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## LETTERS TO THE EDITOR

# Benefits of using the Psychiatric Risk Assessment Checklist (PRE-CL) to assess risk in general hospital inpatients

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The high prevalence (up to 60%) and severity of psychiatric and behavioral disorders among inpatients in general hospitals[1] have prompted the search for different models of mental health care.[2] Ideally, these models would address the identification of high-risk situations, such as undetected psychiatric diagnosis, inadequate treatment, and disruptive or self-harmful behavior,[3] and enable adequate care, focusing on the current reality for hospitals: limited budgets, short lengths of stay, and safety concerns. Within these parameters, we developed the Psychiatric Risk Assessment Checklist (PRE-CL), an 11-item screening tool to be routinely applied by nurses upon patient admission and every 48 hours thereafter or in case of emergency, at any time during a hospital stay.[2] Risk-positive screening forms are systematically notified to the hospital psychiatrist and, via case discussion and chart review, an intervention plan is proposed.[2] In a 6-month period, 21,007 screening forms were completed at admission. Of these, 2,820 (13.4%) indicated the presence of risk, 2,420 of which were evaluated by a psychiatrist, who confirmed risk in 2,396 forms (99.0%). The categorization of interventions and the descriptive results are shown in Table 1.

The results highlight that important interventions can be accomplished by using this new model of care, in addition to referrals for further mental health care. The high percentage of ''case management guidance'' (95.4%) confirms the importance of the specialist's support to the healthcare team, mainly to nurses, who oversee patient care around the clock. This support is also expressed in the number of cases that required medication-related interventions and, moreover, guidance on safety measures. Interestingly, the need for guidance was much higher than the need to trigger mental health interventions, suggesting that, with proper advice, the healthcare team can at times successfully manage mild psychiatric/behavioral conditions and safety issues in general hospitals, thereby optimizing costs and resources.

**Table 1** Risk intervention categories

| | n | % |
|---|---|---|
| Case management guidance<br>To the nursing team; to the attending physician; to the hospital leadership | 2,285 | 95.4 |
| Medication-related prevention measures<br>Examples: To reinforce the need to address the patient's use of psychiatric medications on admission in order to prevent relapses and/or abstinence through reconciliation; prevention of patient's self-medication; optimizing the use of psychiatric medications through discussion and guidance of nursing team and medical staff | 1,163 | 48.6 |
| Calling for safety measures during hospitalization<br>Examples: Ensure patient has family member or caregiver as chaperone; remove medications or psychoactive substances from the room; room arrangements, such as keeping windows locked; recommending safety measures for when the patient needs to leave the room | 4,83 | 20.2 |
| Referral for mental health consultations<br>Examples: Referral to mental health care during hospitalization; referral to psychiatric care upon discharge | 233 | 9.7 |
| Presumptive diagnosis<br>When a diagnostic hypothesis is presumed through the risk discussion:<br>- Hypothesis of the presence of a diagnosis that had not been previously reported<br>- Hypothesis of a second diagnosis<br>- Hypothesis of a diagnosis other than that originally reported | 180 | 7.5 |
| Most common presumptive diagnoses: | n=180 | 100 |
| Organic disorders | 45 | 25 |
| Depression | 29 | 16.1 |
| Personality disorders | 25 | 13.8 |
| Alcohol, drug, or medicine abuse | 24 | 13.3 |
| Adjustment disorder | 19 | 10.5 |
| Anxiety disorder | 16 | 8.9 |
| Bipolar disorder | 11 | 6.1 |
| Others | 11 | 6.1 |
| Suicide prevention measures<br>Examples: Referral to mental health care during hospitalization; referral to mental health follow-up after discharge; calling for safety measures on admission for patients at risk | 34 | 1.4 |

Nevertheless, the psychiatrist did trigger a mental healthcare consultation in 9.7% of notifications. This raises the question of whether these patients would have been correctly treated otherwise, as patients who are referred for psychiatric consultation by the healthcare team are often not those who truly need psychiatric care, while those in need are not always referred.[4] These results suggest that case discussion with a specialist can help identify which patients can be managed by the healthcare team and which actually need specialist care.

