

Stigma as a Barrier in the Emergency Section for a Patient with Neuroleptic Malignant Syndrome: A Case Report

Forouzan Elyasi¹ (MD); Mohsen Fazlali² (MD); Seyed Mohammad Hosseininejad^{3*} (MD)

¹ Psychiatry and Behavioral Sciences Research Center, Addiction Institute, School of Medicine, Mazandaran University of Medical Sciences, Sari, Iran.

² Department of Psychology, Sari Branch, Islamic Azad University, Sari, Iran.

³ Department of Emergency Medicine, Imam Khomeini Hospital, Mazandaran University of Medical Sciences, Sari, Iran.

ARTICLE INFO	ABSTRACT
<p>Article type: Case Report</p> <hr/> <p>Article history: Received: 05-Jan-2018 Accepted: 01-Feb-2018</p> <hr/> <p>Keywords: Emergency Neuroleptic malignant syndrome Schizophrenia Stigma</p>	<p>Introduction: Stigma is defined as a set of negative attitudes and beliefs toward specific conditions, such as mental disorders. Mental disorders are among the most stigmatizing conditions throughout the world. In general, the principle of stigma involves the physical health of the patients with mental conditions.</p> <p>Case: In this article, we presented the case of a 28-year-old single, male patient with paranoid schizophrenia and neuroleptic malignant syndrome. Stigma was a significant barrier in the emergency sections of the psychiatric and general hospitals.</p> <p>Conclusion: According to the results, the curricula of health education must be revised in undergraduate and postgraduate levels.</p>

► *Please cite this paper as:*

Elyasi F, Fazlali M, Hosseininejad S.M. Stigma as a Barrier in the Emergency Section for a Patient with Neuroleptic Malignant Syndrome: A Case Report. *Patient Saf Qual Improv.* 2018; 6(1):671-673.

Introduction

For the family caregivers of patients with schizophrenia, the associated stigma is considered to be the most significant burden (1). Stigma is defined as a set of negative attitudes and beliefs toward a specific condition. Mental disorders equally affect the patients and their families (2). Stigma could deprive people of their individual, social, and citizenship rights (3).

Mental disorders are among the most stigmatizing conditions throughout the world for clear reasons.

Despite recent therapeutic advances, schizophrenic patients experience considerable stigma, which may limit their access to treatment and social integration (4).

Even in the presence of optimistic evidence on the level of public knowledge regarding mental disorders, there are strong stereotypes about the dangerous nature of the mentally challenged, and there is a general tendency for social distance from these individuals (5).

Stigma is a notable challenge in Iran despite pervading religious beliefs and developed mental health services (6). In 2014, a study on the community attitudes and knowledge about mental disorders in Tehran (Iran) indicated that the overall level of negative attitudes toward mental disorders in the population of Tehran is similar to those in other countries and cultures (7). An interesting element in Islamic teachings is that mental disorders may be the effect of the will of

Allah and not necessarily a punishment for one's sins (8). This belief lessens the stigmatization of mental patients, and their unique lifestyle and behaviors may not be considered a result of personal defects (7).

The stigma attached to mental disorders leads to the isolation of mental patients in the healthcare system (4).

In addition, the medical comorbidities among the patients with mental abnormalities are a major public health concern (9). Schizophrenic patients not only have higher rates of physical diseases compared to those without schizophrenia, but they also experience excess difficulty in obtaining adequate health care.

Several recent studies have denoted a more significant gap between the diagnosis and treatment of physical diseases in mental patients compared to the general population (10).

The issues associated with the high rate of medical comorbidities in mental patients have multidimensional consequences, including challenges in their management (9). Integration, optimism, and hope from healthcare professionals are essential to reducing the stigma related to these patients and improving health care (9).

The stigma attached to the management of mental patients is considered as a lack of a specific form within the public stigma.

The origin of such stigmatized settings could be traced back to medical education and the current prevailing paradigms in clinical practice.

In general, the principle of stigma in mental patients is associated with their physical health problems.

