

CCU INDUCED PSYCHOSIS SYNDROME-CASE STUDY**Sadma Vijayakumar*, Pranavya P. L., Said Ali Muhammad and Aisha Jalaludeen**

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CCU psychosis is a disorder in which patients in an intensive care unit or a similar setting, experience a cluster of serious psychiatric symptoms. Another term that may be used interchangeably for CCU psychosis is CCU syndrome. CCU psychosis is also a form of delirium, or acute brain failure. In our study we discuss the case of a 68 year old male patient who developed CCU psychosis syndrome.

KEYWORDS: CCU psychosis syndrome.**INTRODUCTION**

CCU psychosis is a condition where the patients in an CCU or a similar hospital setting may experience anxiety, become paranoid, hear voices, see things that are not there, become severely disoriented in time and place, become very agitated, even violent etc. The condition has been formally defined as “Acute brain Syndrome” involving impaired intellectual functioning which occurs in patients who are being treated within a Critical Care Unit.

ICU delirium may be classified as hyperactive, hypoactive, or mixed type. Hypoactive and mixed types are the two frequently observed types in ICU patients.^[1] It is hypothesized that cholinergic deficiency might contribute to the occurrence of delirium.^[2] Another hypothesis is that excessive release of dopamine along with a decrease in acetyl choline may cause delirium.^[3]

The patient experiences a potentially bewildering and frightening array of tubes, cables, monitors, alarms and beeper, inappropriate staff communication, treating the patient as if he were hearing impaired, gossip, conferences about other patients and lack of contact is particularly distressing to patients.^[4]

The treatment of CCU psychosis depends on the causes. Family members, familiar objects and calm words may help. Dehydration should call for fluids. Infections must be diagnosed and treated. Sedation with antipsychotic agents may help. One patient in every 3 who spends more than 5 days in an ICU experiences some form of psychotic reaction.^[5]

CASE REPORT

A 68 year old male patient was admitted in the Critical Care Unit of a tertiary care centre with complaints of fever, cough, breathing difficulty since 4 days. He was diagnosed with Lobar pneumonia and was being treated with IV Antibiotics, Steroid and Bronchodilators. He was recovering. It was observed that he quenched for water repeatedly and by the 3rd day of his hospital stay he developed agitation, aggressive behaviour, anxiety, restlessness, hallucinations, sleep disturbance, stress and disorientation. He was diagnosed with CCU Psychosis Syndrome which resolved when he was shifted to ward from the CCU on the 8th day. The syndrome subsided on its own without any specific treatment. He returned to normal life and was hence discharged.

CONCLUSION

Some of the underlying causes of delirium such as anxiety, sleep deprivation, sensory deprivation and overload, immobilization, and unfamiliar environment and pain, are often preventable or correctable. Early detection, investigation and treatment may prevent significant morbidity and mortality. The patient / physician relationship is one of the keystones of therapy. More severe cases may require psychopharmacological measures. An educative and supportive approach by the family physician maybe quite helpful in rehabilitation.^[6]

To prevent ICU psychosis many critical care units now have instituted visiting hours, they try to minimize shift changed in the nursing staff caring for a patient, the lightening is coordinated with normal day-night cycle, etc. ICU psychosis usually goes away when the patient leaves the ICU.

It has been reported that the effort required from the nursing staff to deal with patients having this problem is overwhelming more mentally than physically. Here we described briefly about some aspects of this issue so that we can make it more easily recognisable by the ICU personnel since an early intervention before it reaches its peak is mostly beneficial for our critically ill patients.

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