88. POST-TRAUMATIC STRESS DISORDER (PTSD)

Primary reference: Kaplan & Sadock's Comprehensive Textbook of Psychiatry / DSM-5-TR

KMU SCENARIO PICKUP LINES

> *"28-year-old male, 3 months after RTA, reports recurrent nightmares of the crash, avoids driving past the accident site, hypervigilant while driving, and has intrusive memories 5x/day" → pick: PTSD with intrusive symptoms*

> *"Female refugee, 6 months post-conflict, complains of emotional numbness, detachment from family, exaggerated startle response to loud noises, and flashbacks when hearing fireworks" → pick: PTSD with negative alterations in cognition/mood*

> ***WRONG TEMPTATION:*** *"Patient has recurrent distressing memories but NO avoidance symptoms" → This is Adjustment Disorder, NOT PTSD (requires 1 avoidance symptom minimum per DSM-5)*

DEFINITION

Psychiatric disorder characterized by failure to recover after exposure to actual or threatened death, serious injury, or sexual violence. Involves intrusive memories, avoidance, negative alterations in cognition/mood, and marked alterations in arousal/reactivity lasting >1 month.

ETIOLOGY / RISK FACTORS

Category	Specific Factors
Trauma Type	Combat exposure, sexual assault, natural disasters, serious accidents, violent personal assault, sudden death of loved one, life-threatening illness
Pre-traumatic	Female gender, childhood trauma, pre-existing anxiety/depression, low education, lack of social support
Peri-traumatic	Severity/duration of trauma, perceived life threat, dissociation during event
Post-traumatic	Lack of social support, subsequent life stress, maladaptive coping

DSM-5-TR DIAGNOSTIC CRITERIA

Exposure: Direct experience, witnessing, learning of close family/friend's violent/accidental trauma, or repeated/extreme exposure to aversive details (e.g., first responders)

Intrusion Symptoms (≥1): Recurrent distressing memories, recurrent distressing dreams, dissociative reactions (flashbacks), intense psychological distress to cues, physiological reactions to cues

Avoidance (≥1): Efforts to avoid distressing memories/thoughts/feelings OR external reminders (people, places, activities)

Negative Cognitions/Mood (≥2): Inability to remember important aspect, persistent negative beliefs, distorted cognitions, persistent negative emotional state, diminished interest, detachment, restricted affect

Arousal/Reactivity (≥2): Irritable behavior/anger outbursts, reckless/self-destructive behavior, hypervigilance, exaggerated startle, concentration problems, sleep disturbance

Duration: >1 month; **Distress/Impairment:** Significant

CLINICAL FEATURES

Domain	Features
Re-experiencing	Flashbacks (dissociative reactions), nightmares, intrusive thoughts, physiological reactivity
Avoidance	Behavioral (avoid driving past accident site), cognitive (avoid thinking about trauma)
Cognitive/Mood	Anhedonia, guilt, survivor guilt, negative self-perception, foreshortened future
Hyperarousal	Insomnia, irritability, poor concentration, hypervigilance, exaggerated startle
Associated	Dissociative symptoms (depersonalization, derealization), somatic complaints, substance use

DIFFERENTIAL DIAGNOSIS

Condition	Mimic	Distinguishing Feature
Acute Stress Disorder	PTSD early phase	Duration 3 days to 1 month (vs >1 month in PTSD)
Adjustment Disorder	Trauma response	Stressor can be ANY severity (not just Criterion A trauma); no specific symptom clusters required
Major Depression	Negative mood, anhedonia	No Criterion A trauma exposure; no intrusion symptoms
Panic Disorder	Physiological arousal	Attacks unexpected, not tied to trauma cues
Dissociative Disorders	Flashbacks	PTSD flashbacks are trauma-specific; dissociative amnesia more extensive

INVESTIGATIONS (EXAM LOGIC)

Scenario	First	Best Next	Gold Standard
Initial assessment	CAPS-5 (Clinician-Administered PTSD Scale)	PCL-5 (PTSD Checklist)	Structured Clinical Interview for DSM-5 (SCID-5)
Screening	Primary Care PTSD Screen (PC-PTSD-5)	PCL-5	CAPS-5
Dissociative subtype	CAPS-5 with dissociative items	Dissociative Experiences Scale (DES-II)	SCID-D (Structured Clinical Interview for Dissociative Disorders)

MANAGEMENT

Algorithm: Trauma-Focused Psychotherapy (First Line) → Pharmacotherapy (SSRI/SNRI) → Augmentation → Intensive Interventions

