Psychiatry 7 Day New Cases

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Case scenario 1

- **You are an HMO at a psychiatry ward of a major hospital. John, son of your patient Theresa, 55 years, who is admitted to the ward with severe depression has come to you to discuss about ECT. ECT was advised by the consultant as Theresa was not responding to anti depressant medications.**
- **Tasks**

  1 Explain ECT to John

  2 Answer John's queries

ECT

- **Introduction**
- **Consent**
- **Confidentiality**
- **Concerns**

ELECTRO CONVULSIVE THERAPY

Indications

- **Severe depression not responding to antidepressants(reason in his mom)**
- **Acute mania**
- **Acute schizophrenia**
- **Depression with severe suicidal tendencies**
- **Post partum psychosis/ depression**

Advantages and contraindications of ECT

ADVANTAGES

- Quick and effective
- Does not cure the condition but gets the condition under control

Contra indications

- Absolute- Raised intra cranial pressure
- Relative- HT, MI,arrythmias

ECT

PRE ECT

- **Investigations- basic bloods**
- **ECG**
- **Physical examination**
- **Anaesthetic evaluation**
- **Consent of patient after explaining procedure**
- **If patient not able to consent, approach Mental Tribunal Court**

PROCEDURE AND SIDE EFFECTS of ECT

PROCEDURE

Small, low frequency electrical stimulus passed through 2 electrodes placed on either side of the head for a few seconds under GA and muscle relaxant, just enough to induce therapeutic jerks in the patient which corrects chemical imbalance within brain thought to be the cause of depression

No pain as patient is in G/A, short period of time

POST ECT SIDE EFFECTS

- **Head ache, N, V, muscle pain**
- **Disorientation and confusion**
- **Memory loss which recovers in 4-6 weeks but rarely permanent**

ECT

Number of ECT to be given

- **depends on patient's response. May take up to 2-3 sessions to see any difference and 4-5 sessions to notice a major difference**
- **Need to continue antidepressants**

If ECT not given- can risk her life due to suicidal ideations and negligence of food and drinks

ALTERNATIVE TO ECT

TMS- transcranial magnetic stimulation

Less effective than ECT

Reading materials on ECT

CASE SCENARIO 2

- **Your next patient at your GP is 24 year old Alice, referred to you by her dentist because of repeated severe dental problems. She is otherwise in a stable condition. Her BMI is 22.**
- **Tasks**

  1 Further history from patient

  2 Explain diagnosis to the patient

  3 Discuss management with the patient

BULIMIA NERVOSA

HISTORY

- Concerns and confidentiality
- H/O presenting complaints (Type-dental caries, duration, under control, medications)
- Dental hygiene
- Focus on diet(any cravings) binge eating, guilty feeling, induced vomiting, use of laxatives, excessive exercise (all positive)
- Duration
- What do you think about your appearance? (not happy)
- Do you believe that you are overweight(yes)
- Triggering factors(her boyfriend)
- Psychosocial history (living alone, not going out with friends, no insight)
- Period history (irregular, LMP)
- Other symptoms like palpitations, dizziness, tiredness
- Other M/S conditions, Medications, allergies
- Personal or family history of mental health issues

BULIMIA NERVOSA

- **Bulimia is an eating disorder were you think that you are overweight but in reality it is not**
- **Because of this overvalued idea of being overweight, you try to stick on to a healthy diet but sometimes you loose control and have cravings resulting in binge eating episodes after which you will guilty and go for compensatory behaviours like inducing vomiting, taking water pills and doing excessive exercise**

BULIMIA NERVOSA

- **Potentially dangerous condition**
- **Affects you both physically and mentally**
- **Dental caries due to repeated vomiting**
- **Irregular periods due to hormonal derangement**
- **If continuing, can affect all major systems of your body including your heart**

BULIMIA

Management

- **Investigations**
- **FBE, CRP, UCE(hypokalemia, metabolic alkalosis)**
- **LFT, TFT, FBS, ECG (arrythmias)**
- **FSH, LH, oestradiol if menstrual irregularities**
- **Urine routine, UPT**
- **Multi disciplinary team- dietician, psychologist (CBT)**
- **Family based therapy**
- **Support groups**
- **Life style modifications- cut down exercise**
- **If not working, will start on SSRI and give psychiatrist referral**

To diagnose bulimia, there should be at least 2 episodes of binge eating and compensatory behaviours per week for 3 months

ANOTHER SCENARIO

- **20 year old Amy comes to your GP clinic referred by her dentist as she has repeated dental caries**
- **She gives h/o self induced vomiting**
- **Her BMI is normal**
- **Her knuckles shows callosities**
- **Tasks**
- **1 Take history from Amy**
- **2 Discuss with her your diagnosis and differentials**
- **3 Tell her your further management plan**

BULIMIA

DDx

- **Anorexia nervosa**
- **Binge eating disorder**
- **Body dysmorphic disorder**
- **Obesity**

CASE SCENARIO 3

- **You are an HMO at the ED of a major hospital.**
- **You are about to see 30 year old Mike brought to you by the police from the streets. He is a schizophrenic patient on antipsychotics but he admits not taking them regularly. He takes ice at times.**
- **TASKS**

