Name: OB

Sex: male

Age: 59 years

Date and Time: October 24, 2022; 10:00 AM

Location: NYC H+H/Queens Hospital Center – Comprehensive Psychiatric Emergency Program (CPEP)

Source of Information: unreliable

Source of Referral: self

Mode of Transport: EMS

Chief complaint: agitation

History of Present Illness: 59yo Honduran male, unemployed, domiciled with wife, past psychiatric history of dementia-related disorder, past medical history of BPH, hyperlipidemia, GERD, and HTN brought in by EMS activated by wife for agitation with wife and worsening dementia. Per pt chart review, patient is known to QHC CPEP/MER with multiple prior visit for similar complaints. Pt was last brought to MER for agitation on 9/14/22. Pt admitted to CPEP after wife expressed safety concern at home and unable to pick him up. Per wife, patient went outside of house in the middle of the night and talks to self. She states he has hallucinations. Wife also reports that pt is aggressive toward his house assistant and throws things at her. During stay patient appears to be intrusive, walking in and out of other patients' rooms and needs constant redirection which appears related to his dementia.

Upon morning re-evaluation, pt appears calm, is cooperative with exam and thoughts are goal oriented. Patient has normal speech and good eye contact. Pt has full affect with euthymic mood. Patient has adequate insight, impulse control and judgement. Pt denies alcohol of drug use. Today, patient wife agrees with discharge. Patient denies suicidal ideation, plan or intent. Pt denies any visual or auditory hallucination. Pt denies any homicidal ideation.

Past Medical History:

- Benign Hypertrophic Prostate
- Hyperlipidemia
- GERD
- HTN
- Unspecified Dementia

Past Psychiatric History

- Dementia with other behavioral disturbance

Allergies

- Denies any food or medication allergies

Medication:

- Alfuzosin 10mg daily
- Amlodipine-benazepril, 5-10mgdaily
- Finasteride 5mg daily
- Metoprolol 25mg daily
- Myrbetriq 25mg SR 24 hour ER, daily
- Pantoprazole 40mg, daily
- Simvastatin 10mg, daily
- Tamusulosin, 10mg
- Risperidone .5mg, daily
- Donepezil (Aricept) 10mg nightly
- Gabapentin 600mg nightly

Family History

-

Social History:

- Denies smoking
- Denies alcohol use

Review of Systems:

- *General* –Denies any change in appetite, weight loss or gain, fever, and fatigue
- *Skin* – No evidence of self-inflicted wounds, intravenous drug use, or skin picking
- *Neurology* –denies headache, loss of consciousness, history of head trauma, unsteady gait, and unintentional body movements
- *Neurological* – He is alert and oriented x 1 (person only). Mental status is at baseline

Vital Signs:

- BP: 122/77 (left arm, sitting)

- Pulse: 71 beats/minute (regular)
- Respiratory rate: 18 breaths/minute (unlabored)
- Temperature: 97.6 F (oral)
- SpO2: 98% (room air)
- Height: 60 inches
- Weight: 88 pounds
- BMI: 17.2

Physical Exam:

- Constitutional
  - Not in acute distress, ill-appearing, or diaphoretic
- HENT
  - Normocephalic, atraumatic; moist mucous membranes
- Eyes
  - Extraocular movements intact; PERRL; No scleral icterus; conjunctivae normal
- Cardiovascular
  - Regular rate, rhythm, S1 and S2; no murmurs, gallops or rub; S3/S4 heard
- Pulmonary
  - Clear to auscultation to all fields
- Abdominal:
  - Soft, non-tender, BS+
- Extremities:
  - No b/l LE edema
- Neurological
  - General: no focal deficit present
    - I: smell; not tested
    - II: visual acuity OS: intact OD: intact
    - II: visual fields full to confrontation
    - II: pupils: ERRL
    - III, VII: no ptosis
    - III, IV, VI: full extraocular ROM
    - V: Mastication: normal
    - V: facial light and hard sensation intact
    - V, VII: corneal reflex; not tested
    - VII: facial muscle function upper/lower intact
    - VIII: hearing intact
    - IX: soft palate elevation normal
    - IX, X: gag reflex; not tested
    - XI: trapezius strength 5/5