Step	Intervention	Details	Duration/Notes
1	Psychoeducation	Normalize symptoms, explain conditioning model	Initial sessions
2	Trauma-Focused CBT	Prolonged Exposure (PE), Cognitive Processing Therapy (CPT)	12-16 sessions, 60-90 min
3	EMDR	Eye Movement Desensitization and Reprocessing	8-12 sessions
4	SSRI (Sertraline)	Start 25mg daily, titrate to 50-200mg	First-line pharmacotherapy
5	SSRI (Paroxetine)	Start 20mg daily, max 60mg	Alternative first-line
6	Venlafaxine XR	Start 37.5mg daily, titrate to 75-225mg	SNRI alternative
7	Augmentation	Risperidone 0.5-2mg or prazosin 2-6mg HS (nightmares)	For refractory cases
8	Intensive	Residential PTSD programs, ketamine infusion	Chronic, severe, refractory

COMPLICATIONS

Early	Late
Acute stress reaction, substance use initiation, relationship conflict, occupational impairment	Chronic PTSD, major depression, substance use disorders, cardiovascular disease, metabolic syndrome, neurocognitive deficits, suicide attempts

RARE BUT TESTED

- **Dissociative Subtype:** Meets PTSD criteria + persistent depersonalization/derealization (10-30% of PTSD cases)
- **Delayed Expression:** Onset >6 months after trauma (rare, <5%)
- **PTSD with Psychotic Features:Hallucinations (usually trauma-related), transient paranoid ideation**
- **Complex PTSD: ICD-11 diagnosis, prolonged/repeated interpersonal trauma with affect dysregulation, negative self-concept, disturbed relationships**
- **PTSD and TBI overlap: "Shell shock" historical term; shared symptoms of concentration, irritability, sleep**

KMU Exam Traps:

- **PTSD requires Criterion A trauma (actual/threatened death, serious injury, sexual violence) - routine stressors do NOT qualify**
- **Duration MUST be >1 month; <1 month = Acute Stress Disorder**
- **Avoidance is REQUIRED (≥1 symptom) - if absent, consider Adjustment Disorder**
- **First-line treatment is Trauma-Focused Psychotherapy, NOT medication**
- **Prazosin is specifically for trauma-related nightmares, not general PTSD**
- **Do NOT confuse flashbacks (dissociative reactions) with intrusive memories**
- **PTSD can present with anger outbursts - do NOT misdiagnose as Intermittent Explosive Disorder**
- **Children may present with repetitive play (trauma reenactment) rather than verbal memories**

GOLDEN RULE: TRAUMA - Trauma exposure, Re-experiencing, Avoidance, Unable to recover (negative mood), Months (>1), Arousal symptoms

89. OBSESSIVE-COMPULSIVE DISORDER (OCD)

Primary reference: Kaplan & Sadock's Comprehensive Textbook of Psychiatry / DSM-5-TR

KMU SCENARIO PICKUP LINES

> *"22-year-old medical student spends 3 hours daily washing hands until raw, recognizes it's excessive but cannot stop, experiences intense anxiety if prevented" → pick: OCD with cleaning/washing compulsions*

> *"35-year-old executive checks door locks exactly 7 times before leaving, must count steps in multiples of 4, seeks reassurance from family repeatedly" → pick: OCD with checking and ordering compulsions*

> *WRONG TEMPTATION: "Patient has intrusive thoughts about harming others but NO compulsions" → This is OCD (Pure-O/Primarily Obsessional OCD) - compulsions may be mental (counting, praying, reviewing)*

DEFINITION

Disorder characterized by presence of obsessions (recurrent, intrusive thoughts, urges, or images) and/or compulsions (repetitive behaviors or mental acts) that are time-consuming (>1 hour/day) or cause significant distress/impairment. Individual attempts to ignore, suppress, or neutralize obsessions with compulsions.

ETIOLOGY / PATHOPHYSIOLOGY

Domain	Findings
Neuroanatomy	Cortico-striato-thalamo-cortical (CSTC) circuit dysfunction; hyperactivity in orbitofrontal cortex, caudate nucleus, anterior cingulate
Neurotransmitters	Serotonin dysregulation (5-HT2A/2C hypersensitivity); dopamine modulation in striatum
Genetic	Heritability 45-65%; candidate genes: SLC1A1, BDNF, COMT
Autoimmune	PANDAS/PANS - Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infections
Psychological	Thought-action fusion (belief that thinking equals doing), inflated responsibility, intolerance of uncertainty

DSM-5-TR DIAGNOSTIC CRITERIA

A. Presence of obsessions, compulsions, or both:
Obsessions: Recurrent/persistent thoughts, urges, or images experienced as intrusive/unwanted; individual attempts to ignore/suppress them
Compulsions: Repetitive behaviors or mental acts that individual feels driven to perform in response to obsession or according to rigid rules; aimed at preventing/reducing anxiety or preventing dreaded event

