Full H&P 2

Rotation 1: psychiatry

Jinjin Lin

Identification:

Patient's name: Ms. Liu

DOB: 23 years old

Gender: female

Race: Asian

Location: Medical ER, Queens Hospital Center, Jamaica NY

Date and Time: 1/15/2019, 11pm

Informant: self, partially reliable; patient's mother and patient's aunt, reliable

CC: Acetaminophen overdose, suicide attempt vs. accidental overdose

HPI:

Ms. Liu is a 23 years old Asian female, domiciled, employed, with no reported past psychiatric history and past medical history, BIBEMS for medical and psychiatric evaluation S/P Tylenol overdose. Patient is evaluated in medical ER. Patient speaks Mandarin primarily, and is interviewed in Mandarin by psychiatry staff. Patient is noted to be fairly-groomed, calm, AO x3, superficially cooperative, in tears, with depressed mood, guarded, and with poor eye contact. Patient reports she took 20-30 pills of 500mg Tylenol around 7pm tonight because she felt dizzy and she thought it will help her to feel better. Patient admits that she hasn't been feeling well for the past couple of days, not sleep well and loss appetite. Patient states that she did not realize she took 20-30 pills. Patient lives in an apartment by herself in Flushing, and her mother, Ms. Guo (XXX-XXX-XXXX) works in Florida. Patient's aunt, Ms. Bao (XXX-XXX-XXXX) is interviewed separately, and sharing that patient's mother called her tonight and asked her to go to the patient's apartment to help. Pt.'s aunt states that she found the pt. crying in her apartment when she went there and pt.'s aunt states that pt. has no prior psychiatric history and she has never attempted to hurt herself before. Pt.'s mother, Ms. Guo is contacted via phone. Pt.'s mother states that she resides in Florida and has not seen the pt. in the past few years, but states that the pt. expressed to her that she has been depressed (couple months ago) and that the pt. called her today after ingesting the pills, crying. Pt's mother is unable to provide further details. At this time, pt. presents to be a threat to herself, she is minimizing events and presents with poor insight and judgement. Pt. requires further psychiatric observation and stabilization and once she is medically cleared, she may be sent to CPEP for further psychiatric management.

PMH:

Patient denies any past psychiatric history and past medical history.

Past Surgical History:

Patient denies any past surgical history.

Medications:

Patient denies taking any medications and supplements.

Currently, patient is on NS 100ml/hr; charcoal; acetylcysteine 100mg/kg, IV; heparin 5000 unites, subQ; pantoprazole 40mg, IV.

Allergies:

Patient denies any drug, food or environment allergies.

Family History:

Father- 47, alive and well

Mother- 44, alive and well

Social History:

Ms. Liu came to the United States 13 months ago, and she lives by herself in Queens NY. She is not sleeping well, often wakes up at nights and couldn't go back to sleep anymore. She is not eating well and most likely food delivery or takeout. She works in a nail salon and highest education level is high school degree. The patient denies recent travel, smoking, alcohol consumptions, past or present illicit drug use.

ROS:

General: Patient reports fatigue and loss of appetite. Patient denies recent weight loss or weight gain, generalized weakness, fever, chill or night sweats

Skin, Hair, Nails: Patient denies any changes of texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair condition

Head: Patient reports headache. Patient denies vertigo, head trauma, or fracture

Eyes: Patient denies visual disturbance, lacrimation, photophobia, pruritus, or last eye exam

Ears: Patient denies deafness, pain, discharge, tinnitus

Nose/Sinuses: Patient denies discharge, epistaxis, or obstruction

Mouth and throat: Patient denies bleeding gums, sore tongue, sore throat, mouth ulcers or last dental exam

Neck: Patient denies localized swelling or lumps, stiffness or decreased range of motion

Breast: Patient denies lumps, nipple discharge, pain, or last mammogram

Pulmonary System: Patient denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular System: Patient denies chest pain, palpitations, edema, syncope, or known heart murmur.

Gastrointestinal System: Patient reports loss of appetite and nausea, and patient denies intolerance to specific foods, vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool or stool guaiac test or colonoscopy.

Genitourinary System: Patient denies changes in frequency, nocturia, urgency, oliguria, polyuria, dysuria, change in color of urine, incontinence, awakening at night to urinate, or pain.

Sexual history: Patient is sexually inactive, patient denies STD.

Menstrual and Obstetrical: Patient last normal period is 20 days ago, the time of menarche is 14, her menstrual cycle is 28 days with medium flow without clots. Patient denies postcoital bleeding, dyspareunia.

