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Online Clinical Cases

Wk 4 Psych

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**Kendra’s Law, EPS & Tardive Dyskinesia, Serotonin Syndrome, and Stevens-Johnson Syndrome**

**1) Kendra’s Law:**

 Kendra’s Law is a piece of NY State legislation effective since 1999 concerning involuntary outpatient commitment, also known as assisted outpatient treatment. This was inspired by a series of incidents involving physical violence as a result of untreated or undertreated mental illness, culminating in the death of Kendra Webdale (for whom the law was named after) when she was pushed from a subway platform in front of an oncoming train by Andrew Goldstein, a 29 y/o male diagnosed with schizophrenia but noncompliant with medication.

Kendra’s Law grants authority to issue orders that require patients who meet certain criteria to undergo psychiatric treatment. Failure to comply could result in commitment for up to 72 hours. Kendra’s law does not mandate that patients be forced to take medication.

Criteria:

* Pt is 18 y/o or older; and
* Pt is suffering from a mental illness; and
* Pt is unlikely to survive safely in the community without supervision, based on clinical judgement; and
* Pt has a history on noncompliance with treatment for mental illness that has:
	+ At least twice within the last 6 months been a significant factor in hospitalization or forensic or mental health services in a correctional facility, not including any period of time during which the person was hospitalized or incarcerated immediately preceding filling of the petition; or
	+ Resulted in at least one threat, attempt or act of violence towards self or others within the last 4 years, not including any period in which the pt was hospitalized or incarcerated immediately preceding the filing of the petition; and
* Pt is unlikely to voluntarily participate in recommended treatment; and
* In view of pt’s treatment history and current behavior, pt is in need of assisted outpatient treatment in order to prevent a relapse or deterioration; and
* It is likely that pt will benefit from assisted outpatient treatment; and
* If patient has executed a health care proxy, that any directions included in such proxy shall be taken into account by the court in determining treatment plan; and
* The treatment plan set forth will be the least restrictive plan reviewed to achieve the most likely benefit to the patient.

**2) EPS & Tardive Dyskinesia:**

 Extrapyramidal symptoms (EPS) are a common side effect of antipsychotics. This set of side effects includes akathisia, parkinsonism, and dystonias. Akisthisia is the most common among these. EPS is more common with typical antipsychotics such as haloperidol, fluphenazine, thiothixene, and trifluoperazine, and less common with others such as quetiapine, clozapine, and iloperidone.

 Patients starting an antipsychotic medication should be monitored for EPS weekly until dose has been stable for at least 2 weeks. Two weekly assessments should follow any increase in dosage. Either a cautious reduction in dosage can treat EPS or beta-blockers or anticholinergics can be added to regimen to treat for EPS.

 Tardive dyskinesia (TD) is a drug-induced hyperkinetic movement disorder associated with the use of dopamine-receptor blocking agents, particularly antipsychotics as well as two antiemetics (metoclopramide and prochlorperazine). TD typically manifests as oro-bucco-lingual and facial dyskinesia often with limb/trunk/respiratory involvement. There may also be tics, tremors, or akathisia. While second-generation or atypical antipsychotics are associated with a lower incidence of TD, the difference between the two classes are not a significant as initially thought. Higher doses are thought to be associated with increased risk of TD. It is also common for TD to first appear after a sudden reduction of dosage, discontinuation, or switch to a less potent antipsychotic drug. Treatment includes switching to clozapine ( associated with lower risk of TD), benzodiazepines (clonazepam), anticholinergic, botulinum injections, or vesicular monoamine transporter 2 inhibitors.

**3) Serotonin Syndrome:**

Serotonin Syndrome, aka serotonin toxicity, is a potentially life-threatening condition associated with serotonin overactivity of the CNS. It is associated with interactions between mood stabilizing meds (SSRI’s) and other medications or supplements. It is classically described as a triad of symptoms: mental status change, autonomic hyperactivity, and neuromuscular abnormalities. However there is a spectrum of clinical findings ranging from benign to fatal.

 Treatment for serotonin syndrome includes discontinuing all serotonergic agents, supportive care targeting vital signs, sedation with benzodiazepines, serotonin antagonists (cyproheptadine), and assessment of need to resume serotonergic agent after resolution of symptoms.

**4) SStevens-Johnson Syndrome;**

Stevens-Johnson Syndrome (SJS) is a mucocutaneous reaction, most commonly triggered by medications, characterized by extensive necrosis and detachment of epidermis. Mucous membranes are affected in over 90% of cases, usually at 2 or more distinct sites (ocular, oral, and genital). SJS often involves <10% BSA of skin detachment (whereas TEN involves >30% BSA detachment). There is usually a prodromal syndrome of fever with URI-like symptoms for 1-3 days prior to the development of cutaneous lesions.

 While it is often an acute reaction to medication, other risk factors include HIV, malignancy, and genetic predisposition/family history. The most commonly implicated drugs are allopurinol, aromatic antiepileptic drugs (phenytoin, phenobarbital, carbamazepine) and lamotrigine, abx sulfonamide, nevirapine, and oxicam NSAID’s.

**Sources:**

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