during the first 10 days of the month was examined psychologically and physically. History was taken from the patient and his informants. Most cases were accompanied by one or more of their relatives and acquaintances reflecting the degree of social disturbance caused by the disorder on one hand and helping to estimate the degree of social support on the other hand.

The majority of cases came from the middle and low social classes that constituted the main bulk of clients to the hospital.

At the end of the initial meeting with each patient, the clinician filled out a sheet that includes:

(a) Family Variables
Availability of family and peer supports

(b) **Clinical Variables**
Main presenting symptoms
Diagnosis
Type of admission:
voluntary, involuntary
Need for consultation of a senior
Time of examination (Day and Hour)

(C) **Main lines of Management**
Hospitalization or not
Oral or parenta. medications
Prescription fr m outside
Cerebral or ext a-cerebral stimulation
Referral for psychotherapy
Referral to othe r specialities

Results The sample included a total number of 162 cases who visited the E.R. during the study period. They were distributed as 102 males and 60 females as shown in the following table.

Table (1): Distribution of the cases

	Male		Female		Total
	No.	%	No.	%	
Admitted	47	46.08	17	28.33	64
Outpatient	38	37.25	41	68.33	79
Referred	17	16.67	2	3.34	19
Total	**102**		**60**		**162**

The main reasons for emergency visits were: the degree of psychopathology, the lack of an available support network and the history of serious maladjustment.

The main diagnosis included: schizophrenia, conversion disorder, substance use disorder and depressive disorder.

Sixty-four cases (39.51%) were admitted, 93 (57.41%) were advised to follow up as out-patients, while 4 cases (2.47%) were referred to other specialities.

The admission was voluntary in 12 cases and involuntary in 52 cases. The main presenting picture in involuntary admission included excitement, withdrawal symptoms, disturbed behavior, drug intoxication and elated mood.

The age of admission ranged between 17 to 51 years in males and between 17 and 68 years in females.

The main reasons for admission were:

Prominence of symptom along with dangerousness.
Diagnosis especially for those which have a widely accepted therapeutic armamentarium.
Previous history of psychiatric disorder.
Previous history of hospitalization.
The absence of alternative therapeutic approaches.

The main lines of treatment applied in the E.R. included: IV drugs (12%) IM drugs (49%) IV+IM (4%), oral drugs (7%) prescription and follow-up at the patient level (30%), cephalic stimulation (9%), appointment for psychotherapy (27%) and other lines in 7% of cases.

The characteristics of admitted patients and those followed at the out-patient are presented in the following tables.

Table (2): Characteristics of Admitted Patients

Sex	**Females**		**Males**	
No	17		47	
Age	33.29± 15.29		27.57 ± 6.73	
Day	Thu 4	23.5%	Sat 14	29.8%
	Fri 4	23.5%	Thu 8	17.0%
	Wed 3	17.6%	Fri 7	14.9%
	Sat 2	11.8%	Wed 6	12.8%
	Sun 2	11.8%	Sun 5	10.6%
	Mon 1	5.9%	Mon 5	10.6%
	Tue 1	5.9%	Tue 2	4.3%
Time				
Before 10pm	13	76.5%	30	63.8%
After 10pm	4	23.5%	17	36.2%
Presenting symptoms				
Excitement	6	35.3%	7	36.2%
Disturbed behavior	5	29.4%	6	12.8%
Depressive c/o	3	17.6%	-	-
Withdrawal c/o	-	-	14	29.8%
Diagnosis				
Schizophrenia	9	52.9%	8	17.0%
Major depression	4	23.5%	-	-
Mania	2	11.8%	-	-
Substance use	-	-	8	38.3%
Acute psychosis	-	-	8	17.0%

Table (3): Characteristics of Outpatients

Sex	Females		Males	
No	41		38	
Age	28.54 ± 11.65		28.79 ± 12.4	
Day	Fri 10	24.4%	Sat 12	31.6%
	Thu 9	22.0%	Fri 12	31.6%
	Sat 8	19.5%	Wed 9	23.7%
	Thu 7	17.1%	Tue 7	18.4%
	Wed 3	7.3%	Thu 6	15.8%
	Mon 2	4.9%	Mon 4	10.5%
	Sun 2	4.9%	Sun 2	5.3%
Time				
Before 10pm	22	53.7%	36	94.7%
After 10pm	19	46.3%	2	5.3%
Presenting symptoms				
Hysterical c/o	6	14.6%	17	44.7%
Depressive c/o	5	12.2%	-	-
Disturbed behavior	3	7.3%	-	-
Extrapyramidal	-	-	14	36.8%
Somatic complaints	-	-	6	15.8%
Diagnosis				
Conversion	9	22.0%	8	21.1%
Majordepression	4	9.8%	-	-
Schizophrenia	2	4.9%	18	47.4%
Anxiety disorder	-	-	8	21.1%

Discussion Research into the ER decision-making process plays an important part in better understanding and treating patients. The decision to hospitalize, for instance, is a matter of controversy and debate regarding which is more important, diagnosis or symptoms, remains unanswered. Skodal & Karasu (1980), believed that attention should be given to the underlying disorder not to symptoms. Since symptoms even violent or suicidal behavior, could result from many diverse causes only some of which required in-patient treatment.

