



Clinical logbook for Simon Downes

Psychiatry, Jackson Park Hospital, 2019

Attending physician: Thodur Ranganathan, M.D.

Duration: from Nov 4th to Dec 20th, 2019

Student details:

Name: Simon Downes
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Clinical supervisor details

Name: Thodur Ranganathan, M.D.

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Clinical procedures performed/observed

**there were no procedures for this rotation. The skill of the clinician is the method of using the clinical interview to effect changes*

Clinical procedure #1

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**Name of the procedure:**

Psychiatric clinical interview

**Principle of the procedure:**

Effective clinical interview on the hospital ward within a short period of time.

Indication(s) for the procedure:

Daily rounds are made by both the medical doctor and psychiatrist to visit new and returning patients. Sometimes when the physician is familiar with the patient, the meeting is quick, but first-time interviews require a very careful approach.

Associated risk(s) with the procedure:

Dr. Ranganathan often repeated to us that in psychiatry, even when all the symptoms and definitions of the DSM5 seem to fit the patient, it can often be something else. For example, you may be seeing a patient when they are taking their medication so the symptoms may be absent which may cause you to make a mistake. For this reason, the clinical interview, including thorough history is very important in psychiatry.

Method:

Firstly, while it is important to maintain a safe distance from the patient, it is important to establish a strong rapport/trust early in the relationship. One of the ways to do this is to simply sit down and not stand while looking down at the patient.

Next, a thorough history is taken including all the major points that are taken during regular medical histories. However, from my experience on this rotation, it seems that the social history played a big part in helping the doctor to come to a decision.

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Many of the patients at Jackson Park Hospital come from disadvantaged backgrounds – and understanding how they live, where they live, whether they take drugs, or have been exposed to violence can paint quite a clear picture. For example, many of the patients are in nursing homes, some of which are not very well maintained, and others are in group homes, which are often bad environments. While some certainly come off the street to escape the cold saying ‘I am hearing voices’, most are referred to the hospital (voluntarily or sent there without choice) for a good reason. They need their medication in order to maintain a normal life. A refill of a needed medication which followed a psychotic episode can really be lifesaving.

In addition, the method in which the doctor speaks with the patient can make all the difference. I have noticed how the doctor’s voice tone can affect the patient’s response, making them compliant or aggressive.

Expected outcome/ advantage/ interpretation:

Each week, Dr. Ranganathan explained in his lectures certain skills he had developed over many years that made his days go well, and patients get what they need.

Over the rotation month, my daily rounds covered both the male and female section of the hospital. The doctor was familiar with many of the patients there, and the way he greeted them was with understanding and compassion.

The medical students were often asked to obtain the histories, and it is not as easy as it looks. Some of the patients are not compliant, and it is very hard to obtain a basic history.

Clinical procedure #2

Name of the procedure:

Patent care over short stays (4 days)

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Principle of the procedure:

The reality of psychiatric care in recent years is that there has been a huge reduction in patient beds, and psychiatric hospitals. The funding for psychiatric wards suffers as insurance companies and government spending reduces. In Chicago, 65% of beds have been lost in the last 40 years, most lost within the last 10 years. For patients, this means that they are afforded less time to take care of their issues.

As a result, it is common to have to deal with a major psychiatric episode within 4 days. This leaves the physician in a very difficult position. It is very challenging to be able to achieve the balance of treating the patient adequately so that they meet the deadline and avoid malpractice by sending them home when they are not ready.

Indication(s) for the procedure:

We were surprised to hear that nowadays, most of the patients must be treated within 4 days. If they are kept too long, they risk losing their spot in a nursing home (on the medical wards it is 10 days).

Associated risk(s) with the procedure:

Malpractice is a great fear for psychiatrists. If a patient kills themselves while at the hospital, the doctor will be pulled into years of litigation. Dr. Ranganathan shared with us a story of how one of the patients in the ER hanged themselves in the waiting room bathroom, and even though he had not seen the patient, he was required to undergo many depositions with lawyers as a great deal of money is involved.

Certainly, in addition to not adequately treating the patient, psychiatrists must also be careful not to cause themselves or the hospital to be sued for malpractice.

