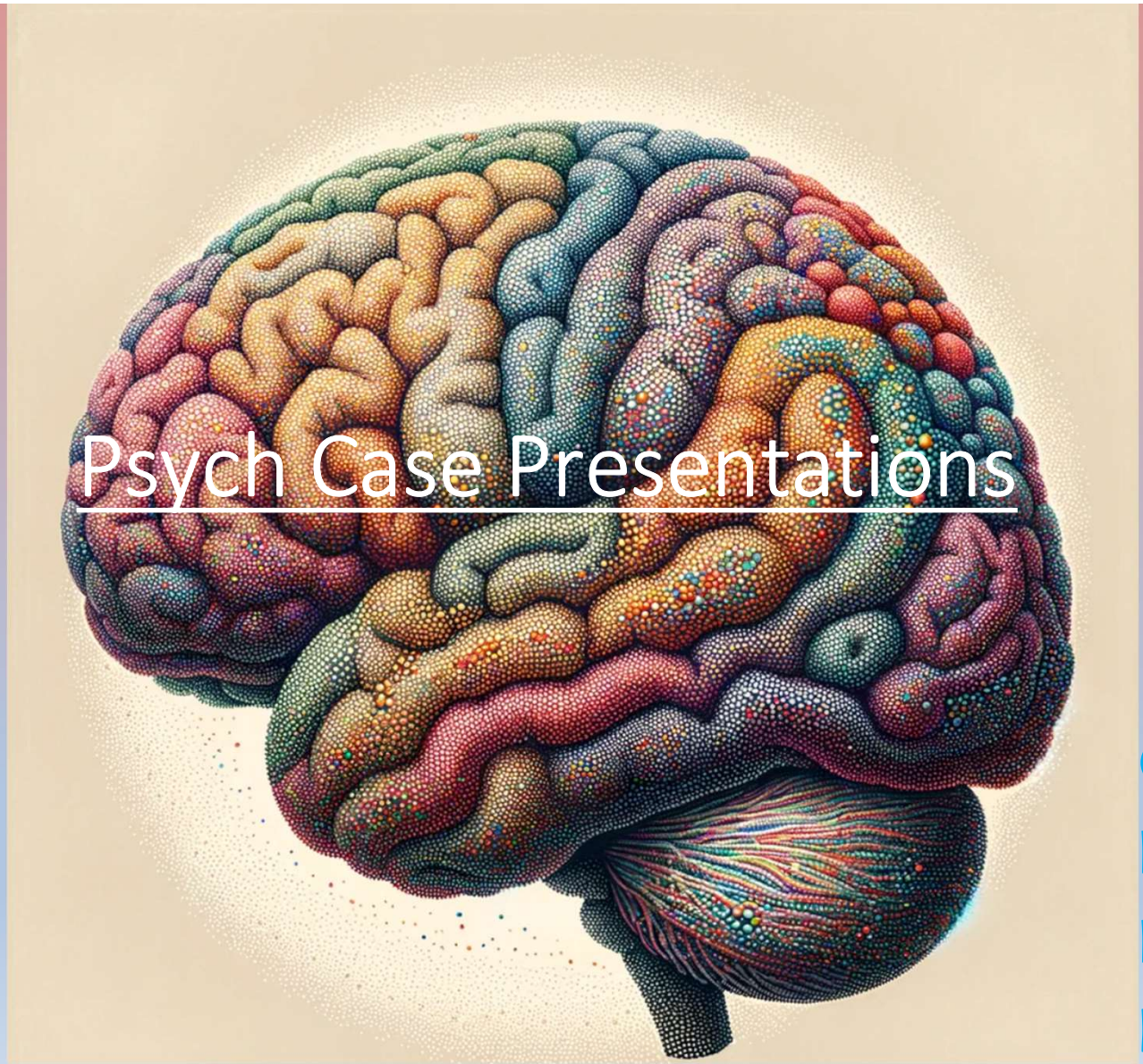
Psych Case Presentations



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Disclosures

- *I have no relevant relationships with ineligible companies to disclose within the past 24 months. (Note: Ineligible companies are defined as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.)*

Educational Objectives

- **At the conclusion of this session, participants should be able to:**

•Become more familiar with symptoms and presentation of several conditions including ADHD, Schizophrenia, Schizoaffective Disorder, and Bipolar Disorder (type I)

•Be mindful of "polydiagnosis patients" w/ multiple overlapping conditions – and appreciate that diagnostic clarity (and med reduction) comes with time, stability, and expert help