  1 Further history from Mike (5 minutes)

  2 Present MSE to the examiner (3 minutes)

  3 Your diagnosis and management with the patient

SCHIZOPHRENIA

- **Reason why the police had booked him**
- **Confidentiality**
- **Psychosocial history**
- **Mood- ok/ anytime feeling high**
- **Energy levels**
- **Eating well/ sleeping well**
- **Delusions- messenger of God, neighbours jealous**
- **Hallucinations- auditory from God, what God is telling him, any commands**
- **Duration**
- **No insight- schizophrenia duration, duration of non compliance with medications, reason for**
- **non compliance**
- **Idea of self harm or harm to others**
- **Judgement/ Cognition**

SCHIZOPHRENIA

HEADSS

- **Lives in streets**
- **On centre link assistance**
- **No anhedonia**
- **Smoking**
- **Alcohol- when last taken, how often, how much**
- **Ice at times- when last taken, how often, other drugs**
- **Sexual H- casual partners, STI screen, safe sex practice**
- **Other M/S- infections, head injury, hyperthyroidism**

SCHIZOPHRENIA

MSE

- **Intro**
- **Appearance- unkempt, dishevelled**
- **Behaviour- not much cooperative, eye contact at times, restless**
- **Speech- normal in rate, volume, tone**
- **Mood and affect- mood he reports is ok but affect disturbed and not congruent**
- **Perception- auditory hallucinations of hearing god's voices**
- **Thought form- normal with no loosening of associations**
- **Thought content- delusions- grandiose, paranoid**

Schizophrenia

- **Insight- absent**
- **Judgement- impaired**
- **Cognition- normal**
- **Rapport- could not maintain a very good rapport**
- **Reliability- not reliable. Take collateral history from police.**

SCHIZOPHRENIA

Risk assessment

At risk due to

1 Relapse of schizophrenia with active delusions and hallucinations

2 Non compliance to medications

3 Lack of insight

4 Impaired judgement

5 Substance abuse

6 No proper support

SCHIZOPHRENIA

DIAGNOSIS TO PATIENT

- **Relapse of schizophrenia were you start loosing contact with reality and starts having false believes called delusions and also sees, hears or feels strange things that others cannot called hallucinations**
- **Potentially dangerous situation as sometimes you loose control over yourself and can end up harming yourself or others**
- **Cause can be non compliance with medications**

SCHIZOPHRENIA

MANAGEMENT

- **Admission**
- **Organic workup with STI and toxicology screen**
- **Assessment by mental health team**
- **Antipsychotics by psychiatrist**
- **CBT by psychologist**
- **Will be supported by mental health nurse**

  Upon discharge

  Referral to drug rehab if needed
- **Social worker**
- **Community mental health worker**
- **LSM**
- **Regular reviews with psychiatrist and GP.**

DD of Schizophrenia

DD

- **Schizophreniform disorder**
- **Schizoaffective disorder**
- **Mania**
- **Bipolar disorder**
- **Delirium**
- **Substance abuse**
- **Organic conditions- hyperthyroidism, brain tumors, infections**
- **head injury**

ORDERS IN PSYCHIATRY

GP can give ASSESSMENT ORDER after assessing the patient

Assessment order can be in

- **Community when the patient will be seen by psychiatrist in 24 hours OR**
- **IP when patient is admitted and will be seen by psychiatrist in 96 hours.**

Psychiatrist gives TEMPORARY TREATMENT ORDER

Temporary treatment can be in

- **Community OR**
- **As IP**

CASE 4

- **30 year old John is brought in by the police to the ED of your hospital where you are an HMO. He was shouting and trespassing into his neighbour's home by climbing over the fences. The house owner then locked his house doors and called the police**
- **When the police came and checked, his blood alcohol level was 0.17. Patient is un cooperative**
- **You are going to assess him in a private room of the hospital with security guards and police waiting outside**
- **TASKS**
- **1 Take a brief history regarding his substance abuse**
- **2 Take history to assess his mental state**
- **3 Present MSE of the patient to examiner**

CASE 4

- **Reason why police had booked him**
- **Ensure confidentiality**
- **Ask for SAD**
- **Drinking positive**
- **Duration, frequency, how much**
- **Type of alcohol (mostly beer, sometimes other types)**
- **Reason for starting drinking**
- **Pattern of drinking**
- **Tolerance**
- **Dependence- CAGE (negative)**
- **Withdrawal symptoms like tremors, headaches, irritability, craving**
- **Binge drinking**
- **Awareness about safe limits**
-

CASE 4

Street drugs

- **Smokes weed**
- **Duration**
- **How often(from time to time)**
- **Tolerance**
- **Any withdrawal symptoms if not taking weed like insomnia, tummy pain, fever, chills**
- **Ever tried quitting/ cutting down**
- **Any other illicit drugs, smoking**

CASE 4

ASK PSYCHOSOCIAL HISTORY

Mood – not high or low

Energy levels

Eating/ sleeping well

- **No delusions/ hallucinations**
- **No suicidal/ homicidal ideations**
- **Insight impaired**
- **Judgement not assessed as he said stupid question**
- **Cognition aware of place, person but time(he said how he can know as he is inside the room)**
- **HEADSS**
- **Previous h/o mental health problems**

  Other M/S conditions, medications, allergies
- **Any recent infections, head injury, weather preference**

CASE 4

MSE

- **Intro**
- **A- unkempt, dishevelled**
- **B- un cooperative**
- **eye contact at times**
- **appears restless**
- **S- slurred**
- **E- mood not high or low**
- **affect- disturbed**

