HANDS-ON ADVICE FOR MANAGING PSYCHIATRIC CONDITIONS

OXFORD HANDBOOK OF PSYCHIATRY

David Semple | Roger Smyth

Provides practical advice on all aspects of general adult psychiatry and other psychiatric sub-specialties

Includes the latest changes in legislation and psychiatric training, and new information on Adult ADHD, new drugs of abuse, and up-to-date clinical guidelines

Revised to ensure direct relevance for trainees as well as professionals in psychiatry



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First edition published 2005

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Great Clarendon Street, Oxford, OX2 6DP United Kingdom

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First edition published 2005 Second edition published 2009 Third edition published 2013

Impression: 1

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British Library Cataloguing in Publication Data Data available

Library of Congress Cataloging in Publication Data Library of Congress Control Number: 2012944040

ISBN 978-0-19-969388-7

Printed in China by C&C Offset Printing Co. Ltd

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Reference ranges

Haematologic	cal values	
Haemoglobin		13–18 g/dL
		11.5–16 g/dL
Mean cell volum	ne (MCV)	76–96 fL
Platelets		150-400×10 ⁹ /L
White cell coun	it (WCC)	4-11×10 ⁹ /L
Neutrophils		2.0-7.5×10 ⁹ /L
Eosinophils		0.04-0.44×10 ⁹ /L
Lymphocytes		1.3-3.5×10 ⁹ /L
Dischanistm	values	
Biochemistry Sodium	values	135–145 mmol/L
Potassium		3.5–5.0 mmol/L
Creatinine		70–150 μmol/L
Urea		2.5–6.7 mmol/L
Calcium (total)		2.12–2.65 mmol/L
Albumin		35–50 g/L
Protein		60-80 g/L
	ransferase (ALT)	535 iu/L
Alkaline phosph	natase	30–150 u/L
Bilirubin		3–17 μg/L
Gamma-glutamy	yl-transpeptidase (®GT)	11–51 iu/L
		7-33 iu/L
Thyroid stimula	ting hormone (TSH)	0.5–5.7 mu/L
Thyroxine (T4)		70-140 nmol/L
Thyroxine (free)	9-22 pmol/L
Tri-iodothyroni	ne (T3)	1.2-3.0 nmol/L
Vitamin B12		0.13-0.68 nmol/L
Folate		2.1 μg/L
Glucose (fasting	3)	3.5-5.0 mmol/L
Prolactin		<450 u/L
		<600 u/L
Creatinine kinas	se (CK)	25195 iu/L
		25-170 iu/L
Osmolality		278–305 mosmol/kg
Urine		
Osmolality		350–1000 mosmol/kg
Sodium		100–250 mmol/24h
Protein		<150 mg/24h
Hydroxymethyl	mandelic acid (HMMA, VMA)	16-48 mmol/24h
Reference ran	nges for selected drugs	
Lithium	0.8-1.2 mmol/L	(p336)
	0.6-0.8 mmol/L (as an augm	

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350-500 µg/L (0.35-0.5 mg/L)

(>7 mg/L may be more efficacious in bipolar disorder)

50-125 mg/L

4-12 mg/L

50-150 μg/L

(p342)

(p346)

(p210)

Valproate

Clozapine

Nortriptyline

Carbamazepine

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Care 2e

Oxford Handbook of Dialysis 3e

Oxford Handbook of Emergency Medicine 4e

Oxford Handbook of Endocrinology and Diabetes 2e

Oxford Handbook of ENT and Head and Neck Surgery

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Oxford Handbook of Genetics

Oxford Handbook of Genitourinary Medicine, HIV and AIDS 2e

Oxford Handbook of Geriatric Medicine

Oxford Handbook of Infectious Diseases and Microbiology

Oxford Handbook of Key Clinical Evidence

Oxford Handbook of Medical Dermatology

Oxford Handbook of Medical Imaging

Oxford Handbook of Medical Sciences 2e

Oxford Handbook of Medical Statistics

Oxford Handbook of Nephrology and Hypertension

Oxford Handbook of Neurology

Oxford Handbook of Nutrition and Dietetics 2e

Oxford Handbook of Obstetrics and Gynaecology 2e

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Oxford Handbook of Oncology 3e