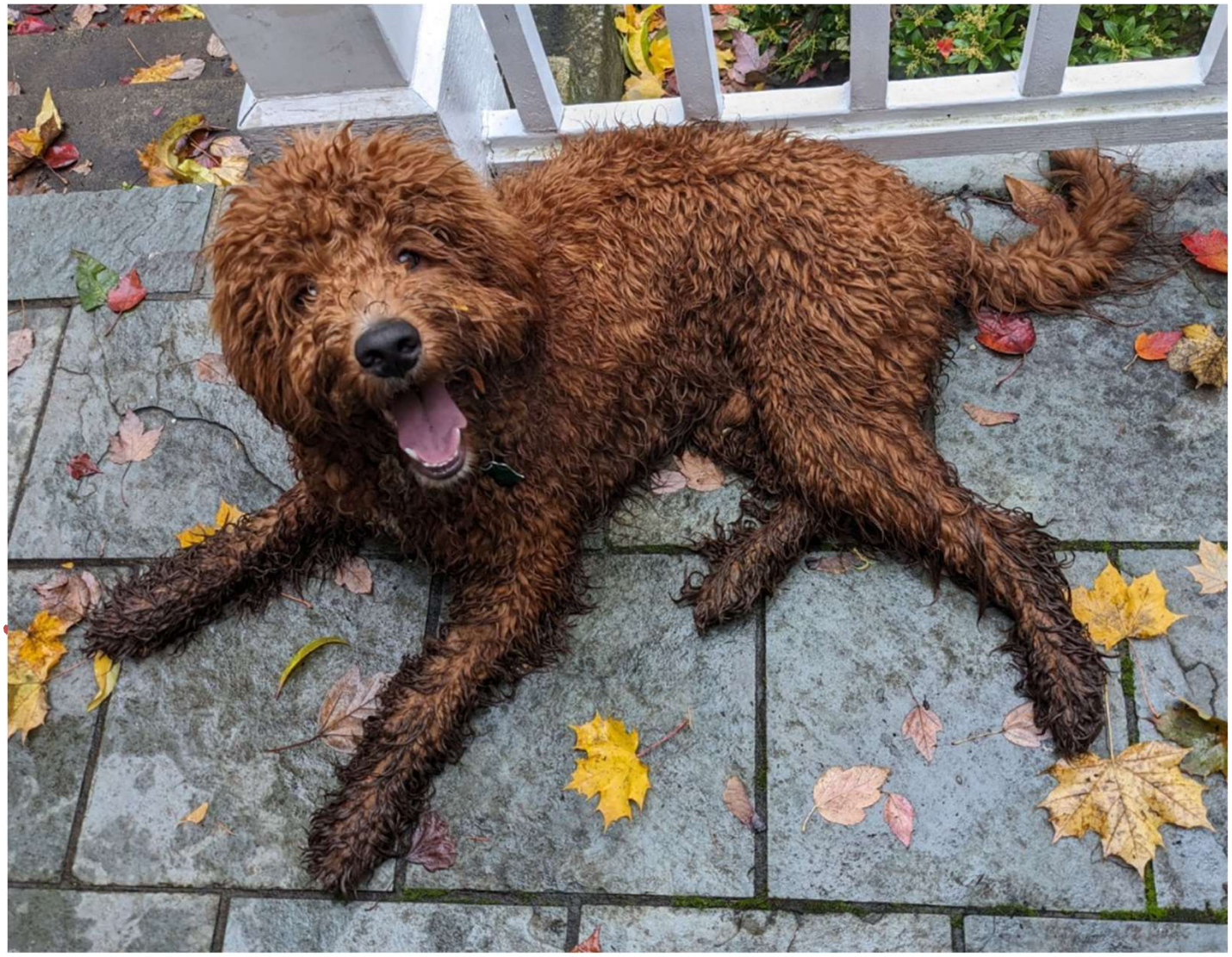
•Be able to discuss the Criteria for Bipolar Disorder

Overview

- **We'll talk about a series of patient cases using highly condensed case histories of real patients, without PHI. Generally we'll talk about initial presentations with minimal prior work-up, or I'll omit/modify previous psychiatric work-up. We're going to focus on chronic conditions especially.**

- **We will discuss diagnostic considerations and some pearls for the conditions, but NOT complete disease monographs (ie, little to no discussion of pathyophys, epidemiology, comprehensive DDx, etc); and we won't be taking a deep dive into one treatment vs another, but I'm happy to answer questions on this subject**

- **And hopefully we'll have some fun, despite overwrought PPT pages (case in point). We'll use analog audience polls – hands! Let's begin!**



so
much
energy...

so
little
focus

Case #1: "Doc, my mind is everywhere and nowhere all at once!"

HPI: 40 YO man who denies previous psychiatric history and is here for evaluation. He likes himself and enjoys life, and had a safe, supportive childhood. As a child struggled in most subjects except sports, and in K-8th was referred to the principal's office many many times for being disruptive and loud. He graduated high school and entered but did not complete college, then drifted through a 4-year US Army enlistment and afterward several jobs. Organization and time management have been consistent, lifelong issues. "The best job I ever had, was managing a gym, I miss it but the money and benefits now are too good." He is driving a 'Vactor' truck for the city and is very anxious about meeting all of his work demands and consistently starting work on-time.

Completed the PHQ-9 today: 8. GAD-7: 8.