CASE 4

- **P- good**
- **Thought form- linear**
- **Thought content- normal**
- **Insight- poor**
- **J- not assessed**
- **C- oriented to place, person but could not assess time**
- **R- cannot maintain good rapport**
- **R- history not much reliable**
- **R- at risk as currently his blood alcohol level is high, chronic drinker, abuses weed, breaking law, no insight, no proper support**

CASE 5

- **57 years old Mary has been brought in by the police, to the ED of your hospital, for loitering on the streets. You are the HMO at the ED. On examination you noticed that her right foot is swollen and has an ulcer on the medial side of her foot**
- **TASKS**
- **1Take a brief history from Mary**
- **2 Do MSE**
- **3Present MSE to the examiner**
- **(no further investigations or management needed)**

CASE 5

- Confidentiality
- Reason why police had brought her to the hospital
- History regarding ulcer
- duration
- painful or not
- any injury/ insect bites
- any fever
- sensory loss
- first time
- any medical or surgical conditions like DM, HT
- (patient not aware)

CASE 5

Psychosocial history

- **Mood- not sure**
- **Not feeling high or low**
- **Energy levels- normal**
- **No ideas of self harm**
- **Eating well**
- **Sleeping well**
- **No delusions**
- **Has auditory hallucinations of mumbled voices**
- **No commands**

CASE 5

- Insight- absent
- Judgement- good
- Cognition – normal
- Home- living alone
- Not working. On centre link assistance
- No anhedonia
- Smoking and drinking for long time. No street drugs
- Social activities impaired
- Sexual activity
- Past mental illness- Schizophrenia since 7 years, non compliant with meds, reason for non compliance, duration
- No weather preference, head injury or recent brain infections

CASE 5

MSE

- **Intro**
- **Appearance**
- **Behaviour**
- **not much co-operative**
- **no eye contact**
- **body posture- fidgety**
- **Speech**
- **normal in rate, tone and volume**
- **Mood she is unsure and affect is disturbed so cannot assess congruency**
- **Perception- auditory hallucinations**
- **Thought form- linear with no loosening of associations**

CASE 5

- Thought content- normal
- Insight- poor
- Judgement- present
- Cognition- oriented
- Rapport- not much
- Reliability- not much reliable. Need to take collateral history
- Risk
- at risk as she has relapse of schizophrenia with active hallucinations, non compliance with medications, no insight, substance abuse, no proper support with foot ulcer that she is not aware off

CASE

- **Jessy, 45 years, was brought in by the police to the ED where you are the HMO. The police tell you that she was chanting that God will save the world and disturbing public peace in some way. She has history of chronic schizophrenia and was seen at the hospital for a leg ulcer 1 year ago**
- **TASKS**
- **1 Take history from patient**
- **2 Explain to patient your assessment, cause and risks of her**
- **condition**

CASE

- **Confidentiality**
- **(Opening statement god is wonderful)**
- **Reason why she was booked by police**
- **Mood- very happy**
- **Duration- 2 weeks**

  Energy level

  Suicidal ideations (life is wonderful as God is within me)
- **Eating well**
- **Sleep- not much**
- **D/ H- grandiosity, jealous, persecutory**
- **Insight- when diagnosed with schizophrenia, medications, non compliant with medications as she**
- **ran out of medications and was feeling fine so didn't get more**
- **Judgement- impaired (God will protect me)**
- **Cognition- oriented**

CASE

- **Home- in shelters**
- **Work- no**
- **Financial stress- yes**
- **No anhedonia**
- **Smoking- yes, duration, how many/day**
- **Alcohol- duration, little like 10 cans/ week cannot afford more, last time taken**
- **Drugs- marijuana, duration, how often, last time**
- **No social activities**
- **Sexual H**
- **No h/o head injury/ infections , weather preference**
- **No other M/S illness**
- **Family H of mental issues- Dad on lithium for bipolar**

CASE

ASSESSMENT

- **Relapse of schizophrenia with active delusions and hallucinations**
- **Explain schizophrenia**

CAUSE

- **due non compliance with medications and due to marijuana and alcohol abuse use as it can precipitate mental problems**

CASE

RISKS

- **At risk to yourself and others as sometimes these intense joyous feelings can become quickly overwhelming and confusing**

as you have

Relapse of schizophrenia with active delusions and hallucinations

Being non compliant to medications

Lacking insight

Impaired judgement

Substance abuse

No proper support

CASE 6

- **You are at your GP when a 42year old nurse Jane is brought to you. She had been accused of an incident at her hospital 2 months ago when one of her patients had died who was a child with meningococcemia. She had been cleared of the incident by the coroner and case closed.**
- **Yesterday her partner found her piling drugs around her bedside for overdosing and he got very much concerned and had brought her to you for help.**
- **TASKS**

  1 Take psychosocial history from Jane

  2 Present MSE to the examiner with risk assessment

  3 Give further management to examiner

CASE 6

HISTORY

- **Confidentiality**
- **Her feelings about being cleared off the case(still feeling guilty)**
- **Other delusions (paranoid/ persecutory)**
- **Hallucinations(hearing and seeing the child)**
- **Nightmares and flash backs**
- **Psychosocial history with orientation to time and place**
- **Past history of head injury/ thyroid disturbances/ infections**

