H.P 3 Final Evaluation

H&P Final Evaluation
Name: Abd-Manaaf Bakere
Rotation 2: Psychiatry
Date: 03/08/2024
Rotation Location: Queens Hospital Center.

Name: MR
DOB: xx/xx/1996
Age: 27 y/o
Address: 85-86 street t NY
Date/Time: March 04,2024, 10:00 AM
Location: Queens Hospital Center (QHC)
Source of Information: Self and collateral father
Reliability: Not Reliable

CHIEF COMPLAINT/ REFERRAL REASON:

Psychiatric Evaluation from Medical ER

HISTORY OF PRESENT ILLNESS:

MR is a 27 y/o Bangladeshi male, past psychiatry history of schizophrenia, depression, and past medical history of hyperparathyroidism, parathyroid adenoma, domiciled with parents, single, who was brought in by EMS, activated by father for agitation and aggressive behavior in context of medication non-compliance. Patient was given Intramuscular droperidol (Inapsine) 2.5 mg and midazolam (Versed) 2 mg in Medical ER for safety and stabilization. He states he does not know why he is in the hospital. He is continually shrugging shoulders indicating "I don't know" and refuses to speak to providers despite multiple attempts. He admits being treated by outpatient psychiatrist, Dr. Sultana, at Jamaica Hospital. Per Dr. Sultana, patient has been non-compliant with medications.
Collateral father, Shafiqul reports that patient has been increasingly agitated. He has been talking and laughing to himself for days. Patient has poor sleep and is disruptive in the middle of the night. He starts screaming and banging on parent's door for no reason. He has been having hallucinations in regard to "the holy spirit." Patient is due for long acting injection (LAI) Haldol Dec. Father expresses safety concerns. Patients currently denies suicidal Ideation, suicidal attempt, and homicidal ideation.

HISTORY SECTION

PAST PSYCHIATRIC HISTORY
Depression
Psychosis
Schizophrenia

PAST MEDICAL/SURGICAL HISTORY

Hyperparathyroidism
Parathyroid adenoma
Symptomatic cholelithiasis.
Parathyroidectomy
Arthroscopic repair ACL (Right); and
Laparoscopy surg cholecystectomy (N/A, 4/28/2022).

Trauma History

Questions	Responses
Emotional Abuse	No
Neglect	No
Physical Abuse	No
Sexual Abuse	No
Trauma History	No
Type of Violence	No
Victim	No

SOCIAL HISTORY:

Living situation: Lives with Mom and Dad,
Highest level of education: Associate degree
Employment: unemployed
Relationship status: Single
Sleep: poor
Appetite: reduce
Alcohol: Denies use
Tobacco: Denies use
Illicit drug: Denies use
Past arrest/incarceration history: yes

FAMILY HISTORY:

None on file

MEDICATIONS:

Prior to Admission medications

Haloperidol decanoate
Bupropion HCl (WELLBUTRIN PO)
Paliperidone (INVEGA PO)
Sertraline HCl (ZOLOFT PO)

CPEP Medications given:

Haloperidol (HALDOL) 2 mg/mL solution 5 mg
Benztropine (COGENTIN) tablet 1 mg
Diphenhydramine (BENADRYL) capsule 50 mg

Aluminum-magnesium hydroxide-simethicone (MAALOX PLUS) 200-200-20 MG/5ML suspension 30 mL
Bisacodyl (DULCOLAX) EC tablet 10 mg
White petrolatum (VASELINE) ointment 1 Application

ALLERGIES:
No Known Allergies

Review of Systems
General: Constitutional: Negative. Negative for chills, diaphoresis, fever, malaise/fatigue and weight loss.
HENT: Negative. Negative for congestion, ear discharge, ear pain, hearing loss, nosebleeds, sinus pain, sore throat and tinnitus.
Eyes: Negative for blurred vision, double vision, photophobia, pain, discharge and redness.
Respiratory: Negative for cough, hemoptysis, sputum production, shortness of breath, wheezing and stridor.
Cardiovascular: Negative for chest pain, palpitations, orthopnea, claudication, leg swelling and PND.
Gastrointestinal: **admit constipation**. Negative for abdominal pain, blood in stool, diarrhea, heartburn, melena, nausea and vomiting.
Genitourinary: Negative for dysuria, flank pain, frequency, hematuria and urgency.
Musculoskeletal: Negative for back pain, falls, joint pain, myalgias and neck pain.
Skin: Negative for itching and rash.
Neurological: Negative for dizziness, tingling, tremors, sensory change, speech change, focal weakness, seizures, loss of consciousness, weakness and headaches.
Endo/Heme/Allergies: Negative for environmental allergies and polydipsia. Denies bruise/bleed easily.
Psychiatric: admit depression. Denies nervousness, anxiety.

Physical Exam
Visit Vitals
B/P 119/70, Location right arm
Pulse 72,
R: 16
SpO2: 98%
Ht: (5' 8") Wt: 154 BMI-24.6

Constitutional:
General: He is not in acute distress.
Appearance: Normal appearance. He is normal weight. He is not ill-appearing, toxic-appearing or diaphoretic.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: Ear canal and external ear normal.
Left Ear: Ear canal and external ear normal.
Nose: Nose normal.
Mouth/Throat:

Mouth: Mucous membranes are moist.
Pharynx: Oropharynx is clear.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds.
Pulmonary:
Effort: Pulmonary effort is normal.
Breath sounds: Normal breath sounds.
Abdominal:
General: Abdomen is flat. Bowel sounds are normal.
Palpations: Abdomen is soft.
Musculoskeletal:
General: No swelling, tenderness, deformity or signs of injury. Normal range of motion.
Cervical back: Normal range of motion and neck supple.
Right lower leg: No edema.
Left lower leg: No edema.
Skin:
General: Skin is warm.
Coloration: Skin is not jaundiced or pale.
Findings: No bruising, erythema, lesion or rash.
Neurological: intact cranial nerves, strength, sensations, reflexes,
General: No focal deficit present.