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Method:

After completing a detailed history, the patient is seen by both the medical doctor and the psychiatrist. Often, the patient is first sent to the middle of the 4th floor which is the area where both men and women are evaluated before being sent to the men or women's side. It is during this holding time, that they are first seen by the medical doctor to be sure there are no pressing medical issues that must first be dealt with. Patients with serious medical problems do not enter the psychiatric wards until their medical issues have been resolved.

Some of the patients are repeat clients so their care is straightforward. They follow protocol, and the deadline of 4 days is met without problems. In other cases, a more severe case might require coordination with multiple agents such as social care workers, group home, or nursing home staff. Moreover, a patient may have a psychiatrist who treats them regularly who must be consulted.

Expected outcome/ advantage/ interpretation:

In an ideal situation, the patient is familiar with the routine, and the staff work together to treat the acute symptoms and re-medicate the patient so they can return to from where they were sent in time.

The unfortunate reality of this situation is many are not adequately treated and will return with the same condition. The necessity to take care of a patient in such a short window means some will not benefit from their psychiatric care.

Seminars presented/attended

In addition to the weekly lectures, we were required to create an power point presentation focused on a particular area of psychiatry.

1. Seminar topic: Defense Mechanisms: 15 ways people protect themselves from unpleasant thoughts, feelings or behaviors

Duration: 1hr (6:30 am to 7:30am)

Copy of the slides: N/A

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DEFENSE MECHANISMS

15 ways people protect themselves from unpleasant thoughts, feelings or behaviors

1. DENIAL

- When you refuse to accept a reality and instead, act as though it did not exist

EG: An alcoholic says “I don’t have a drinking problem! Look how well I function in my job and at home!”

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2. REGRESSION

- When you revert to an earlier stage of development to avoid unacceptable thoughts or impulses

EG: An adult stays in bed rather than face a work problem. A child wets his bed to avoid facing adult feelings of responsibility

3. ACTING OUT

- When you do something extreme to avoid expressing difficult thoughts or feelings

EG: A child has a tantrum or an adult throws something or intentionally injures themselves

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4. DISSOCIATION

- When someone enters another world or moment in order to handle a certain situation

EG: A person who was abused as a child may have multiple selves in order to cope

5. COMPARTMENTALIZATION

- When someone uses a different set of values for a certain behavior, and disconnects from it

EG: A person who is dishonest on tax returns but is an honest businessman

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6. PROJECTION

- When one converts disagreeable thoughts or feelings onto another

EG: When a spouse accuses the other of shouting when they are the one who is shouting

7. REACTION FORMATION

- When one converts unwanted or dangerous thoughts to the opposite

EG: When an employee says they love working at a place when in fact they hate it - they are not able to express the emotion or unhappiness

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8. REPRESSION

- When memories or experiences are blocked

EG: A person who had a traumatic event will unconsciously erase the memory and as a result, not constantly suffer from it

9. DISPLACEMENT

- When uncomfortable thoughts or feelings are directed to another

EG: An employee who is treated badly by his boss comes home and is angry with his wife or his pet

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10. INTELLECTUALIZATION

- When a person avoids an unacceptable feeling or situation by focusing more on thinking than expressing the emotion

EG: When someone diagnosed with a terminal illness focuses only on trying to figure out the remedy rather than deal with the painful emotions

11. RATIONALIZATION

- When a person changes their internal story in order to make the new situation fit their own thoughts

EG: When a person in love is dumped and then says they never liked them from the beginning

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12. UNDOING

- When someone tries to erase unwanted behavior by doing the opposite in attempt to balance it out

EG: When someone insults a person, then only gives them compliments to try to erase the harsh words

13. SUBLIMATION

- When unacceptable thoughts or impulses are rechanneled into good ones

EG: When humor is used to reduce the intensity of a situation, or in order to not watch pornography, a person channels the energy into exercise

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14. COMPENSATION

- Supporting one's self esteem by emphasizing a strong area in order to hide a weak are

EG: When someone is not able to do the home accounting but points out how well they do the laundry

15. ASSERTIVENESS

- Being respectful, direct and firm, but not overly aggressive

EG: A timid medical student who learns to speak with confidence and respect to attending physicians when expressing opinions about patient cases

Other activities*

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Provide details of any other activities. Examples of other activities include: medical research, medical counseling, and health education

n/a

Case history #1: Paranoid schizophrenia



(Example image)

Patient details

Age: 57

Sex: M

Marital status: S **Occupation:** No work - Supplemental Security Income (SSI)

Date: 12-17-19

Attended out-patient department: n/a

Admitted to Med/Surg ward:

Jackson Park Hospital Psychiatric Ward

Admission:

Patient was admitted to the central intake center of the 4th floor, then transferred to the men's section. Patients who are not violent are given a

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roommate and await the medical doctor and psychiatrist in their room. The rooms are mostly empty with only a bed. There are no tubes or wires etc. that they could use to hang themselves or as weapons. There is a day room where they can watch TV, and a also common lunch area where they can watch TV. When they are not in their rooms, they pace around the ward which is rectangular, with no exit point. The nurse station does not have protective glass as it does in the holding area.