Past Psych Hx: Unremarkable; no hospitalizations, self-injury, mania, suicide attempts, eating disorders. No substance use whatsoever, aside from hx cigarettes, and ongoing caffeine (3-4 C coffee or energy drinks daily).

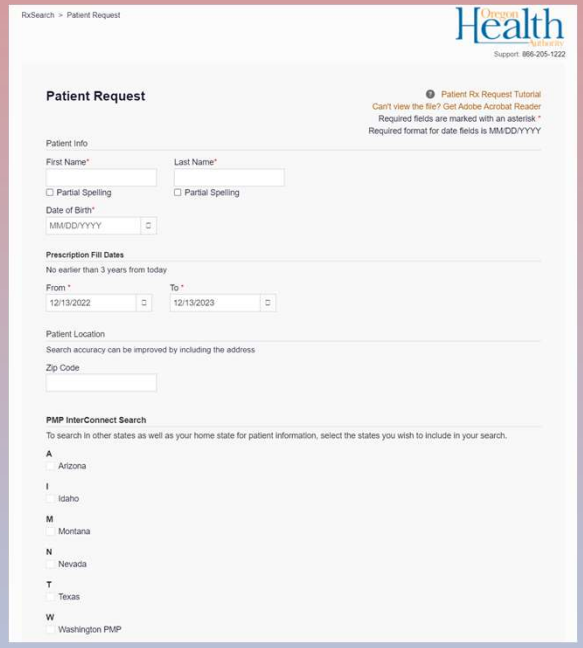
Family Psych Hx: none
PMHx: HSV, o/w unremarkable. **PSHx**: none. **Allergies**: none.
ROS: negative – particularly denies feeling unusually warm, hungry, or sweaty, and denies weight loss last 12 mos.

SOC Hx: safe, secure, denies P/E/S abuse. HS grad. No kids; stable relationship; no legal hx; no substances.

MSE highlights: +rapid but not pressured speech; +scattered concentration; + positive, congenial affect
Notable GEN appearance of round, slightly bulging eyes, and behaviorally being animated & fidgety

Case #1: preliminary considerations for suspected ADHD

1) Drug seeking? Check Prescription Drug Monitoring Program (PDMP) database if available (it is, in AZ).
- Terrific resource that should be used routinely.
- Good to discreetly check early in visit, or before
- This case: NO controlled medications in last 12 mos.



2) Diagnostic Guidelines? YES! *For children.*
The American Academy of Pediatrics
"Action statement 1: The [PCP] should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity" (quality of evidence B/strong recommendation)

2: To Dx, the PCP "should determine [DSM] criteria is met…(including documentation of impairment in more than 1 major setting)…*and information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians.* involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation). Disclaimer: AAP recognizes kids 4-6 may not conform fully to DSM sxs/criteria, and, gathering hx from teachers is harder for adolescents.

Action Statement 3 (Summary), consider co-occurring conditions including anxiety, depressive conditions, oppositional defiant disorder, conduct disorder, substance use disorder, learning difficulties and neurodevelopmental disorders.

"Effort Underway to Develop First U.S. Guidelines for ADHD in Adults" – Columbia Univ. Dept of Psychiatry, 2023.

Estimated between 2.5 and 4.4% of adult US population has ADHD, prevalence (2-3) : 1 - males : females.
Per Dr. Frances R. Levin (Columbia faculty; co-chair, American Professional Society of ADHD and Related Disorders [APSARD]) both over and under-diagnosis are occurring in ADHD.

Case #1: ADHD Diagnostic Criteria (Inattention)

DIAGNOSTIC CRITERIA:

Inattention: 6+ sxs of inattention for children up to age 16 years, or 5+ for adolescents/adults 17+
Sxs must have been present for at least 6 months and are inappropriate for developmental level.
17+: present before age 12, was/is present in at least 2 settings, and sxs were present < 12 years of age.

1. Often **fails to give close attention** to details or makes careless mistakes in schoolwork, at work, other Often has **trouble holding attention** on tasks or play activities.
2. Often **does not seem to listen** when spoken to directly.
3. Often **does not follow through** on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
4. Often has **trouble organizing** tasks and activities.
5. Often **avoids tasks requiring mental effort** or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
6. Often **loses things necessary for tasks** and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
7. Is often **easily distracted**
8. Is **often forgetful** in daily activities.

Case #1: ADHD Diagnostic Criteria (Impulsivity)

DIAGNOSTIC CRITERIA:

Hyperactivity: (like before; 6 sxs for children, 5+ for ages 17+; impact and onset as before).

1. **Often fidgets** with or taps hands or feet, or squirms in seat.

2. **Often leaves seat** in situations when remaining seated is expected, i.e., social impulsivity. ***Think about informal settings – BBQ, camping, cards, board games – this is the person who is getting up and getting called back to the group, or quick to jump up before a plan is really finalized.***

3. Often **runs about** or climbs in situations **where it is not appropriate** (*adolescents or adults may be limited to feeling restless*).

