Focused Medical Assessment of Pediatric Behavioral Emergencies

Joshua A. Rocker, MD*, Jeffrey Oestreicher, MD

KEYWORDS

• Medical clearance • Anchoring bias • Momentum bias • Child psychiatry
• Adolescent psychiatry • Suicide • Emergency • Psychiatric admission

KEY POINTS

- No uniformly accepted standard of care exists for medical clearance of pediatric patients with psychiatric complaints.
- Few patients in the emergency department present a broader differential than those with an apparent psychiatric chief complaint.
- Relevant history and examination findings should guide subsequent ancillary testing, interventions, and ultimately disposition because emerging data suggest that reflexive screening laboratory tests are of limited utility.
- Providers should remain mindful of anchoring or diagnosis momentum bias when caring for these patients, especially patients with a psychiatric history.

INTRODUCTION

Accounting for approximately 7% of all pediatric emergency department (ED) visits nationally,[1–4] the number of children presenting with psychiatric issues is increasing faster than any other medical emergency.[5] In addition, these visits require more ED resources, have longer lengths of stay, and have high admission and transfer rates.[1] However, despite this large volume of patients, there is no uniformly accepted standard of care on how providers should medically clear behavioral health patients.

The term medical clearance generally implies that the provider has proved that the psychiatric complaint does not have a medical cause. Often the term "organic" is used to denote a medical disorder as opposed to one that is psychiatric. This terminology reflects a dualist mind-body distinction, which may contribute to an already existing stigma and belief that psychiatric illness has no biological origins.

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Division of Pediatric Emergency Medicine, Cohen Children's Medical Center of New York, Northwell Health, 269-01 76th Avenue, New Hyde Park, NY 11040, USA
* Corresponding author.
E-mail address: JRocker@northwell.edu

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Inherent in the task of medical clearance is an obvious medical and ethical obligation to rule out any medical causes for the psychiatric presentation. However, there are tragic case reports of psychiatric symptoms falsely attributed to a primary psychiatric diagnosis before thorough investigation of medical causes.[6] The common thread in these cases is a provider who anchored to a psychiatric diagnosis too early and did so before ruling out organic medical causes, particularly in children with past psychiatric history in whom it is tempting to attribute a behavioral or cognitive change to the underlying psychiatric disease.[5,7–15]

This article provide a rational, stepwise approach to medical clearance of children and adolescents with psychiatric symptoms. It addresses the diverse differential for these presentations, including those caused by medical illness, psychiatric illness, and psychiatric medications, and then discusses what needs to be included in the medical evaluation, which comprises a detailed and thorough physical as well as relevant diagnostic studies.

DIFFERENTIAL DIAGNOSIS

Few patients in the ED present a broader differential than those with an apparent psychiatric chief complaint. Horowitz and Schreiber[16] found that 150 pediatric patients presenting to an ED with a primary psychiatric chief complaint ultimately represented 21 different diagnoses. This article divides the different presentations into 7 unique categories: a psychiatric emergency, a psychiatric concern, a medical emergency caused by a psychiatric condition, a medical emergency/condition caused by a psychiatric medication, a medical condition appearing like a psychiatric condition, a medical condition caused by a psychiatric condition, and a medical condition occurring concurrently with a psychiatric condition (**Table 1**).

When a provider is confronted with distinguishing medical causes from psychiatric ones, it has been shown that certain factors are more suggestive of a medical cause: new or sudden-onset symptoms or onset of symptoms before the age of 12 years, history of visual or tactile hallucinations (as opposed to auditory), seizures, and negative family psychiatric history.[4]

Table 1
Differential diagnosis categories for an apparent psychiatric chief complaint

Categories of Different Disorders Encountered	Examples
Psychiatric emergency	Suicidality, homicidality, uncontrollable violence
Psychiatric concern	Depression, anxiety, conduct disorder, truancy
Medical emergency caused by a psychiatric condition	Asphyxia, toxic overdose, gunshot wound
Medical emergency/condition caused by a psychiatric medication	Neuroleptic malignant syndrome, serotonin syndrome, lithium toxicity
Medical condition appearing like a psychiatric condition	Anemia, brain tumor, encephalitis, thyroid disease, seizures
Medical condition caused by a psychiatric condition	Lacerations from self-inflicted cutting or punching glass in uncontrolled anger
Medical condition co-occurring with a psychiatric condition	UTI, STI, pregnancy, substance abuse concurrent with psychiatric diagnosis

Abbreviations: STI, sexually transmitted infection; UTI, urinary tract infection.