Oxford Handbook of Ophthalmology 2e

Oxford Handbook of Oral and Maxillofacial Surgery

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Oxford Handbook of Pain Management Oxford Handbook of Palliative Care 2e

Oxford Handbook of Practical Drug Therapy 2e

Oxford Handbook of Pre-Hospital
Care

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Oxford Handbook of Public Health Practice 2e

Oxford Handbook of Reproductive Medicine & Family Planning

Oxford Handbook of Respiratory Medicine 2e

Oxford Handbook of Rheumatology 3e

Oxford Handbook of Sport and Exercise Medicine

Oxford Handbook of Tropical Medicine 3e

Oxford Handbook of Urology 3e

Dedication the first

To Fiona dical student and doctor is familiar with that strange moture of (D.M.S.) a perplexity which occurs when, despite having spent what seems like endless hours studying, one is completely at a loss as to what to do when confronted with a real patient with real problems. For doctors of our generation that sense of panic was eased somewhat by the reasoning presence in the white coat pocket of the original Oxford Mondbook of Clinical Medicine. A quick glance at one of its pages before approaching the patient served to refresh factual knowledge, guide initial assessment and highlight hour to be missed areas, allowing one to enter the room with a sense of at least initial confidence which would otherwise have been lacking the way as a sense of at least initial confidence which would otherwise have

The initial months of psychiatric practice are a time of particular analyees, when familiar medical knowledge seems of no use and the patients and their symptoms appear baffling and strange. Every new psychiatrist is familiar with the strange sense of relief when a 'medical' problem arises in energy their patients. 'finally comething I know about. At this time, for us, the absence of a similar volume to the Oxford Handbook of Clinical Medicine for Psychiatrists was keenly felt. This volume attempts to fulfil the same function for medical students and doctors beginning psychiatric training or practice. The white cost pocket will have gone, but we hope that it can provide that same portable reassurance.

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R.S.
I.K.
A.P.U.

Preface to the first edition

Every medical student and doctor is familiar with that strange mixture of panic and perplexity which occurs when, despite having spent what seems like endless hours studying, one is completely at a loss as to what to do when confronted with a real patient with real problems. For doctors of our generation that sense of panic was eased somewhat by the reassuring presence in the white coat pocket of the original Oxford Handbook of Clinical Medicine. A quick glance at one of its pages before approaching the patient served to refresh factual knowledge, guide initial assessment, and highlight 'not to be missed' areas, allowing one to enter the room with a sense of at least initial confidence which would otherwise have been lacking.

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D.M.S. R.S.S. J.K.B. R.D.

A.M.M.

Preface to the second edition

It is entirely unoriginal for authors to think of their books as their 'children'. Nonetheless, during the process of creating the first edition of this handbook we found ourselves understanding why the comparison is often made: experiencing the trials of a prolonged gestation and a difficult delivery, balanced by the pride of seeing one's offspring 'out in the world'. And of course, the rapid forgetting of the pain leading to agreement to produce a second a few years later.

We have updated the handbook to reflect the substantial changes in mental health and incapacity legislation across the UK, updated clinical guidance, the continuing service changes across psychiatric practice and the more modest improvements in treatments and the evidence base for

psychiatric practice. The second partial properties of the properties of the properties of the psychiatric practice.

The main audience for this handbook has been doctors in training. Unfortunately the most recent change experienced by this group has been profoundly negative, namely the ill-starred reform of medical training in the UK. This attempt to establish a 'year zero' in medical education is widely agreed to have been a disaster. A 'lost generation' of juniors has been left demoralized and bewildered—some have left our shores for good.

Despite this, we have been impressed and heartened by the cheerful optimism and stubborn determination shown by the current generation of trainees and we have been tremendously pleased when told by some of them that they have found our handbook useful. To them and their suc-

cessors we offer this updated version.

