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Online Clinical Cases

Wk 4 Psych

Prof. Alie

**PTSD H&P with MSE:**

**HPI:** 32 y/o M presents to ED via EMS c/o “panic attack” 1 hour ago. Reports sudden onset of elevated heart rate and breathing rate when a loud siren sound played on the radio while driving, so severe that pt needed to pull over and call 911. Reports coinciding dizziness and weakness, but denies LOC. Reports that this episode resolved before EMS arrived. Reports several other episodes of sudden transient “panic attacks” within the last year. Denies any alleviating factors besides rest, and says they are aggravated by stress or sudden noises that resemble “tone drops” from work. Reports irregular episodes of difficulty sleeping, irritability, anxiety, and nightmares alternating with depression and diminished appetite and sex drive for weeks at a time also over the last year. Denies any recent illness or injury. Denies fever, CP, headaches, loss of consciousness, seizures, DM, HTN, HLD, or DM2.

**Medication:** Reports multivitamins PO daily, last dose this morning. Reports IBU or ASA PO PRN for minor lower back pain or headaches. Reports melatonin 10 mg PO nightly for insomnia. Up to date on vaccinations.

**Allergies:** NKDA. Denies any other allergies.

**PMHx:** Denies any significant PMHx. No regular PMD. Medical clearance for work 2 y/a, no reported issues. Denies hx of blood transfusions.

**SurgHx:** Denies surgical history.

**FamHx:** Both parents alive and healthy in their 60’s. HTN on father’s side of family.

**SocHx:** Married and monogamous with wife for 5 years. Use oral contraceptive pills for birth control. No children. Live together in an apartment with no other housemates. No pets. Works as an EMT for 2 years. Reports “moderate” drinking, 7-10 beers weekly, sometimes more with friends. Reports 10-packyear smoking history from 20 to 30 y/o, quit for 2 years but started smoking again this year. Denies illicit drug use. Reports regular daily diet and exercise 3 times weekly.

**ROS:**

**General: *Reports fatigue and dizziness.*** Denies recent weight change, weakness, fever, night sweats, anorexia, malaise.

**Skin:** Denies color change, pruritus, bruising, petechiae, infections, rashes, sores, changes in moles, or changes in hair or nails.

**Head:** Denies headache or head injury.

**Eyes:** Denies pain, redness, excessive tearing, diplopia, floaters (spots in front of eyes), loss of any visual fields, history of glaucoma or cataracts. Denies glasses/contact lens. Last eye 6 years ago, normal.

**Ears:** Denies hearing loss, change in hearing, tinnitus, or ear infections.

**Nose and Sinuses:** Denies frequent colds, nasal stuffiness, hay fever, epistaxis, rhinorrhea, obstruction, discharge, pain, change in ability to smell, sneezing, post-nasal drip, or nasal polyps. Denies sinus pain or pressure.

**Mouth and throat:** Denies soreness, dryness, pain, ulcers, sore tongue, bleeding gums, pyorrhea, dental caries, abscesses, extractions, dentures, sore throat, or hoarseness. Denies history of recurrent sore throats, strep throat, or rheumatic fever.

**Neck:** Denies lumps, swollen lymph nodes or glands, goiter, or pain.

**Lymphatics:** Denies swollen lymph nodes in neck, axillae, epitrochlear areas, or inguinal area.

**Breasts:** Denies lumps, pain, nipple discharge, or gynecomastia.

**Pulmonary:** Denies cough, dyspnea, wheezing, hemoptysis, pleurisy, cyanosis, recurrent pneumonia, or env exposure. Denies history of TB. PPD/QFTB Dec 2019, negative.

**Cardiovascular:** ***Reports SOB, palpitations, and elevated heart rate.*** Denies chest pain, dyspnea, PND, orthopnea, edema, hypertension, known heart disease, murmur, history of rheumatic fever, syncope, calf pain, varicosities, thrombophlebitis, or history of an abnormal electrocardiogram.

**Gastrointestinal:** ***Reports loss of appetite.*** Denies dysphagia, odynophagia, nausea, vomiting, hematemesis, food intolerance, indigestion, heartburn, early satiety, change in BM, rectal bleeding, melena, constipation, diarrhea, abdominal pain, eructation, flatus, hemorrhoids, jaundice, liver or gallbladder problems, or history of hepatitis .

**Urinary:** Denies hematuria, dysuria, frequency, suprapubic pain, CVA tenderness, nocturia, polyuria, stones, inguinal pain, hesitancy, incontinence, or hx UTI.

**Genital tract (male):** ***Reports diminished libido.*** Denies penile discharge, lesions, hx STD, testicular pain, testicular swelling, scrotal mass, infertility, impotence, or hernias.

**Musculoskeletal:** Denies joint pains or stiffness, arthritis, gout, backache, joint swelling/tenderness/effusion, limitation of motion, or history of fractures.

**Neurologic:** Denies fainting, blackouts, seizures, paralysis, local weakness, numbness, tingling, tremors, memory changes, headaches, vertigo or dizziness, or muscle atrophy.

**Psychiatric:** ***Reports anxiety, depression, irritability, nightmares, insomnia.*** Denies nervousness, hypersomnia, phobias, tension. Denies SI or HI. Has never seen a mental health professional.