B. Obsessions/compulsions are time-consuming (>1 hour/day) or cause clinically significant distress/impairment
C. Not attributable to substance or other medical condition
D. Not better explained by another mental disorder

CLINICAL FEATURES & SUBTYPES

Subtype	Features	Frequency
Contamination/Washing	Fear of germs, dirt, toxins; washing, cleaning, avoiding	~45%
Harm/Checking	Fear of harm to self/others; checking locks, appliances, retracing steps	~30%
Symmetry/Ordering	Need for exactness, evenness; arranging, counting, repeating	~15%
Forbidden Thoughts	Intrusive sexual, religious (scrupulosity), or violent thoughts; mental compulsions	~20%
Hoarding	Difficulty discarding, accumulation (now separate diagnosis in DSM-5)	~5%

DIFFERENTIAL DIAGNOSIS

Condition	Mimic	Distinguishing Feature
Generalized Anxiety Disorder	Worry	Worry is about real-life concerns; obsessions are ego-dystonic, intrusive
Specific Phobia	Avoidance	Fear limited to specific object/situation; no compulsions
Illness Anxiety Disorder	Health concerns	Preoccupation with having serious illness; minimal somatic symptoms
Tic Disorder/Tourette	Repetitive behaviors	Tics are semi-involuntary, preceded by urge not obsession; brief, non-purposeful
Schizophrenia	Bizarre thoughts	Delusions are ego-syntonic; poor insight; no compulsive neutralization
OCPD	Rigidity	Ego-syntonic personality style; no true obsessions/compulsions; pleasure in order

ASSESSMENT SCALES

Y-BOCS (Yale-Brown Obsessive Compulsive Scale): Gold standard severity measure (0-40 scale)
0-7: Subclinical; 8-15: Mild; 16-23: Moderate; 24-31: Severe; 32-40: Extreme
Y-BOCS-II: Updated version with improved psychometrics

MANAGEMENT

Step	Intervention	Details
1	ERP (Exposure and Response Prevention)	First-line psychotherapy; gradual exposure to obsessional triggers while preventing compulsions; 15-20 sessions
2	SSRI (High Dose)	Sertraline 50-200mg, Fluoxetine 20-80mg, Fluvoxamine 100-300mg, Paroxetine 40-60mg, Citalopram 20-60mg
3	Clomipramine	Tricyclic; start 25mg, titrate to 150-250mg; most effective but side effects
4	Augmentation (Antipsychotic)	Risperidone 0.5-2mg, Aripiprazole 5-15mg, Haloperidol 2-5mg for refractory cases
5	Augmentation (Glutamate)	Memantine 5-20mg, N-acetylcysteine 2400-3000mg
6	DBS/Neurosurgery	Anterior capsulotomy, cingulotomy for severe, refractory, debilitating OCD

Medication Pearl: OCD requires HIGHER SSRI doses than depression and LONGER trial (10-12 weeks vs 4-6 weeks). Response rate: 40-60% with SSRI alone, 70% with SSRI + ERP.

COMPLICATIONS

- Early: Skin damage (excessive washing), impaired academic/occupational function, relationship strain
- Late: Depression (major depressive disorder comorbidity 50%), suicide risk (10x general population), social isolation, unemployment

RARE BUT TESTED

- PANDAS/PANS: Pediatric acute-onset OCD after streptococcal infection; treat with antibiotics, IVIG, plasmapheresis
- Body Dysmorphic Disorder: Preoccupation with perceived defects; high comorbidity with OCD
- Trichotillomania/Excoriation: Body-focused repetitive behaviors; now separate from OCD in DSM-5
- Primary Obsessional OCD (Pure-O): Mental compulsions only (counting, praying, reviewing); often missed
- Magical Thinking OCD: "If I don't tap 3 times, my mother will die"

KMU Exam Traps:
- OCD requires BOTH obsessions AND compulsions OR one with significant distress/impairment
- Time criterion: >1 hour/day (ask specifically in history)
- First-line is ERP (psychotherapy), NOT medication alone
- Clomipramine is most effective pharmacologically but SSRIs preferred due to safety
- Do NOT confuse OCD with OCPD (personality disorder - ego-syntonic)
- Insight varies: "with good/fair/poor/absent insight" specifier important for prognosis
- Tic-related OCD specifier indicates different treatment response (may need antipsychotic earlier)
- Hoarding disorder is SEPARATE diagnosis in DSM-5 (not OCD subtype)

GOLDEN RULE: OCD - Obsessions (intrusive), Compulsions (neutralizing), Dysfunctional (time-consuming >1hr/day)

