Patient ID: M7044
26 May 2011
14:40

Patient ID: Patient is a 53 year-old divorced white male with a history of depression who is unemployed and currently living with his ex-wife in _____, IA.

CC: "I have been off of my meds…depressed...Seeing my daughter has helped but it wasn't the magic bullet for the way I was feeling…My ex-wife said some silly words that upset me and I felt like I wanted to kill myself or kill someone else and I thought the best thing to do was to be in the hospital."

HPI: Information was obtained from my own interview of the patient, Dr. Iqbal's interview of the patient, and the medical chart.

Patient is a 53 year old male with Depression, EtOH dependence, a history of polysubstance abuse, and psychosis NOS who presents with escalating depressive symptoms over the past few months. He admits that he has not taken any medication for the past 4-5 years, but states that his mood has been well controlled until a few months ago. When asked about any stressors at that time he states that he realized that he was never going to be able to get a job due to chronic joint pain, mainly in his knees, that limits his ability to work. He states that his pain today is an 8/10.

He admits to poor sleep, stating that he has only been sleeping 2-4 hours at night, although he does doze some during the day. He describes decreased interest in previously pleasurable activities such as fishing, playing PlayStation, reading, and watching movies. He feels guilty about the way he talks to his ex-wife and daughter, but feelings of guilt do not interfere with his daily activities. He describes prominent decreased energy and amotivation. He also admits to some degree of psychomotor retardation and suicidal ideation. He denies problems with concentration or changes in his appetite.

He admits to both suicidal and homicidal ideation. These feelings were triggered after an exchange with his ex-wife where he felt she was criticizing him and telling him what to do. His homicidal ideations are not directed at a specific person, and he states, "I wanted to hurt or kill someone and I didn't care who." His plan for suicide was to overdose on pills, but he did not have a specific plan for where to do this or a time when he was going to do it. In addition to his suicidal ideation, he also describes a long-standing passive death wish, present for many years without clear onset.

Mr. M admits to generalized, nonspecific anxiety. He is unable to identify triggers for the anxiety and has been seeking relief through playing Play Station. He admits to auditory hallucinations, describing these as "like a crowd at a ballgame" and saying that there are not distinguishable voices or messages involved. He does feel that he sees things that are not there, but these are more "shadowy images" in the periphery of his vision. Patient denies any history of manic episodes.

Past Psych History:

- Premorbid Personality:
    - The patient describes his premorbid personality as very outgoing. He states, "I wasn't the life of the party, but I had a lot of fun." On questioning he does admit to intense emotional feelings with very high highs and very low lows.
    - Chart review reveals pervious diagnoses of both Antisocial Personality Disorder and Borderline Personality Disorder. While the patient does describe emotional intensity consistent with a diagnosis of borderline personality disorder, it is difficult to corroborate the degree of impairment that this was causing for the

patient. See social history for description of childhood problems consistent with conduct disorder/antisocial personality disorder.

- Current Psychiatric Care: None at the time of admission.
- Phemenological History:
    - Review of the patient's chart shows 5 previous mental health hospitalizations in the VA system, most recently in 2005 for MDD with suicidal ideation. It is unclear exactly when his depression was diagnosed, but based on a note indicating a suicide attempt in 1993, it is clear that he has had ongoing issues for at least 18 years.
    - Patient's typical depressive symptoms include a desire to be alone, frustration and easy irritation, feelings that "people are [mad] at me and think I'm an idiot," auditory hallucinations, and suicidal and homicidal ideation.
- Treatment History:
    - Patient has been on multiple medications for depression, including Paxil, Prozac, Nortriptyline, Venlafaxine, and Celexa, but does not feel that any of these have been successful. He has received Haldol in inpatient settings in the past for psychotic features of his depressive episodes. The most recent medications, which the patient states were working well, are as follows:
        - Venlafaxine, 150 mg BID mood.
        - Ziprasidone 80 mg BID mood.
        - Trazadone 300 mg QHS prn insomnia.
- History of Suicide Attempts/Self-Injury:
    - Patient describes one previous suicide attempt, which he believes took place in 2006. He states that he attempted to overdose on pills at a friend's house. It was difficult to clarify what type of pills these were. His friend was home at the time, and stopped him as he was attempting to ingest the pills. He states that he was having auditory hallucinations at this time. He does not know if his intention was to die, starting "I was drunk and mad."
    - Chart review describes a previous suicide attempt in 1993 by means of overdose at a time when the patient was not having auditory hallucinations. Due to the limited information available about this attempt it is not possible to determine if this is the same attempt described above by the patient or a separate attempt.
- Access to firearms:
    - The patient does not have access to firearms, as he is a felon due to 3 DUI convictions in the state of Missouri.

