Darielle Connor
9/8/2020
Queens Hospital Center CPEP

Identifying Data:

- *Name:* WR
- *Sex: Male*
- *Age:* 39 years
- *Date and Time: September 8*, 2020; 1:50 PM
- *Location:* NYC H+H/Queens Hospital Center – Comprehensive Psychiatric Emergency Program (CPEP)
- *Source of Information:* (patient non-reliable), EMS, mother
- *Source of Referral:* Medical ED
- *Mode of Transport:* EMS

Chief Complaint:

Insomnia x4 days

History of Present Illness:

Patient is a 39 year old Caucasian male, domiciled with his mother, unemployed with documented past psychiatric history of Schizoaffective disorder - bipolar type, substance abuse and PMHx of dyslipidemia. Patient was brought in by emergency medical services/activated by self secondary to insomnia and expressed visual hallucinations. Chart is reviewed and labs are reviewed and the patient is currently treated by Dr. Yung at Elmhurst Medical center and had Lithium level of .07 on 9/6/20 and is well known to CPEP, he has had inpatient admission to P5 in the past. Patient evaluated in CPEP triage, noted to be alert and oriented x3, calm and cooperative, with constricted affect and Anxious/ dysthymic mood and coherent speech. Patient is able to express himself but appears somewhat paranoid and guarded. Patient states he feels Anxious after seeing "specks and spots floating around me and had a visual hallucination, he was fearful and called 911. Patient denies any suicidal ideations/Homicidal ideations/Auditory hallucinations. Patient denies any drug or alcohol use. Patient states he has family stressors and his mother is controlling. Patient states he is compliant with his medications: Lithium 900 mg orally in the morning qd, Abilify 25 mg orally qd, Lopid 600 mg orally 2x day. Patient states that he is not diabetic and takes metformin to prevent weight gain caused by current psych medications. Patient states he has not slept in four nights and feels "very anxious".

Collateral information obtained from mother (Erica). She states the patient has been experiencing “mild symptoms” including paranoia, insomnia, leaving the house for long periods of time, restlessness and not wanting to be touched or approached. Mother states that the patient is taking all medications (Lithium 300 mg, abilify 25mg) and follows up outpatient with Dr young @ Elmhurst hospital. Mother states that at last visit the patient’s Lithium levels were very low but he does take all his medications and he is “very on top of his illness and keeping himself safe”. Patient warrants further observation and stabilization in EOU for medication adjustment. Case discussed in detail with Dr. O.

Past Medical History:

- has a past medical history of Hyperlipidemia,
- Denies past surgical history

Past Psychiatric History:

- Aggressive behavior
- Anxiety disorder
- Mood disorder
- Psychotic disorder
- Schizoaffective disorder, bipolar type (8/5/2016)
- Sleep - wake disorder.

Allergies:

No known allergies to medications, foods, or environmental factors

Medications:

- Lithium 900 mg orally in the morning qd
- Abilify 25 mg orally qd
- Lopid 600 mg orally 2x day
- Metformin 500 mg orally 2x day

Family History:

Patient and patient's parents deny any known family history of psychiatric illnesses

Social History:

WR is a Patient is a 39 year old Caucasian male, single, heterosexual, domiciled with mother only, unemployed with documented past psychiatric history of Schizoaffective disorder - bipolar type, substance abuse and PMHx of dyslipidemia. He states he has not been employed since his diagnosis of schizoaffective disorder, bipolar type (8/5/2016) and he declined to state what his employment type was prior to his admission or what type of education he received. He admits to recently starting to smoke cigarettes again after having stopped for the last six months, he owes his relapse to "covid related stress". He is now smoking 10-15 cigarettes per day. Patient denies any alcohol or illicit drug use. Patient states he hasn't been sleeping well now for four days due to "stress". Patient states his eating habits are normal and he denies any sexual activity within the last 9 months. He denies any past history of sexually transmitted diseases. He also denies any history of incarceration, or arrests.