Nervous System: Patient reports headache, dizziness, and patient denies seizures, loss of consciousness, sensory disturbances, numbness, paresthesia, dysesthesias, ataxia, loss of strength, change in cognition, mental status, memory, or weakness

Musculoskeletal System: Patient denies muscle or joint pain, deformity or swelling, redness, arthritis

Peripheral System: patient denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes

Hematological System: Patient denies anemia, easy bruising or bleeding, or lymph node enlargement

Endocrine System: Patient denies polyuria, polydipsia, polyphagia, heat or cold intolerance or goiter

Psychiatric: Patient reports depression and sadness, denies feeling of helplessness, hopelessness, lack of interest in usual activities, anxiety, obsessive or compulsive disorder, seen a mental health professional, or use medications

Physical Examination: (physical exams are done by Genin, PA)

General: 23 years old female, alert, slender, well developed, fairly-groomed, and tearful.

Vital Signs:

BP (seated): 90/62

HR: 97 BMP, regular

RR: 18, not labored

Temp: 98.7 F oral

O2 sat: 98%, room air

Height: 5’5” weight: 116lb BMI: 19.2, normal

Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: Average quantity and distribution

Nails: No clubbing, capillary refill <2 seconds throughout.

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity with glasses 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA (old people do not accommodate), EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:Disk < 0.5 OU, no AV nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU

Ears: Symmetrical and normal size. No lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM's pearly white, cone of light at 4 o’clock in right ear, 7 o’clock in the left ear. Auditory acuity intact to whispered voice AU. Weber midline, and Rinne reveals AC>BC AU.

Nose: Symmetrical with no masses, lesions, deformities, or trauma. Nasal mucosa pink, no discharge or foreign bodies. Anterior septum deviated to left, no lesions, deformities, injection perforation.

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Lips: Pale pink, dry, no cyanosis or lesions.

Mucosa, Palate, Teeth, Gingivae, Tongue, Oropharynx: Cannot do the exam due to injection of activated charcoal.

Neck: No masses, lesions or scars. Trachea midline, pulsation noted. Supple nontender to palpation. 2+ carotid pulses, no thrills, bruits bilaterally. No palatable adenopathy.

Thyroid: Nontender, no palpable masses, no thyromegaly, no bruits.

Chest: Symmetrical, lat to AP diameter 2:1, no deformities, no trauma. Respirations unlabored. Nontender to palpation.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No wheezing, crackles, rales.

Heart: S1, S2 without murmur, no gallops, S3 or S4. RRR. No JVD. Carotid pulse are 2+ bilaterally without bruits.

Abdomen: Flat, symmetrical, no scars, striae, caput medusae or abnormal pulsations. Bowel sounds in all 4 quadrants. No bruits. Tympany to percussion throughout. Nontender to percussion or to light and deep palpation. No organomegaly, guarding, or rebound tenderness. No CVAT bilaterally.

Female genitalia: Not examined.

Rectal: Not examined.

Peripheral vascular: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted.

Neurological:

Mental status exam:

General:

- Appearance: Ms. Liu is small build, well-nourished, fairly-groomed, guarded, tearful Asian female, lying on stretcher. There are no scars on her face or hands. Ms. Liu's skin and lips are dry.
- Behavior and psychomotor activity: Ms. Liu has no unusual movements or psychomotor changes. Poor eye contact.
- Attitude towards examiner: Ms. Liu is superficially cooperative.

Sensorium and cognition:

- Alertness and consciousness: Ms. Liu is alert and she can maintain her consciousness for entire interview.
- Orientation: Ms. Liu is oriented to person, time, the place of exam, and the date.
- Concentration and attention: Ms. Liu demonstrates satisfactory attention. She is able to concentrate and give relevant responses to questions. She is able to do calculation to give how months she has been in the United States.
- Capacity to read and write: Ms. Liu needs translator to understand conversations most of the time.
- Abstract thinking: Ms. Liu is able to explain things, and clarify her thoughts. Her thought process is logical and coherent.
- Memory: Ms. Liu's recent and remote memory are intact.
- Fund of information and knowledge: Ms.Liu's intellectual performance is consistent with her high school level of education.

Mood and affect:

- Mood: Ms. Liu's mood is depressed and sad.
- Affect: Ms. Liu's affect is constricted with tearful facial expression.
- Appropriateness: Ms. Liu's mood and affect are consistent with the event (overdose on Tylenol) she is experiencing. She does not have labile emotion or angry burst.

