A/P Template for Patients Awaiting Inpatient Psych Placement

Plan:

 # Suicidal ideation

- Suicide precautions
- Utox and EKG
- Psych following, dispo to inpt psych facility when bed available
- Psych recs: 1:1 sitter w/i arm's reach, safety tray, room restriction, observed bathroom/shower use.

Agitation plan: (**update when formal psych recs available**)

- Mild: Verbal redirection and Ativan PO 0.5 mg PRN aggressive or dangerous behavior
- Moderate: Risperidone 0.25mg PO (may give 0.125mg after 30 min) OR haldol 2mg PO (may give 1mg dose after 30min)
- Severe: Haldol 2mg IM OR Olanzapine 2.5mg IM

 # Nutrition

- POAL

 # Dispo: pending placement to inpatient psych

Depression Medications

Serotonin Reuptake Inhibitors (SSRIs)

MOA	**5-HT-specific reuptake inhibitor**
Use	**Depression, Gen. anxiety disorder, Panic disorder, OCD, bulimia, social anxiety disorder, PTSD, premature ejaculation, premenstrual dysphoric disorder** ** It normally takes **4–8 weeks** for antidepressants to have full effect.
EX	**Fluoxetine** (Prozac)**, Paroxetine (**Paxil)**, Sertraline (**Zoloft)**, Citalopram** (Celexa)**, Escitalopram** (**Fl**ashbacks **par**alyze **se**nior **cit**izens) • **Paroxetine** → short half-life → **discontinuation syndrome** (flu-like sxs, dizzy, diaphoretic, "electric shock," + depression) • **Fluoxetine** → long half-life → no need to taper/good for poor compliance, **P450 inhibitor,** can ↑antipsychotics → ↑SEs • **Citalopram/Escitalopram** → Dose dependent QTc prolongation (usually minimal)
SE's	GI distress**, SIADH, sexual dysfunction (anorgasmia,↓libido), insomnia, anorexia, ↑suicidality in adolescents , QTc prolongation, mildly ↓Na (i.e. 128)** **Serotonin syndrome:** 2 meds that ↑ serotonin (**MAOis, SNRIs, TCAs, Opoids, Tramadol, Linezolid**) → ↑↑serotonin in brain. (ex: triptan/SSRIs) **3 A's**: neuromuscular **A**ctivity (clonus, hyperreflexia, hypertonia, tremor, seizure), **A**utonomic stim (hyperthermia, diaphoresis, diarrhea), and **A**gitation. • Tx: **cyproheptadine** (5-HT2 receptor antagonist) or **benzodiazepines**
Notes	No paxil/paroxetine in kids,

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

MOA	**Inhibit 5-HT** and **NE reuptake**
Use	**Depression, general anxiety disorder, diabetic neuropathy.** • **Venlafaxine** → also indicated for **social anxiety disorder, panic disorder, PTSD, OCD, menopausal depression** (b/c of NE effects) • **Duloxetine** → also used for **neuropathy (vs. Amitriptyline** is better in suicidal patient who might overdose)
EX	**Venlafaxine** (Effexor)**, Duloxetine** (Cymbalta), **desvenlafaxine, levomilnacipran, milnacipran.**
SE's	↑**BP** most common; also **stimulant effects, sedation, nausea**

Depression Medications	
Tricyclic Antidepressants (TCAs)	
MOA	Block reuptake of **NE and 5-HT. (-triptyline, -pramine –doxepin)**
Use	**Major depression, OCD** (clomipramine), **peripheral neuropathy, chronic pain, migraine prophylaxis**.
EX	**3°-Amitriptyline** (pain/migraines**), Imipramine** (enuresis), **clomipramine** (OCD)**, doxepin 2°-Nortriptyline, amoxapine, desipramine** (ADHD)
SE's	**Tri-C's**: **C**NS toxicity (**C**onvulsions/**C**oma), **C**ardiotoxicity (**arrhythmia** -Na+ channel inhib, ↑QT int), anti**C**holinergic (urinary retention); • **Sedation, α1-blocking effects** (postural hypotension), **anticholinergic SEs** (tachycardia, urinary retention, dry mouth) • 3° TCAs (amitriptyline) have more anticholinergic effects than 2° TCAs (nortriptyline). • **QRS duration >100 msec** → assoc. w. ↑risk of arrhythmias and/or seizures =indication for Tx: **NaHCO3-**stabilizes myocardium, alkalinize urine • **Confusion/hallucinations** in elderly due to anticholinergic side effects (use nortriptyline)
Monoamine Oxidase Inhibitors (MAOi)	
MOA	**Nonselective MAO inhibition → ↑levels of amine neurotransmitters (NE, 5-HT,dopamine)**
Use	**Atypical depression** (hypersomnia, ↑appetite, heavy extremities, ↑sensitivity to interpersonal rejection)**, anxiety.** • **Selegiline** → only antidepressant that comes in dermal patch form (good for patient that cannot tolerate p.o.)
EX	**Phenelzine, Isocarboxazid, Tranylcypromine, (MAO T**akes **P**ride **I**n **S**hanghai**), Selegiline (selective MAO-B inhibitor – Parkinson's, Transdermal).**
SE's	**Hypertensive crisis** (tyramine (cheese, wine)→↑↑BP, HA, sweating, N/V, photophobia, autonomic inst, stroke/death Tx: **Nitroprusside, Phentolamine** **Serotonin Syndrome -** contraindicated w/ SSRIs, TCAs, Tramadol, Linezolid, St. John's wort, meperidine, dextromethorphan • Wait 2 weeks after stopping MAO inhibitors before starting serotonergic drugs or stopping dietary restrictions.
Notes	Rarely used anymore -- Linezolid is a weak MAO-I, and warrants avoidance of norepi and serotonergic drugs (big problem in CF patients w/ antidepressants) otherwise hypertensive urgency and/or serotonin syndrome are a risk. This should be emphasized.
Norepinephrine-Dopamine Reuptake Inhibitors	
MOA	**↑norepinephrine and Dopamine via unknown mechanism**
Use	**MDD w/ sexual side effects from SSRI's, MDD w/ wt gain/hypersomnia** (**bupropion is PRO** penis, not **BU**lemic). **Smoking cessation.**
EX	**Bupropion (**Wellbutrin)
SE's	**Seizures (in anorexic/bulimic/seizures in past), stimulant effects** (tachycardia, insomnia**), headache, No** sexual side effects

Depression Medications continued on next page →