ACLP 2024

Advance Practice Provider (APP) Skills Course

Interactive Cases

Psycho-Oncology Case #1

Margo, a 42-year-old-female with a history of breast cancer has been recently diagnosed with a recurrence. She was first diagnosed 6 years ago and underwent a mastectomy of her left breast, as well as chemotherapy. She continued experiencing anxiety regarding her long-term prognosis, even though she was followed at regular intervals.

She was working in retail but had been laid off during the COVID pandemic. She is the mother of 2 children, now aged 14 and 16, and had recently been hired by a new company, but is still in the probationary period.

She is anxious and tearful when speaking with her oncologist. She is asking for emotional support from a psychiatrist since she has not been sharing this information with friends or her children; only her husband is aware of the recurrence.

When you see her in your office, she is highly distressed and begins by asking some difficult emotionally laden questions.

Questions:

1. What is the approach that you would take with this patient? How would you best engage her?

   Acknowledge the distress, provide a safe place to verbalize concerns, work towards calmness to engage.

2. She feels unheard by her oncology team and that her questions are not being answered. She tells you that her husband is not supportive since he tells her she's depressed and needs medication. How does this change your approach?

   Important role of team dynamics, communication, proactive consultation, family dynamics, support by others, including diagnostic issues of depression in the oncology patient (Endicott)

3. How do you address mortality-related distress and hopelessness in a terminally ill patient?

   Address mistrust – blame, anger, coping history in the face of adversity, consider personality, altered sense of self, role changes, increased help seeking, reflection on

one's life, introducing painful topics while supporting and respecting defences.
Death: is it possible to live while dying? (Yalom)

Strategy	Details
Addressing physical symptoms	Meds for pain, sleep, anxiety
Bearing witness	"How are your spirits today?" "What is the hardest part for you right now?"
Psychoeducation	The label demoralization can be validating Demoralization is a natural human response, "we are not machines, anyone would be disheartened in your situation"
Promoting assertive coping with illness	Asking targeted questions (see next slide)

Griffith existential questions to ask

Existential themes	Questions to ask	Other interventions
Confusion <---> coherence	How do you make sense of what you're going through? If confused, how do you deal with that? To whom do you turn for help when you feel confused?	Having patient write down questions for team Having patient ask for a meeting with the primary team
Isolation <---> communion	Who really understands your situation? When struggling, who do you confide in? What role do you play in your family social/group?	Spiritual care consult Encourage reconnection Integrating support network into care More on next slide
Despair <---> hope	From where do you get hope? What keeps you from giving up?	Explore global meaning, eliciting patient narrative of life and current events, spiritual care consult ?
Meaninglessness <---> purpose	For whom or what do you continue to live? For terminal patients: What do you hope to contribute in the time you have remaining?	Arrange a meeting with supportive friends where pt can discuss how to use pt skills to "contribute"
Helplessness <---> agency	How have you kept illness from taking charge of your life? What is your prioritized list of concerns?	Encouraging PT, etc Making plan for how to get concerns addressed
Cowardice <---> courage	How do you remain strong even when you are afraid? Can you imagine that others who witness how you cope with this illness might describe you as courageous?	Ask patient to make note of times when acting courageously
Resentment <---> gratitude	For what/whom are you grateful? If you could look back on this illness, what would you say you took from the experience?	?

Refer to "How to Guide" Demoralization

4. How can an interdisciplinary team communicate in a way to ensure collegial dynamics and to minimize stress? Does interdisciplinary work help to “prevent” burnout? If so, how?

Self-awareness, regular team consultation with colleagues to discuss difficult cases, working as a team to support each other by sharing tasks/responsibilities, allowing for breaks for team members who may be stressed due to professional or personal commitments, providing retreats to promote wellness.

Interprofessional theme of teams/teamwork

Psycho-Oncology Case #2

Juliet is A 49-year-old woman who was diagnosed with Hodgkin lymphoma 1 year ago. She underwent treatment both inside and outside the hospital.

She completed treatment 2 months ago and is following up with her oncologist every other week. He referred her with new complaints of mental fatigue, inattention, mild aphasia, and increased time to take care of tasks. His referral note says only "Pls see for depression, THX!"

On evaluation she reports that these symptoms are new, and she has never had a prior similar episode. She is worried that these symptoms mean her cancer is not fully cured.