4. Often **unable to play or take part in leisure activities quietly** (except screens, and even then, may talk to the screen or comment/exclaim disruptively.) Note: 'Problematic Internet Usage' is much more common in ADHD than other conditions – Archi et al, Frontiers in Psychiatry, April 2022.

5. Is **often "on the go"** acting as if "driven by a motor" (this tends to fade with age)
6. Often **talks excessively** (again, consider multiple areas of life, relaxed conditions).
7. **Often blurts out** an answer before a question has been completed (*sometimes to stop the conversation or question*, i.e., actively disengages in thinking – "yeah I know, I know, but…")
8. Often has **trouble waiting their turn (*think games, stoplights*)**.
9. Often **interrupts or intrudes on others** (e.g., butts into conversations or games)

Case #1: Diagnosing Suspected Adult ADHD

1) **This is a clinical diagnosis. Expand the HPI, asking about each symptoms of ADHD throughout lifetime. Consider use of forms and screening tools to organize your interview and both your and patient's thinking, such as the ASRS 1.1 or the Wender-Utah Rating Scale (which has online calculators).**
   At the very least – take advantage of phrases and templates built into EHRs.

2) **Is the condition best explained by ADHD, *and* did the ADULT patient meet the background prerequisites for age of onset, chronic impact in at least 2 life settings, *and* at least 5 criteria for inattentive symptoms of ADHD – but did not meet the Hyperactive criteria?**
   → If so, *Dx is ADHD, Predominantly Inattentive (Inattentive Type)*

3) **Did the pt meet criteria for hyperactive ADHD – but not the inattentive criteria?**
   → *Dx: ADHD, Hyperactive Type*.

4) **Did they meet criteria for *both* hyperactivity and inattention?**
   → *Dx: ADHD, Combined type*

THIS PATIENT: had ADHD, Combined Type, and no, didn't have hyperthyroidism or Graves Disease.

ADHD: Diagnostic Confidence

Any ADHD treatment can carry risk, the first-line stimulants are in the same DEA drug schedule as oxycontin, and you have every right to require a high level of confidence before prescribing them.

Diagnostically, when in doubt – whether about the diagnosis itself, or patient appropriateness with respect to prospective (or current) medications – investigate further. Preserve patient dignity always but DO voice your duty to due diligence and your obligation to do no harm.

Examples where further work-up (and documentation) is appropriate:
- Timeline makes childhood onset doubtful, you suspect more acute Anxiety or MDD behind sxs
- Patient w/ previous diagnosis of ADHD (of whatever vintage) and a co-occurring eating disorder
- Patient w/ hx of Epilepsy (via catecholamine release stimulants lower seizure threshold, though in studies of CWE (children w/ Epilepsy) MPH (Ritalin) seldom triggered szs except at high doses.
- And of course, new or established ADHD pt with Hx of substance use, especially stimulant abuse

So, DO obtain collateral history. Ask the patient to return with a parent, sibling or partner, someone who's known the patient for a long time. Serious patients will come back – and vid/phone makes it easy

DO gather personal stories beyond screening forms- like the "ADHD Tax" (the emotional, financial, embarrassment costs experienced b/c of ADHD.) Or frustrations they / partners have about the condition. Genuine cases will have zero shortage of stories to tell about their symptoms.

ADHD: Treatment

Current practice guidelines suggest Behavioral exercise for children younger than 6, first line stimulant medications for kids age 6-11, and medications +/- therapy for patients w/ consent for age 12+.

Behavioral interventions/therapy are a great idea for pediatric pts, good for adults, too – if available (and covered by insurance.)

Book (or Youtube, app, etc) recommendations – i.e. self-help – are a good idea for highly motivated patients, who can realistically agree to treating self-guided exercises with follow-through similar to starting or maintaining physical exercise, or a task of similar focus and effort. They have to want it.

Whether with exercise or self-help, encourage your patients:

'Once a week is better than Nonce per week.'

ADHD: Treatment

Adults: no tx guidelines!

But going with a conservative dose of first line stimulant is fine, and outcomes are typically superior to non-stimulants.

Wellbutrin was never indicated for ADHD, but may be the best (and best tolerated) alternative for some patients who are not appropriate for stimulants. Watch for insomnia.

Atomoxetine is the best of the non-stimulants, but can have a host of unwanted SEs and a high rate of non-compliance. But pls, consider Atomoxetine (mono or combined therapy) for your patients with anxiety and ADHD; and my feeling is all ADHD patients should try Atomoxetine at some point.

Re: Stimulants…

- **I like Ritalin over Adderall (less addictive, less theft/diversion/abuse)**
- **Start with IR dosing, monitor response, watch for red flags (euphoria, "raving and craving")**
- **Individuate tx; many pts will find ER dosing convenient, some (esp w/ variable schedules) IR dosing.**
- **In my practice and among my colleagues, BZDs have been the most abused meds – not the stimulants**
- **Start w/ one med, and AFTER 4-8 weeks consider augmenting w/ low-dose Atomoxetine**

Finally, re: supplements: consider Gingko (ev. B) and Omega-3s (Fish, Flax oils)

When you hear hoofbeats, think

…how’s my lasso game?