90. SOMATIC SYMPTOM DISORDER

Primary reference: Kaplan & Sadock's Comprehensive Textbook of Psychiatry / DSM-5-TR

KMU SCENARIO PICKUP LINES

> *"34-year-old female with 5-year history of multiple pain complaints, GI symptoms, and fatigue; has seen 12 specialists, all investigations normal; constantly worried about having serious illness" → pick: Somatic Symptom Disorder with predominant pain*

> *"Patient presents with neurological symptoms (paralysis, seizures) inconsistent with neurological disease; shows la belle indifference; symptoms worsen after stress" → pick: Conversion Disorder (Functional Neurological Symptom Disorder) - distinct from SSD*

> *WRONG TEMPTATION: "Patient has multiple somatic complaints but NO excessive thoughts/behaviors about them" → This is NOT SSD; may be medical condition or other psychiatric disorder*

DEFINITION

Characterized by one or more distressing somatic symptoms plus abnormal thoughts, feelings, or behaviors in response to these symptoms. Symptoms may or may not be medically explained. Persistence (typically >6 months) and disproportionate response are key features.

DSM-5-TR DIAGNOSTIC CRITERIA

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life
B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least ONE of:
1. Disproportionate and persistent thoughts about the seriousness of one's symptoms
2. Persistently high level of anxiety about health or symptoms
3. Excessive time and energy devoted to these symptoms or health concerns
C. State of being symptomatic is persistent (typically >6 months)
Specify if: With predominant pain (previously pain disorder)

RELATED DISORDERS (SOMATIC SYMPTOM CLUSTER)

Disorder	Key Feature	Duration
Illness Anxiety Disorder	Preoccupation with having/acquiring serious illness; minimal somatic symptoms	≥6 months
Conversion Disorder	Neurological symptoms (motor/sensory) incompatible with neurological disease	Variable
Psychological Factors Affecting Medical Condition	Psychological/behavioral factors adversely affect general medical condition	Ongoing
Factitious Disorder	Falsification of physical/psychological signs; deception without external reward	Variable
Malingering	Intentional production of symptoms for external gain (secondary gain)	Variable

CLINICAL FEATURES

- Multiple, variable symptoms: Pain (headache, back, joint), GI (nausea, bloating, diarrhea), sexual, pseudoneurological
- Doctor shopping: Multiple specialists, repeated investigations
- High healthcare utilization: Frequent ER visits, unnecessary surgeries
- Associated features: Anxiety, depression, personality disorders (borderline, histrionic, dependent)
- La belle indifference: (More common in Conversion Disorder) - lack of concern about symptoms

MANAGEMENT

Approach	Intervention	Details
Psychotherapy	CBT	First-line; address illness beliefs, reduce avoidance, activity scheduling
	Psychodynamic therapy	Explore secondary gain, trauma history
Pharmacotherapy	SSRI (Sertraline, Fluoxetine)	For comorbid anxiety/depression
	SNRI (Duloxetine, Venlafaxine)	Especially with pain predominant
Medical	Regular scheduled visits	NOT as-needed; prevents ER utilization
	Single primary physician	Coordinate care, avoid iatrogenic harm

KMU Exam Traps:

- SSD replaced Somatization Disorder, Hypochondriasis, Pain Disorder, and Undifferentiated Somatoform Disorder in DSM-5
- Symptoms MAY have medical explanation; key is disproportionate response
- Illness Anxiety Disorder = minimal symptoms + high anxiety about illness
- Conversion Disorder = neurological symptoms + incompatibility with disease
- Do NOT confront patient about "faking" - this destroys therapeutic alliance
- High risk of iatrogenic harm from unnecessary procedures

GOLDEN RULE: SOMATIC - Symptoms distressing, Thoughts excessive, Anxiety high, Time-consuming, Inconsistent response, Chronic (>6mo)

91. AUTISM SPECTRUM DISORDER

Primary reference: Kaplan & Sadock's Comprehensive Textbook of Psychiatry / DSM-5-TR

KMU SCENARIO PICKUP LINES

> *"3-year-old boy not speaking, doesn't respond to name, lines up toys obsessively, has meltdowns when routine changed, avoids eye contact since infancy" → pick: ASD Level 2 (requiring substantial support)*

> *"8-year-old with above-average IQ, obsessed with train schedules, speaks in monologues about trains, cannot make friends, was hyperlexic (early reader)" → pick: ASD Level 1 (formerly Asperger's) with restricted interests*

> *WRONG TEMPTATION: "Child has language delay but good social skills and imaginative play" → This is Language Disorder, NOT ASD (must have social communication deficits)*

DEFINITION

Neurodevelopmental disorder characterized by persistent deficits in social communication and social interaction across multiple contexts, along with restricted, repetitive patterns of behavior, interests, or activities. Symptoms present in early developmental period and cause significant functional impairment.