CASE 6

MSE

- **Short intro**
- **Appearance** unkempt, dishevelled
- **Behaviour** not very co-operative, no eye contact
  stooped body posture
- **Speech** low volume, slow rate and monotonous
- **Mood/ affect** low and depressed and disturbed
- **Perception** auditory/ visual hallucinations
- **Thought form** mono syllabic
- **Thought content** delusion of guilt, paranoid/ persecutory delusions
- **Insight** absent
- **Judgement** impaired
- **Cognition** normal
- **Rapport** could not establish a very good rapport
- **Reliability** not much reliable. Take collateral history from partner

MAJOR DEPRESSION WITH PSYCHOTIC FEATURES

RISK ASSESSMENT

At a high risk of self harm due to

- **Major depression with psychotic features of active delusions and hallucinations**
- **Suicidal ideations with definite plan**
- **Lack of insight**
- **Alcohol abuse**

MAJOR DEPRESSION WITH PSYCHOTIC FEATURES

MANAGEMENT

- **Referral to hospital for admission**
- **Organic work up**
- **Assessment by mental health team**
- **Antidepressants + antipsychotics by psychiatrist**
- **CBT by psychologist**
- **Support from mental health nurse**
- **Family meeting with partner**

Upon discharge

- **Regular reviews with psychiatrist and GP**
- **Support groups**
- **Life style modifications**
- **Inform community mental health worker.**

CASE 7

- **You are at your GP when 42 year old Grace, mother of 16 year old Ella, comes to see you to discuss about her condition since Ella has been diagnosed with psychosis 2 weeks back. Ella was hospitalised and now she is at home after discharge**
- **TASKS**

  1 Take further history from Grace

  2 Discuss the condition that Grace is going through

  3 Tell her what she is having and your management plan

CASE 7

- Confidentiality
- Ella's situation- symptoms at the time of diagnosis, similar symptoms now, taking medications
- Concerns
- Coping up with the situation
- Show empathy(I can certainly imagine why you feel this way. I am sorry this has been a distressing situation for you)
- Reassurance (We are all here to support you and to get you through this difficult situation)
- Mood (worried)
- No ideas of self harm
- Eating well
- Sleep (disturbed)
- No delusions/ hallucinations
- Insight- poor
- Judgement- good
- Cognition- oriented

CASE 7

- **H- partner and younger daughter**
- **Partner and younger daughter coping with the situation**
- **Partner supportive**
- **Any other family members/ friends to support**
- **Caring for younger daughter(cannot)**
- **E- not going for work. Has financial stress**
- **Not enjoying activities**
- **SAD- negative**
- **Social activities- impaired**
- **Anxious personality**
- **Other symptoms – SOB, palpitations, dizziness, headaches**

CASE 7

- **Weather preference-Hyperthyroidism**
- **Head trauma**
- **Recent infections**
- **Past M/S history/ mental illness/ medications**
- **Family history of mental illness**

CASE 7

Explanation of condition

- **What you have is a psychological stress or reaction seen in carers and family members related to a patient with mental health problem**
- **This is a sort of adjustment disorder with anxiety in response to stressful changes in our environment and also because of role strains**
- **For Ella it is possible to have a single psychotic episode and then to have complete recovery**

CASE 7

ASSISTANCE TO MOM

Lot of support available

- **Arrange investigations- basic bloods, TFT**
- **Referral to psychologist for CBT**
- **LSM- relaxation techniques like yoga and meditation**
- **Not working- SSRI or anxiolytics and referral to psychiatrist**
- **Family psychoeducation for other family members by referral to counsellor as family members experience significant stress in coping. Partner and younger daughter can also be involved**
- **Support groups-Mental Health Carers Australia for family members supporting people with mental health problems**
- **Financial support is also available from centre link**
- **Can get online information regarding psychosis from SANE Australia and EPPIC (Early psychosis prevention and intervention centre)**
- **As you are the primary carer of your daughter, you need to be strong to provide physical and mental support to your daughter**
- **Review with results**
- **Reading materials**

CASE

- **You are an HMO at the psychiatric ward of a major hospital**
- **Grace , mom of 14 year old Ella, comes to see you concerned about her daughter who was behaving abnormally. Ella was running out of the house saying aliens are coming. Parents got worried and called their GP who arranged the crisis assessment team who took her to the hospital. She has already been diagnosed with acute psychotic episode by the psychiatrist and is undergoing further assessment now**
- **TASKS**
- **1 Take history from mother**
- **2 Discuss Ella's condition and immediate management with mom**

CASE

- **Concerns**
- **Coping up with the situation**
- **Confidentiality**
- **Show empathy(I can certainly imagine why you feel this way. I am sorry this has been a distressing situation for you)**
- **Reassurance (We are all here to support you and to get you through this difficult situation)**
- **Anybody to support her**
- **Partner coping with the situation**

ACUTE PSYCHOSIS

Psychosocial H of Ella

- **First episode**
- **Duration- last few days**
- **What exactly happened**

(isolating herself, increasingly irritable, not eating well, uncharacteristically angry with mom, shouting at herself in her room, running out of house saying aliens are coming and whole family is in danger, refusing to go to school, some students picking on her at school, scared of assault, school performance deteriorating)

ACUTE PSYCHOSIS

- **Ella is having acute psychosis which means that at the moment, she is psychiatrically and emotionally unwell and her thoughts and feelings are unpredictable so that treatment is required which will definitely help**
- **It is a temporary state of experiencing an altered reality. It is a result of continual interaction of specific biologic disorders of brain with specific psychosocial and other environmental factors**
- **Psychosis is not a mental illness by itself but a symptom of underlying mental health disorder**
- **It is possible to have a single psychotic episode and to have a complete recovery**