2008

D.M.S. R.S.S.

Preface to the third (Forensic psychiatry), and Dr.T. Ryan (Organic illness and Old age psychiatry). editioned to acknowledge the assistance of Prof. J. Hall

One of the ironies of writing books is that the preface, that part to which the reader comes first, is the very part to which the writers come last of all. Once the rest of the book is finished, composing the preface can allow the authors an opportunity for reflection and an attempt at summing-up their initial aims and current hopes for the book as it leaves their hands Dr H. Kennedy, Dr F. Browne, Dr C. Faullener, and Dr. Sennedy, Dr F. Browne, Dr C. Faullener, and Dr. Sennedy, Dr. F. Browne, Dr. C. Faullener, and Dr. S. Sennedy, Dr. F. Browne, Dr. C. Faullener, and Dr. S. Sennedy, Dr. F. Browne, Dr. C. Faullener, and Dr. S. Sennedy, Dr. F. Browne, Dr. C. Faullener, and Dr. S. Sennedy, Dr. F. Browne, Dr. C. Faullener, and Dr. S. Sennedy, Dr. F. Browne, Dr. C. Faullener, and Dr. S. Sennedy, Dr. S

While writing this third preface we found it interesting to examine its two predecessors, to see what they revealed about our thoughts at those times. Reading the first preface it's clear we were writing to ourselves, or at least to our slightly younger selves, reflecting on the book we wished we'd had during our psychiatric training. The emotions conveyed are those of anxiety and hope. Moving on to the second, it is addressed to our junior colleagues, and seems to us to convey a mixture of indignation and pride.

In this third edition we have continued to revise and update the book's contents in line with new developments in clinical practice. While these changes reflect ongoing and incremental improvement, one cannot fail to be struck by how unsatisfactory the state of our knowledge is in many areas and how inadequate many of our current treatments are. On this occasion we finished the book with the hopes that it would continue to serve as a useful guide to current best practice and an aid in the management of individual patients, and that these current inadequacies would inspire, rather than discourage, the next generation of clinicians and researchers. Our feelings at the end of a decade of involvement with this handbook are therefore of realism mixed with optimism.

2012 preparation of the first edition of this handbook we were joined by three colleagues who contributed individual specialist chapters:

.Z.M.d Darjee (Forensic psychiatry, Legal Issues, and Personality disor-

2.2.8 Dr J. Burns (Old age psychiatry, Child and adolescent psychiatry, and Organic illness) and Dr A. McIntosh (Evidence-based psychiatry and

and adolescent psychiatry), Dr. A. McKechanie (Learning disability) and We are also pleased to acknowledge the assistance of Dr S. MacHale,

leagues, who revised and updated specialist sections: Dr L. Brown (Child

Acknowledgements

First edition

In preparing this Handbook, we have benefited from the help and advice of a number of our more senior colleagues, and we would specifically like to thank Prof. E.C. Johnstone, Prof. K.P. Ebmeier, Prof. D.C.O. Cunningham-Owens, Prof. M. Sharpe, Dr S. Gaur, Dr S. Lawrie, Dr J. Crichton, Dr L. Thomson, Dr H. Kennedy, Dr F. Browne, Dr C. Faulkner, and Dr A. Pelosi for giving us the benefit of their experience and knowledge. Also our SpR colleagues: Dr G. Ijomah, Dr D. Steele, Dr J. Steele, Dr J. Smith, and Dr C. McIntosh, who helped keep us on the right track.

We 'piloted' early versions of various sections with the SHOs attending the Royal Edinburgh Hospital for teaching of the MPhil course in Psychiatry (now reborn as the MRCPsych course). In a sense they are all contributors, through the discussions generated, but particular thanks go to Dr J. Patrick, Dr A. Stanfield, Dr A. Morris, Dr R. Scally, Dr J. Hall,

Dr L. Brown, and Dr J. Stoddart.

