Fredrique Green

Psychiatry Rotation: H&P 2
Elmhurst Hospital
Site Evaluation 2: 7/22/24

Chief complaint: noncompliance with treatment/medication for over 6 months

HPI: R.S. is a 28-year-old Bangladeshi-American male with PMHx asthma and past psychiatric history of schizoaffective disorder, depressive type domiciled with family who was BIB by parents to the ED on 7/10/24. Parents requested that patient be evaluated for “progressively worse” behavior due to patient noncompliance with psychiatric medication for “over 6 months”. Patient has a history of multiple CPEP visits, inpatient psychiatric admissions (last admission: 8/14/21-8/23/21), medication noncompliance, outpatient treatment at Elmhurst Hospital’s Ambulatory Behavioral Health Services where he was receiving monthly IM Invega Sustema 117mg (last given 6/29/23), polysubstance abuse (cigarettes, marijuana [daily use, last use: this morning]), cocaine occasionally), a self-reported legal history of incarceration multiple times for “stealing and drugs”, and a self-reported history of a self-aborted suicide attempt last year. Patient presented to the ED as AOx2 (person, place), calm, cooperative, casually groomed in street clothing, good eye contact, slightly pressured speech, and a circumstantial thought process with loose associations. Patient’s insight was poor; he reported he came to the hospital because he doesn't understand why "everyone is happy and I am sad”, and was perseverative on wanting to live a good life and not be bad (“you have one life and need to do good”). He reported that he has not been taking medications, but could not elaborate further. He denied suicidal/homicidal ideations or hallucinations, and reported "seeing things that are scary and happy" but was unable to elaborate further. Collateral was obtained from patient’s mother who reported that over the last 6 months, patient has been talking to himself, walking around naked in the house, laughing inappropriately, randomly crying or getting angry, throwing things in the house, and destroying property. Parents called mobile crisis several times in the last few weeks, and were informed that patient needs to go directly to the hospital; patient was only willing to come to hospital that day. Patient was admitted to CPEP on 7/11/24 and started on risperidone 1mg PO BID. He was admitted to inpatient psychiatry on 7/14/24 for continued stabilization due to aggressive and erratic behavior, and risperidone nightly dose was increased to 2mg (for total 3mg daily).

Today, patient was seen in the psychiatry unit with primary treatment team. He presented to the interview in personal clothing, appearing casually groomed. He was calm and cooperative throughout the interview with normal motor activity, hyperverbal and non-pressured speech, and denying any hallucinations. He continued to have poor insight into his symptoms: he denied/minimized awareness of disorganized and erratic behavior reported by family ("I don't walk around naked at home? Maybe in the shower. That's it. And I don't play with water in the kitchen. I only spray the cockroaches, we have a lot of them."), and endorsed being diagnosed with schizophrenia, but that he does not believe he has a mental illness. Patient was also unable to articulate details concerning past psychiatric history, frequent CPEP visits and inpatient hospitalizations, and medication noncompliance. When team attempted to gain further information about his insight into his condition, the patient’s thought process remained

circumstantial with loose associations. When team inquired about events that led to current hospitalization, patient replied, "I smoke a lot of cigarettes and weed, but not cocaine anymore. I am fine, you know? Everything seems fine. When I'm happy, I'm happy. What is our purpose in this world? You know, we only have one year." When team attempted to explore his behavior in the past few weeks prior to admission, patient continued on similar tangents and was not able to elaborate on the question being asked. Throughout the interview, patient demonstrated self-deprecating perseverance ("I want to do good things, but I'm bad", "I want to be happy and live a good life", "I deserve bad things", "I just wish I could be good"). He admitted to occasionally feeling sad with moments of hopelessness for a couple years, but could not articulate why. When asked about substance use, he reported last cocaine usage "around New Year's this year" and that he smokes marijuana because he likes the way it makes him feel ("it stimulates my body").

Patient endorsed 1 previous self-aborted suicide attempt, and was able to communicate that his family is a significant protective factor. He denied active suicidal or homicidal ideation, intent, or plan. When recounting his past suicide attempt, patient said, "I took the kitchen knife to my chest, it was like a movie really" and subsequently started to laugh. Patient also endorsed sexual abuse by uncle at age 14. Patient denied anhedonia, endorsing that he continues participating in enjoyable activities (video games). On the unit, patient has been compliant with scheduled medications and denies any tremors, dystonia, or akathisia. He denied any feelings of grandiosity, delusions, hallucinations, current chest pain, shortness of breath, or dizziness/lightheadedness.

Past psychiatric history:
Schizoaffective disorder, depressive type

Current psychiatric medications:
Not currently taking any psychiatric medications. Last IM Invega Sustenna 117g given 6/29/23.

Suicide:
1 self-aborted attempt with kitchen knife, last year

Violence:
Denies having any thoughts of violence towards others or any past acts of violence.