ACUTE PSYCHOSIS

MANAGEMENT

Investigations to rule out organic causes

- FBE, ESR/CRP, TFT, LFT, FBS, S. lipid profile, Vitamin B12 and folate
- Urinary drug screen

Assessment by MAT

- Admission
- Will be started on antipsychotics +/- antidepressants/ mood stabilisers by psychiatrist
- CBT by psychologist
- Support by mental health nurse

Upon discharge

Address trigger if any, arrange social worker if needed

Community mental health worker will be informed

Support groups for mom

LSM once back home

Regular reviews by psychiatrist/ GP

CASE

Psychotic disorders include

- **Schizophrenia- disorder that affects a person's ability to think, feel and behave clearly**
- **Schizophreniform disorder- similar to schizophrenia but lasts less than 6 months**
- **Schizoaffective disorder- schizophrenia + mood disorder like depression**
- **Bipolar disorder- disorder associated with mood swings ranging from depressive lows to manic highs.**
- **Delusional disorder- patient has trouble recognising reality**
- **Psychosis due to physical causes like CNS infections, brain tumours, head injury, Thyroid overactivity, SLE**
- **Substance abuse**

CASE 8

- **You are an HMO at the ED. Sophie, 19 years, is your next patient. She has self inflicted wrist cuts on both her hands**
- **The cuts were superficial and had been cleaned and dressed by the nurse. She is stable at present and wants discharge**
- **TASKS**
- **1 Take further history from Sophie**
- **2 Discuss your diagnosis and differentials with patient**

CASE 8

- **Intro**
- **Any pain**
- **Any other injuries**
- **How are you feeling now (guilty and stupid)**
- **Confidentiality**
- **Reason (room mate wearing pink dress which she didn't like,**
- **had arguments and then cut herself)**
- **Did you do it with the intention of committing suicide or just to relieve your inner tension**
- **Any previous episodes- when, reason, type of injury, what was done at that time**

CASE 8

Psychosocial H

- Mood- (numb)
- Anytime feeling low or high (no)
- Life enjoyable (yes)
- Any thoughts of harming yourself again (no)
- Feeling hopeless (no)
- Eating well (yes)
- Sleep- disturbed (has nightmares of abusive father)
- Any flash backs (yes)
- Overly vigilant
- Since how long have you got these nightmares/ flashbacks (since childhood)
- Thoughts interfering with your ADL (only with sleep)

CASE 8

- **Physical or sexual abuse (physical- Mom locks children in the room as parents fight a lot)**
- **Where are you living at present (at a hostel with her room mate)**
- **Room mate supportive (yes, brought her to the hospital)**

  What about your sister (at home, feels guilty about leaving her behind)
- **Do you think she is safe**

CASE 8

- Any other stressors (no)
- Insight- poor
- Judgement- good

  Cognition- normal
- Working or studying- performance, stress
- Financial problems
- Anhedonia (no)
- SAD- drinks occasionally
- Any binge drinking, gambling, overspending, reckless driving or trouble with law
- Any childhood hyperactivity (no)
- Finding trouble sticking to rules (no)
- Social- active
- Any relationship you are into

CASE 8

- Anybody to take you to the hostel
- What are your plans once you get back to the hostel
- Any plans for tomorrow
- General health issues
- Previous or family H/O mental disturbances

CASE 8

DIAGNOSIS

- **Borderline personality disorder with PTSD**
- **BPD is a mental health disorder that impacts the way you think and feel about yourself and others causing problems in functioning in everyday life**
- **Can lead to frequent distressing emotional states finding it a little difficult to co- relate with others**
- **To get over the emotional stress you may have repeated self harming behaviours by which you feel relieved of your inner conflict**

CASE 8

The fore most cause could be PTSD which is a trauma and stress related disorder experienced by people who had gone through a severe distressing psychological event, in your case the severe childhood abuse leading to recurrent recollection of the events in the form of nightmares and flash backs

BPD can start from the stem of traumatic events

Thoughts, feelings and behaviours seen in BPD can be the result of childhood trauma

Genetic factors also contribute

CASE 8

- **DDx**
- **Antisocial PD (no trouble with law)**
- **Histrionic personality disorder (no attention seeking behaviours)**
- **Adult ADHD (no hyperactivity)**

  Mania(mood not high)
- **Bipolar disorder (Because of mood instability but here no low or high mood)**
- **Psychotic disorders (no delusions/ hallucinations)**
- **Substance abuse (no history)**

CASE 8

MANAGEMENT

- **Psychologist referral- CBT like Interpersonal psychotherapy**
- **Support groups**
- **LSM**
- **Referral to psychiatrist for a complete formal assessment and if needed for medications**

BPD

RISK ASSESSMENT

- Any thoughts of harming yourself again
- Is this the fist time that you have done this
- Do you think life is enjoyable
- Are you feeling hopeless at the moment
- Mood
- SAD
- Do you have a good support at home
- What are your plans once you get back home
- Any plans for tomorrow
- Previous mental disturbances

CASE 9

- **You are seeing 26 year old Jane who comes to your GP to review the result of her MRI scan of brain which was requested by the neurologist**
- **Jane underwent MRI as she has repeated episodes of headache associated with severe neck spasm. MRI has come out normal**
- **TASKS**
- **1 Take history from Jane**
- **2 Tell her the likely cause of her headache**
- **3 Discuss further management with her**