DSM-5-TR DIAGNOSTIC CRITERIA

A. Persistent deficits in social communication/interaction (ALL THREE):
1. Deficits in social-emotional reciprocity (abnormal social approach, failure of back-and-forth conversation, reduced sharing of interests/emotions)
2. Deficits in nonverbal communicative behaviors (poor eye contact, body language, gestures)
3. Deficits in developing/maintaining relationships (difficulty adjusting behavior to social contexts, difficulty sharing imaginative play, absence of interest in peers)

B. Restricted, repetitive patterns of behavior (≥2):
1. Stereotyped/repetitive motor movements, speech, or use of objects
2. Insistence on sameness, inflexible adherence to routines, ritualized patterns
3. Highly restricted, fixated interests (abnormal in intensity or focus)
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects

C. Symptoms present in early developmental period
D. Clinically significant impairment
E. Not better explained by intellectual disability

SEVERITY LEVELS

Level	Social Communication	Restricted Behaviors
Level 3 (Requiring very substantial support)	Severe deficits; minimal response to social overtures; limited initiation	Inflexibility; extreme distress with change; preoccupying repetitive behaviors
Level 2 (Requiring substantial support)	Marked deficits; limited initiation; reduced/abnormal response	Inflexibility; difficulty coping with change; repetitive behaviors obvious to casual observer
Level 1 (Requiring support)	Deficits noticeable to supports; may appear awkward; difficulty initiating	Organization/planning problems; interferes with functioning

ASSOCIATED FEATURES

- Intellectual disability: 50% have IQ <70; 30% have IQ 70-85; 20% have average/above IQ
- Language: 30% nonverbal; hyperlexia (early reading without comprehension) in some
- Savant skills: 10% have isolated exceptional abilities (memory, calculation, music, art)
- Medical: Epilepsy (20-30%), sleep disturbances, GI problems, feeding difficulties
- Psychiatric: ADHD (50%), anxiety disorders, depression (adolescence/adulthood), OCD

ASSESSMENT TOOLS

Tool	Purpose	Age Range
ADOS-2 (Autism Diagnostic Observation Schedule)	Gold standard observational assessment	12 months to adult
ADI-R (Autism Diagnostic Interview-Revised)	Parent interview	Mental age >2 years
CARS-2 (Childhood Autism Rating Scale)	Rating scale	>2 years
M-CHAT-R/F	Screening (Modified Checklist for Autism in Toddlers)	16-30 months

MANAGEMENT

Domain	Intervention	Details
Core symptoms	ABA (Applied Behavior Analysis)	Intensive (20-40 hrs/week), early (age 2-5); Lovaas model
	Early Start Denver Model (ESDM)	Developmental-relationship base for ages 12-48 months
	TEACCH	Structured teach visual supports
Communication	Speech therapy	PECS (Picture Exchange), AAC devices
Social skills	Social skills training	Group interventi social stories
Pharmacotherapy	Risperidone/Aripiprazole	For irritability/aggre (FDA approved)
	Methylphenidate	For comorbid AI (lower doses, mo carefully)
	SSRI	For anxiety/OCI symptoms

COMPLICATIONS

- Family stress: High divorce rates, parental depression
- Educational: Special education needs, bullying
- Adult outcomes: 50% remain dependent; 30% semi-independent; 20% independent
- Mortality: 2-3x increased risk (accidents, epilepsy, suicide in high-functioning)

KMU Exam Traps:

- ASD is SPECTRUM - severity varies widely (nonverbal to highly intelligent)
- Must have symptoms in EARLY childhood (even if diagnosed later)
- Asperger's no longer exists as separate diagnosis (now ASD Level 1)
- Regression occurs in 20-30% (loss of language/social skills around 18-24 months)
- Females often underdiagnosed - better masking/camouflaging skills
- Differentiate from Rett syndrome (genetic testing for MECP2), Childhood Disintegrative Disorder (late regression)

GOLDEN RULE: AUTISM - Atypical social interaction, Unusual communication, Typical routines/repetitions, Interests restricted, Sensory issues, Manifests early

92. SUBSTANCE USE DISORDER

Primary reference: Kaplan & Sadock's Comprehensive Textbook of Psychiatry / DSM-5-TR

KMU SCENARIO PICKUP LINES

"45-year-old male with 20-year history of heroin use, presents with lacrimation, rhinorrhea, piloerection, yawning, and severe muscle cramps 12 hours after last use; restless and anxious" → pick: Opioid Withdrawal Syndrome

"Chronic alcoholic admitted for surgery, develops tremors, hallucinations (seeing bugs), autonomic instability (HR 120, BP 160/100), and seizures 48 hours post-admission" → pick: Alcohol Withdrawal Delirium (Delirium Tremens) - EMERGENCY

WRONG TEMPTATION: "Patient uses cocaine on weekends only, no tolerance or withdrawal, no occupational problems" → This is NOT Substance Use Disorder (requires 2+ criteria including often larger amounts, persistent desire, important activities given up, etc.)

