Emily Yeung
Rotation 1: QHC Psychiatry
Final Rotation Site Evaluation

Identification:

- Date: 1/22/19
- Time: 10:15 PM
- Name: NM
- Sex: M
- Race: Asian
- Age: 13
- Marital status: Single
- Address: QHC, Psychiatry CPEP

Informant:

- Source of history: Mother, patient, unreliable

Referral Source: EMS, mother

Chief Complaint:

- Agitation

Present Illness:

- Nilanjan is a 13-year-old male, domiciled, with past psychiatric history of bipolar disorder and ADHD BIB NYPD activated by mother for agitation. Patient states that he started "throwing plates and apples after my mom took away my stuff (CPU, tablet) while talking shit about my dad and brother." Patient also reports that he stopped taking Risperdal a few weeks ago since he felt anxious after taking the medication (mother is aware of this). He is also on Depakote and Methylphenidate. He admits to seeing his psychiatrist regularly (last visit was earlier this month, next visit is on 1/30/19). However, patient states that he did not tell his psychiatrist that he was feeling anxious after taking Risperdal. Patient reports being hospitalized at LIJ (for 1 day) and South Oaks (for 2 weeks) for similar behavior last year, also activated by mother. Upon being interviewed, patient was calm and cooperative, A/O x3. He denies any suicidal or homicidal ideations, auditory or visual hallucinations current ETOH or illicit drug use, physical/verbal/sexual abuse at home. Mother, K. Halder (646-457-6791) was interviewed separately. She states that patient spent many hours playing on his computer and tablet after coming home from school even though she told him to stop. Mother further reports that the situation escalated to the point where she had to call her neighbors to restrain her son from hitting her while calling 911. Mother states that patient has taken Xanax in the past, as given by his older brother but they do not live together anymore. At this time, patient does not appear to be a threat to self or others. Mother expresses that she wants to take the patient home. Case discussed with Dr. Reddy.

Past Medical History:

- Present illnesses
    - Bipolar disorder x 1 year
    - ADHD x 1 year

- Immunizations up to date, including the flu shot.
- Patient denies any childhood illnesses.

Past Surgical History:
- Denies any surgical history.
- Denies past transfusions and injuries.
- Hospitalized last year at LIJ for 1 day before being transferred to South Oaks for 2 weeks for similar agitated behavior.

Medications:
- Methylphenidate 18mg QD, last dose this morning
- Depakote 250mg BID, last dose this morning
- Respiradone 1mg QD, last dose 2 weeks ago

Allergies:
- Denies any drug, food, or environmental allergies.

Family History:
- Mother is alive and well.
- Mother and father are divorced. Older brother lives with father.

Social History:
- Non-smoker. Denies drinking caffeine or alcohol.
- Took Xanax in the past as given by his older brother.
- Single, lives with mother in a house.
- Occupation: student.
- Denies any recent travel.
- Not sexually active.

ROS (done by S. Cortes, MD on 01/22/19)**:**
- General
    - Denies any recent weight gain/loss, loss of appetite, weakness/fatigue, fever, chills, night sweats.
- Skin, hair and nails
    - Denies any discoloration, moles/rashes, pruritus, changes in hair distribution, excessive dryness/sweating, change in hair/skin texture, lacerations.
- Head
    - Denies headache, vertigo, head trauma, facial swelling.
- Eyes
    - Denies photophobia, pruritus, blurring, diplopia, lacrimation, other visual disturbances. Last eye exam unknown.
- Ears
    - Denies any deafness, pain, discharge, use of hearing aids.
- Nose/Sinuses
    - Denies any epistaxis, obstruction, discharge, congestion.
- Mouth and throat

    - Denies any dry mouth/lips, bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, use of dentures.
- Neck
    - Denies localized swelling/lumps, stiffness/decreased range of motion.
- Breast
    - Denies any lumps, nipple discharge, pain.
- Pulmonary system
    - Denies any SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND, choking, chest tightness, stridor.
- Cardiovascular system
    - Denies any chest pain, palpitations, irregular heartbeat, syncope, heart murmur, edema.
- Gastrointestinal system
    - Has bowel movements twice daily. Denies any indigestion, nausea, loss of appetite, constipation, vomiting, pyrosis, flatulence, diarrhea, jaundice, bloating, anal bleeding, rectal pain.
- Genitourinary system
    - Denies any frequency, polyuria, urgency, nocturia, oliguria, dysuria, incontinence, flank pain.
- Nervous system
    - Denies headaches, loss of consciousness, sensory disturbances, ataxia, change in cognition, loss of strength, weakness.
- Musculoskeletal system
    - Denies any muscle/joint pain, deformity, erythema, edema, tenderness, arthritis.
- Peripheral vascular system
    - Denies any peripheral edema, intermittent claudication, varicose veins.
- Hematologic system
    - Denies any easy bruising, bleeding, lymph node enlargement, blood transfusions.
- Endocrine system
    - Denies any polyuria, polydipsia, polyphagia, goiter, excessive sweating, Hirsutism, heat intolerance.
- Psychiatric
    - Admits to past psychiatric history of bipolar disorder and ADHD, agitation, behavioral problems.

