Alena Rakhman
H&P #3
Rotation 8 – Psychiatry

Location: CPEP, Queens Hospital Center
Date: 10/22/2019
Time: 9:26 PM
Source of Info: patient, patient's family, chart review

CC: bizarre behavior and medication noncompliance

HPI

51-year-old Hispanic female, domiciled with son and 2 daughters, with past medication history of HTN, HLD, and psychiatric history of schizoaffective disorder, anxiety and depression, BIBEMS activated by family for bizarre behavior and medication noncompliance. Pt states that her psychiatric history consists of anxiety and depression only and denies hx of schizoaffective disorder. Pt reports that for the past 6-7 months, she has been experiencing auditory hallucinations, several voices talking to each other but not directly to her, and she does not understand what the voices are saying. Pt also reports that she sometimes hears "stroke" repeatedly (hx of TIA about 8 years ago). She also reports visual hallucinations for the past month, seeing "spirits without heads" which then tend to disappear. She states that she does not experience auditory and visual hallucinations on a daily basis. Pt sees a psychiatrist at Queens Hospital Center, Ms. Maria Ramirez, on a monthly basis and reports that the last time she saw her was last week, discussed her auditory and visual hallucinations with her, and reports that her medication has been altered due to the fact. Pt also reports that she feels "scared" all the time overall, sometimes of "stupid things." Pt denies suicidal or homicidal ideations.

Writer spoke with pt's son, who accompanied the pt, Arturo (646-222-2222), who reports that his mother has been acting "weird" for the past 2-3 weeks, "seeing dead bodies and rays," packing up clothes and lining up the luggage along the home stating that they're moving, and that God has been telling her that she and her family are going somewhere. Mr. Arturo also reports that his mother has been noncompliant with her medication for the past month. He brought a list of his mother's medications with him, and states that he has been attempting to monitor the pt's medications by getting her a daily pill organizer box, which has been unsuccessful. He also states that his mother has been staying up all night on the computer and stays out on the balcony overlooking things for a prolonged period of time. He reports that his mother tends to act agitated and paranoid whenever she is off her medication, and reports past incidents of his mother thinking that one of her neighbors had a bomb, and on another occasion the pt calling EMS for her daughter thinking that something might be wrong with her. Pt's son states that when pt is on meds, she still acts "odd" and will continue to do "little things" out of the ordinary, but not to the extent seen at this time. Son also states that pt has not seen her psychiatrist in a while. In fact, pt's psychiatrist is currently on vacation until November 5th.

Writer also spoke with pt's oldest daughter, Mrs. Alice Cabello (917-222-2222), who states that her mom is "very paranoid," refuses to eat food or drink water thinking that it might be poisoned, barely sleeps and when she does sleep it only lasts for about 20 minutes. Today, pt went to the supermarket with her daughter, and Mrs. Alice reports that she was putting random things in the shopping cart, which prompted her to activate EMS.

Past medical/psychiatric history

- HTN
- HLD
- obesity
- menopause (LMP 05/20/2017)
- TIA (2011)
- schizoaffective disorder
- anxiety
- depression

Immunizations

- Up to date
- No influenza vaccine this year

Past surgical hx

- Appendectomy (2009) – no complications

Past hospitalizations
- See surgical hx

Medications
- Clonazepam/Klonopin 0.5 mg (1 tab PO BID PRN)
- Paliperidone/Invega 3 mg 24 hr tab (1 tab PO in the AM)
- Sertraline/Zoloft 100 mg tab (1 tab PO daily)
- Amitriptyline/Elavil 25 mg tab (1 tab PO nightly)
- Amlodipine/Norvasc 5 mg tab (1 tab PO daily)
- Atorvastatin/Lipitor 20 mg tab (1 tab PO daily)

Allergies
- Tylagesic/Acetaminophen (SOB)
- No known food or seasonal allergies

Family history
- Pt does not know

Social History
- She is divorced and lives with son and 2 daughters.
- She currently does not work, and her last profession was as a babysitter.
- Denies hx of smoking cigarettes, alcohol consumption or illicit drug use.
- She eats a diet low in sodium, saturated and trans fats.