Interestingly, the psychiatrist was able, through case discussions, to question the accuracy of previously established psychiatric diagnoses or suggest a second hypothesis that could be addressed by the healthcare team. Notably, the most prevalent presumed diagnostic hypothesis represents a major issue of concern in general hospitals: organic disorders, which, left undiagnosed, can lead to death; depression, which affects disease prognosis; and personality disorders, which may cause adverse events.[5] Further studies should address the consistency of the hypothesis achieved through risk discussion, thereby clarifying its contribution to quality of care.

In conclusion, the PRE-CL can be an important tool to address mental health situations in general hospitals.

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## Disclosure

The authors report no conflicts of interest.

## References

1 Lipowski ZJ. Current trends in consultation-liaison psychiatry. Can J Psychiatry. 1983;28:329-38.
2 Camargo AL, Maluf Neto A, Colman FT, Citero Vde A. Development of psychiatric risk evaluation checklist and routine for nurses in a general hospital: ethnographic qualitative study. São Paulo Med J. 2019;133:350-7.
3 Briner M, Manser T. Clinical risk management in mental health: a qualitative study of main risks and related organizational management practices. BMC Health Serv Res. 2013;13:44.
4 Seltzer A. Prevalence, detection and referral of psychiatric morbidity in general medical patients. J R Soc Med. 1989;82:410-2.
5 Carr VJ, Lewin TJ, Walton JM, Faehrmann C, Reid A. Consultation-liaison psychiatry in general practice. Aust N Z J Psychiatry. 1997; 31:85-94.

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# New-onset psychiatric symptoms following intracranial meningioma in a patient with schizophrenia: a case study

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Intracranial tumors affect the central nervous system (CNS) by different mechanisms, including pressure and edema.[1] Despite adaptive mechanisms, when this compensatory system is exhausted, CNS deterioration can occur rapidly with a host of manifestations, including neuropsychiatric symptoms.[2] These may include new-onset psychiatric symptoms and treatment resistance.[1] Herein, we describe the case of a patient diagnosed with schizophrenia who developed reactivation of psychiatric symptoms secondary to a meningioma.

A 52-year-old woman with a 20-year history of schizophrenia, with 15 years' remission of positive symptoms under adequate pharmacotherapy (olanzapine 20 mg daily), presented with new onset of persecutory delusions, anhedonia, disorganized speech, decreased appetite, and suicidal ideation over a 2-week period. Clozapine 50 mg/day was initiated; however, within 5 days of this medication change, the patient experienced dizziness and a convulsive episode, followed by expressive aphasia. Computed tomography (CT) of the head showed a 7-cm tumor in the left frontoparietal transition (Figure 1). The patient underwent neurosurgery for tumor removal and recovered uneventfully, with no neurological deficit and progressive amelioration of psychiatric symptoms. Histopathological examination was consistent with a meningothelial meningioma. Throughout a 3-year follow-up period, the patient remained stable with a new medication regimen: sertraline 150 mg/day, valproate 1,000 mg/day, lithium carbonate 300 mg/day, and aripiprazole 60 mg/day.

Meningiomas may present initially with psychiatric symptoms. In a study conducted by Gupta and Kumar, 21% of meningioma cases presented with psychiatric symptoms in the absence of neurological manifestations. Affective disorders were the most common presentation, and no correlation between brain laterality and psychiatric comorbidity was reported.[3] In another study, psychiatric disorders were diagnosed in 44% of convexity meningiomas, with a significant correlation between edema volume and the presence of coexisting psychiatric disorders, but not between tumor mass volume and psychiatric symptoms.[4] It has also been reported that meningiomas compressing the frontal lobes may cause progressive behavioral and intellectual changes with no other symptoms or signs until the mass effect becomes too great.

A recent meta-analysis of published cases reports that the associations between brain tumor location and specific psychiatric symptoms are not precise, except for anorexia