DSM-5-TR DIAGNOSTIC CRITERIA (SUD)

Pathological pattern of substance use leading to clinically significant impairment/distress, manifested by ≥2 of following within 12 months:
1. Substance often taken in larger amounts or over longer period than intended
2. Persistent desire or unsuccessful efforts to cut down/control use
3. Great deal of time spent obtaining, using, or recovering
4. Craving or strong desire to use
5. Recurrent use resulting in failure to fulfill major role obligations
6. Continued use despite persistent/recurrent social/interpersonal problems
7. Important social, occupational, or recreational activities given up or reduced
8. Recurrent use in physically hazardous situations
9. Continued use despite knowledge of persistent physical/psychological problem
10. Tolerance (marked increase in amount/marked decrease in effect)
11. Withdrawal (characteristic syndrome/substance taken to relieve withdrawal)

Severity: Mild (2-3 criteria), Moderate (4-5), Severe (6+)

WITHDRAWAL SYNDROMES

Substance	Onset	Duration	Key Features
Alcohol	6-24h	2-7 days	Tremor, anxiety, insomnia, autonomic hyperactivity, sei hallucinations
Opioids	6-12h	5-10 days	Lacrimation, rhinorrhea, yawn piloerection, myd muscle cramps, diarrhea
Benzodiazepines	1-4 days	Weeks-months	Anxiety, insomni seizures, psychos
Cocaine/Amphetamines	Hours-1 day	Days-weeks	Dysphoria, fatigu vivid dreams, insomnia/hypers increased appetit
Nicotine	Hours	2-4 weeks	Irritability, anxie difficulty concentrating, increased appetit craving

MANAGEMENT: ALCOHOL WITHDRAWAL

EMERGENCY: Delirium Tremens - Mortality 5-15% if untreated

Step	Intervention	Details
1	CIWA-Ar assessment	Clinical Institute Withdrawal Assessment; score >15 = severe
2	Thiamine 100mg IV/IM	BEFORE glucose to prevent Wernicke's encephalopathy
3	Benzodiazepines	Chlordiazepoxide 25-100mg Q6H or Lorazepam 2-4mg Q6H (preferred if liver disease)
4	Symptom-triggered	Titrate to CIWA <10; may require massive doses
5	Phenobarbital	If refractory to benzodiazepines
6	Supportive care	IV fluids, electrolyte correction, magnesium repletion

MANAGEMENT: OPIOID USE DISORDER

Life-saving; may need multiple doses for synthetic opioids

Phase	Medication	Dosing	Notes
Withdrawal Danger	Buprenorphine-naloxone	Start 2-4mg SL when COWS >12; titrate to 12-16mg	Precipitates withdrawal if given too early
Delirium tremens	Clonidine	0.1-0.2mg TID (max	Symptomatic relief;

		1.2mg/day)	monitor BP
	Methadone	20-30mg initial; titrate to 40-60mg	Only in licensed OTP programs
Maintenance	Methadone	60-120mg daily	Full agonist; QTc monitoring
	Buprenorphine	8-24mg SL daily	Partial agonist; safer in overdose
	Naltrexone	50mg PO daily or 380mg IM monthly	Blockade; requires 7-10 days opioid-free
Overdose	Naloxone	0.4-2mg IV/IM/IN; repeat q2-3min	

COMPLICATIONS

- Medical: Liver disease (alcohol, hepatitis C), HIV/AIDS (IV drug use), endocarditis, TB, malnutrition
- Psychiatric: Depression, anxiety disorders, personality disorders, suicide (especially alcohol, opioids)
- Social: Unemployment, homelessness, incarceration, family disruption

KMU Exam Traps:

- Always give THIAMINE before glucose in alcoholics to prevent Wernicke's
- Benzodiazepines are treatment of choice for alcohol withdrawal; phenytoin is NOT effective for alcohol withdrawal seizures
- Buprenorphine precipitates withdrawal if given when patient is NOT in moderate withdrawal (COWS <12)
- Methadone can only be dispensed for addiction treatment through licensed OTP (Opioid Treatment Programs)
- Delirium tremens typically occurs 48-96 hours after last drink (not immediately)
- Polysubstance use is common; always screen for multiple substances