General Survey:

- Small build male, well developed and well nourished, adequately groomed, looks his stated age of 13 years, breathing unlabored. A/O x3.

Vital Signs:

- HR: 102 beats per minute, regular
- Respiratory rate: 18 breaths per minute, unlabored
- BP: 120/78, bilateral arms, sitting
- Temperature: 99.2°F, orally
- O2 sat: 99%, room air
- Height: 60 inches
- Weight: 99 lbs.
- BMI: 19.3

Physical Examination (done by S. Cortes, MD on 01/22/19)**:**

- Skin: Warm and moist, good turgor. Nonicteric, no lesions, no scars, no tattoos, no lacerations.
- Hair: Average quantity and distribution.
- Nails: No clubbing, capillary refill <2 seconds throughout.
- Head: Normocephalic, atraumatic, no specific facies, nontender to palpation throughout.
- Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white, conjunctiva & cornea clear. Visual acuity 20/20 OU. Visual fields full OU. PERRLA. EOMs full, no nystagmus. Fundoscopy – red reflex intact OU. Cup to disk ratio <0.5. No evidence of copper wire, AV nicking, papilledema, hemorrhage, cotton wool spots, exudates, neovascularization OU.
- Ears: Symmetrical, normal size. No lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canals AU. Tympanic membrane pearly white, cone of light intact in normal position AU. Auditory acuity intact with whispered voice AU. Weber midline and Rinne reveal air conduction > bone conduction AU.
- Nose: Symmetrical with no obvious masses, lesions, deformities, trauma, discharge. Nares patent bilaterally. Nasal mucosa pink and well hydrated. No discharge on anterior rhinoscopy. Septum at midline without any lesions, deformities, infection, perforation. No foreign bodies.
- Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.
- Lips: Pink, moist, no cyanosis or lesions.
- Mucosa: Pink, hydrated. No masses, lesions, leukoplakia.
- Palate: Pink, hydrated. Palate intact with no lesions, masses, or scars.
- Teeth: Good dentition, no obvious dental caries noted.
- Gingivae: Pink, moist. No masses, lesions, erythema, discharge, hyperplasia.
- Tongue: Pink, well papillated. No masses, lesions, deviation noted.
- Oropharynx: Hydrated. No masses, lesions, foreign bodies, infection, exudate. Tonsils present with no infection or exudate. Uvula pink, no lesions or edema.
- Neck: Trachea midline. No masses, lesions, scars, pulsations, stridor noted. Supple, non-tender to palpation. No thrills, bruits noted bilaterally, no palpable adenopathy.
- Thyroid: Non-tender to palpation, no palpable masses, no thyromegaly, no bruits noted.
- Chest: Symmetrical, no deformities, trauma. Respirations unlabored. No use of accessory muscles noted. Lat to AP diameter 2:1.
- Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout, no adventitious sounds.
- Heart: JVP is 2.5 cm above the sternal angle with head of bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. S1 and S2 are normal. No murmurs.
- Abdomen: Soft, symmetrical. No scars, striae, caput meducsea or abnormal pulsations. BS present in all 4 quadrants. No bruits over aortic, renal, iliac, femoral arteries. Tympany to percussion throughout. Non-tender to percussion or to light, deep palpation. No organomegaly, masses, guarding, rebound tenderness. No CVAT noted bilaterally.
- Breast: Symmetric, no dimpling, masses, discharge. No axillary nodes palpable.
- Male genitalia: patient denied.
- Rectal: patient denied.
- Peripheral vascular: Extremities unremarkable in color, size, temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis, edema bilaterally. No stasis changes or ulcerations.

- Mental Status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.
- Cranial Nerves
  - 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. Mastication normal
  - 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/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+	Babinskineg	neg	
Abdominal	2+/2+	2+/2+	Clonus	negative	

- Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.
- Musculoskeletal upper: No soft tissue swelling, erythema, ecchymosis, atrophy, deformities in upper extremities. Non-tender to palpation. No crepitus noted throughout. FROM of all upper extremities bilaterally. No spinal deformities.