Her only psychiatric history is couples' counseling around the time of her second child's birth. She has never taken any psychiatric medication except for off-label use for nausea. She has never had any suicidal ideation. She does have a family history of lymphoma (father) and anxiety (younger sister). She smoked THC for a few years in her 20s, and drinks 1-3 glasses of white wine about once a month. She works as the administrative assistant in a school and is supposed to go back to work next fall.

Questions:

1. Other than depression, what would be on your differential?

CRCI, Radiation-related, medication side effects from any residual medications, relapse with CNS lymphoma, menopause, the most likely explanation would be a combination of chemotherapy and radiation effects but CNS relapse is an urgent rule out

2. What medications and treatments would you want to know about? And how will you approach communicating with the oncologist?

What chemotherapy did patient receive, did patient get radiation, any heroic cellular treatments like BMT/SCT/CART, did patient get steroids and/or is she still on them, is she perimenopausal.

Interprofessional theme of roles/responsibilities-how to share skills/knowledge to enhance patient care and the referral process.

3. What additional questions would you have and/or workup would you recommend?

Deeper look at timeline

Substitutive depression evaluation (i.e., assess for depression without using vegetative symptoms – hopelessness, worthlessness, inappropriate guilt, thoughts of death)

Psychosocial evaluation of factors, any new tasks or roles she has resumed now that family perceives her as “cured”.

Family history of early dementia, depression, etc., and evaluate for potential perimenopause.

Neuro exam: ensure that lymphoma is truly in remission, look at labs, electrolyte and/or hormonal abnormalities, consider imaging (CT obviously required if acute onset, concern for CVA).

4. If nothing additional was found on workup, what treatment would you recommend?

Reassurance, CBT, cognitive retraining, exercise, OK to treat symptomatically, therapy to explore significance from her perspective.

Medication is OK, but unrealistic default during acute care (whether you think its depression or cognition).

Medication Safety Case #1 (Antipsychotics)

Mr. A is a 65-year-old male with schizoaffective disorder-depressive type, hypertension, and non-insulin dependent diabetes, who was admitted to the psychiatric unit for increasing psychosis, agitation and disorganized behavior at home. He had constructed a metallic satellite dish, turned off the water to the house, and was expressing paranoia about the water supply being contaminated. Prior to his admission, he had been followed at a local outpatient mental health center, was last seen several months ago, and at that time was maintained on Risperdal 4 mg bedtime and venlafaxine 225 mg daily. He had discontinued both of his medications one month prior to admission. On admission, vital signs stable, CBC and metabolic panel within normal limits, urine tox screen negative. He was restarted on Risperdal 3 mg bedtime, increased to 6 mg at night on day 2. The venlafaxine was titrated to 150 mg daily by day 2. Agitation begins to show some improvement.

On day 4, he is noted to be confused and altered on the unit, with fluctuating somnolence, declining to get out of bed. He spikes a temperature of 101F and is tachycardic with HR 120-130's. Nursing calls you to come evaluate the patient and provide recommendations. On examination, the patient is noted to be disoriented and unable to fully participate in the interview.

Questions:

1. What are the next steps in your evaluation and what is your initial differential diagnosis?

History: Review timeline of symptom onset, assessment of baseline risk factors for toxicity syndromes (multiple medications), recent changes (such as renal or liver function changes that may impact metabolism or elimination),

Conduct physical exam and mental status exam.

Order tests (fingerstick, BMP, CBC, LFTs, Creatinine Kinase level)
Consider head imaging (head CT for acute bleed/infarct), CXR (aspiration PNA).
EKG

Differential Diagnosis: NMS vs serotonin syndrome, clinical presentations:

Table 1: Clinical Presentation of Major Toxidromes

	Neuroleptic Malignant Syndrome	Serotonin Syndrome	Anticholinergic Toxicity
Precipitated by	Dopamine antagonists	Serotonergic agents	Anticholinergic agents
Onset	Variable (1-3 days)	Variable (<1d)	< 12 hours
Vital signs	Hypertension, tachycardia, tachypnea	Hypertension, tachycardia, and tachypnea	Hypertension, tachycardia, tachypnea
Temperature	Hyperthermia	Hyperthermia	Hyperthermia (<38.8)
Mucosa	Sialorrhea	Sialorrhea	Dry
Skin	Diaphoresis	Diaphoresis	Hot/red
Mental Status	Delirium	Delirium	Delirium
Muscles	"Lead pipe" rigidity	Increased tone	Normal
Reflexes	Hyporeflexia	Hyperreflexia, clonus	Normal
Pupils	Normal	Dilated	Dilated
Bowel sounds/movements	Normal or decreased	Hyperactive, diarrhea	Decreased or absent, constipation

