Keziah Babu- Psych Rotation HPI#1

Identifying information:
Full Name: E.F
Address: lives with mother
Date of Birth: 8/2001
Date & Time: 5/23/2022
Location: QHC, Jamaica, NY, CPEP
Religion: catholic
Source of Information: Self; collateral from mother
Reliability: Self unreliable, mother reliable
Source of Referral: n/a
Mode of Transport: BIB NYPD (not under arrest) activated by mother
Chief Complaint: "Acting bizarre after not taking his medication for some time"

HPI
21 year old Hispanic male, single, unemployed, domiciled with mother with PPHx of schizophrenia was BIBEMS/ police (not under arrest), activated by his mother due to bizarre behavior secondary to noncompliance to medication. Patient states that he "feels totally fine and does not know why he is here".
Collateral information provided by mother (via phone call). Mother states that the patient has been acting more bizarre since he stopped taking his medication two weeks ago. In recent 2 weeks, he would often go to the city late at night and return the next morning with no memory of where he went. The mother endorses witnessing the patient climbing a tree the day prior and stayed up there for a considerable amount of time. He was also found naked at his mother's doorstep the night prior. He has not shown signs of aggression towards her in the past two weeks. According to his mother, the patient had a psychiatrist appointment at LIJ, which he did not go to.

Upon psychiatric evaluation, the patient appears to be anxious, casually dressed, initially uncooperative but later improved, and had a blunted affect. When asked about the quality of his sleep, the patient voiced somatic delusions, explaining that he felt that he was fighting a dark presence in his sleep. He believes the "dark force" appeared because of the McDonalds he ate the night before. Patient denies suicidal or homicidal ideations. The patient drinks alcohol 3 times a week. Denies other drug abuse.

At this time, the patient displays poor insight and poor judgment. Patient wishes to be transferred to LIJ. Case discussed with Dr. Hasan, who is in agreement with assessment and plan.

PMHx

Patient denies history of HTN, DM, HLD, CVD, Cancer or childhood illnesses.
Immunizations and COVID **vaccinations not up to date**

PSHx

Denies past history of surgeries, past injuries, blood transfusions or complications.

Medications

- **Prior to admission medications: not on file**

Allergies

- NKDA
- Denies food, cat, dog and environmental allergies.

Family Hx

- Denies family history of psychiatric illnesses, allergies, cancer, lung disease, thyroid disease, diabetes, gastrointestinal disease and gallbladder disease.

Social Hx

- E.F. is a single 21 year old male, unemployed, domiciled with his mother. Patient denies smoking cigarettes or marijuana, drinking alcohol or illicit drug use.
- Patient endorses good appetite, and poor sleep
- Heterosexual, Denies history of STI.

Review of Systems

General – Denies weight loss or weight gain, fever, loss of appetite, generalized weakness, chills, or night sweats.

Skin, hair, nails – Denies any recent changes in skin texture, masses or lesions, excessive sweating, change in pigmentation, moles/rashes or changes in hair distribution.

Cardiovascular system – Denies history of coronary artery disease, angina, syncope, murmurs,

palpitations, irregular heart rate, feet swelling and dizziness.

Nervous – Denies history of syncope, dizziness, muscle weakness, seizures, sensory disturbances, ataxia, loss of strength, change in cognition, memory, or balance and coordination.

Psychiatric – Admits to somatic delusions and is religiously preoccupied. Denies suicidal/ homicidal ideations. Patient admits to history of multiple psychiatric hospitalizations in NYPQ. Denies thoughts of hurting others, auditory or visual hallucinations.

Physical exam

Vital Signs:

BP: 110/85

R: 18 breathes per min, unlabored

P: 98, regular

T: 97.5°F, oral

O2 Sat: 99% Room air

Height: 5'8" **Weight**: 122 lbs. **BMI:** 18.5

Skin, hair, nails: No visible lesions, rashes, bruising, ulcers, lesions or masses on exposed hands, neck or face. Capillary refill 2 seconds. No bruising, open wounds, or seborrheic dermatitis.

Chest: Symmetric, no evident deformities. Respiration unlabored on Room air, no audible wheezes. No paradoxical respiration or accessory muscle use noted.

Heart: S1 and S2 have regular rate and rhythm. No murmurs, S3, S4 or S2 splitting. No friction rubs. Carotid pulses are 2+ bilaterally. No bruits appreciated. PMI not appreciated on exam. No JVP pulsation or distention visible on exam.