Mental Status:

General

- Appearance: Nilanjan is an average height and weight Asian male. He has no scars on his face or body. He is casually groomed, well developed and well nourished. Nilanjan’s physical appearance is consistent with his age.
- Behavior and psychomotor activity: Nilanjan has normal psychomotor activity with unlabored breathing.
- Attitude towards examiner: Nilanjan was calm and cooperative with the examiner.

Sensorium and Cognition

- Alertness and consciousness: Nilanjan is fully alert and conscious.
- Orientation: Nilanjan is orientated to person, place, and time of the exam and date.
- Concentration and attention: Nilanjan demonstrated satisfactory attention and gave relevant responses to questions.
- Capacity to read and write: Nilanjan has fair reading and writing ability.

- Abstract thinking: Nilanjan used several simple metaphors in English to explain his frustration towards his mother. He can mentally perform simple mathematical calculations to determine his age and significant points in life.
- Memory: Nilanjan's remote and recent memory are unimpaired.
- Fund of information and knowledge: Nilanjan's intellectual performance is average and consistent with his level of education.

Mood and Affect

- Mood: Nilanjan has neutral mood consistent throughout the entire interview.
- Affect: Nilanjan's affect was flat and rarely displayed his emotions.
- Appropriateness: Nilanjan's mood and affect were consistent with the topics he discussed.

Motor

- Speech: Nilanjan's speech pattern was of normal rate but monotonous.
- Eye contact: Nilanjan made adequate eye contact.
- Body movements: Nilanjan had no extremity tremors or facial tics. He is ambulatory with a steady gait.

Reasoning and Control

- Impulse control: Nilanjan's impulse control is satisfactory. He denies any suicidal or homicidal urges.
- Judgment: Nilanjan denies any paranoia, bizarre delusions, or auditory or visual hallucinations.
- Insight: Nilanjan is aware of his problems but has poor insight into his psychiatric condition and need to reduce playing with computers or tablets. He is unable to relate them to issues within self.

Assessment: Nilanjan is a 13-year-old male, domiciled, with past psychiatric history of bipolar disorder and ADHD BIB NYPD activated by mother for agitation. Patient states that he started "throwing plates and apples after my mom took away my stuff (CPU, tablet) while talking shit about my dad and brother." At this time, patient does not appear to be a threat to self or others. Patient does not warrant overnight observation. Recommend checking Depakote level. Patient is to follow up with regular outpatient psychiatrist upon discharge.

1. Bipolar I disorder
   - Mother states that patient was increasingly agitated, had decreased need for sleep since he was playing on his computer often, with racing thoughts and distractibility.
   - Patient reports being depressed in the past, partly due to his parents divorcing and separation from his older brother.
2. Oppositional defiant disorder
   - In the past 6 months, patient often and easily loses temper and is often angry.
   - He argues with his mother (person of authority) but not with other people of authority like teachers.
   - However, patient does not seem to be spiteful or vindictive.
3. Conduct disorder
   - In the past 12 months, mother reports that patient is aggressive towards her and will physically hit her when patient is agitated. However, she does not report any aggression towards animals or stealing from others.
   - Patient destroyed property in the house during the altercation with his mother.
   - However, patient denies breaking into other people's houses, stealing, running away from home or not going to school.

4. Childhood-onset schizophrenia
    - Although the patient is 13 years old, his symptoms began at least one year ago. Even though the criteria for childhood-onset schizophrenia occurs at age 12 or younger, he has a history of negative symptoms and disorganized behavior. However, he denies any delusions or hallucinations, making this diagnosis unlikely.
5. Substance-induced psychotic disorder
    - Patient has a history of taking Xanax in the past. He may have gotten illicit drugs from friends or other people.
    - Will need utox to further rule this out.

Plan:

1. Bipolar I disorder
    - Restart Respiradone 1mg QD and educate patient about the importance of adherence.
    - Obtain vitals, routine labs, and urine toxicology.
    - Check Depakote levels, continue Depakote 250mg BID.
    - Patient is medically and psychiatrically stable. Does not warrant admission to CPEP at this time. He should f/u with his psychiatrist upon discharge.
    - Educate patient and mother about psychotherapy to help find the best ways to identify and respond to manic/depressive symptoms when they occur.
        - Behavioral therapy: focuses on behaviors to decrease stress
        - Cognitive therapy: identify/modify patterns of thinking that accompany mood shifts
        - Interpersonal therapy: helps improve relationships
        - Social rhythm therapy: especially helpful for the ADHD as well since it helps in maintaining a normal sleep schedule

2. ADHD
    - Continue Methylphenidate 18mg QD.