Hunter Serotonin Toxicity Criteria (may miss mild cases): Serotonergic agent in past 5 weeks + ANY of the following symptoms: 1) tremor and hyperreflexia; 2) spontaneous clonus; 3) Muscle rigidity, temperature >38C, and either ocular or inducible clonus; 4) ocular clonus and agitation or diaphoresis; 5) inducible clonus and agitation or diaphoresis

Sternbach Criteria (Non-specific and overlap with other toxidromes): 1) Recent addition or increase in known serotonergic agent; 2) Absence of other possible etiologies; 3) No recent addition or increase of a neuroleptic agent; 4) ≥3 of the following symptoms: mental status change, agitation, myoclonus, hyperreflexia, diaphoresis, shivering, tremor, diarrhea, incoordination, fever

Refer to How to Guide: Medication Syndromes

On a review of recent events, he has had decreased oral intake, including fluids for several days. His other outpatient medications which included metformin 500 mg daily and metoclopramide 5 mg QID for chronic GERD were restarted several days previously as the decreased intake was attributed to GERD. Vitals are rechecked and temperature is now 103, he continues with tachycardia and diaphoresis, and alteration in mental status. Muscle rigidity is noted on examination.

2. What are some of the patient's risk factors? What are some of the notable lab findings to be aware of?

Risks: Initiation and rapid increase of antipsychotic, use of multiple antipsychotics, dehydration, malnutrition, geriatric patient

Elevation of Serum Creatinine >1.5 x baseline→ AKI/dehydration

Elevation of CPK (rhabdomyolysis) 4X normal
Elevation of WBC
Low Serum Iron
Metabolic acidosis

The patient is transferred to the medicine floor, and over a period of a week is medically stabilized. Antipsychotics are discontinued, and IV hydration is provided with supportive care (including lorazepam and bromocriptine). Mr. A begins to express psychotic symptoms, expressing delusional beliefs about drinking water and ingesting food. The medicine team calls you about restarting an antipsychotic.

3. How do you respond to the medicine team?

Bromocriptine (dopamine agonist) can reverse parkinsonism but may worsen psychosis. What is the plan for taper?

Recurrences of NMS do occur (30-50%), especially if antipsychotic restarted too quickly. Generally, after a two-week waiting period, very slow titration with careful monitoring can be considered. It is thought to be prudent to trial a different lower potency atypical antipsychotic.

You review the chart the next morning and see that overnight the on-call team restarted Mr. A on 6 mg of Risperdal as he was restless and wanted to go outside the unit.

4. How can the interdisciplinary team bring patient safety concerns to the attention of the system?

Discussion of processes related to multiple antipsychotics being prescribed (for different indications).

Role of team members in patient safety reporting, entering adverse event, following up with discussion as to alerting providers if two antipsychotics are initiated.

Interprofessional theme of values/ethics: who is accountable for care, for continuity, for medication safety.

Medication Safety Case #2 (Antipsychotics)

Mr. B. is a 55-year-old male with a history of coronary artery disease, hypertension and peripheral vascular disease with no known psychiatric history who is post op day 3 from a coronary artery bypass graft. Surgery went as planned with no complications and he was successfully extubated on post op day 1. Since being extubated, Mr. B has become progressively more confused with fluctuating periods of wakefulness, disruptions in sleep cycle, and agitation to the point he is aggressively swinging at staff and pulling out IV lines. The ICU initially started Seroquel 25mg po BID and consulted psychiatry for further management of hyperactive delirium.

Upon assessment, you find Mr. B. was placed in bilateral soft restraints for safety. He appears disheveled and remains restless throughout the exam. He is grossly confused and unable to hold any meaningful conversation. Nursing reports that he was pulling off his gown and reaching for objects in the air prior to being placed in restraints. In reviewing his labs, you note leukocytosis and hyponatremia. EKG and telemetry monitoring both show a QTc of 440ms. You decide to start antipsychotic medication for symptom management of agitation in delirium.

Questions:

1. Which antipsychotic medication are you considering to trial and what are some of the factors influencing your recommendation?