SOMATIC SYMPTOM DISORDER

History

Specific concerns

History of headache

- **Any headache now**
- **Duration(8 months) onset (gradual) site, radiation, type, character (constricting pain on and off all over head going towards neck) aggravating/ relieving factors**
- **Treatment taken earlier (multiple doc visits, physio, different medications)**
- **Associated symptoms like N,V, vision problems, runny nose, watery eyes, pain in the ear or teeth, head injury, previous brain infections**
- **Any other site of pain apart from headache**
- **GIT symptoms- bloating/ food intolerance**
- **CNS symptoms- loss of balance, numbness, tingling**

SOMATIC SYMPTOM DISORDER

- **Are you worried about your headache so much that it has started interfering with your ADL**
- **Do you think there is any serious underlying disorder or just worried about headache (for hypochondriasis)**
- **CONFIDENTIALITY**
- **PSYCHOSOCIAL HISTORY (mood- worried, living with parents after leaving job, divorced, not interested in sex for 1-2 years)**
- **Medications**
- **Surgeries**
- **Past history of mental illness**

SOMATIC SYMPTOM DISORDER

EXPLANATION

- **What you have is tension headache due to a somatic symptom disorder**
- **Your MRI is normal which means you have no underlying serious conditions within your brain**
- **Tension headache is a part of a mental condition called somatic symptom disorder that causes one or more bodily symptoms including pain. The symptoms are not usually traceable to an underlying physical illness or other mental illness or substance abuse. But regardless they cause excessive levels of distress and persistently high level of anxiety The symptoms can involve one or more different organs and body systems.**
- **But the symptoms you experience are real and is due to mind body relationship.**

SOMATIC SYMPTOM DISORDER

MANAGEMENT

- **I know you feel the headache but I can find no evidence of changes within your brain and that is why no medical or surgical treatments are going to make the pain go away. On the other hand there are a number of things that you can do to make you feel better. Would it be ok to have a look at these options .The goal of treatment is to improve your symptoms and your ability to function in daily life.**
- **Pain management**
  - **Referral to psychologist for CBT to learn how to cope with physical symptoms, how to reduce stress, improve ADL**
  - **SSRI**
  - **Family based therapy with your consent to improve family relationships and to get adequate support**
  - **LSM- relaxation techniques like yoga/ meditation**

    Support groups
  - **Referral to psychiatrist if above does not work**
  - **Warning signs**
  - **Reading materials**
  - **Review in 1 month**

CASE 10

- **You are at your GP when Steve, a carer comes to meet you. He wants to discuss about 27 year old James . James has complex partial seizure and mild cognitive impairment due to a motor vehicle accident many years ago. The patient is currently living in support accommodation and is on financial aid. The patient is on carbamazepine 400 mg bd and valproic acid 500 mg /day.**
- **The carer is concerned about recent behaviour changes in James and the carer has consent to talk about patient's medical condition**
- **TASKS**

  1 Further history from Steve

  2 Talk to the carer regarding James condition giving diagnosis /differentials

  3 Discuss your plan of management of James

CASE 10

- Confidentiality
- Type of behavioural disturbance (sexually inappropriate behaviour like masturbation in public, urinating in flower pots, verbally abusive towards other tenants)
- Duration (1 week)
- Any self harm/ tendency to harm others
- Violent/ aggressive behaviour
- How long carer knows James
- Any previous episodes

CASE 10

- **PSYCHOSOCIAL H**
- **Mood- disturbed/ irritated**
- **Eating well**
- **Sleep- not aware**
- **No delusions/ hallucinations**
- **Cognition- normal**

CASE 10

- H- not getting along well with other tenants
- No recent stressors at home
- Informed family(No family living around/ visits- dad died , mom in QLD with new family)
- E- not getting up in the morning to go to work saying he is too tired
- A- not getting out of room
- SAD- negative
- Social- impaired
- Not sexually active
-

CASE 10

Head injury- when, type of head injury, surgery

H/O epilepsy- duration, last episode, who gives him medication, any chance of overdosing or skipping,

last neurologist check

Recent infections with fever, rash, early morning vomiting/ frequent headaches, weakness of extremities, speech disturbances, HT/ memory loss

General health

Past h/o mental health issues

CASE 10

DIAGNOSIS

- **Behavioural changes due to acquired brain injury**
- **ABI is any type of brain injury that happens after birth**
- **In him it can be MVA**
- **Long term effects of ABI are difficult to predict. Will be different for each person and can range from mild to profound. This is mainly because recovery continues for many years after a head injury**
- **It can be considered as a hidden or invisible disability which comes out later.**

CASE 10

DDX FOR BEHAVIOURAL CHANGES

- **Seizures**
- **Drug toxicity**
- **Delirium**
  - **Meningitis, encephalitis**
- **Brain tumour**
- **Stroke**
- **Neurosyphilis**
- **Hypertensive encephalopathy**
- **Wernicke's encephalopathy**
- **Psychotic disorders**

CASE 10

MANAGEMENT

- **Has to see James. Arrange appointment ASAP**
- **Organic work up**

  Blood tests- TFT/ toxicology screen/ CT/ MRI brain
- **Referral to neurologist and psychiatrist**
- **Referral to psychologist for CBT**
- **Warning signs- self harm or harmful behaviour to others report immediately**
- **Reading materials**