GOLDEN RULE: WITHDRAWAL - Wernicke's prevention (Thiamine), Intensity assessment (CIWA/COWS), Treat with appropriate agent, Hydration, Rescue meds (Naloxone), Observation, Avoid precipitated withdrawal, Long-term maintenance considered

93. DRUG-INDUCED DYSTONIA (ACUTE)

Primary reference: Kaplan & Sadock's Comprehensive Textbook of Psychiatry / Stahl's Essential Psychopharmacology

KMU SCENARIO PICKUP LINES

> *"19-year-old male started on haloperidol 5mg BID yesterday for psychosis, now presents with torticollis (neck twisted to right), oculogyric crisis (eyes rolled upward), and jaw trismus; anxious and in pain" → pick: Acute Dystonic Reaction - treat with anticholinergic immediately*

> *"Patient on metoclopramide for vomiting develops facial grimacing, tongue protrusion, and difficulty speaking 2 days after starting medication" → pick: Drug-induced dystonia from D2 antagonist*

> *WRONG TEMPTATION: "Patient has tardive dyskinesia with lip smacking and choreiform movements after 6 months of antipsychotic use" → This is TARDIVE (delayed onset), NOT acute dystonia; treatment is different (VMAT2 inhibitors, not anticholinergics)*

DEFINITION

Acute, sustained muscle contraction causing twisting, repetitive movements or abnormal postures. Drug-induced acute dystonia is an extrapyramidal side effect (EPS) occurring early in treatment with dopamine D2 receptor antagonists (antipsychotics, antiemetics).

CAUSATIVE AGENTS

Category	Agents	Risk
Typical antipsychotics	Haloperidol, Fluphenazine, Chlorpromazine	High (5-10%)
Atypical antipsychotics	Risperidone, Olanzapine (lower risk), Clozapine (very low)	Moderate (1-5%)
Antiemetics	Metoclopramide, Prochlorperazine, Promethazine	High
Antidepressants	SSRIs (rare), TCAs	Low
Other	Carbamazepine, Phenytoin, Cocaine	Rare

CLINICAL FEATURES

Type	Presentation	Frequency
Torticollis	Neck twisting, lateral flexion	Most common
Oculogyric crisis	Forced upward deviation of eyes	Very characteristic
Trismus	Jaw clenching, difficulty opening mouth	Common
Blepharospasm	Forced eye closure	Common
Lingual/Pharyngeal	Tongue protrusion, dysphagia, dysarthria	Can compromise airway
Opisthotonus	Arched back, rigid posture	Severe
Laryngeal dystonia	Stridor, respiratory distress	Life-threatening

RISK FACTORS

- Young male (M>F, 2:1)
- High potency antipsychotics
- Rapid dose escalation
- Previous episode of dystonia
- Cocaine use
- Family history of dystonia

MANAGEMENT

EMERGENCY if laryngeal involvement or respiratory compromise

Step	Intervention	Dose/Details
1	Anticholinergic (IM/IV)	Benztropine 1-2mg IM/IV (drug of choice)
Alternative	Diphenhydramine	25-50mg IM/IV
Alternative	Biperiden	2-5mg IM/IV
2	Observation	Symptoms resolve within 15-30 minutes
3	Oral anticholinergic	Continue benztropine 1-2mg BID for 1-2 weeks
4	Switch antipsychotic	To lower EPS agent (quetiapine, clozapine, aripiprazole)
5	Prophylaxis	Anticholinergic with initiation of high-risk agents

DIFFERENTIAL: OTHER EPS

Condition	Onset	Features	Treatment
Acute Dystonia	Hours-days	Sustained muscle contraction, abnormal postures	Anticholinergics
Parkinsonism	Days-weeks	Tremor, rigidity, bradykinesia, postural instability	Anticholinergics, amantadine, switch agent
Akathisia	Days-weeks	Subjective restlessness, inability to sit still	Propranolol, benzodiazepines, switch agent
Tardive Dyskinesia	Months-years	Choreiform movements (orofacial), tardive dystonia	VMAT2 inhibitors (deutetrabenazine, valbenazine)
Neuroleptic Malignant Syndrome	Days	Fever, rigidity, autonomic instability, elevated CK	Stop agent, dantrolene, bromocriptine, ICU

KMU Exam Traps:

- Acute dystonia occurs EARLY (hours to days); tardive dyskinesia occurs LATE (months to years)
- Benztropine is drug of choice for acute dystonia; diphenhydramine is alternative
- Always check airway in severe dystonia - laryngeal dystonia is emergency
- Do NOT confuse with neuroleptic malignant syndrome (fever, autonomic instability, elevated CK)
- Metoclopramide and prochlorperazine are common causes - not just antipsychotics
- Prophylactic anticholinergics may be needed when starting high-risk agents in young males