McNiel et al., (1992) added that many patients who had displayed overt aggression before or after coming to the psychiatric emergency service were not felt to require in-patient psychiatric treatment and were instead referred to alternatives such as out-patient treatment, drug programs and the legal system that hospitalizes the most severely disturbed patient with diagnoses such as schizophrenic and manic disorders for which a widely accepted therapeutic armamentarium existed.

The current study agreed with the McNiel et al; (1992) postulation that the main indication for hospitalization depends upon the diagnosis and the recent violence. Cases needing admission included schizophrenia, major depression, mania and conversion disorders in females. In males, substance use disorder was added to the list.

Along the same line, Aspler et al., (1983) pointed out that acute psychotic episodes, schizophrenia and bipolar affective disorders were related to hospitalization, while patients with personality disorders without psychotic features tended not to be hospitalized.

It is noteworthy to mention that ER diagnosis (in comparison with subsequent ward diagnosis) was accurate only for broad diagnostic categories such as psychosis, depression and alcoholism, but not for more specific subtypes of mental illness such as schizophrenia and bipolar affective disorders.

A significant direct relationship between dangerousness and hospitalization was reported in most of the studies that examined this variable (*Gerson and Bassuk,1980*). This explains why symptoms like excitement, disturbed behavior including suicide and withdrawal manifestations were predominant among the admitted cases especially in involuntary cases, while transitory symptoms like hysterical presentation and side-effect of drugs were more common in the group referred to the out-patient clinics.

Generally speaking, males are younger in admitted cases, a factor that denotes the preference to give a chance of treatment to females at home, for fear of the mental stigma that may affect marriage later on. Also the admission of women usually leads to social handicap of the family that depends largely on her activity. Females are preferably treated in families and not in hospitals. In addition, males are supposed to be more socially active; any disturbance affecting them will be earlier and easier to be detected.

Tischler (1966) found that significantly greater proportions of patients were hospitalized as age increased. Schwartz & Errera (1963) reported that hospitalization rates increased with age only for patients with diagnosis of alcoholism or organic brain syndrome. However, the current study is paralleling more recent studies (*Meyerson et al. 1979; Aspler Bassuk, 1983*) that concluded that age was not significantly related to disposition.

Most of the research, including the current one, showed that men were significantly more likely to be referred for in-patient treatment. It seems that men, do not use E.R. services except for serious conditions. Contrary to other studies (*Meyerson et al.,1979, Aspler, 1983*), we found that men used psychiatric emergency services more than women. Nevertheless, women were more likely to be referred to an overnight hospital for

observation than to be directly hospitalized (*Ianzito et al.,1978*).

Our study confirmed the findings that previous psychiatric history (*Baxter et al., 1968; Asyler 1983*) and previous history of hospitalization (*Mendel & Rapport, 1969*) were important determinants of disposition.

The presence of a senior psychiatrist limited the rates of admission. The same was described by Mendel & Rapport (1969). Decision makers who had less than 6 months experience hospitalized a significantly larger number of patients then did the more experienced clinicians.

Inexperienced clinicians lack the confidence to make less restrictive dispositions and choose hospitalization as a means of limiting decision-making responsibility.

Also, when residents were introduced involving more exposure to alternative treatment options, there was a dramatic drop in admission rates (*Meyerson et al.,1979*).

Lastly, the therapist's positive emotional response to the patient is an influential variable. Tichler (1966) observed that likeable and interesting patients whom the examining residents would choose to follow up were more likely to be referred for out-patient services. On the other hand, Jones et al., (1965) found that the therapeutic rapport per se was non significant. Recently, Aspler & Bassuk (1983) accepted that the factors of therapist comfort and rapport between the therapist and the patient were significant in discriminating hospitalized from non-hospitalized patients.

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الخصائص الإكلينيكية للحالات المترددة على قسم استقبال الأمراض النفسية فى مستشفى جامعة عين شمس (نتائج أولية لدراسة وبائية)

أجرى هذا البحث لدراسة الخصائص الاكلينيكية للحالات التى تتردد على قسم استقبال الأمراض النفسية بمستشفى جامعة عين شمس فى الفترة مابين فبراير و يوليو سنة ١٩٩٢ حيث تمت دراسة الحالات المترددة على قسم الإستقبال فى الأيام العشرة الأولى من كل شهر خلال هذه الفتة. والهدف من هذه الدراسة هو القاء مزيد من الضوء على العوامل التى تؤثر على اتخاذ القرار فى قسم الاستقبال.