        - XI: sternocleidomastoid strength: 5/5
        - XI: neck flexion strength 5/5
        - XII tongue strength normal
    - Motor: no weakness
    - Coordination: no deficit; steady gait
    - DTR:reflexes are normal and symmetric
    - MSE:
        - He is alert and oriented to person
    - Limited MMSE:
        - Temporal orientation: 0/5
        - Spatial orientation: 0/5
        - Registration 1/3
        - Attention and Calculation: 1/5
        - Remote memory: 0/3
        - Naming 2 objects: 2/2
        - Repeat: 0/1
        - Stage command: 0/3
        - Writing: 0/1
        - Reading and obey: 0/1
        - Copy diagram: 0/1

<u>Mental status Exam</u>

General:

- **Appearance**: OB is a thin, honduran male with narrow frame and short straight grey hair. Pt is well groomed with good hygiene. Pt appears older than stated age and does not have any acute wounds or injuries
- **Behavior**: rational, calm; confused; needs refocusing; no tics, tremors or psychomotor agitation or retardation
- **Attitude**: OB calm, cooperative with adequate eye contact. He does not display any hostility or aggression towards the examiner or other unit staff

Sensorium and cognition:

- **Alertness and consciousness:** conscious and alert through interview
- **Orientation to**: Time: no, Place: no, Person: yes
- **Concentration**: fair
- **Attention**: inattentive
- **Thought pattern/process**: Poverty of thought with thought blocking
- **Thought content:** logical
- **Suicidal ideation:** Denies
- **Homicidal ideation**: denies
- **Delusion**: none
- **Hallucinations**: denies

- **Hallucination remarks**:
- **Memory**: poor
- **Ability to abstract**: unable to assess due to dementia
- **Intellectual function**: unable to assess due to dementia

Mood and Affect:

- **Mood**: euthymic
- **Affect**: full

Motor

- **Speech**: Hesitant with selective mutism
- **Speech remarks**: pt answers questions selectively; states she is confused a lot
- **Eye contact**: Appropriate amount of eye contact
- **Body movements**: patient is sitting upright in bed slightly hunched over and fidgeting with hands. She does not display any tics or unintentional body movements. All movements were fluid.

Reasoning and Control

- **Impulse control:** impaired; denies suicidal or homicidal urges; She is compliant with urine and blood samples, accepting food but refusing medication
- **Judgement**: impaired; currently has visual hallucination; unable to participate in judgement questions due to poverty of thought/content and though blocking
- **Insight**: Poor; she is unable to say why she is in the hospital and what happened

Labs

- COVID
    - neg
- CBC
    - all WNL
- CMP
    - all WNL
- UA with reflex microscopy
    - neg
- Blood alcohol level
    - neg
- Drug screen
    - neg
- Magnesium
    - 1.9 10/22/22
- Syphillis
    - Neg
- TSH

    - WNL
- Vit B12
    - WNL

Imaging:

- CT of head without contrast
    - No acute hemorrhage, hydrocephalus or territorial infarcts
    - Showed mild periventricular and subcortical white matter hypodensities
        - Non-specific and commonly seen in setting of chronic small vessel ischemic disease

Assessment:

59yo Honduran male, domiciled with wife, past psychiatric history of dementia-related disorder, past medical history of BPH, hyperlipidemia, GERD, and HTN brought in by EMS activated by wife for agitation with wife and worsening dementia. On CPEP, pt agitation has resolved he appears calm, cooperative, rational and not exhibiting symptoms of psychosis. At this time pt displays adequate impulse control, insight, ad judgement. He does not display ay acute anxiety, depression, mania, or psychosis. Pt denies any suicidal ideation, intent or plans.

- Patient is not an immediate threat to self or others at this time, wife is now comfortable with him returning home
- Dr. Javi (neurologist) is treating him outpatient (his next appt is 10/26/22) and Dr. Doyle psychiatrist
- Wife states she has had a difficult time trying to put patient in a nursing home due to personal and family reasons however she is interested

<u>Differential diagnoses</u>:

1. **Dementia with other behavioral disturbance**
2. Dementia with psychosis

Plan (in chart)

- Continue medication
    - Risperidone
    - Donepezil
    - Gabapentin
- Discharge patient home to wife with support of home health assistant and appt with Neurologist on Wednesday
- Encourage discussion of nursing home with family if wife feels she can no longer give pt the level of care he requires

Upon research what my plans for this patient:

- Continue with outpatient geriatric psychiatrist
    - Pt does not appear to have psychosis, be in distress or a danger to others
    - He does need redirection and environmental structuring
    - Educate wife that if he is living the house in the middle of the night and wandering then this is a concern for his safety
    - He needs more caregiver support and this might look like a nursing home if other services aren't able