Chief complaint(S):

The patient presented as mute. This presented a big problem as were were not able to obtain a verbal history at first. The medical doctor was able to bring up his medical record, but there was no record of him being mute. The medical students were given the task of trying to communicate with him. Eventually, after 20 minutes, he began talking spontaneously.

He companied of that he was unable to move his mouth or ears, saying that from time to time, they stop working. He was concerned that he was being poisoned by the staff of the nursing home, and this hospital.

History of present illness (HPI):

Past history:

His previous medical record showed he had been diagnosed with paranoid schizophrenia, but had no significant medical problems.

Family history:

Mother and father alive with no significant medical problems, both sister and brother have hypertension but no psychiatric illness

Personal and social history:

Single, no children, smokes 1pk/day, drinks 3 beer/day, no drugs

Review of systems:

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NEURO –no dizziness or Hx of neuro Dx, HEENT – No allergies, no glasses, no throat pain, RESP - No wheezing, never had resp diff, CV – no hx chest pain or orthopnea, no PND, atypical chest pain, GI- no report of abnormalities, MSK – needs cane to walk, GU – WNL, Endo – normal function, hormonal WNL, HEME/IMM– not anemic, normal coagulation

Physical examination

General survey:

Very this, normal gait, says has difficulty making his mouth and ears work

Vital signs:

T: 98.6, BP: 130/76, P: 78, RR: 20, O2: 99, Pain: 0

Skin:

Psoriasis on face, no scars, bruises, rash or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no redness, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged, no pain with turning

Back:

No discoloration or scars

Thorax and lung:

Lungs – clear, no wheezing, no crackles, rales, no rhonchi

Cardiovascular system:

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S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Very thin, soft, not distended not tender. BS + in all quads. No bruits noted. No rebound tenderness. Liver WNL no hepatosplenomegaly, No Rovsing sign. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis, no edema.

Nervous system:

A&Ox3 (no pain), CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

No blood tests performed that day

Differential diagnoses:

Bipolar I Disorder with psychotic features; Delusional Disorders; Schizoaffective Disorder; Brief Psychotic Disorder; Psychosis NOS

Provisional diagnosis:

Paranoid schizophrenia

Investigations and result:

Interview only with physical exam

Final diagnosis:

Paranoid schizophrenia

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Characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations.

Treatment and follow-up:

In this case, the medical doctor, working with the psychiatrist refilled his medication of Olanzapine (Zyprexa) and continued his request for acetaminophen for occasional headaches.

Final outcome:

Pt was sent back to the day room/his room.

Review of case:

This was an interesting situation for medical students because the physician had seen the patient before and knew he was not mute. His medications were fully understood, and he was what the doctor called a 'frequent flyer', who came to the psych ward every now and then, usually voluntary to reassess his situation.

As a student, I was surprised that more was not being done for this man who had no support through his nursing home or through a private doctor. Coming the psych ward was part of his monthly plan, and it seemed likely that it would continue indefinitely.

1. Correct protocol:

Schizophrenia: Overview and Treatment Options

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4159061/>

Pharmacotherapy for schizophrenia: Acute and maintenance phase treatment

<https://www.uptodate.com/contents/pharmacotherapy-for-schizophrenia-acute-and-maintenance-phase-treatment>

2. Relevant research articles:

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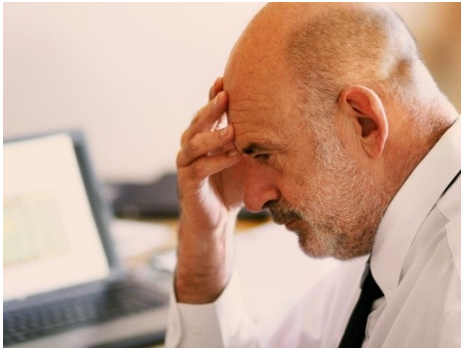
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Is paranoid schizophrenia really camouflaged depression?

