**Diana Stamatopoulos**

**Mental Health**

***SimPat Static Patient Cases***

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# Individual Details:

* Initials Used: DFS
* WhatsApp Number: XX XXXX XXXXX

# Notes:

*Use Table of Heading to Organise:*

*Case Code = “Heading 1”, - Highlight then press “Control + alt +1”*

*Homepage vignette = “Heading 2” - Highlight then press“Control + alt +2”*

*Click the update button on the table of headings to update everything*

***Delete these examples when happy***

# DS\_01\_Schizophrenia

Homepage Vignette:

## “A 37-year-old female named Danika presents with hallucinations.”

Individual Page Vignette:

Role: You are a medical student conducting an initial assessment on Danika, a 37-year-old female librarian, at the Emergency Department. She presents with auditory hallucinations.

Patient Name: Danika Laree. Pronounced: dah-NEE-kuh luh-REE. Prefers to be called Danika.

Age: 16/09/1986

Location: Emergency Department

Personality: Danika is a reserved individual, speaking softly and hesitantly. She seems anxious and fidgety.

Presenting Complaint: Hallucinations

Quote: "I keep hearing voices that no one else can hear. It's been quite distressing for me."

Quote: "I try to ignore them, but they just won't stop. It's been affecting my sleep and making me feel really anxious."

History of Presenting Complaint:

Duration: Present over the past 6 months

Previous Treatments: None attempted

Progression: Voices have become louder and more frequent, they are critical and demeaning

These voices persist constantly

Associated anxiousness and insomnia, reports difficulty falling asleep at night due to the voices and worries

Impact on Daily Life: Distressing, affecting sleep and causing anxiety

Risk Assessment:

- Does not have any history of self-harm or previous suicide attempts

- Does not have suicidal thoughts

Systemic Symptoms:

- Negative for all systemic symptoms

Past Medical History:

- Negative for any significant medical conditions or surgeries

Drug History:

- Not currently taking any medications or supplements

Allergies:

- No known allergies or intolerances

Family History:

- Negative for any relevant medical conditions

Social History:

- Lifestyle: Sedentary lifestyle

- Occupation: Librarian

- Activities of Daily Living & Hobbies: Enjoys reading and gardening

- Smoking: Non-smoker

- Alcohol: Rare social drinker

- Recreational Drug Use: None reported

- Diet: Balanced diet with occasional sweets

- Exercise: Minimal exercise routine

Quote: "I work at the library during the day and like to relax with a book in the evening."

Ideas, Concerns, and Expectations:

- Ideas: Thinks the voices are real and fears they may get worse

- Concerns: Worried about the impact on her mental health and ability to work

- Expectations: Hopes for an explanation and treatment for the voices

Observations:

- Respirations: 14/min

- Oxygen Saturation: 98%

- Air or Oxygen: Room air

- Blood Pressure: 120/80 mmHg

- Pulse: 72/min

- Consciousness: Alert

- Temperature: 37.0°C

- NEWS Total Score: 1 (O2 Saturation)

Physical Examination:

- Inspection: No abnormal findings

- Auscultation: Normal breath sounds

- Assessment of mental status: Shows signs of anxiety

Diagnostic Tests:

- No specific imaging or lab tests required for schizophrenia diagnosis

Condition: Schizophrenia

Patient Questions:

1. "Why am I hearing these voices?"

- Possible Answer: "It could be due to a condition called schizophrenia."

2. "Can I get rid of these voices completely?"

- Possible Answer: "Treatment can help manage the symptoms, but complete elimination may not be possible."

3. "Will this condition affect my ability to work?"

- Possible Answer: "With proper treatment, you can continue with your daily activities, including work."

Examiner Questions:

1. "What are the common symptoms associated with schizophrenia?"

- Possible Answer: Hallucinations, delusions, disorganized thinking, and negative symptoms.

2. "How is schizophrenia typically treated?"

- Possible Answer: Treatment usually involves antipsychotic medications, therapy, and lifestyle modifications.