ROS **(completed by CPEP triage RN)**

General
- denies generalized weakness/fatigue, loss of appetite, recent weight loss or gain, fever or chills, or night sweats

Skin, hair and nails
- denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution

Head
- denies HA, vertigo, or head trauma

Eyes
- denies visual disturbance, lacrimation, photophobia, or pruritus; does not wear glasses or contacts

Ears
- denies deafness, pain, discharge, or tinnitus

Nose/Sinuses
- denies congestion, rhinorrhea, epistaxis or obstruction

Mouth and throat
- denies sore tongue, sore throat, mouth ulcers, voice changes, or bleeding gums

Neck
- denies localized swelling/lumps, or stiffness/decreased range of motion

Breast
- denies lumps, pain, or d/c

Pulmonary System
- denies cough, SOB, wheezing, DOE, orthopnea, hemoptysis, cyanosis, or PND

Cardiovascular System
- **reports hx of HTN and HLD;** denies CP, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur

Gastrointestinal System
- denies loss of appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, abdominal distention, constipation, diarrhea, change in bowel habit, hemorrhoids, or melena

Genitourinary System
- denies urinary urgency, urinary frequency, flank pain, nocturia, oliguria, polyuria, dysuria, incontinence, or awakening at night to urinate

Nervous System
- denies HA, seizures, loss of consciousness, weakness, sensory disturbances, ataxia, loss of strength, or change in cognition/mental status/memory

Musculoskeletal System

- denies muscle/joint pain, deformity/swelling, redness, or arthritis

Peripheral Vascular System

- denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change

Hematologic System

- denies easy bruising or bleeding, hx of blood transfusions, lymph node enlargement, or history of DVT/PE

Endocrine System

- denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism

Psychiatric

- **reports depression/sadness and sees a mental health professional, has hx of schizoaffective disorder, anxiety and depression**

Physical Exam

General appearance: Alert, obese, appears stated age, guarded, casually groomed and well-nourished, in no distress.

Vitals:

BP → 111/76 (left arm, sitting)
HR → 88 bpm, regular
RR → 18 bpm, unlabored
Temp → 98.6 F (oral)
SpO2 → 98% (room air)
Height → 68.4 inches
Weight → 264.56 pounds
BMI → 41.4

Skin: Intact, warm, dry; **refused skin assessment for chest, abdomen and lower extremities.**
Head: Normocephalic and atraumatic, no specific facies, nontender to palpation.
Nails: No signs of clubbing.
Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal. No discharge noted in both eyes. No scleral icterus.
Ears: Symmetrical and normal in size. No evidence of lesions, masses, trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TMs unremarkable.
Nose: Symmetrical, no obvious masses, lesions, deformities, trauma, discharge, evidence of foreign bodies.
Sinuses: Non-tender to palpation.
Lips: Pink, moist, no evidence of cyanosis or lesions.
Mucosa: Pink, well hydrated. No masses or lesions noted. No evidence of leukoplakia.
Palate: Pink, moist. Palate intact with no lesions, masses, or scars.
Teeth: Good dentition.
Gingivae: Pink, moist. No evidence of hyperplasia, masses, lesions, erythema or discharge.
Tongue: Pink, well papillated, no masses, lesions or deviation noted.
Oropharynx: Well hydrated, no evidence of injection, exudate, masses, lesions, foreign bodies.
Neck: Good ROM. No masses, lesions, scars, pulsations noted, non-tender to palpation. No stridor noted. No thrills, bruits, palpable adenopathy.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored and no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation.
Lungs: Clear to auscultation and percussion bilaterally. No adventitious sounds. No rales, rhonchi, or wheezing.
Heart: No JVD noted. Carotid pulses are 2+ bilaterally without bruits. RRR; S1 and S2 are normal. No murmurs, rubs, or gallops noted.
Abdomen: Round, symmetrical, no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits. Non-tender to light & deep palpation. No evidence of hepatomegaly or splenomegaly. No masses noted. No evidence of guarding or rebound tenderness.
Peripheral Vascular: The lower extremities are warm and dry. Pulses are 2+ bilaterally in extremities. No bruits noted. No ulcerations noted bilaterally.
Musculoskeletal: Normal range of motion. No edema, tenderness or deformity.
Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tremors or fasciculations. Strength equal and appropriate for age bilaterally, 5/5 throughout.
Neurological: Alert and oriented to person, place, and time. She has normal reflexes and exhibits normal muscle tone. Coordination normal.