Attitudes of family physicians and general practitioners are often more stigmatizing in this regard, and these individuals seem to have pessimistic attitudes toward the outcomes of mental conditions. Since the admission of mental patients is among the basic needs in their healing process, negative attitudes and tendency to maintaining a distance and avoiding mental patients is considered to be an obstacle to the health improvement of these patients. Furthermore, the stigma attached to poor medical management indicates a need for the development of unique anti-stigma programs, which are focused on the medical and psychiatric education of physicians and psychiatrists, as well as the expansion of the related services and research.

In many countries, mental hospitals are often faced with a lack of adequate equipment to detect physical diseases and administrate drugs and other amenities for the diagnosis and treatment of the physical diseases in mental patients (4). In some countries, psychiatrists do not wear white coats (as a widely accepted symbol of a physician), overlooking the fact that they are primarily medical doctors, and only pay attention to mental symptoms.

Establishment of a specialized field known as 'liaison psychiatry' emphasizes on the fact that only a small proportion of psychiatrists are interested in dealing with physically ill patients in a comprehensive manner. However, there are no liaison internal medicine physicians, liaison dermatologists or liaison surgeons. Only a few psychiatrists have been sufficiently trained on medicine to be able to face and deal with the patients who are simultaneously affected by mental and physical disorders (4).

Case report

A 28-year-old single, male patient with paranoid schizophrenia and a history of three admissions to the department of psychiatry was referred without prior medical history. The patient was receiving treatment with risperidone (2 mg), perphenazine (8 mg), and biperiden (2 mg) at night in February 2017 (emergence of neuroleptic malignant syndrome [NMS]).

According to the observations of the patient's family (mother and brother), he had excessive sweating, drooling, and mild rigidity in the distal portions for a week before referral. Akathisia, agitation, urinary incontinence, and decreased consciousness were also detected in the patient. His mother stated that the patient had been acting "differently" within the week prior to his admission in the emergency section of a general teaching hospital in Sari, Iran.

Levels of creatine phosphokinase were 12040, 40500, 29022, 27401, and 5233 U/L, with lactate dehydrogenase of 465, 1452, 795, 952, and 957 U/L,

aspartate aminotransferase of 148, 507, and 390 U/L, alanine aminotransferase of 79, 93, and 93 U/L, and white blood cell count of 12730 U/L. Differential diagnoses of NMS included heat stroke, metabolic tetanus, septicemia, and central nervous system infection, which were rejected in the clinical and laboratory tests. Antipsychotic drugs were discontinued, and hydration and intravenous midazolam and diazepam were initiated.

Body temperature of the patient was normal after 48 hours, and his consciousness level gradually increased.

On the admission day (2-11 AM), the patient was referred from a specialized psychiatric hospital to the emergency section at the university hospital, being returned three times without admission. The emergency assistant at the psychiatric hospital attributed the symptoms to head trauma, and the emergency specialist at the general hospital attributed the symptoms to underlying psychological problems (i.e., schizophrenia), considering the symptoms as agitation.

The patient was transferred to the emergency section at the general hospital by his family caregivers one week after the onset of symptoms when he showed urinary incontinence in at home (in the kitchen).

Following that, the patient was referred to the specialized psychiatric hospital after a normal brain CT-scan to rule out head trauma. It should be noted that the family caregivers had difficulty commuting three times by car.

Discussion & Conclusion

Emergency physicians must pay special attention to patients in agitated states and consider the observed symptoms and possible underlying causes. In addition, emergency physicians play a key role in the early diagnosis and treatment of NMS. Therefore, it is crucial that physicians are aware of the risk factors and possible complications associated with antipsychotic clinical signs.

Although NMS is a rare side-effect of neuropathic drugs, it could be fatal in some cases, and its mortality rate has been estimated at 10% [11]. Early diagnosis of NMS could potentially make the difference between life and death [12]. Knowledge of the process of NMS, along with meticulous evaluation and early interventions of the morbidity and mortality associated with this condition, may reduce life-threatening clinical syndromes.