**Endocrine:** Denies heat or cold intolerance, excessive sweating, flushing, or polyuria/polydipsia/polyphagia.

**Hematologic:** Denies anemia, easy bruising or bleeding, past transfusions or reactions.

**Physical Exam:**

**General:** A/O x 3. NAD, but appears ***tired, anxious***. Appears stated age. Normal hygiene. Appropriate dress.

**V/S:** ***BP 130/88, HR 100***, RR 18, Temp 98.9\*F, O2 98% ORA.

 **Skin:** Warm, dry. Good turgor. No rash, lesions, icterus, pallor, edema, or cyanosis.

**HEENT:** Normocephalic. Atraumatic. Hair normal texture & distribution.

No ptosis. Sclerae white, conjunctivae normal, cornea clear. Full EOM. PERRLA intact. Visual acuity and fundoscopy not performed.

Pinna and EAM normal. No lesions, discharge, or FB. Otoscopic exam not performed.

Nasal septum midline. No sinus tenderness to palpation and percussion.

Lips normal. Good dentition. Gingivae, tongue, and oral mucosa pink and moist.

Tonsils not visible. Uvula midline. No pharyngeal erythema, swelling, or exudate.

**Neck:** Supple, FROM. Trachea midline. No JVD. Thyroid non-palpable. Carotid pulse 2+. No bruit.

**Lymphatics:** No cervical lymphadenopathy. No axillary, epitrochlear, or inguinal lymphadenopathy.

**Chest:** CTA b/l.No rales, wheezes, rubs, or rhonchi.Symmetrical chest rise. No accessory muscle use.

**Heart:** ***Subjective tachycardia.*** Regular rhythm. S1/S2 present. No murmurs, rubs, or gallops.

**Abdomen:** flat, soft, NTTP. BS x 4.

**Back/spine:** Normal mobility and curvature. Good posture. No vertebral or CVA tenderness.

**Extremities:** No C/C/E. Distal pulses intact 2+. Cap refill > 2 secs. No joint swelling, deformities, tenderness, warmth, erythema, or effusion. Full AROM and 5/5 strength.

**GU:** No assessed.

**Rectal:** Not assessed.

**Neurologic:**

CN II - XII intact. Normal gait, muscle tone and strength. No contractures, atrophy, fasciculation, or tremor. Sensation intact to light tough b/l upper and lower exts. Positional sensation intact. DTRs +2 intact b/l upper and lower ext. Absent Babinski.

Sensory - pinprick, light touch, graphesthesia, stereognosis, double simultaneous touch intact.
Cerebellar – Normal gait. No ataxia. Finger-to-nose, heel-to-shin, rapid alternating movements intact.
Posterior column - vibratory and positional sensations intact. Romberg sign negative
Reflexes – brachioradialis, patellar, and Achilles tendon DTRs 2+ b/l. Babinski absent.

**MSE:**

**Observations:**

1. **Appearance**: Pt is alert. Normal stature. Appropriate dress and hygiene. Normal gait, full amb.
2. **Attitude:** Cooperative and pleasant.
3. **Behavior:** Mild restlessness. Normal eye contact.
4. **Speech:** Fast rate of speech, regular rhythm. Normal volume. Content normal, appropriate.

**Emotions:**

1. **Mood:** described as “tired” and often nervous or irritated.
2. **Affect:** Pt appears appropriately anxious. Congruent with described mood.

**Thoughts & Perceptions:**

1. **Thought process:** Coherent and goal-oriented. Abstraction intact.
2. **Thought content:** Negative SI/HI. Expresses anxiety over experiences working in EMS. Difficulty sleeping at work and home. Fear of waking up to alarms. Sense of doom/dread when dispatched or on-call. Doesn’t want co-workers to know. Afraid of losing ability to work.
3. **Perceptions:** Denies hallucination or illusions. Denies delusions.

**Cognition:**

1. A/O x 3.
2. Serial 7’s and “D-L-R-O-W” intact.
3. Memory: Immediate, delayed, short-term, and long-term recall intact.

**Insight and Judgment**

1. **Insight:** Aware of problem, escalating patterns of anxiety and panic attacks.
2. **Judgment**: Patient knows to avoid some triggers, but is hesitant to seek definitive dx or tx for PTSD.

**Labs:**

**CBC w/diff:** normal

**CMP:** normal

**Cardiac panel:** normal

**Troponin:** 0.01 (normal)

**TFT:** Normal

**Fasting BSL:** 90 (normal)

**EKG:** NSR, tachycardia 100-110 bpm

**Assessment/Plan:**

32 y/o M c/o elevated heart rate and SOB x 5 minutes, multiple episodes over last year. Describes them as “panic attacks”. These episodes coincide with multi week-long episodes of insomnia, nightmares, and changes in appetite, mood, and libido. Patient sites experience in EMS as source of anxiety and loud sounds as triggering these “panic attacks”. Pt has not sought treatment for anxiety or seen a mental health professional before. PE normal except for tachycardia and mild HTN. EKG NSR. No focal neuro symptoms. Pt denies any recent illness or injury.

* **PTSD with acute panic attacks:** encourage outpatient group therapy through employer or union;refer to CBT if no support groups offered through employer or pt wishes to maintain privacy from colleagues.
	+ Rx Zoloft (sertraline) 25 mg PO daily, may increase dose in 25 mg increments weekly, do not exceed 200 mg/daily. Counsel pt on risk of potential SI/HI and major depression side effects. Counsel on risk of serotonin syndrome when used with other antidepressants or St. John’s wart.
* **Insomnia/Nightmares:** Continue outpatient melatonin 5 mg PO PRN for insomnia.
	+ **For persistent nightmares:** Prazosin 1 mg PO PHS x 2 days, then 2 mg PO PHS, titrating up 1 mg/week until therapeutic range. Do not exceed 15 mg/day.
* **ETOH:** counsel on reducing or eliminating alcohol consumption; refer to counseling or CBT if pt prefers