Trauma/abuse:
Endorses sexual abuse by family friend ("uncle") at age 14.

Past medical history:
- Asthma
- Obesity

Non-psychiatric medications:
Denies taking any medications or supplements at this time.

Hospitalizations:
Multiple psychiatric hospitalizations.

Allergies:
Denies any allergies.

Family history:
Denies any family history of mental illness or other diseases.

Social history:

- **Residence:** private residence, domiciled with family
- **Level of education:** 11th grade
- **Employment:** unemployed, last employment was 1 year ago at Dunkin
- **Children:** denies
- **Dependents:** denies
- **Alcohol:** 1 drink/week
- **Tobacco:** cigarettes, 0.5 packs/day for 5.0 years
- **Drugs:** marijuana 3x/daily, cocaine occasionally, denies other substance use

Mental status exam:

- **Appearance:** appears stated age, wearing personal clothing that is well-kept, hygienic state appears clean, appears casually groomed, no visible scars or tattoos, good eye contact
- **Behavior:** cooperative and pleasant with interviewer, established rapport within 5min
- **Motor activity:** restless (tapping and bouncing leg under table), normal posture, gait is normal, unlabored, coordinated, and without signs of limping, unsteadiness, or ataxia
- **Speech:** hyperverbal, fluent, conversational and non-pressured rate, appropriate volume, normal rhythm and tone
- **Mood:** “I feel a lot better today, I ate so much yesterday.”
- **Affect:** mood-congruent, inappropriately elated
- **Thought process:** circumstantial with loose associations and perseverations about “being good” and “not bad”
- **Thought content:** delusions vs. depressive cognitions (unspecified/poorly articulated reasons for feeling excessive guilt)
- **Perceptions:** denies hallucinations, denies illusions
- **Cognition:** AOx4 (person, place, time, situation), alert, aware, awake, provided recent memory of recent events when asked
- **Insight:** poor, minimizes vs. does not understand current hospitalization
- **Judgment:** poor, has over 1 year of medication noncompliance

Physical exam:
BP: 137/81
HR: 82
RR: 18

T: 97.6
O2 %: 99%
Weight: 269lbs
General: AO3, NAD, obese
Cardiovascular: NRNR, normal S1, S2, no murmurs, rubs, or gallops
Pulmonary: lungs clear to auscultation b/l, normal respiratory effort
Neurological: AO3 (person, place, time), mental status is at baseline, no cranial nerve deficit, no motor weakness, normal coordination, normal gait, CN11-X11 intact, sensation and reflexes throughout, normal strength

Differential diagnosis:

1. Schizoaffective disorder, depressive type
    a. Supported by diagnosis history and current presentation (depressive symptoms [feelings of worthlessness, self-deprecating statements] vs. manic symptoms [psychomotor agitation, talkativeness] and disorganized behavior (talking to himself, playing in water, walking around naked); *more history is needed to determine supporting time frame*
2. MDD with psychotic features
    a. Reported depressive symptoms (feelings of hopelessness and worthlessness, 1 suicide attempt) with disorganized behavior (walking around naked, playing in water, talking to himself) and potential psychotic features (seeing things that are "scary and happy"); *less likely because only 2 depressive symptoms reported making presentation more psychotic predominant; also, insight is poor and more history is needed to rule out*
3. Substance-induced psychotic disorder
    a. Daily marijuana and occasional cocaine use for >12 months with history of diagnosed schizophrenia spectrum disorder and disorganized, psychotic behavior; *less likely considering there are no withdrawal symptoms and disorganized behavior has persisted for a few weeks, making it less consistent with substance-induced psychosis*

Assessment: R.S. is a 28-year-old, unemployed, Bangladeshi-American male with PMHx asthma and past psychiatric history of schizoaffective disorder, depressive type domiciled with family who was BIB by parents to the ED on 7/10/24 for medication noncompliance (monthly IM Invega Sustema 117mg last given 6/29/23). His psychotic and manic symptomatology align with differential diagnoses: schizoaffective disorder (depressive type vs. bipolar type) vs. substance-induced psychotic disorder (cannabis dependence) vs. MDD with psychotic features. Presentation precipitated by medication noncompliance and ongoing history of substance use, and complicated by poor insight. At present, patient warrants further inpatient medication optimization for psychiatric stabilization to ensure medication compliance and safe disposition back to the community.

Plan:

- Continue AM risperidone 1mg

- Increase PM risperidone to 3mg (for total 4mg/day)
- Start valproate (valproic acid) 500mg/day q12 hours
- Start nicotine transdermal patch 14mg/day
- Plan for monthly LAI when patient is psychiatrically stabilized
- Observation: routine (q30)
- Diet: regular
- Continue to encourage participation in group activities
- Ambulate prn
- PRN: haloperidol 5mg oral q8h prn for agitation