CASE 11

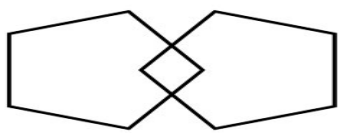
- **47 year old Maria is your next patient at your GP**
- **She is a heavy drinker having more than 6 standard drinks a day for the past 10 years. She has stopped taking alcohol since the past 3 weeks. She is a known diabetic patient on Metformin but admits that she forgets to take medications quite often. Her blood sugar level is pretty high**
- **TASKS**
- **1 Explain MMSE to the patient**
- **2 Perform MMSE with patient (no need to score, last 2 tasks have already been done and they are normal)**
- **3 Discuss your diagnosis with reasons and differentials with patient**

MINI MENTAL STATE EXAMINATION (MMSE)

Name:

DOB:

Hospital Number:

One point for each answer	DATE:		
ORIENTATION Year Season Month Date Time	...../ 5	...../ 5	...../ 5
Country Town District Hospital Ward/Floor	...../ 5	...../ 5	...../ 5
REGISTRATION Examiner names three objects (e.g. apple, table, penny) and asks the patient to repeat (1 point for each correct. THEN the patient learns the 3 names repeating until correct).	...../ 3	...../ 3	...../ 3
ATTENTION AND CALCULATION Subtract 7 from 100, then repeat from result. Continue five times: 100, 93, 86, 79, 72, 65 (Alternative: spell "WORLD" backwards: DLROW).	...../ 5	...../ 5	...../ 5
RECALL Ask for the names of the three objects learned earlier.	...../ 3	...../ 3	...../ 3
LANGUAGE Name two objects (e.g. pen, watch).	...../ 2	...../ 2	...../ 2
Repeat "No ifs, ands, or buts".	...../ 1	...../ 1	...../ 1
Give a three-stage command. Score 1 for each stage. (e.g. "Place index finger of right hand on your nose and then on your left ear").	...../ 3	...../ 3	...../ 3
Ask the patient to read and obey a written command on a piece of paper. The written instruction is: "Close your eyes".	...../ 1	...../ 1	...../ 1
Ask the patient to write a sentence. Score 1 if it is sensible and has a subject and a verb.	...../ 1	...../ 1	...../ 1
COPYING: Ask the patient to copy a pair of intersecting pentagons 	...../ 1	...../ 1	...../ 1
TOTAL:	...../ 30	...../ 30	...../ 30

MMSE scoring
24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: ***Ask the questions in the order listed. Score one point for each correct response within each question or activity.***

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

(Adapted from Rovner & Folstein, 1987)

- MMSE EXPLANATION
- Screening test to assess cognitive or mental functioning
- Simple test to assess your process of knowing and perceiving things
- Tests your memory, thinking, planning and judgement which are brain functions
- Has 30 points in total
- Will take approximately 5-10 minutes
- During the test I will be asking you few questions and also will ask you to follow simple commands
- I will guide you through it once we start
- If you have any problem or questions please don't hesitate to stop me
- Are you happy to proceed

CASE 11

Perform MMSE

- **Patient has problem remembering date in orientation to time**
- **Registration getting the 3 words only on second attempt**
- **Attention- cannot spell WORLD backwards**
- **Recall- only 1 word out of 3**

CASE 11

Explanation of results to patient

- **You have trouble in learning new things and recalling what you have learnt which shows you may be having short term memory loss as registration and recall are short term memory functions**
- **In addition there is a slight problem with attention, concentration and orientation with date which may indicate a faster decline rate if necessary steps are not undertaken**

CASE 11

DIAGNOSIS

- **Could be because of an alcohol induced brain injury associated with excessive hazardous alcohol use**

Patient says I am not taking alcohol any longer

- **Appreciate her in not taking alcohol**
- **Effect of alcohol in the brain can be there for a long time even after a person stops drinking**
- **Memory, attention and reaction time can take quite some time to return**

CASE 11

DDx

- **Uncontrolled DM which increases risk of memory problems if blood sugar remains uncontrolled for a long time**
- **Amnestic alcohol disorder associated with Vitamin B1 or other nutritional deficiencies due to alcohol abuse**
- **Delirium tremens which is alcohol withdrawal delirium with a confused mental state and memory loss but will have associated vision problems and loss of balance**
- **Electrolyte imbalances where there is salt and water disturbances**
- **Hypothyroidism due to lack of hormone secretion from thyroid gland in front of your neck**
- **TIA/ mini stroke due to high sugar levels and heavy drinking of alcohol but you will have associated speech problems and weakness of your limbs along with memory problems**

CASE 12

- **Jane, 22 years, a university student is at your GP referred by Uni counsellor as she is skipping university and has poor study performance. She also has multiple sexual encounters recently**
- **Tasks**
- **1 History from patient**
- **2 Discuss diagnosis to patient**
- **3 Explain immediate management to patient**

MANIA

HISTORY

- **Patient fidgeting and restless**
- **Says she is here as her counsellor asked her and she didn't want to come**
- **Reason for skipping Uni - Says she knows everything better than others**
- **Mood- really good. Not low any time**
- **Energy levels- high**
- **Duration- 3 weeks**
- **No ideas of self harm**
- **Eating well**
- **Sleep- don't need sleep**
- **Delusions – other students jealous of her**
- **No hallucinations**
- **Insight- poor**
- **J/ C - good**

