Version 1.0

The Sad, Depressed or Withdrawn Patient

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Common presentation which may be a normal response to loss/stress, associated with physical illness or occur in mental illness (depression, anxiety, personality disorder or psychosis).

Management

Safety
Assessment
Confirmation of provisional diagnosis
Consultation
Immediate treatment
Transfer of care

Safety:

Close observation. Risk of absconding from ED and committing suicide. ?Children involved.

Assessment

History:

- Elucidate reason for presentation and any precipitating event or stressor?
- Any substance use, past history of depression or psychiatric treatment?

Depression symptoms include:

- Pervasive low mood
- ↓Enjoyment from usual activities
- Suicidal ideation or fixated with death
- Hopelessness or helplessness
- Worthlessness or guilt
- Biological symptoms (sleeping probs, early waking, lethargy, ↓libido, ↓appetite)
- Psychomotor retardation or agitation
- Poor concentration
- Anxiety

There may be psychotic symptoms.
Elderly may present with somatic symptoms, self-neglect or change in function and/or cognition
Adolescents may be atypical - irritability, somatic complaints, labile mood, ↑sleep, ↑wt, impulsive

Exam – Physical & Mental State

- Will the patient talk? Is there evidence of intoxication?
- Note psychotic features (e.g. delusions, hallucinations)
- Note depressed appearance/facies, psychomotor agitation or retardation.
- Assess the risk of self-harm: be alert for hopelessness, suicidal ideation and agitation.

Medical conditions associated: viral infection, endocrine (hypothyroidism, hyperPTH, adrenocortical insufficiency, Cushing's), malignancy, Vit B12 def, cerebrovascular disease, drugs

Confirmation

Corroboration: from GP, family & friends, medical notes.
Investigations: If possible underlying medical condition suspected

Consultation

Timely MH review if marked depression, psychotic symptoms or suicidal ideation.

Initial treatment

Rarely started w/o MH team input. Options : Counselling, CBT, psychotherapy, Rx (SSRI 1stline).

Transfer of care

If no suicidal ideation and adequately supported can d/c with firm f/u arrangements (GP, crisis team, psychiatrist). If mod-sev depression or high suicide risk then admission may be required.