<https://psycnet.apa.org/record/1988-23546-001>

Case history #2: Schizophrenia



(example image)

Patient details

Age: 56

Sex: M

Marital status: M

Occupation: Walmart employee

Date: 11-19-19

Attended out-patient department: Emergency department referral

Admitted to Med/Surg ward: n/a

Admission: Pt. was not admitted at first, walk-in only Jackson Park Hospital, then admitted to the psychiatric ward

Chief complaint(S):

Pt. says he hears voices that tell him to do things, and he is depressed. He wishes to have his drug prescription refilled.

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**History of present illness (HPI):**

3-year history of hearing voices, and depression. No manic episodes.

Past history:

High blood pressure, Type 2 diabetes, BPH, takes Seroquel (Quetiapine) and Lithium

Family history:

Father died of heart disease, mother is alive and well. Brother died of stomach cancer.

Personal and social history:

Married, one child, drinks socially, no tobacco, marijuana occasionally

Review of systems:

NEURO – No dizziness, never had any head issues, HEENT – Throat is not, no infections, RESP – breathes with ease, not SOB, CV – no MI, no orthopnea, no PND, denies chest pain, GI- WNL, MSK – no pain or abnormalities, no leg swelling, no numbness in toes, GU – BPH, Endo – WNL, HEME/IMM– no coagulopathies

Physical examination**General survey:**

Alert and oriented x 3, no difficulty communicating, truncal obesity

Vital signs:

T: 97.3, BP: 185/90, P: 90, RR: 22, O2: 99, Pain: 0

Skin:

Supple, no scars, some bruises, no rash, no edema

Head, eyes, ears, nose, throat (HEENT):

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NC/AT, nontender, PERRLA, EOMI, pharynx soreness, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

Denies any pain, can touch toes, stretch with no difficulty

Thorax and lung:

Lungs – clear to auscultation, no crackles, rales, no rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis clubbing or edema

Nervous system:

A&Ox3, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

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No additional tests performed

Differential diagnoses:

- Brief psychotic disorder
- Delusional disorder
- Schizoaffective disorder
- Schizophreniform disorder
- Schizotypal personality disorder

Provisional diagnosis:

Schizophrenia

Investigations and result:

The patient came with a list of his medications and history of his treatment to give to the psychiatrist. There were no additional investigations.

Final diagnosis:

Schizoaffective disorder

Symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression.

Treatment and follow-up:

The patient was asking to have his prescription filled so he could go home. However, as he had come in through the emergency room, and he was displaying symptoms of major depression in addition to his hearing of voices, it was determined that he should stay the full four days for observation.

Final outcome:

The pt. was given his medications again and agreed reluctantly to stay in the psych ward for four days but remarked that he was afraid of the other

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patients, and did not feel safe at Jackson Park Hospital. Security was consulted and the pt. went back to his room to rest.

Review of case:

I had trouble understanding how the patient ended up in the psychiatric ward after voluntarily coming to the Emergency department to refill his medications. I am thinking that as he was displaying worrisome symptoms of depression, the legal responsibility now lay on the hospital to protect him until they decided he was ready to go home.

One other issue is whether he was correctly diagnosed with schizophrenia by his first diagnosis. This new diagnosis of schizoaffective disorder, while more inclusive, may cause the pt. to be confused with his condition, and further complicate his medication regimen. The articles below deal with some of these issues, psychiatry how schizoaffective disorder is not widely understood or accepted.

1. Correct protocol:

The diagnosis is difficult as symptoms of schizophrenia such as delusions or hallucinations may be present as well as depression or mania. Therefore, they may be misdiagnosed with schizophrenia or depression only. While the definition and protocol seem to be clear, there is some disagreement as to whether schizoaffective disorder should exist as a diagnosis.