CNI: smell → Intact
CNII: visual acuity → OS: Intact, OD: Intact
CNII: visual fields → Full to confrontation
CNII: pupils → Equal, round, reactive to light
CNIII, VII: ptosis → None
CNIII, IV, VI: extraocular muscles → Full ROM
CNV: mastication → Normal
CNV: facial light touch sensation → Normal
CNV, VII: corneal reflex → Present
CNVII: facial muscle function – upper → Normal
CNVII: facial muscle function – lower → Normal
CNVIII: hearing → Intact
CNIX: soft palate elevation → Normal
CNIX, X: gag reflex → Present
CNXI: trapezius strength → 5/5
CNXI: sternocleidomastoid strength → 5/5
CNXI: neck flexion strength → 5/5
CNXII: tongue strength → Normal

Labs

CBC and differential

	Ref Range & Units	
WBC	**4.80 – 10.80 x10(3)/mcL**	**10.90 ↑**
RBC	4.70 – 6.10 x10(6)/mcL	4.77
HGB	14.0 – 18.0 g/dL	12.9
HCT	42.0 – 52.0 %	42.2
MCV	80.0 – 99.0 fL	88.5
MCH	27.0 – 31.0 pg	27.0
MCHC	29.8 – 35.2 g/dL	30.6
RDW	12.0 – 15.0 %	13.6
PLT	150 – 450 x10(3)/mcL	312
Neutrophil %	44.0 – 70.0 %	60.3
Lymphocyte %	20.2 – 45.0 %	30.6
Monocyte %	2.0 – 10.0 %	6.5
Eosinophil %	1.0 – 4.0 %	1.3
Basophil %	0.0 – 2.0 %	0.4
Imm Gran %	0.0 – 2.0 %	0.9
Neutrophil Abs	2.10 – 7.60 x10(3)/mcL	6.58
Lymphocyte Abs	1.00 – 4.90 x10(3)/mcL	3.33
Monocyte Abs	0.10 – 1.10 x10(3)/mcL	0.71
Eosinophil Abs	0.10 – 0.40 x10(3)/mcL	0.14
Basophil Abs	0.00 – 0.20 x10(3)/mcL	0.04
Immature Gran Abs	0.00 – 0.20 x10(3)/mcL	0.10
NRBC Abs	<=0.00 x10(3)/mcL	0.00
NRBC %	0.0 – 0.0 %	0.0

CMP

	Ref Range & Units	
BUN	6 – 23 mg/dL	11
Sodium	136 – 145 mmol/L	142
Potassium	3.5 – 5.1 mmol/L	3.8
Chloride	98 – 108 mmol/L	102
CO2	22 – 29 mmol/L	29
Glucose	74 – 110 mg/dL	99
Creatinine	0.70 – 1.20 mg/dL	0.67
Calcium	8.6 – 10.0 mg/dL	9.4

Total Protein	6.6 – 8.7 g/dL	7.3
Albumin	3.5 – 5.2 g/dL	4.4
Total Bilirubin	0.0 – 1.2 mg/dL	0.3
ALK PHOS	40 – 129 U/L	76
AST (SGOT)	**5 – 40 U/L**	**43 ↑**
ALT (SGPT)	**0 – 41 U/L**	**45 ↑**
Anion Gap	8 – 16 mEq/L	11
eGFR, Non-African-American	>=60 ml/min/1.73m2	>60