Emergency medical assistants that are likely to be faced with NMS should receive specific training on this syndrome. Residents and emergency medicine specialists play a pivotal role in the diagnosis of NMS and prevention of death due to this disorder. However, since NMS is a rare occurrence, even the professionals with psychiatric experience may have never witnessed a patient in the acute phase of this syndrome. Adequate knowledge and vigilance for the clinical signs of NMS could result in the early diagnosis and treatment of this disorder, which is considered to be the most important

strategy for minimizing the associated mortality rate and improving the prognosis of patients.

A qualitative study was conducted in the United Kingdom (2015), aiming to enhance the detection of physical conditions among mental patients in emergency departments. The authors offered five main proposals in this regard, including the presence of a consultation-liaison psychiatry team available 24 hours in the emergency section, guidelines with developed details on patients with poisoning, parallel evaluation of patients by the emergency and psychiatry personnel simultaneously, and regular meetings between these departments [13].

Patients with schizophrenia are not only affected by a high rate of physical diseases compared to those without schizophrenia [14], but they also have great difficulty in receiving adequate health care. In many countries, psychiatric hospitals lack the necessary facilities to diagnose physical diseases, as well as the drugs and other materials required for treatment.

References

- 1- Chan SW. Global perspective of burden of family caregivers for persons with schizophrenia. *Archives of psychiatric nursing*. 2011 Oct 1;25(5):339-49.
- 2- Pinto-Foltz MD, Logsdon C. Reducing Stigma Related to Mental Disorders: Initiatives, Interventions, and Recommendations for Nursing. *Arch Psychiatr Nurs*. 2009; 23(1): 32- 40.
- 3- Angermeyer MC, Dietrich S. Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatr Scand*. 2006; 113(3):163-79.
- 4- Norman Sartorius. *Physical illness in people with mental disorders*. Geneva, Switzerland World Psychiatry 6:1 - February 2007
- 5- Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *Am J Public Health*. 1999; 89(9):1328-33.
- 6- Nojomi M, Malakouti SK, Ghanean H, Joghataei MT, Jacobsson L. Mental Illness Stigma in City of Tehran, 2009. *Razi Journal of Medical Sciences*. 2010-2011;17 (78):45- 52. [In Persian].
- 7- Ghanean H, Nojomi M, Jacobsson L. A Community Study on Attitudes to and Knowledge of Mental Illness in Tehran. *Open Journal of Psychiatry*. 2015; 5:26-30.
- 8- Bolhari, J., Nouri GhassemAbadi, R. and RamezaniFarani, A. In: Hussain Khan, Z., Ed., *Quranic Psychiatrists and physicians in other fields are often reluctant toward the treatment of physical diseases in mental patients; consequently, they are unable to identify the patients with mental disorders and reject the need for their treatment* [4].
- 9- Ku'ey L. The impact of stigma on somatic treatment and care for people with comorbid mental and somatic disorders. *Current Opinion in Psychiatry*. 2008; 21:403-411.
- 10- Mitchell AJ, Malone D, Doebbeling CC. Quality of medical care for people with and without comorbid mental illness and substance misuse: systematic review of comparative studies. *Br J Psychiatry*. 2009; 194:491-9.
- 11- Strawn, J. R., Keck, P. E., Jr., & Caroff, S. N. Neuroleptic malignant syndrome. *American Journal of Psychiatry*. 2007; 164(6):870- 876.
- 12- Agar L, RN. Recognizing Neuroleptic Malignant Syndrome in the Emergency Department: A Case. *Perspectives in Psychiatric Care*. 2010; 46(2): 143.
- 13- Shefer G, Cross S, Howard LM, Murray J, Thornicroft G, Henderson C. Improving the diagnosis of physical illness in patients with mental illness who present in emergency Departments: Consensus study. *Journal of Psychosomatic Research*. 2015; 78(4): 346-351.
- 14- Meyer JM, Nasrallah HA. *Medical illness and schizophrenia*. Washington: American Psychiatric Publishing, 2003.