Schizoaffective disorder

<https://www.nami.org/learn-more/mental-health-conditions/schizoaffective-disorder>

Schizoaffective disorder overview

<https://www.mayoclinic.org/diseases-conditions/schizoaffective-disorder/symptoms-causes/syc-20354504>

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2. Relevant research articles:

Is schizoaffective disorder a distinct categorical diagnosis? A critical review of the literature

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2646642/>

Schizoaffective Disorder: Concept and Reality

<https://academic.oup.com/schizophreniabulletin/article/10/1/14/1861765>

Case history #3: Anti-social personality disorder



Patient details

Age: 33

Sex: M

Marital status: S **Occupation:** No work - Supplemental Security Income (SSI)

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Date: 11-21-19

Attended out-patient department: n/a

Admitted to Med/Surg ward: n/a

Admission: Pt. was sent by his group home after fight with residents via the police to the psychiatric care unit of Jackson Park Hospital

Chief complaint(S):

Pt. denied any need to be in the psychiatric facility. He said he was forced to come against his will and had been compliant with all the rules of the facility.

During the medical interview, prior to the visit with the psychiatrist, a security guard said to him that it was impossible that he was there for no reason. The pt. became angry and so did the security guard, and this resulted in 6-8 people jumping on the patient and dragging him down the hall to be tied to the bed in hard restraints. He was given Ativan and Haldol to calm down.

History of present illness (HPI):

Pt. presented looking healthy, with no apparent medical conditions. He was angry, but calm without acting out, and no aggression.

Past history:

The patient has a history of over ten years being in an out of the psych ward, incarceration, and ant-social behavior.

Family history:

No significant family history

Personal and social history:

Single. He lives in a group home most of the time, goes in and out of nursing homes. He denied smoking, alcohol, or drugs, and his tox screen on his medical record did not show any of these.

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Review of systems:

NEURO – reports some Hx of head injuries/syncope, HEENT – no nodules, pain erythema, RESP – no lung abnormalities, CV – no Hx of chest pain, GI- WNL, MSK – no pain or abnormalities, no leg swelling, no numbness in toes, GU – WNL, Endo – no Hx of problems, HEME/IMM– no coagulopathies

Physical examination:

General survey:

Pt appears healthy, with contusion on eye as a result of fight in group home. Non-impaired physically, A&O x3.

Vital signs:

T: 98.6, BP: 120/85, P: 75, RR: 18, O2: 98, Pain: 1

Skin:

Contusion around eye, bruises on arms, no rash or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL

Thorax and lung:

Lungs – clear to auscultation, no rales, no rhonchi

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**Cardiovascular system:**

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis or clubbing or edema in legs, or arms

Nervous system:

A&Ox3, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups, DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

No other labs were taken

Differential diagnoses:

Narcissistic personality disorder, MDD

Investigations and result:

The report was read from the group home and a phone call was made to the administrators to confirm what had happened. It was confirmed that he had started a fight with a resident who questioned his diagnosis.

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Final diagnosis:

Anti-social personality disorder

Characterized by a long-term pattern of disregard for, or violation of, the rights of others. A low moral sense or conscience is often apparent, as well as a history of crime, legal problems, or impulsive and aggressive behavior.

Treatment and follow-up:

The patient was given fluoxetine (Prozac) and sertraline (Zoloft).

I had never seen a patient subdued with such power, and it was quite disturbing to see him dragged half naked down the hall to his room and put into restraints. From the side of the medical students, it seemed that that security guard had aggravated the patient by denying his story, and before the patient was violent, the security team decided to subdue him. I thought it had been unnecessary to treat him in this manner.

Final outcome:

Twenty minutes following the incident with the security team, the patient escaped from the restraints and went to have lunch with the other patients. When I saw him calmly eating his lunch as if nothing had happened, I had respect for his fortitude to recover despite his poor treatment. He returned to his group home four days later.

Review of case:

In this case, the patient needed his medication refilled, and to have some time away from his group home. I thought that the system in this case was working well for him. However, I thought that the security team overstepped their authority by questioning the patient during his clinical interview. If it had not been for their behavior towards him, the patient would not have acted out. It is unfortunate that the training is inadequate, and that hospitals in this neighborhood are not desirable places to work. Many things go unchecked because of the lack of resources.