Review of Systems:
Constitutional: Negative for chills and fever.
Respiratory: Negative for shortness of breath and wheezing.
Cardiovascular: Negative for palpitations or chest pain
Gastrointestinal: Negative for abdominal pain, diarrhea, nausea and vomiting.
Neurological: Negative for dizziness, tremors, seizures, syncope, facial asymmetry, speech difficulty, weakness, light-headedness, numbness and headaches.
Psychiatric – Patient denies any visual/auditory hallucinations, feelings of paranoia, feeling down, or loss of interest in activities for the past month, denies suicidal/homicidal ideations.
Vital Signs:Patient Vitals for the past 24 hrs:

- BP: 136/82 (right arm, sitting)
- Pulse: 85 beats/minute (regular)
- Respiratory rate: 14 breaths/minute (unlabored)
- Temperature: 97.6 F (oral)
- SpO2: 98% (room air)
- Height: 70 inches
- Weight: 220 pounds
- BMI: 29.83

All tox screening negative

Lithium levels: 9/1-0.19 9/3-0.07 - sub therapeutic range

Triglycerides 153, cholesterol 165, hdl 38, ldl 96.4

Mental Status Exam:

- *General*
    - Appearance – WR is a tall, average sized, white male with an average frame, who is balding and has some short red hair that surrounds the hairless crown of his head . He is dressed appropriately and is casually groomed with good hygiene. He appears his stated age. He does not appear to have any acute wounds or injuries.
    - Behavior – Upon initial evaluation in Comprehensive Psychiatric Emergency Program triage, the patient is seated looking at the ground and around the room and appears restless as noted by him intentionally rubbing his hands across his knees while sitting. He does not appear to have any tics, tremors, or psychomotor agitation or retardation.
    - Attitude Towards Examiner – WR is calm and cooperative and responds to all questions appropriately. He appears somewhat guarded and nervous during the interview and maintained adequate eye contact. He does not display any hostility or aggression towards the examiner or other unit staff. He was able to establish quick rapport with the examiner in a few minutes.
- *Sensorium and Cognition*
    - Alertness and Consciousness – WR was conscious and alert consistently throughout the interview
    - Orientation – Patient was oriented to person, place, time, and situation
    - Concentration and Attention – WR maintained attention and concentration throughout the interview and did not appear distractible or internally preoccupied. He was able to answer all questions appropriately.
    - Visuospatial Ability – The patient displays normal visual perception as suggested by appropriate balance on his feet, normal gait, and purposeful body movements. He maintained consistent eye contact and displayed normal gaze when he did make eye contact.
    - Capacity to Read and Write – WR displayed average reading and writing ability as shown by his review and signing of admission documents and questioning of documents presented to him at time of interview.
    - Abstract Thinking – The patient displays intact abstract thinking by interpretation of commonly used English metaphors
        - The grass is always greener on the other side – “Some people are never satisfied with what they have.”
        - What makes apples and oranges similar? – “Fruit.”
    - Memory – The patient’s remote and recent memory appear normal as suggested by his ability to provide his mother’s phone number from memory and recollection of recent events leading up to her presentation to the facility.
    - Fund of Information and Knowledge – WR’s intellectual performance was average and consistent with her education level and training.

- *Mood and Affect*
    - Mood – The patient's mood appears anxious and dysthymic. He sat with his hands on his legs and looked about the room throughout the interview. He stated that he wants to be safe to return home to his mother.
    - Affect – WR appeared anxious and his affect was constricted.
    - Appropriateness – WR's mood and affect were congruent throughout the interview.
- *Motor*
    - Speech – WR's speech rate was fast, rhythm was normal, and volume was high. His speech was coherent and organized. The patient's answer latency was normal. He did not require redirection to answer questions.
    - Eye Contact – WR maintained eye contact normally throughout the interview.
    - Body Movements – Patient appeared fidgety during the exam as shown by rubbing his hands on his knees. He reports that he feels restless and like he wants to move but is able to sit still when asked to. He does not display any tics or unintentional body movements. All movements were fluid.
- *Reasoning and Control*
    - Impulse Control – WR displays appropriate impulse control. He denies suicidal or homicidal urges. He is compliant with all requests (urine sample, blood samples, accepting food and drinks etc.)
    - Judgment – WR denies current paranoia, delusions, and auditory/visual hallucinations. His judgment is appropriate.
        - If you were walking on the street and noticed a letter with a stamp and address on the ground next to a mailbox you drop mail in, what would you do? – "Put it in the box."
    - Insight – WR's insight is appropriate; he is aware of his current condition and why he was brought to the hospital ("I have not been sleeping and I feel restless."). He would like to figure out why his lithium levels are so low as he maintains he is compliant with all medications (see HPI).