GOLDEN RULE: DYSTONIA - D2 blockade, Young males at risk, Sudden onset, Treat with anticholinergic, Onset early (hours-days), Never delay treatment, Immediate benztropine, Always check airway

94. ANOREXIA NERVOSA & BULIMIA NERVOSA

Primary reference: Kaplan & Sadock's Comprehensive Textbook of Psychiatry / DSM-5-TR

KMU SCENARIO PICKUP LINES

> *"17-year-old female BMI 16.5, intense fear of gaining weight despite being underweight, amenorrhea for 6 months, exercises 4 hours daily, restricts food intake to 500 calories/day; bradycardic (HR 48), hypotensive" → pick: Anorexia Nervosa, Restricting Type - MEDICAL EMERGENCY*

> *"22-year-old university student normal BMI, binge eats large amounts of food when stressed, then induces vomiting 3-4 times weekly for past year; dental erosion, parotid enlargement, hypokalemia (K+ 2.8)" → pick: Bulimia Nervosa*

> *WRONG TEMPTATION: "Patient binge eats but does NOT compensate with vomiting/laxatives; overweight" → This is Binge Eating Disorder (BED), NOT bulimia; no purging behaviors*

DEFINITIONS

Anorexia Nervosa: Restriction of energy intake leading to significantly low body weight (<85% expected or BMI <18.5 in adults), intense fear of gaining weight or becoming fat, and disturbance in self-perceived weight/shape

Bulimia Nervosa: Recurrent episodes of binge eating (eating large amount in discrete period with sense of lack of control) + recurrent inappropriate compensatory behaviors (vomiting, laxatives, fasting, excessive exercise) to prevent weight gain; self-evaluation unduly influenced by body shape/weight

DSM-5-TR CRITERIA COMPARISON

Feature	Anorexia Nervosa	Bulimia Nervosa
Weight	Significantly low (BMI <18.5)	Normal or above (BMI typically >18.5)
Fear of weight gain	Required	Not required (but body image disturbance common)
Body image	Disturbance in self-perception	Self-evaluation unduly influenced by weight/shape
Binge eating	May occur (binge/purge subtype)	Required (≥1 episode/week for 3 months)
Compensatory behaviors	May occur	Required (≥1 episode/week for 3 months)
Amenorrhea	NO LONGER REQUIRED (DSM-5 removed)	Not applicable

MEDICAL COMPLICATIONS

System	Anorexia	Bulimia
Cardiovascular	Bradycardia, hypotension, QT prolongation, cardiomyopathy, sudden death	Arrhythmias (hypokalemia), cardiomyopathy (ipecac)
Electrolytes	Hypokalemia, hyponatremia, hypophosphatemia (refeeding)	Hypokalemia (vomiting/laxatives), hypochloremic metabolic alkalosis
GI	Constipation, gastroparesis, hepatitis	Parotitis, dental erosion, Mallory-Weiss tears, gastric rupture (rare)
Endocrine	Hypothyroidism, hypogonadism, cortisol elevation, growth hormone resistance	Menstrual irregularities
Bone	Osteopenia/osteoporosis (elevated cortisol, low estrogen)	Less severe
Neurological	Seizures (hypoglycemia), cognitive impairment	Seizures (electrolyte disturbances)

MANAGEMENT: ANOREXIA NERVOSA

MEDICAL EMERGENCY if: BMI <14, HR <45, BP <90/60, QTc >500, electrolyte abnormalities, acute food refusal

Phase	Intervention	Details
Medical stabilization	Hospitalization	Cardiac monitoring, electrolyte repletion, thiamine before refeeding
Nutritional rehabilitation	Refeeding	Start 1000-1200 kcal/day, increase 200-300 kcal every 3-5 days; target 2-3 lbs/week gain
Psychotherapy	Family-Based Treatment (FBT)	First-line for adolescents; parents control eating
	CBT-E	Enhanced CBT for adults; 40 sessions over 40 weeks
Pharmacotherapy	Olanzapine 2.5-10mg	Weight gain, reduces obsessional thinking; only agent with evidence
	SSRI (Fluoxetine)	For comorbid depression/anxiety; NOT effective for weight gain

MANAGEMENT: BULIMIA NERVOSA

Intervention	Details
CBT	First-line; 20 sessions over 20 weeks; 50% abstinence rate
Fluoxetine	60mg daily (higher dose than depression); reduces binge/purge frequency
Nutritional counseling	Regular meal patterns, avoid restriction
Interpersonal Therapy (IPT)	Alternative to CBT; slower onset but similar efficacy at 1 year
Topiramate	100-400mg; reduces binge frequency but causes weight loss (contraindicated in AN)

REFEEDING SYNDROME

Life-threatening: Occurs when maln