Motor:

- Speech: Ms. Liu's speech pattern is normal with soft volume.
- Eye contact: Ms. Liu makes poor eye contact.
- Body movements: Ms. Liu has no extremity tremors or facial tics.

Reasoning and control:

- Impulse control: Ms. Liu has recent suicidal attempt, fair impulse control, no homicidal ideation.
- Judgement: Ms. Liu has no paranoia, bizarre delusions, auditory or visual hallucinations.
- Insight: Ms. Liu has poor insight into her self-defeating and endangering behavior.

Cranial nerve:

I - Intact no anosmia.

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD, discs yellow with sharp margins. No AV nicking, hemorrhages or papilledema noted.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Facial sensation intact, strength good. Corneal reflex intact bilaterally.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active and passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally

Reflexes	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinski	neg	neg
Abdominal	2+/2+	2+/2+	Clonus	negative	

Meningeal signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Musculoskeletal System:

Upper extremities and lower extremities: No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. Nontender to palpation, no crepitus noted throughout. Full range of motion of all upper and lower extremities bilaterally. No spinal deformities.

Assessment:

Patient is a 23 y/o Asian female, with no reported psychiatric hx, BIBEMS S/P overdose on 20-30 tablets of Tylenol (500mg each). Pt. is evaluated in MER, and pt.'s aunt and mother are interviewed for collateral information. At this time, pt. presents to be with depressed mood, constricted affect, is guarded, and is deemed to be a threat to herself. Pt. is minimizing events and presents with poor insight and judgement.

Differential Diagnosis:

- Major depressive disorder

  Patient has reported being depressed for a couple months, and feels sad, fatigue, loss of appetite, and not sleeping well for more than 2 weeks. Her overdose on Tylenol maybe a suicidal attempt. All these presentations meet criteria of depressive disorder.

- Adjustment disorder with depressed mood

  Patient came to the United States for 13 months now. Mother lives in Florida (parents are separated when she was a kid, and she does not mention her father during the interview at all), she lives by herself in New York, and she has not seen her mother for several years. In addition, she has language barrier, which may limit her interpersonal relationships. This maybe a stressor, and patient's depressive episode and overdose event occurs in response to it.

- Bipolar disorder

  Patient may be in the depressive episode of bipolar disorder. But she does not have manic or hypomanic episodes. And she is minimizing, she is the first time in QHC, and we cannot get details past psychiatric history or medical history from her mother, which makes it impossible to know if she had a manic or hypomanic episode before.

- Persistent depressive disorder

  Patient's presentations meet criteria of major depression disorder. But she does not have these symptoms for 2 years, according to the patient and pt.'s mother, she does not have the continuous chronic form of depression for 2 years.

- Depression induced by substance abuse/alcohol abuse

  Patient's depressive symptoms, like insomnia and loss appetite may be due to substance or alcohol use. For example, a person suffering from cocaine withdrawal would be presented with depressed mood. However, patient's drug screen result is negative, which makes this differential unlikely.

Plan:

- After medically cleared, pt. may be transfer to CPEP for further psychiatric management
- If pt. is not medically cleared and requires inpatient medicine admission, recommend continuation of 1:1 observation for suicide precautions and follow up with psychiatry consultation and liaison services in the morning
- Social services as needed

Notes:

Patient is not medically stable at that time, and she is being transferred to MICU. After two days of staying in MICU, patient is transferred to medical floor, and then be discharged after 1 day. I reviewed the notes from ICU and medical floor, which medically cleared patient and inpatient psychiatrist re-evaluated the patient at medical floor. Ms. Liu denies any suicidal ideation, and insists that overdose is an accident, and she also denies any feelings of depression, loss appetite or fatigue. Mother also denies everything.

<u>Brief Lab results summary from initial visit to discharge</u>

Acetaminophen level: Initially is 175, 49 last day in the ICU, and then <5 when discharge to the medical floor

INR: increase from 1.6 to 2.3

PT: increase from 12.4 to 15.1

PTT: increase from 30.5 to 37.6

ALT: increase from 5 to 43

AST: increase from 13 to 92

H&H: 10.9 and 32.8

Drug screen: negative

<u>Suggested follow up plan after discharge since the patient is not admitted to CPEP</u>:

- Follow up with PCP the next day
- Provide patient with social services
- Provide patient with the phone number of QHC psych OPD 883-2710 to ask for help if needed after discharge