Case #2: “My grandma wanted me to come here. I don’t need meds.”

ID: 21 YO Caucasian male w/ shaved head, intense stare, here with his Grandmother

HPI: pt is a reluctant historian who recently lost his job as a pizza delivery driver, after making a coworker uncomfortable with romantic overtures but also insinuations that she was an extraterrestrial. Over later months he became more erratic, reclusive, restricted, especially from family – but he had already been somewhat flat and restricted since age 17, perhaps. Last month he stole a truck and drove to a nearby city (out on parole). He doesn’t volunteer why. Labs from that time were negative for substances. This visit is part of the effort to stabilize the patient and attain considerations for his legal troubles – not his idea.

His grandmother states that he began having auditory hallucinations several years ago. He declines to elaborate. He is consistently guarded and evasive when asking questions about his internal experience, and positive and negative symptoms of pyschosis.

He has not taken medications, but they were recommended after an abrupt, unplanned but serious overdose attempt at age 18. When asked when whether he was feeling depressed at that time, or to elaborate, he is non-commital. At request of family he had therapy after the suicide attempt but it was unproductive and he quit treatment after just a few sessions.

Lately he’s had difficulty sleeping, and seems to be getting about 4 or 5 hours a night.
Both he and his grandmother give either negative or equivocal answers re: DIGFAST symptoms (but he definitely does not appear to be manic, or mixed).

Case #2: Schizophrenia vs Schizoaffective?

FHX: a twin brother with similar presentation and age of symptom onset, (but without the suicide attempt or current legal troubles). Otherwise no past or known family history of psychosis, hospitalizations, or severe MH conditions

Negative Psych Rx trials; no PMHx, SHx, ROS, no Allergies.
SOC Hx: unremarkable, quiet upbringing; HS grad; denies abuse, no substances.

MSE: 5'9, 180 lbs, WDWN. WNL cognition, memory, orientation.
Speech is laconic and monotone.
Affect is flat, guarded, with occasional non-sequitur smile.
Associations intact… but with reluctance, he does admit that sometimes people can put thoughts into his head (delusions of thought insertion) and that sometimes the Internet or television will have stories about him (delusions of reference)

About 0.25-0.64% of the population has Schizophrenia, and ~0.3% have Schizoaffective D/O

Sometimes, those who most need help are the least likely to ask for it…

Case #3: (NB: We're not fully done w/ Case #2 yet, BRB to that)

ID: 48 YO single Black male

HPI: pt w/ long history of mixed mood and psychosis symptoms (including hallucinations and elaborate existential delusions) transferring care from his previous psychiatrist. he had bouts of magical thinking as a teenager, and some delusions as early as age 19. In college he began experiencing sxs of depression interlaced with his delusions, and then had a Major Depression episode in 1990. Next, a psychotic break w/ hyper-religious delusions in 1992. He was hospitalized for 4 weeks, started on Haldol, w/ waxing/waning medical compliance for 3 years after that, "6 months on meds until I couldn't stand 'em, then 6 months off until I needed it…"

A few brief hospitalizations followed between age 22-25, w/ various Rx trials. When highly psychotic he could become violent, but when medicated had, and still has, great insight into his symptoms. On most recent SGA (second generation antipsychotic) Saphris "I bloomed, absolutely, in terms of being able to think freely, and interact with others."

These days he continues to experience intermittent depression and anxiety sxs (improved w/ SSRI Viibryd) and also ~daily delusions and hallucinations. "It's like a story; I'll see things and hear them, and interact with them, but if I have time to process and manage my stress I can live with them." Most of the time he feels content with his regiment, and feels that his greater challenges rest on making practical decisions about everyday life.

He was started on benztropine for mitigation of TD risk w/ Haldol, and it became a legacy med. He has no sxs of TD, has mildly excessive perspiration at times, but nonetheless is content to try d/c of Cogentin.

Case #3: Schizophrenia vs Schizoaffective?

Psych FHX: denies
Past Psych Hx: Dx'd with schizophrenia, GAD, MDD, schizoaffective disorder, bipolar disorder back in the 90s, sleep maintenance insomnia, and has seen at least 6 psychiatrists. 4x hospitalizations, a suicide attempt spontaneously in 1992 , but no history of routine SIB (self-injury behavior).

Past Psych Rx trials; multiple 'typical' antipsychotics (Haldol, Mellaril, Stelazine), and SGAs (Seroquel – weight gain; Risperdal – effective but cognitively harsh; Clozapine – drooling) and Saphris (his best SGA to date). Multiple SSRIs; too much sweating w/ Effexor (SNRI). Multiple anxiolytics, but w/o dependence to (now D/C'd) Ativan and other BZDs. Now on Buspar.