3. "What is the prognosis for individuals with schizophrenia?"

- Possible Answer: Prognosis varies, but with treatment compliance, many individuals can lead fulfilling lives.

Treatment:

- Antipsychotic medication (e.g., Risperidone 2mg daily)

- Cognitive Behavioral Therapy

- Regular follow-up appointments for monitoring and adjustment of treatment plan

Monitoring:

- Regular follow-up appointments every 2-4 weeks initially

- Monitoring of symptoms, side effects of medication, and overall well-being

- Immediate medical attention if experiencing severe side effects or suicidal thoughts

Prognosis:

- With proper treatment and support, individuals with schizophrenia can lead fulfilling lives

- Response to treatment can vary among individuals

- Adherence to treatment plan is crucial for long-term success

Differential Diagnoses:

1. Bipolar disorder - Less likely given the absence of manic or depressive episodes.

2. Substance-induced psychosis - Less likely as no history of substance abuse reported.

3. Delusional disorder - Less likely as hallucinations are a prominent feature in this case.

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Auditory Hallucinations

Condition Filter: Schizophrenia

Location Filter: Emergency Department

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/Doctor

KEYWORDS = XX

# 

# DS\_02\_Schizophrenia

Homepage Vignette:

## “A 45-year-old male named Ravi presents with delusions.”

Individual Page Vignette:

Role: You are a medical student conducting an initial assessment on Ravi, a 45-year-old male engineer, at a Clinic. He presents with delusions.

Patient Name: Ravi Desai. Pronounced: RAH-vee deh-SIGH. Prefers to be called Ravi.

Age: 03/07/1979

Location: Clinic

Personality: Ravi is a meticulous and analytical individual, speaking in a precise and methodical manner. He appears focused but slightly agitated.

Presenting Complaint: Delusions of being followed and monitored

Quote: "I'm certain that someone is watching my every move, tracking my actions. It feels so real to me."

Quote: "I can't shake off this feeling of being followed, it's making me anxious all the time."

History of Presenting Complaint:

- Duration: Present for the last few months

- Previous Treatments: None attempted

- Constantly feels like everyone is watching him and criticising him

- Has firm beliefs about elaborate conspiracy theories

- Progression: Thoughts have become more elaborate and consuming (Disorganised thought)

- Impact on Daily Life: Distressing, affecting work performance

Quote: "It's hard to concentrate at work with these thoughts in my head all the time."

Systemic Symptoms:

- Negative for all systemic symptoms

Past Medical History:

- Negative for any significant medical conditions or surgeries

Drug History:

- Not currently taking any medications or supplements

Allergies:

- No known allergies or intolerances

Family History:

- Negative for any relevant medical conditions

Social History:

- Lifestyle: Organized and structured lifestyle

- Occupation: Engineer

- Activities of Daily Living & Hobbies: Enjoys solving puzzles and reading

- Smoking: Non-smoker

- Alcohol: Occasional social drinker

- Recreational Drug Use: None reported

- Diet: Healthy, balanced diet

- Exercise: Regular moderate exercise routine

Quote: "I like to keep my mind sharp with puzzles and stay active with exercise."

Ideas, Concerns, and Expectations:

- Ideas: Certain about being monitored, looking for validation

- Concerns: Worried about the implications on his job and personal safety

- Expectations: Hopeful for a solution to ease his fears and regain peace of mind

Observations:

- Respirations: 16/min

- Oxygen Saturation: 97%

- Air or Oxygen: Room air

- Blood Pressure: 130/80 mmHg

- Pulse: 78/min

- Consciousness: Alert

- Temperature: 37.1°C

- NEWS Total Score: 0

Diagnostic Tests:

- No specific imaging or lab tests required for schizophrenia diagnosis

Condition: Schizophrenia

Patient Questions:

1. "Why do I feel like I'm being monitored all the time?"

- Possible Answer: "It could be a symptom of a condition called schizophrenia."

2. "Can medication help me get rid of these thoughts?"

- Possible Answer: "Treatment can help manage the symptoms and make you feel better."