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1. Correct protocol:

Antisocial Personality Disorder: The nice guideline on treatment, management and prevention

<https://www.nice.org.uk/guidance/cg77/evidence/full-guideline-242104429>

Antisocial Personality Disorder

http://drreidmelo.com/wp-content/uploads/2015/12/2007_AntisocialPerso.pdf

2. Relevant research articles:

Psychological interventions for antisocial personality disorder

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4167848/>

The Natural History of Antisocial Personality Disorder

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4500180/>

Case history #4: PTSD and Heroin abuse



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**Patient details**

Age: 65

Sex: W

Marital status: S

Occupation: no work, no income

Date: 12-15-19

Attended out-patient department: n/a

Admitted to Med/Surg ward: n/a

Admission: Pt. admitted to Jackson Park Hospital Psychiatric Ward (holding area)

Chief complaint(S):

Heroin withdrwawal, ptsd, depression

History of present illness (HPI):

The patient was sent to the psychiatric ward due to violence in the nursing home, mostly fighting with other residents. She has tremors and is fearful of men. She was mostly incoherent, babbling without clear expression.

Past history:

Heroin abuse, multi-drug addict for 20 years

Family history:

Both parents dead, unknown causes, no siblings

Personal and social history:

Single with no children, smokes 1.5 packs/day, no week, no drugs

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Review of systems:

NEURO – no dizziness, normal mentation, HEENT – no neck problems or hoarseness, RESP – lungs clear CV – WNL, no PND, no chest pain, GI- WNL, MSK – some weakness in legs, stable, walks slowly, GU – WNL, Endo – denies abnormalities, HEME/IMM– no coagulopathies

Physical examination

General survey:

Slightly overweight, face looks very weathered, sad appearance

Vital signs:

T: 99.1, BP: 128/62, P: 97, RR: 21, O2: 198, Pain: 5

Skin:

Dry, no scars but has marks on arms and legs from needles (she showed us), no bruises, rash or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

Neck:

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL, no scoliosis, slight kyphosis

Thorax and lung:

Lungs – clear, some wheezing on expiration, no crackles, rales, or rhonchi

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**Cardiovascular system:**

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses wnl and equal B/L

Abdomen:

Soft, non-distended. BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis clubbing or edema, marks from needles and erythema

Nervous system:

A&Ox3, CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L, Motor 5/5 in all muscle groups (some weakness walking), DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

No other lab values available

Differential diagnoses:

acute stress disorder, dissociative disorders, depression, generalized anxiety, panic disorder, phobias, substance abuse, psychiatric manifestation of medical malingering

Provisional diagnosis:

PTSD, heroin withdrawal

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Investigations and result:

Physical exam only supported her claim of heroin dependence, she supported the story of PTSD from abuse as a child by men

Final diagnosis:

PTSD, MDD

Treatment and follow-up:

Her treatment was to be determined after consultation between the psychiatrist and medical doctor. However, commonly prescribed drugs for PTSD are SSRIs such as fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil), and medicines to decrease the physical symptoms such as prazosin (Minipress), clonidine (Catapres), guanfacine (Tenex), and propranolol.

Communication was difficult as she spoke without direction. Towards the end of the clinical interview she became angry, and we had to abandon the examination. She was sent back to her room until a consultation between the psychiatrist and medical doctor could be convened.

Final outcome:

Pt received SSRI medications as listed above to deal with her PTSD, and she was referred to a treatment facility for her heroin abuse.

Review of case:

In nursing homes, residents can have access to drugs and alcohol. Despite the advertising that seems to express good care of patients, I was constantly reminded that this is often not the case.

Still, despite her desperate conditions, I was happy that Jackson Park was there for her, and that the psych ward knew her well. As a result, she received the care she needed. I found myself wondering if her life could ever return to

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normal, whether she could escape her addiction, and be treated successfully for her PTSD. I realized that this is the reason we are in medical school.

1. Correct protocol:

Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD)

<https://www.apa.org/ptsd-guideline/>

2. Relevant research article:

Treating PTSD: A Review of Evidence-Based Psychotherapy Interventions

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6224348/>

Posttraumatic Stress Disorder in the National Comorbidity Survey

<https://jamanetwork.com/journals/jamapsychiatry/article-abstract/497313>

Case history #5: Obsessive compulsive disorder

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Patient details

Age: 28

Sex: M

Marital status: S

Occupation: No work, no income

Date: 12-16-19

Attended out-patient department: n/a

Admitted to Med/Surg ward: n/a

Admission: Pt. was admitted to Jackson Park Hospital after walking into the Emergency department with a psychotic episode. He was then sent upstairs to the psychiatric ward for evaluation.

Chief complaint(S): Loss of control over his life, suicidal ideations

History of present illness (HPI):

Pt. had not showered in over a month and his body odor was overpowering. He appeared disheveled but seemed to be happy.