PMHx: HTN, Obesity, OSA, HLD, no diabetes. **PSHx**: appendectomy 1989

SOC Hx: Air Force brat. Youngest of 3 children, felt neglected by parents. Denies abuse. Loves going out to the movies and reading science fiction. Walks every day. Was unable to complete college because of psychotic symptoms. Lives by himself on disability, never married, no children, no legal hx, no substances, rare caffeine (likes taste but not anxiety)

MSE: benign. WDWN. WNL cognition, memory, orientation. Euthymic, reciprocal, fully present. Great insight and description of psychotic sxs. **AIMS**: 1

Schizophrenia Diagnosis: DSM-5

1.Characteristic Symptoms (Criterion A): Two or more of the following, each present for a significant portion of time during a 1-month period (or less, if successfully treated). **At least one of these** should be (1), (2), or (3):

1. **(1) Delusions**: false, firm beliefs despite evidence to the contrary. Like: persecutory delusions (watched, followed, harassed, plotted against, controlled), grandiose (vague wealth, power, importance), referential delusions, etc.
2. **(2) Hallucinations**: sensory experiences in absence of stimuli. Mostly AH. ***Olfactory: get MRI! Tactile: UDS, Drug Hx!***
3. **(3) Disorganized speech** – output of disordered thoughts. Dis-coherence of logic. Derailment, severe tangentiality, neologisms, perseveration (same words or statement over and over), up to total word salad.
4. **Grossly disorganized or catatonic behavior** – often goes along with disorganized speech.
5. **Negative symptoms** (e.g., diminished emotional expression, withdrawal)
   [NB: In totality, these are the "Active Phase" Symptoms.]

2.Social/Occupational Dysfunction: For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas (e.g., work, interpersonal relations, self-care) is markedly below the level achieved prior to onset.

3.Duration: Continuous signs of the disturbance persist for **at least 6 months – including at least one month of the "active phase" above.** [These would be the **prodromal** or **residual** periods, depending on how you're observing pt or obtaining hx.]

4.Exclusion of Schizoaffective, Bipolar and Mood Disorder: Schizophrenia is not diagnosed if symptoms of a mood disorder are substantially present, or if the symptoms are attributable to substance use or another medical condition.
5.Exclusion of disturbance secondary to physiologic effects of a **substance or other medical condition**.
6. If there is a history of ASD/Communication DO of childhood onset, schizophrenia is Dx'd only if prominent positive symptoms

Schizoaffective Diagnosis: DSM-5

Disorder is characterized by a combination of SZO symptoms and mood disorder symptoms. It includes periods of uninterrupted illness during which there is a major mood episode ***concurrent*** with Criterion A of Schizophrenia.

1.Concurrent Diagnosis of Schizophrenia and Mood Episode: An uninterrupted period of illness during which there is a major mood episode (Major Depressive or Manic) concurrent with symptoms that meet Criterion A for Schizophrenia. (If no history of mania, we designate as **Schizoaffective - Depressive Type**. If hx of Mania, **"Schizoaffective – Bipolar Type."**

2.Presence of Psychotic Symptoms: Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the **lifetime duration** of the illness.

3.Mood Episode: Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

4.Exclusion of Substance or Medication-Induced Disorder: The disturbance is not attributable to the effects of a substance or another medical condition.

The key difference lies in the presence of a mood disorder. In Schizoaffective Disorder, sxs of a mood disorder are prominent and occur alongside psychotic symptoms. In Schizophrenia, mood sxs, if they occur, are not as pronounced or sustained.

BOTH conditions carry serious risk for spontaneous suicide attempts of high lethality; ~1/3 attempt suicide, often within one month of hospital admission. Medical dangerousness /severity correlates with positive symptom intensity.

Back to our patients – 21 YO "Don't Need Meds" vs 48 YO "Love my Saphris"

Do both meet criteria for Schizophrenia?

21 YO: Delusions x 1 mo, at least, w/ prodromal and residual sxs; and likely continuous AH x years. Yes.
48 YO: Absolutely – diagnosed multiple times across hospitalizations, continuous to this day.

Do both meet criteria for mood disorder?

21 YO: had a suicide attempt while psychotic, but, exhibited more negative sxs (the absence of expressive and social behaviors that should be there) than depressive sxs. Incidentally, no childhood hx of ASD here.

48 YO: YES. Unambiguous hx of MDD w/ a chronic anxiety and dysthymia. Had a suicide attempt when highly psychotic, delusional in 1992.

Question: Could the 21 YO patient eventually come to resemble the 48 YO patient?

Consider: we don't have the advantage of knowing how our 21 YO pt will look like once their sxs are treated. Hope is good. Family concern is meaningful. Support is available. Meds can be scary. Talk about success stories you have seen for patients who have embraced treatment. Perhaps the 21 YO could "bloom," too, if tx'd.

