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

Oxford Handbook of Psychiatry

THIRD EDITION

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Acute presentations index

Reference ranges

Haematological values

Haemoglobin	13–18 g/dL
	11.5–16 g/dL
Mean cell volume (MCV)	76–96 fL
Platelets	150–400×10^9/L
White cell count (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

Biochemistry values

Sodium	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
Alanine aminotransferase (ALT)	5–35 iu/L
Alkaline phosphatase	30–150 u/L
Bilirubin	3–17 µg/L
Gamma-glutamyl-transpeptidase (®GT)	11–51 iu/L
	7–33 iu/L
Thyroid stimulating hormone (TSH)	0.5–5.7 mu/L
Thyroxine (T4)	70–140 nmol/L
Thyroxine (free)	9–22 pmol/L
Tri-iodothyronine (T3)	1.2–3.0 nmol/L
Vitamin B12	0.13–0.68 nmol/L
Folate	2.1 µg/L
Glucose (fasting)	3.5–5.0 mmol/L
Prolactin	<450 u/L
	<600 u/L
Creatinine kinase (CK)	25–195 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
Hydroxymethylmandelic acid (HMMA, VMA)	16–48 mmol/24h

Reference ranges for selected drugs

Lithium	0.8–1.2 mmol/L	*(p336)*
	0.6–0.8 mmol/L (as an augmentative agent)	
Valproate	50–125 mg/L	*(p342)*
Carbamazepine	4–12 mg/L	*(p346)*
	(>7 mg/L may be more efficacious in bipolar disorder)	
Clozapine	350–500 µg/L (0.35–0.5 mg/L)	*(p210)*
Nortriptyline	50–150 µg/L	

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Oxford Handbook of Psychiatry

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Dedication

To Fiona
(D.M.S.)

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.

The initial months of psychiatric practice are a time of particular anxiety, 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 one of their patients—'finally something 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 coat pocket will have gone, but we hope that it can provide that same portable reassurance.

2004

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 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 successors we offer this updated version.

2008

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

Preface to the third edition

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 for the final time.

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

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

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),

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.

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Symbols and 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).

⚠	Warning
►	Important
►►	Don't dawdle
♂	Male
♀	Female
∴	Therefore
~	Approximately
≈	Approximately equal to
±	Plus/minus
↑	Increased
↓	Decreased
→	Leads to
1°	Primary
2°	Secondary
α	Alpha
β	Beta
γ	Gamma
δ	Delta
σ	Sigma
®	Registered trademark
💣	Bomb (controversial topic)
5-HT	5-hydroxytryptamine (serotonin)
5-HTP	5-hydroxytryptophan
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
ACC	Anterior cingulate cortex
ACE—R	Addenbrooke's Cognitive Examination—Revised
ACh	Acetylcholine
AChE(Is)	Acetylcholinesterase (inhibitors)
ACTH	Adrenocorticotrophic hormone
AD	Alzheimer's disease
ADDISS	Attention Deficit Disorder Information and Support Service
ADH	Alcohol dehydrogenase; antidiuretic hormone
ADHD	Attention deficit hyperactivity disorder
ADI—R	Autism Diagnostic Interview—Revised
ADLs	Activities of daily living
ADOS	Autism Diagnostic Observation Schedule
ADPG	ALS–dementia–Parkinson complex of Guam
AED	Anti-epileptic drug
AF	Atrial fibrillation
AFP	Alpha-fetoprotein
AIDS	Acquired immunodeficiency syndrome
AIMS	Abnormal Involuntary Movement Scale
AJP	*American Journal of Psychiatry*
aka	Also known as
ALD	Alcoholic liver disease
ALDH	Acetaldehyde dehydrogenase
AMHP	Approved mental health professional
AMP	Approved medical practitioner
AMT	Abbreviated Mental Test
AN	Anorexia nervosa
ANF	Antinuclear factor
AP	Anterioposterior
APA	American Psychiatric Association
APD	Antisocial personality disorder
ApoE	Apolipoprotein E
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
bd	Bis die (twice daily)
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
BMJ	*British Medical Journal*
BNF	*British National Formulary*
BP	Blood pressure
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
C(P)K	Creatine (phospho)kinase
Ca^{2+}	Calcium
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
CARS	Childhood Autism Rating Scale
CAT	Cognitive analytical therapy
CBD	Cortico-basal degeneration
CBF	Cerebral blood flow
CBT	Cognitive behavioural therapy
CC	Creatinine clearance
CCF	Congestive cardiac failure
CCK	Cholecystokinin
CD	Conduct disorder
CDD	Childhood disintegrative disorder
CDI	Children's Depression Inventory
CDT	Carbohydrate-deficient transferrin
CER	Control event rate
CFS	Chronic fatigue syndrome
CJD	Creutzfeldt–Jakob disease
CK	Creatinine kinase