Referencing PP slides: “on and off label use of antipsychotics”, “formulation matters” and “adverse effects- anticholinergic effects, sedation, EPS, dystonia, QTc, etc”

Medication	Route	Formulation	Bioavailability	Time to maximum plasma concentration (Tmax)
Aripiprazole	Oral	Tablet	87%	3–5 hours
	Oral	Oro-dispersible	87%	3–5 hours
	Oral	Liquid	87%	3–5 hours
	IM	Injection	100%	1 hour
Droperidol	Oral	Tablet	75%	1–2 hours
	IM	Injection	100%	≤30 minutes
	IV	Injection	100%	seconds/minutes
Haloperidol	Oral	Tablet	60–70%	2–6 hours
	Oral	Liquid	60–70%	2–6 hours
	IM	Injection	100%	20–40 minutes
	IV	Injection	100%	seconds/minutes
Olanzapine	Oral	Tablet	Undetermined	5–8 hours
	Oral	Oro-dispersible	Undetermined	5–8 hours
	IM	Injection	Undetermined	15–45 minutes
	IV	Injection	100%	seconds/minutes
Quetiapine	Oral	Tablet	Unknown	1.5 hours
Risperidone	Oral	Tablet	67%	1–2 hours
	Oral	Oro-dispersible	67%	1–2 hours
	Oral	Liquid	70%	1–2 hours

After deliberating the options, you decide to start Haldol 2mg IV q6 PRN for agitation. After 24 hours, you note improvement in agitation and Mr. B was able to be taken out of restraints. He responds to questions but remains confused and oriented to self and "hospital" only. Telemetry monitoring and repeat EKG now show a QTc of 510 ms (Bazett's Formula) and tachycardia (HR 100).

2. Do you continue the current treatment regimen? Why or why not?

Referencing PP slides 29-32 "Torsades", reviewing now psychiatric medications, risk stratification and QTc correction"

Step 3: Understand relative risk: QTc prolongation and cardiac morbidity

- QTc > 500 ms carries a 1.66 X increase in adverse cardiac events vs QTc = 400 (1)
- QTc > 550 ms carries a 2.14 X increase risk vs QTc = 400

Table 1: Risk Factors for Prolonged QT (2)

Categories of risk factors	**Risk factors for prolonged QT**
Sex	Female sex
Age	Increased age
Genetic	Long QT syndrome: caused by hundreds of mutations in at least 10 different genes
Electrolyte abnormalities	Hypokalemia Hypocalcemia Hypomagnesemia
Cardiac conditions	Prior arrhythmias Left ventricular dysfunction Mitral valve prolapse Congestive heart failure Myocardial infarction
State conditions	Bradycardia Sleep
Specific medications	See Table 2

3. Which formula did you decide to use to recalculate the QTC and what were your results? Additional info: Paper speed 25 mm/sec, QT/QTc 395/510 ms

Referencing last PP slide with formulation + ACLP how to guide on QTc prolongation.

You continue the current regimen. Nursing reports agitation is much improved. They have continued to give haloperidol around the clock, though when you inquire about what the agitation looks like, they report he is only intermittently pulling at the lines. You worry that nursing may be overusing the agitation PRN medications.

4. How do you address this concern with nursing? What are some non-pharmacological alternatives for managing delirium and agitation?

Interprofessional Communication/Teams and teamwork

- Keep the conversation rooted in objective observations (e.g., I noticed that patient is pretty sedated for most of the day. What do you make of that?)
- → share concern with calm tone, non-accusatory language (e.g., I'm worried that this sedation will prolong his delirium. I wonder if we can brainstorm non-pharmacological ways to manage the agitation)

Non-pharmacological alternatives (examples):

-during day, keep curtains open for sunlight & to look out window
-at night, reduce noise/light as much as possible, & make schedule adjustments to allow this (minimize nighttime disruption)
-frequent verbal reorientation and reassurance
-familiar faces as much as possible: consistent staff if possible, visits from family
-place clock/calendar within view
-avoid benzodiazepines (unless specifically treating alcohol/benzo withdrawal)
-appropriate pain management
-minimize use of immobilizing equipment, if possible (bladder catheter, restraints)
-encourage oral fluid intake; early recognition of dehydration
-ensure patient has their needed eyeglasses, hearing aids, and/or dentures

Before nursing has a chance to implement the non-pharmacological strategies, you notice on daily rounding that Mr. B's tongue is protruding out of his mouth and his eyes are gazing up. He is alert and his sensorium is relatively clear.