Cardiac Panel

Troponin T	<0.010

UA w/Rflx Micro

	Ref Range & Units	
PH Urine	5.0 – 7.5	6.5
Color Urine	Yellow	Yellow
Appearance Urine	**Clear**	**Cloudy**
Glucose Qualitative Urine	Negative mg/dL	Negative
Bilirubin Urine	Negative	Negative
Ketones Urine	Negative mg/dL	Negative
Specific Gravity Urine	1.005 – 1.030	1.020
Blood Urine	Negative	Negative
Protein Urine	Negative mg/dL	Negative
Urobilinogen Urine	0.2 – 1.0 mg/dL	0.2
Nitrite Urine	Negative	Negative
Leukocyte Esterase Urine	**Negative**	**Moderate**
White Blood Cells Urine	**0 – 4 HPF**	**7 – 10**
Red Blood Cells Urine	0 – 3 HPF	0 – 3
Bacteria Urine	**Negative**	**Occasional**
Squamous Epithelial Cells Urine	**0 – 4 HPF**	**7 – 10**
Hyaline Cast Urine	0 – 4/lpf	0 – 4

Drug Screen Qual 5 Panel, Urine

	Ref Range & Units	
Barbituates QUAL Urine	Cut-off = 200 ng/mL	Negative
Benzodiazepines QUAL Urine	Cut-off = 200 ng/mL	Negative
Cocaine Qual Urine	Cut-off = 300 ng/mL	Negative
Methadone Qual Urine	Cut-off = 300 ng/mL	Negative
Opiates Urine	Cut-off = 300 ng/mL	Negative
Creat, Urine (DAU)	mg/dL	160.3

Amphetamines Urine Qualitative – Negative

THC Urine Qualitative – Negative

Pregnancy Beta hCG Urine – Negative

ECG – Normal sinus rhythm

Mental Status Exam
Appearance: alert, guarded, casually groomed
Behavior: appears to be responding to internal stimuli
Speech: pressured, soft and fluent
Mood: sad/depressed
Affect: dysphoric, restricted
Thought Pattern/Process: loosening of associations/derailment

Though Content: paranoid ideas (non-delusional)
Suicidal Ideation: none
Homicidal Ideation: none
Delusions: none
Hallucinations: auditory and visual
Orientation To: time, place, person
Concentration: impaired
Memory: unimpaired
Ability to Abstract: poor
Intellectual Functioning: average
Insight: poor
Judgement: impaired

Differential Diagnosis

1) Schizoaffective disorder, depressive type
   - auditory and visual hallucinations
   - loose associations
   - restricted affect
   - exhibiting strange behaviors in a one-month period
   - continuous signs for the past 6 months
   - depressive episode/component
2) Major depressive disorder with drug induced hallucinations
   - female gender
   - trouble sleeping
   - impairment in social areas of functioning
   - however, drug screen is negative for all

Assessment

51-year-old Hispanic female, domiciled with son and 2 daughters, with past medication history of HTN, HLD, and psychiatric history of schizoaffective disorder, anxiety and depression, BIBEMS activated by family for bizarre behavior and exacerbation of psychosis in context with non-compliance with medication. She admits to auditory hallucinations for several months, visual hallucinations, feeling sad and depressed. Pt warrants admission to CPEP for further observation, treatment, and stabilization.

Plan

- Admit to CPEP for observation/stabilization
- Q15 observation
- Restart medications to aid with improving mood and bizarre behavior
- Labs, UA, urine tox, beta hCG, ECG
- Re-evaluate in AM for higher level of care and inpatient admission
- Diet low in sodium, saturated and trans fats
- Individual/Group/Milieu therapy
- Psychoeducation
- Continue HTN meds, hold if BP <120/80
- Continue HLD meds