ولقد وجد أن أكثر الأعراض شيوعاً فى هذه الحالات هى اضطراب السلوك خاصة فى صورة الهياج أو الميول العدوانيه. وكانت أكثر التشخيصات المستخدمة هى الفصام، الاضطرابات التحولية، سوء استخدام العقاقير والاضطرابات الوجدانيه الاكتئابيه.

ولقد لوحظ أن قرار إدخال المرضى المستشفى يعتمد اساساً على التشخيص الاكلينيكى وعلى وجود عنف فى الفترة القريبة وكانت نسبه الذكور أكثر من الإناث فى الحالات التى تم حجزها بالمستشفى وأيضاً اصغر فى العمر من الإناث.

وكانت أكثر العوامل التى تزيد من معدل حجز مرضى الاستقبال بالمستشفى هى وجود تاريخ سسابق للاضطراب النفسى أو الحجز بالمستشفى مع عدم توافر طبيب نفسى أكثر خبرة مع طبيب الاستقبال.

Migraine in Assiut
A clinical and electroencephalographic study

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Abstract

The current study was carried out on 100 migrainous patients of different ages and sex being selected from the neuro OPD, Assiut University Hospital, with the aim of evaluating some clinical aspects and study the EEG patterns of those patients being a sector of Upper Egyptian migrainers.

The study included 87 patients with common migraine and 13 patients with classic migraine with the differentiation being done according to the Headache Classification Committee of the International Headache Society (1988). The clinical results showed predominance of females (73%) with the commonest age of onset being between 10 to 20 years.

Some important aspects which help in differentiating migraine from other types of headache were discussed including: headache characters, associated clinical symptoms, different precipitating factors and recovery phase phenomena. EEG was found to be abnormal in 59% of patients. The abnormalities encountered were varied including: mild to moderate diffuse theta slowing, generalized bursts of theta and sharp waves seen under the effect of hyperventilation and focal sharp waves mainly in the occipital area, sometimes associated with focal slowing.

Correlation between EEG results and some clinical aspects including type of migraine, age, sex, duration and frequency of the attacks failed to give any significant results. Although the encountered abnormalities are not specific and could be shared by other dysrythmic syndromes, however, they can still help in differentiating migraine from other types of headache especially the high reactivity of patients to hyperventilation and the presence of some epileptogenic features whether generalized or focal.

Introduction One of the most common types of vascular headache is migraine. It has been estimated that migraine is found in 8 to 12% of all the patients seen in general practice; it can be in a child of 5 years and in adults in the sixties (*Ryan, 1978*). It is a disease of the civilized; it is more common in women than in men, but in children before puberty; there are no sex differences (*Bille, 1989*).

Sillanpaa (1983) found that the migraine prevalence at the age of 7 years was 1.4% increasing to 5.3% at 15 years. In the study carried out by Walter and David (1990), they found that the highest incidence rate for migraine with aura among males occurred between 8 to 10 years of age and among females at 13 years of age. For the migraine without aura, the highest incidence rate among males occurred between 7 and 9 years and among females at age of 13 years. The classification of migraine done by the Headache Classification Committee of the International Headache Society (1988) included the following sub-types:

1. Migraine without aura;
2. Migraine with aura including:
   a) migraine with typical aura
   b) migraine with prolonged aura
   c) familial hemiplegic migraine
   d) basilar migraine
   e) migraine aura without headache
   f) migraine with acute onset aura
3. ophthalmologic migraine
4. Retinal migraine
5. Childhood periodic syndromes that may be precursors or associated with migraine including:
   a) benign paroxysmal vertigo of childhood
   b) alternating hemiplegia of childhood.
6. Complication of migraine including:
   a) status migrainous
   b) migrainous infarction
7. Migrainous disorder not fulfilling the above criteria.

The main clinical features of migraine are headache, nausea and vomiting, and in case of classic migraine, an aura. Before the attack, prodromal symptoms may occur and after the attack is over, there may be a recovery phase.

The prodromal symptoms according to Blau (1984) consist mainly of altered behavior and mood changes, food craving particularly for carbohydrate, yawing, altered bowel frequency, feeling unduly tired or inappropriately cold.

Headache is the most characteristic symptom of migraine; it lasts for a few hours to 48 hours and occasionally longer if untreated (*Wilkinson, 1989*). The pain usually begins on one side, but it may be bilateral,