5. What side effect is he having? How would you manage this?

Referencing Extrapyramidal Symptoms PPT slide-acute dystonia. Discussion of risk/benefit of use of benztropine or diphenhydramine in geriatric patient with delirium

Challenging Interpersonal Dynamics Case

Mr. P is a 32yo M with a history of opioid and alcohol use disorders who presents after a fall down his stairs, causing polytrauma. The orthopedics service consults you for "anxiety." The patient has been screaming at nursing staff when they don't bring his applesauce right away and calling the ortho service "terrible providers" for not treating his pain (but declines all non-opioid pain medications). No physical agitation or aggression has been reported.

You have completed the consult. Your assessment includes cluster B pathology contributing to the patient's behaviors.

Part 1: As you're leaving the unit, the orthopedic team approaches you regarding the patient. The team expresses their frustration with you regarding your recommendations and demand to speak with another member of the psychiatry team, such as an attending. The team cannot understand why this patient cannot "be transferred to your service, because the patient is clearly "bipolar."

Questions:

1. What type of conflict is this?

    - Relationship conflict/task conflict

2. How would you de-escalate this situation?

    Consider role playing a conflict de-escalation framework:
    - **D:** Describe the specific situation or behavior; provide concrete data.
    - **E:** Express how the situation makes you feel/what your concerns are using "I" statements.
    - **S:** Suggest other alternatives and seek agreement.
    - **C:** Consequences stated in terms of impact on established team goals while striving for consensus.

3. What is the real problem at hand? What does the team need from you?

    - Countertransference of the patient, uncertainty of how to manage the patient; team needs to feel supported. Primary vs Secondary Process (slide 10)
    - Teams want to feel "heard"- similar to patients – IDENTIFY THE NEEDS
    - Validate the feelings not the content.
    - Teams need concrete next steps while acknowledging the uncertainty inherent in any clinical situation

Part 2: After de-escalating the situation with the orthopedic surgeon, you are tasked with brainstorming how to help the team navigate the dynamics with the patient.

4. What targeted recommendations would you provide and to whom?

   (hint: consider applying conflict de-escalation and negotiation concepts)

   - To the primary team and nursing:

   - Listen more than speaking, and validate emotions (**Active Listening/Empathy and Respect**)
   - Be a detective about "why" behind patient behaviors (refers to part 1 of the didactic/**Empathy and Respect)**
   - Avoid power struggles (**Principle II: Do Not Argue on the Basis of Positions)**
   - Appeal to entitlement without calling it out…"you deserve the standard of care, which includes NSAIDS, etc" (**Principle III: Use Objective Criteria)**
   - Negotiate gentle parameters with the patient (**Problem-Solving Approach, Principle IV: Invent Options for Mutual Gain**)
   - Can also model empathic listening and calm affect when interacting with patient
   - Consider a written vs verbal (if written plan would stigmatize patient) behavioral plan.

   Per How-To Guide, behavioral plans should:
   - be created collaboratively, ideally with patient if they have insight into problematic nature of behavior
   - consider which elements of plan to communicate with patient
   - describe problem behaviors
   - describe behavior triggers
   - delineate reasonable, attainable rules
   - recommend staff response options to disruptive behaviors
   - include measurable outcomes and time frame for evaluation

5. How would you help the primary team understand the interpersonal dynamics with the patient?

   • May discuss briefly the archetype at play and how we often play into the cycle of power struggles

   • Validate primary team's emotions but encourage them to abstain from acting on them

6. How would you deliver recommendations across hierarchical boundaries?

- Relationship building
  - Invest in building relationship (good will, trust) from the very first conversation with the team about the patient
  - Group therapy principles
  - Provide holding environment for team's emotions
- Managing "up" (primary team physician)
  - Acknowledge the other's position and experience—distressing situation (**Empathy and Respect, interprofessional competency 2**)
  - And here is what we've found helpful, per our experience with similar patients and the literature (**Objective Criteria**)
    - Targeted to identified needs
  - Know when to escalate to your supervisor. This is not a sign of failure but rather an acknowledgment of inherent hierarchy
- Managing "down" (nursing staff)
  - Acknowledge the other's position and experience, express appreciation (**Empathy and Respect, interprofessional competency 2**)
    - Targeted to identified needs
  - And here is what we've found helpful, per our experience with similar patients and the literature (**Objective Criteria**)