Family History:

Both the patient's mother and father were alcoholics, and both have passed away from "old age." The patient has 4 sisters and 2 brothers. One sister is an alcoholic and one brother was an alcoholic and addicted to crack cocaine. The patient's oldest brother died from a brain tumor at the age of 28. It is not clear if this was a primary brain cancer or a metastatic lesion. There is no history of mental illness, hospitalizations, or suicide in the patient's extended family.

Substance History:

It was difficult to obtain a substance abuse history from the patient, as he became very agitated when the topic was introduced. He admits to having used LSD, heroin, cocaine, opioids, marijuana, tobacco, and alcohol. The patient states that

when he smokes marijuana, he smokes 1 or 2 joints per week. He does admit to marijuana use in the past 30 days. He has smoked 1 pack per day for the past 40 years.

His drug of choice has always been alcohol. He states that he remembers his parents feeding him beer from teaspoons as a very young child. He started drinking regularly sometime between the ages of 5 and 8. Throughout his adult life he has always had at least 6 beers per day, and feels that this is "pretty much not drinking at all." His heaviest intake has been approximately 30 beers per day, and his average adult intake has been 12 – 24 cans of beer per day. He denies any withdrawal symptoms. He did attend an inpatient rehabilitation program in 2004, but did not follow up with outpatient therapy or AA. He states that he has not had anything to drink since 4 April 2011.

He also drinks 1 pot of coffee each day along with 2-6 sodas.

Past Medical History:

1. Chronic pain associated with degenerative joint disease of the knees.
2. Multiple minor head trauma as a child, including once incidence at the age of 5 – 6 when the patient fell from a bunk bead and landed on his head. He reports that he experienced loss of conscious at this time, and also that he vomited blood. It is unclear what treatment, if any, he received.
3. The patient denies other chronic medial conditions and has never had a seizure.

Past Surgical History:

1. Herniorraphy, 6 years old.
2. Hydrocele repair, approximately 1991.

Medications/Allergies: Patient states that nicotine patches cause dermatitis.

1. The patient does not currently take medications on a daily basis.

ROS:

- Constitutional: denies weight change, fever, chills, and night sweats.
- HEENT: Admits to changes in vision recently, and would like to see an optometrist; denies changes in hearing
- Cardiovascular: denies chest pain, palpitations
- Respiratory: denies SOB
- GI/GU: denies changes in bowel or bladder habits
- Integument: Admits minor scratches from being in the woods. Denies other rashes/lesions.
- Neurologic: Denies dizziness, paresthesias, movement disorders.
- Endocrine: Admits polyuria, polydipsia, heat/cold intolerance, but does not experience these on a regular basis.
- Hematologic: Denies easy bruising.

Social History:

- Gestation and Birth: Information unavailable
- Early Development and health: Information unavailable
- Social Position: Middle class
- Home Atmosphere:

    - "Good." However, patient does state that both parents were alcoholic and that his parents were fully aware that he was regularly drinking alcohol in the home at a very young age.
- Behavioral Symptoms in childhood:
    - Chart review reveals a history of animal abuse, theft, and arson in childhood. The patient denies animal abuse, and states that the arson was in relation to a fire that was meant to be contained, but got out of control and burned a field. He does admit to petty theft, and states that the only problems he had at school were a result of truancy. He skipped class because he found school to be boring.
- Schooling:
    - The patient went to school through part of 12th grade, but did not graduate high school and does not have his GED. He states that he was never very interested in school, but his grades were "fine."
- Occupation(s):
    - The patient has worked as a gas station attendant, construction worker, cabinet maker, chef, and most recently at Amazon dot com. He lost the job with Amazon due to missing work because of chronic pain. There has been no consistent reason that he switched jobs – "something better just came up."
- Living Situations:
    - Multiple different living situations throughout adult life including living with a wife and daughter, male roommates, and living alone. He reports no conflicts or interpersonal issues in these situations.
- Relationships: The patient has been married once. This relationship lasted for 4 years and ended because of "my drinking."
    - Marital Status: Divorced
- Abuse:
    - Denies physical or sexual abuse.
- Sexual History:
    - The patient is not currently sexually active. His preferred partner is a female of his own age. He has had 15 – 20 partners in his lifetime, and admits that he has not consistently used condoms or other forms of birth control.
- Children:
    - 1 daughter, Anna Marie, 28 years old and living in ____, IA. She does not live with the patient's ex-wife, and the patient is not sure exactly where his daughter lives.
- Legal:
    - History of multiple legal issues, all involving alcohol. Several arrests for public intoxication. History of 3 DUIs in Missouri, making the patient a felon.
- Religion/Spirituality:
    - "I don't have any."
- Race/Ethnicity: Family can be traced to Sweden, Denmark, Ireland, and Scotland.