Mental Status Exam

General

1. *Appearance:* Average set Hispanic male of average height. Patient looks his stated age, is casually dressed and with decent hygiene.
2. *Behavior and Psychomotor Activity:* Patient has blunted affect but is responsive to communication and questioning. No fidgeting or motor activity noted. Patient able to ambulate with steady gait without assistance.
3. *Attitude towards Examiner:* Patient is cooperative, evasive and vague about his current circumstances.

Sensorium and Cognition

1. *Alertness and Consciousness:* Patient is alert with no signs of acute drowsiness. No alarming distress, discomfort or labored breathing visible.
2. *Orientation:* Patient is oriented only to person and place
3. *Concentration and Attention:* Patient demonstrates adequate attention throughout entire interview but provides vague, lengthy responses to each question.
4. *Abstract thinking*: Patient is able to use metaphor to explain things throughout the interview to express his thoughts or life events. Patient was unable to use exact dates and instead answered with vague timelines.
5. *Memory:* Patient's immediate and remote memory is partially intact
6. *Fund of Information and Knowledge:* Patient has fair intellectual performance.

Mood and Affect

1. *Mood:* Anxious with average intensity and consistent.
2. *Affect:* Blunted affect
3. *Appropriateness:* Patient's mood and affect were inconsistent with the topics discussed with inappropriate laughter and without any angry outburst, mutism, laughter or uncontrollable crying.

Motor

1. *Speech:* Patient's speech was audible and clear with slow rate.
2. *Eye contact:* Adequate eye contact with provider, patient was staring directly at the provider
3. *Body movement:* Patient had no abnormal body movements, tics or tremors. Patient is able to ambulate without assistance with a steady gait. Patient often seen pacing back and forth down the halls

Reasoning and Control

1. *Impulse control:* Patient displayed poor impulse control. Patient denies suicidal or homicidal ideations and plans
2. *Judgment:* Patient displays impaired judgment with presence of somatic delusions
3. *Insight:* Patient has poor insight into his psychiatric condition. He is aware of his past psychiatric diagnoses but does not believe there is anything wrong with him currently.

Differential diagnosis:

Schizophrenia

The patient already has a pre-existing history of schizophrenia, his current bizarre behavior can be a consequence of the patient not adhering to his medication regimen for at least 2 weeks.

Substance-Induced Psychosis

The patient is most probably not being truthful when he denied drug use during the patient interview. Additionally, his urine tox showed that he was positive for benzodiazepines. Taking benzodiazepines recreationally or in larger doses than prescribed can cause mental confusion, memory issues and permanent brain changes; which coincides with the patient's strange behavior.

Bipolar Disorder

This sudden change in the patient's behavior (i.e. climbing up a tree and staying there, appearing naked at his mother's doorstep, and going off into the city all night with no memory of where he has been) may all be due to a manic episode secondary to bipolar disorder. He is of the prime age where bipolar disorder appears. Additionally, males typically have manic episodes first. These manic episodes can include expansive/irritable mood, grandiose thoughts or paranoia, hallucinations, poor judgment and hyperactivity; and the patient fits some of these criteria

Assessment

21 year old Hispanic male, single, unemployed and domiciled with mother with PPHx of Schizophrenia is BIB NYPD (not under arrest) activated by mother due to bizarre behavior secondary to noncompliance to medication. The patient is anxious, has slow speech, and blunted affect, and admits to somatic delusions, describing "fighting a dark force in his sleep". His mother admits to bizarre behavior at home such as climbing a tree and staying up there and appearing naked at his mother's doorstep; stating this behavior began once the patient stopped

taking his medication. The patient nor his mother remembers what medication he was taking. His bizarre behavior is most likely due to schizophrenia secondary to noncompliance to his medication along with an element of substance abuse. His urine drug tox was positive for benzodiazepines and creatinine elevated at 281.4. His BAL was < 10 mg/dL.

Plan

- Admit to CPEP for observation and stabilization
- Labs: CBC, CMP, THC, Alcohol level, UA, urine toxicology
- Medications: Midazolam injection 2 mg- today
    - Lorazepam injection 2 mg- today
    - Lorazepam tablet 1 mg- today
    - Haloperidol tablet 5 mg- today
- q15 observation and re-evaluate the following day
- In the meantime, will work on arranging transfer to LIJ where the patient received care in the past