Other key reviewers have been the Edinburgh medical students who were enthusiastic in reading various drafts for us: Peh Sun Loo, Claire Tordoff, Nadia Amin, Stephen Boag, Candice Chan, Nancy Colchester, Victoria Sutherland, Ben Waterson, Simon Barton, Anna Hayes, Sam Murray, Yaw Nyadu, Joanna Willis, Ahsan-Ul-Haq Akram, Elizabeth Elliot, and Kave Shams.

Finally, we would also like to thank the staff of OUP for their patience, help, and support.

Second edition

In the preparation of the first edition of this handbook we were joined by three colleagues who contributed individual specialist chapters: Dr R. Darjee (Forensic psychiatry, Legal issues, and Personality disorders), Dr J. Burns (Old age psychiatry, Child and adolescent psychiatry, and Organic illness) and Dr A. McIntosh (Evidence-based psychiatry and Schizophrenia). They continue to contribute to this revised version.

For this second edition we have been joined by four additional colleagues who revised and updated specialist sections: Dr L. Brown (Child and adolescent psychiatry), Dr A. McKechanie (Learning disability) and Dr J. Patrick and Dr N. Forbes (Psychotherapy). We are grateful to them

for their advice and help.

We are also pleased to acknowledge the assistance of Dr S. MacHale, Dr G. Masterton, Dr J. Hall, Dr N. Sharma, and Dr L. Calvert with individual topics and thank them for their advice and suggestions.

Other helpful suggestions came from our reviewers and those individuals who gave us feedback (both in person or via the feedback cards).

Once again we thank the OUP staff for their encouragement and help.

Third edition

The contributors named above were joined for this third edition by Dr S. Jauhar (Substance misuse), Dr S. Kennedy (Sexual disorders),

West Lothian, UK

Dr F. Queirazza (Therapeutic issues), Dr A. Quinn and Dr A. Morris (Forensic psychiatry), and Dr T. Ryan (Organic illness and Old age psychiatry). We are also pleased to acknowledge the assistance of Prof. J. Hall and Prof. D. Steele who provided helpful suggestions and engaged in useful discussions. We remain indebted to the staff at OUP for their support of this book and its authors over the last decade.

Forensic psychiatry

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Symbols and atmetro abbreviations

Abbreviations can be a useful form of shorthand in both verbal and written communication. They should be used with care however, as there is the potential for misinterpretation when people have different understandings of what is meant by the abbreviation (e.g. PD may mean personality disorder or Parkinson's disease; SAD may mean seasonal affective disorder or schizoaffective disorder).

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Q	Female Départment of Psychological
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~	Approximately benefit the design of the Approximately benefit to the second of the sec
~	Approximately equal to
± 127 3 10	Plus/minus Eduburgh UK
↑ onsultant	Increased Increa
Į.	Decreased suxes, yoursidaying evidouboage 8 12
→ lash-web	Leads to
1°	Primary
2°	Secondary
α	Alpha : : : : Alpha : : : : : Alpha : : : : : : : : : : : : : : : : : : :
β	Beta
γ	Gamma Markh
δ	UiDelta Vitainoveg ineosetoba bha blinu et
σ	17 Forensic psychiatry amgiZ
®	Registered trademark
6%	Bomb (controversial topic)
5-HT	5-hydroxytryptamine (serotonin) 19429 1921614 41
5-HTP	5-hydroxytryptophan yasadrodoys9 00
6CIT	Six-item Cognitive Impairment Test
A & E	Accident and Emergency
AA	Alcoholics Anonymous
AAIDD	American Association of Intellectual and Developmental Disability
AASM	American Academy of Sleep Disorders
ABC	Airway/breathing/circulation (initial resuscitation checks); antecedents, behaviour, consequences; Autism Behaviour Checklist