Patient Health Questionnaire – 9:

1. In the past 2 weeks have you felt little interest or pleasure in doing things you used to enjoy?
    1. Yes, Nearly every day – +3
2. In the past 2 weeks, have you been feeling down, depressed, or hopeless?
    1. Yes (I feel down sometimes), Nearly every day – +3
3. In the past 2 weeks, have you had trouble falling or staying asleep, or sleeping too much?
    1. Yes (insomnia), nearly every day – *+3*
4. In the past 2 weeks, have you been feeling tired or having little energy?
    1. Nearly every day – +3 (feeling too much energy) – 0
5. In the past 2 weeks, have you had poor appetite or been overeating?
    1. Yes, Nearly every day – +3
6. In the past 2 weeks, have you been feeling bad about yourself or that you are a failure or have let yourself or your family down?
    1. Nearly every day – +3 – 0
7. In the past 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?
    1. Nearly every day – +3 – 0
8. In the past 2 weeks, have you been moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?
    1. Yes (fidgety), nearly every day – *+3*

9. In the past 2 weeks, have you thought that you would be better off dead, or thoughts of hurting yourself in some way?
    1. Nearly every day – +3 – 0

Total Score – 26 – Suggests mild depression which may require only watchful waiting and repeat at follow-up.

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal.
Musculoskeletal: Normal range of motion.
Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: He has an anxious mood and constricted affect.

Assessment:
39 yo male with hx as above, co of chest pain which resolved prior to ED visit. Pt admits to watching a scary Iron Maiden video. Upon morning reevaluation, the patient is calm, cooperative w/ a euthymic mood and full affect. Patient was alert, well-kept, and in a good hygienic state. Patient made good eye contact and answered all questions appropriately. Patient is hyperverbal and staring eye contact. Patient appeared to be anxious, moving his hands across his legs and chest. Patient thinking was coherent. Upon chart review his lithium levels are in a sub-therapeutic range. He states he is compliant with his medications and follows up with outpatient psychiatry. However, he feels that a medication increase may be an option for him but worried about "toxicity" and sexual dysfunction.

Differential Diagnoses:
1. *Schizophrenia* – Based on the patient's psychotic manifestations of visual hallucinations and long standing use of antipsychotic medications. This is likely as the patient admits to visual hallucinations with agitation reported from home.
2. *Major Depressive Disorder with Psychotic Features* - The patient has a long and consistent history of antipsychotic use and a depressed mood and affect. Patient does not engage with peers and mother states he has been more down than usual.
3. *Schizoaffective Disorder, Bipolar type* - The patient displays hyperactive speech with self reported visual hallucinations, and some misdirection during interview. Patient also presents with anxious mood and constricted affect.

DIAGNOSIS:
1. Schizoaffective disorder, bipolar type

Plan:

- Admit patient to Comprehensive Psychiatric Emergency Program under Mental Hygiene Law 9.39 legal status for observation and re-evaluation in the morning due to reported hallucinations, constricted affect and anxious presentation
- Lithium levels in sub-therapeutic range, will discuss raising medication with the patient
- Abilify to be increased at discussion with patient as well
- Repeat vital signs in the morning

- Q15 behavioral observation
- Social work team to set up admission and then evaluate for a safe living situation with the mother of the patient. Patient will be followed by outpatient psychiatry in the long term