Mental Status Examination:

- General Appearance/Behavior: Calm and cooperative. No stereotyped movements or threatening behavior demonstrated.
- Mood: Depressed
- Affect: Full, at times labile.

- Speech: Regular rate and rhythm, appropriate volume.
- Thought Form: Logical and goal directed.
- Thought Content: Focused on current mental health issues and steps needed to "get back to normal." Strong desires to improve his relationship with his ex-wife and daughter and knows that "I have to take care of myself first in order to do that." No suicidal or homicidal ideations today, but has had recent suicidal ideation.
- Perceptions: Auditory hallucinations per HPI. No visual hallucinations.
- Sensorium and Cognition (MMSE): Alert and oriented x3. Cognition not assessed.
- Insight: Patient demonstrates good insight of his depression and the effect it has on his interpersonal relationships. He demonstrates poor insight into the problems associated with his alcohol intake and its relationship to his depression.
- Judgment: Patient demonstrated good judgment by requesting hospitalization and through his desire to resume his medications. He also admits to playing violent video games as a source of release when he has homicidal ideation, and this intentional redirection of his impulse is indicative of good judgment.

Physical Examination: Deferred.

Laboratory Data/Imaging: None

Impression:

The patient appears to be suffering from major depressive disorder with psychotic features. Symptoms supporting major depressive disorder include insomnia, decreased interest, feelings of guilt, decreased energy, psychomotor retardation, and suicidal ideation. The patient's auditory, and perhaps visual hallucinations, are most consistent with psychotic features of a mood disorder. Schizophrenia is ruled out by the fact that psychotic features only occur during episodes of mood disturbance. Schizoaffective disorder is ruled out, as the patient had not had psychotic features independent of mood disturbance during any known previous episode.

The patient clearly has an unhealthy relationship with alcohol which began at an early age. While he is attempting to quit drinking in order to improve his relationship with his daughter, he shows poor insight into the potential harms of his pattern of alcohol intake. It is my feeling that until the patient is willing to attend an ongoing program such as AA he will continue to experience adverse consequences of alcohol abuse and be unable overcome this problem.

Diagnosis:

Axis I:

1. Major Depressive Disorder, recurrent, severe with psychosis.
2. EtOH abuse.
3. History of polysubstance abuse.

Axis II:

1. History of borderline personality disorder. This diagnosis is consistent with information obtained by this examiner.
2. History of anti-social personality disorder. This examiner was unable to verify information that would support this diagnosis.

Axis III:

1. Degenerative joint disease of the knees, associated with chronic pain.
2. Insomnia.

Axis IV:

1. Living with ex-wife.
2. Unemployed.
3. Alcohol abuse.

Axis V: GAF 30.

Plan:

1. Venlafaxine 150 mg BID and Ziprasidone 80 mg BID for depression. Will monitor patient for response, but I am hopeful that this regimen will once again be successful for the patient, as it has worked in the past. If the patient does not respond to this regimen, or if he continues to experience auditory hallucinations, I will consider adding Haloperidol 1-2 mg up to TID as needed.
2. Diphenhydramine 50 mg QHS prn insomnia.
3. Lorazepam 2 mg PO q 4 hours prn alcohol withdrawal or anxiety x4 doses, then 1 mg q 6 hours x8 doses.
4. Ibuprofen 800 mg TID prn pain. Due to his history of opioid abuse, I will not be prescribing opioids, but will consider ketoralac if the pain is unresponsive to NSAIDs. If necessary, the patient will be referred to a pain clinic at the time of discharge.
5. Our social worker is helping the patient with regards to finding more permanent housing in the area. Once his depressive symptoms are under control, I will attempt to attempt to discuss alcohol intake with the patient again. If he is willing, we will help him establish contact with a local AA group. Social work will also discuss programs which might help the patient with finding work in the area.

AJ Ballantyne, M3