Re: Dx, we always have to do our best with the history we have now, treat the symptoms we can now, and when needed re-evaluate down the road. Incidentally: early intervention in either condition (probably most conditions? All conditions?) improves prognosis, fewer hospitalizations, lifetime survival.

COLLEGE OF MEDICINE TUCSON
Psychiatry

EPICenter: Early Psychosis Intervention Center

Call 520-694-1234 x7 for an appointment.

EPICenter is a community mental health program offering specialized treatment for persons early in the course of a psychotic illness, such as Psychosis NOS, Schizophrenia, Schizoaffective, and Bipolar Disorder with Psychotic Features. Signs of these illnesses can include trouble with reality testing, paranoia, hallucinations, delusions, disorganization, odd behavior or thinking, isolating emotional changes, and difficulty with work or school. Our mission is to support our members, reduce the impact of early psychosis through symptom alleviation, and reintegration into their community. At EPICenter our members and their family have the opportunity to discuss their concerns, receive evidence-based specific treatment, get help with educational and professional goals, and be part of a supportive community.

Arizona: https://psychiatry.arizona.edu/patient-care/epicenter

Oregon: https://easacommunity.org/

EASA
Early Assessment & Support Alliance

CREATING OPPORTUNITIES
for young people who have experienced psychosis

Donate to EASA

About EASA | About Psychosis | Select Language
For Families, Allies, and Young Adults | For Professionals | Powered by Google Trans

Why do I feel this way?

Are you or someone you know...

Seeing or hearing things that other people don't, like shadows in the corner of your eyes?

Having unusual thoughts, like experiencing the TV, Internet, or music sending you special messages?

Having a lot more energy than usual and racing thoughts, so much that you can't sleep for days?

Are these things bothering you or causing you to be concerned?

You may be experiencing symptoms of *psychosis*. Psychosis is a lot more common than you think. You are not alone.

The Early Assessment and Support Alliance (EASA) can help. EASA provides information and support to

Need Help Now?

Call 911, go to the emergency room, or **call the local crisis line** services if you need them.

24/7 Suicide Prevention & Crisis Hotline: 1-800-273-8255

National Suicide Prevention Lifeline

Local Crisis Lines ⊕

Refer to EASA ⊕

Find Help in the U.S. ⊕

If Yesterday
was a Hard Day's Night,

and all you wanted
to do was
Twist and Shout

but the week before was
"Here Comes the Sun!"

maybe you'd like some
Help!

Case #4: "Sometimes I think I'm manic? And I don't trust my NP"

HPI: 36 YO married mother of 2 mainly here because she wants 'good medication management from a knowledgeable practitioner.' C/o panic attacks and anxiety problems with dinner parties, social gatherings, being in intimate groups. C/o anxiety for much of her life. She estimates panic attacks 2 to 3 times a week.

The patient feels she has had past manic episodes with racing thoughts, rapid speech, being very impulsive, past episodes of promiscuity, poor management of money. She feels that she is paranoid at times and worries that Zoloft is making her have suicidal thoughts. **No PHQ-9, No GAD-7.**

Past Psych Hx: Dx Postpartum Depression. No hospitalizations. No suicide attempts. No Therapy.
Past Psych Rx Hx: Lexapro: made her feel "weird". Xanax: helped recover /p Panic. Klonopin: same.
Zoloft: went up to 250 mg, had anorgasmia, dropped to 150 mg, now having head zaps, nausea.
Hydroxyzine: felt like she had palps, hated it.

Family Psych Hx: mom, sister – anxiety, alcohol.
PMHx: HSV, o/w unremarkable. **PSHx**: C-Sec x 2. **Allergies**: none.
ROS: not in this note

SOC Hx: slightly insecure, chaotic upbringing with 2 sisters, divorced parents. High school graduate. Spotty, erratic work history. No incarcerations. Drinks about 10 servings of alcohol weekly, down from 20-30 servings during her 20s. Uses marijuana high and CBD's. Past history of ecstasy, LSD and psilocybin use – mentioned only, no timeline

MSE highlights: +WDWN, Present, Alert, WNL cognition – but anxious, fidgety

Case #4: Let's Dig Deeper

First, disclaimer– that was NOT my patient encounter…
…but a portion of an intake note from a patient who later came under my care.

How do we feel about the differential diagnosis in this case?
Do we really know this patient well at this point?

Any suggestions or… follow-up questions?
What could be done to bolster confidence in our diagnosis?

Documentation does not tell the whole story, nobody is perfect, time pressure can make for pro-forma notes…but unlike previous cases today, this note wasn't condensed much. Patient was diagnosed with 'Bipolar,' at this very first appointment, by herself – without further work-up or narrative clinical rationale in Assessment

Pt was started on Lithium ER 300 mg BID, + Zofran 8 mg PRN while d/c Zoloft "as fast as possible." – Everyone on board with that?

Case #4: Let's Dig Deeper

A good diagnosis is worth the wait, and there's no substitute for solid history. Take the time to get it, especially if considering life-changing diagnoses or risky treatments.