Past history:

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OCD, and suicidal ideations such as running into traffic, hanging himself or cutting his neck with scissors.

Family history:

Pt states all in his family are well and no one has a serious illness.

Personal and social history:

Pt. lives on the street, or sometimes in group homes, or with friends. He smokes marijuana daily, and drinks any alcohol he can find (at least 1/5th liters per day), but does not do drugs.

Review of systems:

NEURO – no mental abnormalities, no dizziness or bumps on head, HEENT – no sore throat, no nodules, RESP no history of asthma or breathing diff / trauma, CV – orthopnea, sleeps with no difficulties, no chest pain, GI- WNL, MSK – no numbness or difficulty with gait, GU – WNL, Endo – no reported abnormalities, HEME/IMM– no coagulation or bleeding problems

Physical examination:

General survey:

Pt had no pain, communicates fluently, very thin, not bathed

Vital signs:

T: 97.1, BP: 145/78, P: 95, RR: 18, O2: 99, Pain: 0

Skin:

Clear skin, no scars, bruises, rash or edema

Head, eyes, ears, nose, throat (HEENT):

NC/AT, nontender, PERRLA, EOMI, pharynx WNL, no nasal discharge

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**Neck:**

Supple, JVD neg, no bruits, LN and thyroid not enlarged

Back:

WNL, no scars

Thorax and lung:

Lungs – clear, no wheezing, crackles, rales, or rhonchi

Cardiovascular system:

S1 & S2 WNL, RRR, No rubs, gallops, or murmurs while sitting or supine. No JVD, clubbing or edema noted. No carotid bruits, DP & PT pulses nl and equal B/L

Abdomen:

Soft, non sensitive, BS + in all quads. No bruits noted. No tenderness or masses on light and deep palpation in all 4 quads. No rebound tenderness. Tympanic in all 4 quads. Liver WNL no hepatosplenomegaly, No Rovsing/Psoas/Obturator sign noted. Negative murphy sign. No CVA tenderness.

Extremities:

No cyanosis clubbing or edema.

Nervous system:

A&Ox3 (no communication difficulties), CNs 2-7, 9-12 intact B/L. Sensation to light touch, vibration and proprioception intact in all extremities B/L. Motor 5/5 in all muscle groups (no difficulty with gait), DTRs 2/4 and symmetric in all extremities B/L, Babinski downward pointing toes.

Others:

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No addition labs ordered

Differential diagnoses:

Phobic disorders (water in this case), anorexia nervosa, schizophrenia

Provisional diagnosis:

OCD

Investigations and result:

The patient appeared normal and was not on any medications. His psychotic episode in the ER seemed to have resolved and to have been related to his OCD. We suggested that he should shower, and he said he would consider it.

Final diagnosis:

Obsessive compulsive disorder with brief psychotic episode

Treatment and follow-up:

Initially, after a thorough history and conversation about his life, the medical doctor sent him back to his room. Then, the psychiatrist met with him briefly and dictated his orders, which was Zoloft (sertraline), he was considering adding another, possibly Anafranil (clomipramine), but had not come to his conclusion which was best for him.

Final outcome:

One day, I came into the hospital for rounds, approximately 2-3 days after our initial meeting. He had showered and was walking in laps around the halls, being very friendly with everyone. I was very happy to see he had showered and was in good spirits.

Review of case:

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I was intrigued with this man who refused to shower. As he had OCD, I investigated it further and found that it is quite common for people with mental illness to avoid showering/bathing. Among other reasons, this is due in part to not wanting to be alone with one's thoughts for too long, and not wanting to have their personal space invaded by water, and more specifically, not wanting to mix with others in the showers. Also, not showering is a way to maintain control over their own bodies-physically, while they feel unsettled mentally. Various explanations exist for this phenomenon, and I hope we can move closer to supporting patients with this difficulty to bathe as it causes them problems with social interactions.

1. Correct protocol:

Clinical practice guidelines for Obsessive-Compulsive Disorder

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5310107/>

Brief strategic therapy for obsessive-compulsive disorder: a clinical and research protocol of a one-group observational study

<https://bmjopen.bmj.com/content/6/3/e009118>

2. Relevant research articles:

Obsessive-Compulsive Disorder

<https://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml>

Cause of obsessive-compulsive disorder discovered

<https://www.sciencedaily.com/releases/2017/03/170316112145.htm>

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