Managing a COVID-19–positive psychiatric patient on a medical unit

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With the COVID-19 pandemic turning the world on its head, we have seen more first-episode psychotic breaks and quick deterioration in previously stable patients. Early in the pandemic, care was particularly complicated for psychiatric patients who had been infected with the virus. Many of these patients required immediate psychiatric hospitalization. At that time, many community hospital psychiatric inpatient units did not have the capacity, staffing, or infrastructure to safely admit such patients, so they needed to be managed on a medical unit. Here, I discuss the case of a COVID-19–positive woman with psychiatric illness who we managed while she was in quarantine on a medical unit.

Case report

Early in the COVID-19 pandemic, Ms. B, a 35-year-old teacher with a history of depression, was evaluated in the emergency department for bizarre behavior and paranoid delusions regarding her family. Initial laboratory and imaging testing was negative for any potential medical causes of her psychiatric symptoms. Psychiatric hospitalization was recommended, but before Ms. B could be transferred to the psychiatric unit, she tested positive for COVID-19. At that time, our community hospital did not have a designated wing on our psychiatric unit for patients infected with COVID-19. Thus, Ms. B was admitted to the medical floor, where she was quarantined in her room. She would need to remain asymptomatic and test negative for COVID-19 before she could be transferred to the psychiatric unit.

Upon arriving at the medical unit, Ms. B was hostile and uncooperative. She frequently attempted to leave her room and required restraints throughout the day. Our consultation-liaison (CL) team was consulted to assist in managing her. During the initial interview, we noticed that she had covered all 4 walls of her room with papers filled with handwritten notes. Ms. B had cut her gown to expose her stomach and legs. She had pressured speech, tangential thinking, and was religiously preoccupied. She denied any visual and auditory hallucinations, but her persecutory delusions involving her family persisted. We believed that her signs and symptoms were consistent with a manic episode from underlying, and likely undiagnosed, bipolar I disorder that was precipitated by her COVID-19 infection.

We first addressed Ms. B's and the staff's safety by transferring her to a larger room with a vestibule at the end of the hallway so she had more room to walk and minimal exposure to the stimuli of the medical unit. We initiated one-on-one observation to redirect her and prevent elopement. We incentivized her cooperation with staff by providing her with paper, pencils, reading

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material, and phone privileges. We started oral risperidone 2 mg twice daily and lorazepam 2 mg 3 times daily for short-term behavioral control and acute treatment of her symptoms, with the goal of deferring additional treatment decisions to the inpatient psychiatry team after she was transferred to the psychiatric unit. Ms. B's agitation and impulsivity improved. She began participating with the medical team and was eventually transferred out of our medical unit to a psychiatric unit at a different facility.

COVID-19 and psychiatric illness: Clinical concerns

While infection from COVID-19 and widespread social distancing of the general population have been linked to depression and anxiety, manic and psychotic symptoms secondary to the COVID-19 pandemic have not been well described. The association between influenza infection and psychosis has been reported since the Spanish Flu pandemic,[1] but there is limited data on the association between COVID-19 and psychosis. A review of 14 studies found that 0.9% to 4% of people exposed to a virus during an epidemic or pandemic develop psychosis or psychotic symptoms.[1] Psychosis was associated with viral exposure, treatments used to manage the infection (steroid therapy), and psychosocial stress. This study also found that treatment with low doses of antipsychotic medication—notably aripiprazole—seemed to have been effective.[1]

Nonetheless, it is important to keep in mind a thorough differential diagnosis and rule out any potential organic etiologies in a COVID-19–positive patient who presents with psychiatric symptoms.[2] For Ms. B, we began by ruling out drug-induced psychosis and electrolyte imbalance, and obtained brain imaging to rule out malignancy. We considered an interictal behavior syndrome of temporal lobe epilepsy, a neuropsychiatric disorder characterized by alterations in sexual behavior, religiosity, and extensive and compulsive writing and drawing.[3] Neurology was consulted to evaluate the patient and possibly use EEG to detect interictal spikes, a tall task given the patient's restlessness and paranoia. Ultimately, we determined the patient was most likely exhibiting symptoms of previously undetected bipolar disorder.

Managing patients with psychiatric illness on a medical floor during a pandemic such as COVID-19 requires the psychiatrist to truly serve as a consultant and liaison between the patient and the treatment team.[4] Clinical management should address both infection control and psychiatric symptoms.[5] We visited with Ms. B frequently, provided psychoeducation, engaged her in treatment, and updated her on the treatment plan.

As the medical world continues to adjust to treating patients during the pandemic, CL psychiatrists may be tasked with managing patients with acute psychiatric illness on the medical unit while they await transfer to a psychiatric unit. A creative, multifaceted, and team-based approach is key to ensure effective care and safety for all involved.

Clinical Point

A creative, multifaceted, team-based approach is key to ensure effective care and safety for all involved

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