

Date of H&P: 02/24/04
Location: MMC ED – on call psych

History and Physical

IDENTIFYING DATA: Patient is a 15 year-old Caucasian male who was brought to the emergency department by his parents. The patients and his parents were the sources for the information.

CHIEF COMPLAINT: “My thoughts.”

HISTORY OF PRESENT ILLNESS: Patient is a 15 year-old Caucasian male with a history of Asperger’s disorder who was brought to the emergency department by his parents for suicidal ideations. Patient indicates that he has had thoughts of suicide for the past 3 weeks. He states that while a school today he thought about committing suicide by using the metal from a toilet paper hold/or paper towel holder to cut himself on his neck. He states he has had similar thoughts of suicide when he is home, but indicated that he would use a knife if at home. He felt that these thoughts were stronger today and thought he should tell his guidance counselor. His counselor subsequently called the patient’s mother and she in turn spoke with her son’s psychiatrist who felt that he should be evaluated in the emergency department. Patient does not cite any recent triggers or specific problems this morning to cause the intensity of these feelings. When asked what made him not hurt himself, he stated “because I got help fast.” Patient also states that when these suicidal feelings began 3 weeks ago, he was 10% sure that he would hurt himself, but that today “I felt 100% sure.” Patients states that he has been feeling sad for the past 3 weeks with periods of agitation in which he describes as being irritable and angry-so angry that he feels like “throwing a can of soda at someone’s head.” He states that he feels hopeless and is sad that he has no true friends. He states that he only has one friend. His parents say that is true and this friend is a “friend of convenience” since he lives next door. Patient describes his recent feelings as “being in a dark room with 3 sides closing in on me.” He also states that his peers at school are not nice to him and “nobody likes me, everybody hates me.” He also states that he does not like to be “corrected” by people and that it makes him angry and upset and that he has had recent crying episodes. He states that he had a crying episode last night and worried excessively that his mother was going to die, even though she was safe at home. Patient says that he sleeps through the night and goes to bed around 9:00 pm with the television or radio on and sleeps until he has to get ready for school. He feels rested when he wakes. Patient states that he does not like mornings and is anxious and depressed about going to school; he also states he feels depressed in the evenings sometimes. At times he has feelings of his mind racing with trouble concentrating; these happen periodically throughout the day. Denies any friends or family members that have committed suicide. Cites decreased energy and fatigue. States he still enjoys his computer and watching TV. He also enjoys his pets and emphatically denies ever hurting animals (his parents also indicate this is a true statement). Denies any problems with his parents; denies physical or sexual abuse. Patient is enrolled in the ninth grade in regular classes (although in previous school, he had been enrolled in special ed math). Grades previously were B’s but in now failing gym class-cites difficulty getting along with his teacher. Denies hearing voices; grandiose

ideas. No previous psychiatric hospitalizations; however, patient is seeing psychiatrist for Asperger's Disorder, GAD, OCD, and ADD.

PAST MEDICAL HISTORY:

Psychiatric: Asperger's Disorder – DX approx. 2001
OCD with repetitive thoughts, some rituals-touching things in certain order
Generalized Anxiety Disorder
ADD

Medical/Surgical: Nasal encephalocele – surgery at 17 months of age
Blind if left eye (partial blindness?)
Adrenal insufficiency – 2 degree to pituitary problems
Hypothyroidism 2 degree to pituitary problems from surgery
Febrile seizure – one time only as child

Substance Abuse: Denies any alcohol or illicit drug use. Denies smoking.

Social History: Patient lives in Astoria, Illinois, with his birth parents who are still married. He has no siblings. Attends Astoria H.S. see HPI for school history.

Family Hx: Maternal grandmother-depression
Great aunt-OCD
Mother states that she feels some members of her family are bipolar, but have not had medical treatment; No family suicides.
Parents healthy

Medications: Cortef 5 mg q a.m.
Synthroid 150 mcq qd with 12.5 mcq every other day
DDAVP 0.2 mq po q hs
Nutropin AQ 0.6 ml q hs subcut.
Feosol 45 mg bid
Paxil 20 mg

Allergies: No known drug allergies.

REVIEW OF SYSTEMS:

Constitutional: fatigue; recent weight gain-due to medications.
HEENT: denies headaches
Lungs: denies shortness of breath, no asthma;
Cardiovascular: denies any chest pain; heart palpitations
GI: denies constipation; denies diarrhea; no abdominal pain
GU: has had some night time urinary incontinence – now no DDVAP;
Musculoskeletal/Neuro: denies any problems.

PHYSICAL EXAM:

Vitals: BP 117/82 P100 T6.8
General: Patient is in no acute distress
Lungs: Clear to auscultation with no rales noted.

CV: Regular rate and rhythm; no murmurs noted.

Abdominal: Abdomen is soft, nondistended and nontender. Bowel sounds present.

Extremities: some dysmorphic features of hands/feet-appear large for body

Neuro: CN II – PERL (left pupil also reactive; partial blindness?). CNIII, IV, VI – patient was able to follow examiner’s finger in all cardinal directions with no evidence of dysconjugate gaze. CN V-XII – intact. Muscle strength is 5/5 in all four extremities; DTRs 2/4 in all four extremities. Gait is normal. Rapid alternating movements of each hand were well performed.

Mental Status:

General: Patient is well groomed and neatly dressed; lying on bed relaxed

Attitude: Patient is cooperative with the interviewer.

Motor activity: somewhat restless-moves hands a lot, plays with the side of bed; however, is able to lie still and converse as needed; no evidence of hallucinations

Mood: describes as “sad”

Affect: Restricted; limited range of motion

Speech: normal volume; spontaneous, at times somewhat rapid; not pressured

Orientation: alert and oriented x 3

Thought process/Content: linear; suicidal ideations as described per HPI; no homicidal ideations; no evidence of delusions

Judgment/Insight: fair

Labs: TSH, CBC, CMP, UA , tox screen ordered.

DIAGNOSTIC FORMULATION:

Patient meets the criteria for major depressive disorder. He has had depressed mood for three weeks, suicidal ideations, fatigue, feelings of hopelessness, increased agitation, and some difficulty concentrating. In addition, he has had some recent difficulties with school (failing physical education). From initial assessment, cannot rule out a possible mixed episode. Patient does cite irritable mood for 3 weeks; distractibility; and has some rapid speech; however, does not yet meet all criteria for hypomanic or manic episode. In addition, patient indicates he has periods of increased nervousness (see HPI) and panic attacks should also be considered. Patient has a history of Asperger’s, OCD, GAD, and ADD as described per HPI.

DIAGNOSIS:

Axis I: Major Depressive Disorder – need to rule out if mixed

Rule out BPAD Type II

Generalized Anxiety Disorder – previously diagnosed

Obsessive Compulsive Disorder – previously diagnosed

Asperger’s Disorder – previously diagnosed

ADD – previously diagnosed

Axis II: Deferred

Axis III: Hypothyroidism, adrenal insufficiency, blindness left eye

Axis IV: Lack of social interactions – no friends; teasing by peers, difficulty with school (failing one class)

Axis V: GAF=50

PLAN:

1. Suicidal ideations – Admit to 3A; suicide and elopement precautions
2. Major depressive disorder, single episode, possibly mixed – Paxil discontinued since patient and family cites it has not been effective and may be contributing to symptoms if this is a possible mixed condition.
3. Evaluate for possible panic disorder.
4. Continue home medications except Paxil.
5. Obtain records from patient's psychiatrist.