MENTAL STATUS:

General:
1.Appearance: dressed in hospital garb, presenting a normal appearance without signs of acute distress.
2.Behavior and Psychomotor Activity: displays avoidant eye contact and selective mutism, indicating avoidant behavior. No psychomotor abnormalities are observed.
3. Attitude Towards Examiner: exhibits avoidant behavior, avoiding eye contact and selectively muting responses during the examination.

Sensorium and Cognition:
1.Alertness and Consciousness: alert and conscious, with no signs of altered sensorium.
2.Orientation: oriented to time, place, and person
3.Concentration and Attention: could not be fully assessed due to the patient's limited cooperation.
4.Capacity to Read and Write: have capacity to read and write
5.Abstract Thinking: Positive for auditory hallucinations
6. Memory: Patients remote, and recent memory were unimpaired.
7. Fund of Information and Knowledge: intellectual performance was intact, consistent with his level of education

Mood and Affect:
1.Mood The patient describes his mood as irritable, reflecting a negative emotional state.
2.Affect: The patient's affect is also noted as irritable, indicating a congruence with his reported mood.
3.Appropriateness: The appropriateness of the patient's mood and affect are consistent. Patient did not exhibit labile emotions, angry outbursts, or uncontrollable crying.

Motor:
1.Speech: patient's speech is selectively mute, contributing to his avoidant behavior.
2.Eye Contact: Avoidant eye contact is noted, aligning with the patient's overall avoidant behavior.
3. Body Movements: No specific abnormalities in body movements or psychomotor activity are reported.

Reasoning and Control:

1.Impulse Control: Patient's Impulse control is impaired,
3.Judgment: The patient's judgment is impaired, suggesting difficulties in making sound decisions.
4. Insight: The patient exhibits impaired insight, indicating a lack of awareness regarding his condition and behavior.

Assessment:
MR is a 27-year-old Bangladeshi male with a history of schizophrenia, depression, and hyperparathyroidism. He presented to the Medical Emergency Room (MER) with agitation and aggressive behavior related to medication non-compliance. The patient has a history of poor insight, judgment, and impulse control. Collateral information from the father revealed increased agitation, disruptive nocturnal behaviors, and hallucinations related to "the holy spirit." The patient was uncooperative during psychiatric evaluation, displaying poor insight and judgment, leading to a decision for admission to the Comprehensive Psychiatric Emergency Program (CPEP) for observation and stabilization.

5 differential diagnoses

1.Schizophrenia Exacerbation:
The patient's history of schizophrenia , coupled with the sudden onset of agitation, aggressive behavior, and hallucinations, suggests a potential exacerbation of underlying psychotic symptoms. Further evaluation is needed to determine the severity and nature of the exacerbation, as well as any potential triggers or stressors contributing to the current presentation.

2. Bipolar Disorder with Psychotic Features:

Considering the reported irritability and mood disturbance, bipolar disorder with psychotic features is a plausible differential diagnosis. Exploring the patient's history for episodes of mania

or hypomania, along with the presence of depressive symptoms, will help establish the diagnosis and guide appropriate treatment strategies.

3. Substance-Induced Psychotic Disorder:
Given the patient's history of medication non-compliance and potential substance use, a substance-induced psychotic disorder should be considered. It is crucial to investigate recent substance use, withdrawal symptoms, and the impact of substances on the central nervous system. A toxicology screen may be warranted to assess for substance involvement.

4.Delirium due to Medical Condition:
The presence of hyperparathyroidism raises the possibility of delirium due to a medical condition. Electrolyte imbalances associated with hyperparathyroidism can lead to cognitive disturbances and altered mental status. Close monitoring of laboratory results and collaboration with medical specialists will be essential to rule out or address any underlying medical contributors.

5.Major Depressive Disorder with Psychotic Features:
Major depressive disorder with psychotic features is another potential diagnosis, given the patient's history of depression, disrupted sleep, reduced appetite, and mood symptoms. Exploring the nature and severity of the depressive symptoms, along with any past episodes of psychosis, will aid in the diagnostic process and guide appropriate treatment interventions.

Plan:

Admission to CPEP: Given the history of mental illness, medication non-compliance, and recent agitation, the patient will be admitted to CPEP for observation and stabilization.

Medication Management:

The patient will receive LAI Haldol Dec 75 mg and Intramuscular Cogentin 2 mg, following Dr. Sultana's recommendations due to a history of extrapyramidal symptoms (EPS).
Additional medications given at CPEP include Haloperidol, Benztropine, Diphenhydramine, Aluminum-magnesium hydroxide-simethicone, Bisacodyl, and White petrolatum.
Safety Monitoring: Due to the patient's impaired insight and judgment, continuous safety monitoring will be implemented in CPEP. Possible 1:1 .

Collaboration with Dr. Sultana: Communication with Dr. Sultana will be maintained to ensure continuity of care, and further recommendations or adjustments in the treatment plan will be considered.

Psychosocial Assessment: A more detailed psychosocial assessment will be conducted to explore the underlying factors contributing to non-compliance, disruptive behaviors, and hallucinations.

Family Involvement: Given the patient's domicile with parents, ongoing communication with the family, especially with the father expressing safety concerns, will be crucial for a comprehensive understanding of the patient's condition and treatment support.

Follow-up with Outpatient Psychiatrist: Post-stabilization, the patient will follow up with Dr. Sultana at Jamaica Hospital to address medication adherence and ongoing psychiatric care.