ABG	Arterial blood gas xabni yaatxaA xba8 IA8
ACC	Anterior cingulate cortex (Visb solve) sib al8 bo
ACE-R	Addenbrooke's Cognitive Examination—Revised
ACh	Acetylcholine Acetylcholine Acetylcholine Acetylcholine
AChE(Is)	Acetylcholinesterase (inhibitors)
ACTH	Adrenocorticotrophic hormone
AD PD al	Alzheimer's disease
ADDISS	Attention Deficit Disorder Information and Support
ADH	Alcohol dehydrogenase; antidiuretic hormone
ADHD	Attention deficit hyperactivity disorder
ADI-R	Autism Diagnostic Interview—Revised
ADLs	Activities of daily living and anazana bools 98
ADOS	Autism Diagnostic Observation Schedule
ADPG	ALS-dementia-Parkinson complex of Guam
AED sine	Anti-epileptic drug
AF	Atrial fibrillation
AFP	Alpha-fetoprotein massalobs bas blid A87
AIDS	Acquired immunodeficiency syndrome
AIMS	Abnormal Involuntary Movement Scale
AJP	American Journal of Psychiatry
aka	Also known as solved and appropriate and leading and appropriate and appropria
ALD	Alcoholic liver disease
ALDH	Acetaldehyde dehydrogenase
AMHP	Approved mental health professional
AMP	Approved medical practitioner About MD 29A0
AMT	Abbreviated Mental Test Isolaylana syllingoO TAC
AN	Anorexia nervosa nod stanogab lezad-optico Gas
ANF	Antinuclear factor wolf boold IndensO 380
AP	Anterioposterior
APA	American Psychiatric Association
APD	Antisocial personality disorder
АроЕ	Apolipoprotein E Manual
APP	Addicted Physicians' Programme; amyloid precursor protein
ARDS	Acute respiratory distress syndrome
ARR	Absolute risk reduction
ASD	Autism spectrum disorders
ASPS	Advanced sleep phase syndrome
ASW	Approved social worker
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood alcohol concentration

BAI	Beck Anxiety Index 259 boold Isram D8A
bd	Bis die (twice daily) x 2000 and units notation A 1000 DDA
BDI	Beck Depression Inventory
BDP-SCALE	Borderline personality disorder scale
BDNF	Brain derived neurotrophic factor
BDZ	Benzodiazepine
BIMC	Blessed Information Memory Concentration Scale
BiPAP	Bi-level positive airways pressure
BJP	British Journal of Psychiatry
BMI	Body mass index in assume on by the long in the HUA
BMJ	British Medical Journal
BNF	British National Formulary
BP	Blood pressure anivil ylish to zamivity A 200A
BPD	Borderline personality disorder
BPRS	Brief Psychiatric Rating Scale
BPSD	Behavioural and psychological symptoms in dementia
BSE	Bovine spongiform encephalopathy
C&A	Child and adolescent mistorgotet-edgia 91A
C(P)K	Creatine (phospho)kinase
Ca ²⁺	Calcium 26 Insmerol Movement EmpondA 2MIA
CADASIL	Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy
CAGE	Cut down? Annoyed Guilty? Eye opener
CAMHS	Child and Adolescent Mental Health Services
cAMP	Cyclic adenosine monophosphate bevoraga 9HMA
CARS	Childhood Autism Rating Scale on bevorenA SMA
CAT	Cognitive analytical therapy and beautogradda TMA
CBD	Cortico-basal degeneration sevien axeronA MA
CBF	Cerebral blood flow Antimudean factor AMA
CBT	Cognitive behavioural therapy
CC	Creatinine clearance A Stranger Physics A A A A A A A A A A A A A A A A A A A
CCF	Congestive cardiac failure mozed kbozunA
CCK	Cholecystokinin 3 metagoglogA 3 og A
CD and north	Conduct disorder - 55.9 and Sava 9 best libbA - 99.4
CDD	Childhood disintegrative disorder
CDI	Children's Depression Inventory
CDT	Carbohydrate-deficient transferrings manual Q2A
CER	Control event rate sand geek heapsvoa 292A
CFS	Chronic fatigue syndrome
CJD	Creutzfeldt-Jakob disease
CK	Creatinine kinase obsettnessnos lodosla bool8 DA8