Interdisciplinary Disagreements Impeding Treatment of New Onset, Florid Psychosis

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Introduction

We discuss a consultation-liaison psychiatry case that illustrates how interdisciplinary issues and disagreements can prevent optimal treatment. We describe factors that contributed to diagnostic and therapeutic uncertainty in this case. We propose strategies to improve communication and collaboration in similar cases.

Case

A previously high-functioning, 61-year-old white female college graduate, previously diagnosed with depression but no other psychiatric disorders, developed thought disorganization, internal preoccupation, and profound cognitive decline over a three-month period. She was hospitalized on a Neurology unit, and Psychiatry was consulted for assistance with diagnosis and management. No explanation could be found for her decline other than limbic encephalitis secondary to renal cell carcinoma (RCC). Case reports uncovered by the Neurology service indicated that removal of RCC has been effective in treating seronegative paraneoplastic encephalitis. No case reports could be discovered supporting the use of radiation therapy. However, the surgical service, citing a number of confounding issues, declined to operate. A course of radiation treatment had no effect on the patient's symptoms, and she was placed in subacute rehabilitation, still markedly functionally impaired.

Important Labs/Imaging

- MRI brain: "7 mm colloid cyst in the anterior aspect of the third ventricle; question minimal obstructive hydrocephalus of the lateral ventricles"
- EEG: Mild to moderate diffuse slowing
- CT Abdomen/Pelvis: "exophytic enhancing mass arising posteriorly from the left kidney, measuring approximately 8.5 x 6.8 x 8 cm"
- Negative serum and CSF paraneoplastic autoantibody assay

Diagnostic and Clinical Uncertainty

Four factors contributed to diagnostic and therapeutic uncertainty in this case:

1. The lack of confirming autoantibodies
   - An extensive encephalopathy workup, including paraneoplastic autoantibody assay, was unrevealing. The surgical team concluded that this ruled out limbic encephalitis despite the Neurology team having provided case reports of autoantibody-negative limbic encephalitis that had improved after tumor removal.
2. Stigma about her previous psychiatric diagnosis of depression
   - The patient was labeled as a psychiatric patient and classified as a poor surgical candidate.
3. Confusion of past depressive symptoms with her new psychotic symptoms by the surgeons upon whom the treatment depended
   - Despite input to the contrary from the Psychiatry team, the surgical team concluded that the patient's new-onset psychotic symptoms were a continuation of her pre-existing depressive disorder.
4. Several acute medical complications that muddled the picture
   - After the onset of her psychotic symptoms, the patient developed serotonin syndrome after having been given Sertraline and Linezolid at another facility. She developed a fever of 43.2 degrees Celsius (109.8 degrees Fahrenheit). Other confounding conditions included mild obstructive hydrocephalus, Clostridium difficile colitis, and bilateral pulmonary emboli.

Strategies for Improvement

1. Optimize Communication with Primary Team
   - More frequent in-person and phone communication with other teams rather than secure messaging and email correspondence
   - Encouraging involving multiple teams in the same conversation rather than the primary team meeting with each consulting team individually

Strategies for Improvement

- Communicating with other teams in terms that indicate everyone is on the same side, e.g., using the pronoun "we" rather than "you"
- Better attempts to identify shared goals between teams

2. Maintain Continuity of Communication Throughout Hospitalization
   - More continuity of care in terms of the Psychiatry team
   - Ensuring quality of handoffs between providers on the Psychiatry team
   - Consultant participation in family meetings
   - Ensuring appropriate staff is present for meetings with other teams, e.g., a psychiatry resident is not having phone calls with a surgery attending
3. Institutional Policies
   - Providing education on psychiatric illness and stigma to residents and attendings in other specialties
   - Improving accuracy of documentation in the medical record
   - Merging multiple charts for the same patient
   - Considering and utilizing ethics consults
   - Interdisciplinary hospital-sponsored events to foster collaboration and understanding among physicians from different specialties

Conclusion

Lack of sophisticated understanding of psychiatric conditions among non-psychiatric specialties led to misattribution of symptoms, delays in care, and severe medical complications. Communication efforts by the psychiatric consultants were ineffective in preventing this unfortunate process.

References

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