Some light forensic analysis of our case so far:

- Pt has major history of anxiety and frequent panic attacks.

- No DIGFAST criteria re: mania, no solid timelines re: sub usage or 'manic' symptoms. Were some of these episodes of indiscretion and poor money management taken during the stretch of more severe alcohol use? (20s, self-medicating anxiety…?)

- No collateral hx from any family member. Nor discussion of previous provider notes, or attempt to obtain said notes, or brief curbside case conference.

- Prev Psych NP didn't Rx mood stabilizer, *did* titrate 2 SSRIs, and SEs prompted discontinuation – not a manic switch. SI (unprobed) occurred during dose reduction.

Mania: "mania" originates from the Ancient Greek word "μανία" (mania), which means "madness" or "frenzy". Was recognized as far back as Hippocrates.

Mania described a variety of intense, abnormal mental states, often associated with frenetic energy and sometimes divine inspiration or possession.

Dr. Emil Kraepelin differentiated b/w manic-depressive illness (bipolar disorder) und *dementia praecox** in "Psychiatrie. Ein Lehrbuch für Studierende und Ärzte" (A Textbook of Psychiatry), published 1883

* later “schizophrenia” as named by Dr. Eugen Bleuler

Case #5: "Dr. Ritterman told me I'd need Lithium for the rest of my life."

HPI: 60 YO man here w/ his wife after recent BHU stay. This is his 4th hospitalization following a major manic episode, since age 28 when he was initially diagnosed. He reports that his last hospitalization was in 2012, shortly after he and his wife had moved up from Southern California, and she called 911; expecting the same treatment that she received in California where her husband would be gently escorted to the hospital, instead he was taken to jail, did not receive treatment, and the entire situation became much worse. They became hospital shy. This time, he began exhibiting signs of increasing activity, decreasing sleep, mood swings, major impulsivity, grandiosity, for 2 weeks until she called for help; and he was admitted on an NMI for 9 total days.

He's very talkative, quick to smile and laugh, but has been compliant with medications, and is beginning to stabilize, sleeping better. For a decade he's taken maintenance Lithium but had a lithium level of 0.2 on first hospital day; last 0.8. He also has Abilify, which is a new prescription for him, and lorazepam which is not new.

Of note he has been taking lisinopril for hypertension, and I discussed the particular renal issues with lisinopril and lithium, however he is tolerating both medications and he reports that his lithium dose was lowered by PCP to accommodate the Lisinopril. **PHQ-9: 8. GAD-7: 10**

Past Psych Hx: bipolar disorder type I, panic disorder without agoraphobia
Symptom Onset: first diagnosed at age 28, although had prodromal sxs of bipolar disorder for years prior.
Inpatient Hx: 4 previous hospitalizations, with fairly wide intervals between them
Psychosis Hx: psychosis only during manic episodes (AH, Delusions he was divine, godly)
Suicide attempts: denies/ Self-Injury Behavior (SIB): denies. EDO: No. SUBS: Alcohol (10+/week)
Past Psych Fam Hx: Father, suspected bipolar. A sister, a brother, paternal step-brother, all Bipolar.

DIGFAST Mania Mnemonic. NOTE: MANIA ISN'T SUBTLE

D - Distractibility: Easy distractibility or difficulty in focusing on tasks.

I - Irresponsibility/Impulsivity: Engaging in activities with high potential for painful consequences without recognizing the risks (e.g., unrestrained buying sprees, sexual indiscretions, foolish business investments).

G - Grandiosity: Inflated self-esteem or grandiosity, which may be delusional.

F - Flight of Ideas: Racing thoughts or the subjective experience that thoughts are racing.

A - Activity Increase: Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

S - Sleep Deficit: Decreased need for sleep (feeling rested with only a few hours of sleep).

T - Talkativeness or Pressured Speech: More talkative than usual or pressure to keep talking.

DSM-5 Bipolar Criteria: One Manic Episode.

MANIC EPISODE: Without this, no Dx of Bipolar D/O

≥3 of the DIGFAST sxs (or 4 If mood is only irritable) present to a significant degree and as a noticeable (I would argue severe) change from baseline behavior

B. Distinct period of mood disturbance x 1+ week: Abnormally and persistently elevated, expansive, or irritable, increased energy, present most of the day, nearly every day, ***or any duration if hospitalization was required***

C. Mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning, or has psychotic features, or needs hospitalization to prevent harm to self or others.

D. Episode is not f/ substance (Rx – *think Steroids!* - or illicit) or other medical condition

Hypomania: Must meet DIGFAST criteria but for 4 or fewer days.
Necessary component for **Bipolar disorder type II Dx**.
Typically very high ratio of depressive to manic days, 30:1 or higher.

"Rapid Cycling" Bipolar:
4 or more mood episodes in 1 year.

References

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All Images: made by me in Midjourney, DALL-E [v3] or taken by me. Thanks!

Questions?

- I will be available after this lecture, or you may reach me at…
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  Thank you!