MANIA

- H- living in a hostel away from family. No stressors. No contact with family
- E- no stress at Uni. Not employed. Has financial problems
- No anhedonia
- SAD- nothing significant
- Social activities- gets along with friends
- Sex- multiple sexual partners, no safe sex, not screened for STI
- Periods- LMP – 4 weeks back
- Over speeding, gambling, overspending, trouble with law
- No other M/S illness, psychiatric problems/ medications, allergies
- No infections, head injury, thyroid problems

MANIA

Mania

- **Is an mood disorder, a psychiatric illness, characterized by extremely elevated and excitable mood resulting in a state of heightened overall activities. This can affect your sleep, energy, activity, behaviour and ability to think clearly**
- **Cause - unknown but could be because of overactivity of a chemical called dopamine in the brain. Environmental and genetic factors contribute.**

MANIA

MANAGEMENT

- Admission in the hospital
- Organic work up

  FBE, ESR/CRP,U&E, TFT,BSL, STI screen

  Toxicology screen for illicit drugs

  Urine UPT, MCS
- Notification of Mental Health Team
- Psychiatrist will start medications- mood stabilisers
- CBT by psychologist
- Support from mental health nurse
- If worsening, ECT

MANIA

Upon discharge

- **Arrange social worker**
- **Support groups**
- **Notify community mental health worker**
- **LSM**
- **Regular reviews with GP/ Psychiatrist**

MANIA

DD

- **Bipolar disorder**
- **Schizoaffective disorder**
- **Schizophrenia**
- **Substance abuse**
- **Organic causes**
- **hyperthyroidism**
  head injury
  infections like encephalitis
  metabolic disturbances

Another scenario for mania

- **Young male referred by uni supervisor to your GP as he is disruptive and loud in class. He is studying Master's in Psychology**
- **TASKS**
- **1 Take psychiatric history from patient**
- **2 Explain diagnosis and differentials with reason to the patient**

MANIA

POSITIVE POINTS

- **Believes others are quite slow and thus thinks that I am disruptive in class as they don't understand what I know**
- **Mood- high**
- **Sleep- poor**
- **Insight/ judgement- poor**
- **Overspending**
- **Increased sexual behaviour**
- **Drinking 5 bottles of wine/day**

CASE 14

- **22 year old Mike is your next patient at your GP. He has come to see you as his Uni teacher advised him to do so as he is having decreased grades recently.**
- **TASKS**

  1 Take history from Mike

  2 Tell him your differentials with probable diagnosis.

OCD

- Confidentiality
- Reason behind failing grades (studies History and whenever I come across the word King, I need to get up and walk around the room thrice)
- Duration
- Feeling relieved after pacing around
- Are these thoughts rational
- Ever tried to resist these thoughts
- Any other repetitive thoughts or rituals
- Perfectionist personality
- DDx Q's

  Any rigid thoughts and behaviours

  Generally anxious person worrying about trivial things

  Any symptom cluster like sweating, palpitation, SOB, dizziness which comes out of the blue

  Any nightmares/ flashbacks regarding any major psychological trauma

  Effect on ADL (needs to recorrect my work often, cannot pay attention)

OCD

- **Psychosocial history (mood- worried, sleep disturbed, financially unstable)**
- **Other medical/ surgical conditions, medications**
- **Head injury, thyroid disturbances, infections**
- **Past history/Family history of mental illness**

OCD

DD

- **OCPD- personality disorder with rigid ,non flexible thoughts and behaviours. Thoughts not recurrent but fixed. Perfectionist personality**
- **GAD- worried about almost all things even if trivial**
- **Panic attack/ disorder- associated with cluster of symptoms like sweating, SOB, palpitations coming out of blue and which gets over in in short time**
- **PTSD- night mares, flash backs with H/O major trauma**
- **Substance abuse**
- **Psychotic disorders- associated with delusions/ hallucinations**
- **Thyroid problems- weather preference**
- **Head injury**
- **Brain infections**

OCD

DIAGNOSIS

- **OCD**
- **Anxiety disorder characterised by recurrent, persistent, intrusive, unwanted thoughts or feelings called obsessions leading to repetitive behaviour or acts which you cannot control called compulsions.**
- **Becomes distressing later as it starts interfering with ADL.**
- **Develops from a combination of genetic and environmental factors.(financial, bullying, strained relationships)**
- **Treatable condition**

OCD

MANAGEMENT

- **Arrange investigations- basic bloods, TFT**
- **Referral to psychologist for**

  CBT- Exposure and response prevention

  Will teach you to confront fears and avoid associated compulsions in turn improving ADL
- **Life style modifications- relaxation techniques**
- **Support groups**
- **Review in 1 month**
- **SSRI and referral to psychiatrist if this does not work**

TYPES OF OCD

- **Safety checking obsessions**
- **Contamination obsessions- cleanliness**
- **Hoarding obsessions**
- **Symmetry obsessions- counting**
- **Repugnant obsessions related to sex, religion**
- **Others**

OTHER OCD SCENARIO

- You will see a video interview. After the video, you need to present MSE to examiner.
- VIDEO
- Patient uni student. Well dressed and groomed.
- Fidgeting with his fingers and with his head down.
- Positive point- perfectionist and takes hours to complete projects and misses deadlines.
- Has strange thought of his mom having sex with his uncle. Cannot get rid of this thought and makes him nervous.
- Has to count till 10 to get over this thought.
- Other Psych history- good.

OTHER OCD SCENARIO

- **30 year old lady presenting to your GP saying she has some kind of thought problem in a health survey.**
- **Positive- recurrent thoughts of her ex- husband having sex with her girlfriend and has to count till 10 to get over this.**