3. "Will these delusions go away completely?"

- Possible Answer: "With treatment and support, they can improve over time."

Examiner Questions:

1. "What are the common symptoms of schizophrenia?"

- Possible Answer: Hallucinations, delusions, disorganized thinking, and cognitive deficits.

2. "How does schizophrenia affect daily life?"

- Possible Answer: It can impact work, social relationships, and self-care routines.

3. "What is the role of medication in managing schizophrenia?"

- Possible Answer: Medication helps control symptoms and improve quality of life.

Treatment:

- Antipsychotic medication (e.g., Aripiprazole 10mg daily)

- Cognitive Behavioral Therapy

- Regular follow-up appointments for monitoring and adjustment of treatment plan

Monitoring:

- Regular follow-up appointments every 2-4 weeks initially

- Monitoring of symptoms, side effects of medication, and overall well-being

- Immediate medical attention if experiencing severe side effects or worsening symptoms

Prognosis:

- With appropriate treatment and support, individuals with schizophrenia can lead fulfilling lives

- Response to treatment can vary among individuals

- Adherence to treatment plan is essential for long-term success

Differential Diagnoses:

1. Anxiety Disorder - Less likely as the beliefs are fixed and complex.

2. Paranoid Personality Disorder - Less likely due to the presence of other characteristic symptoms of schizophrenia.

3. Delusional Disorder - Less likely as other features of schizophrenia are present.

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Delusions

Condition Filter: Schizophrenia

Location Filter: Clinic

Case created by:

Case Created by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student/Doctor

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# DS\_03\_Bipolar Disorder

Homepage Vignette:

## “A 37-year-old female named Aylin presents with mood swings and insomnia.”

Individual Page Vignette:

You are a medical student taking care of Aylin, a 37-year-old female, self-employed artist, presenting with mood swings and insomnia.

Patient Name:

The patient's name is Aylin Kenan (pronounced AY-leen KEE-nan) and she prefers to be called Aylin.

Location:

Clinic

Personality:

Aylin is a soft-spoken and introspective individual who prefers to express herself through her art. She speaks with a calm and thoughtful tone.

Presenting Complaint:

Aylin expresses, "I've been feeling very high and confident one day and extremely low and irritable the next. I also have trouble falling asleep at night."

Symptoms:

- Site: Mood swings and sleep disturbances

- Onset: Gradually worsening over the past few months

- Character: Mood swings involve elevated and depressive episodes

- Radiation: N/A

- Associated Symptoms: Insomnia, changes in appetite, difficulty concentrating

- Timing: Mood changes occur every few days, insomnia nightly

- Exacerbating and Relieving Factors: Stress exacerbates symptoms, no specific relief factors identified

- Severity: Mood swings are severe, affecting daily life; insomnia is moderate

History of Presenting Complaint:

- Symptoms worsening over the past few months

- No previous treatments attempted

- Mood changes impacting daily life and work, insomnia affecting sleep hygiene

Systemic Symptoms:

- No systemic symptoms present

Past Medical History:

- No significant past medical history

Drug History:

- No current medications or past drug history

Allergies:

- No known allergies

Family History:

- No significant family medical history

Social History:

- Aylin works from home as an artist, enjoys painting and drawing in her free time, non-smoker, occasional social alcohol drinker

Ideas, Concerns, and Expectations:

- Ideas: Aylin is confused about her sudden mood changes

- Concerns: Worried about the impact of mood swings on her work and relationships

- Expectations: Expects some clarity on her symptoms and potential treatment options

Observations:

- Respirations: 12/min

- Oxygen Saturation: 98%

- Air or Oxygen: Room air

- Blood Pressure: 120/80 mmHg

- Pulse: 80/min

- Consciousness: Alert

- Temperature: 36.7°C

- NEWS Total Score: 0 (normal observations)

Patient Questions:

1. "Could my mood swings be due to stress?"

- Possible Answer: "It's a possibility, we will explore that further."

2. "Is insomnia a common symptom with mood disorders?"

- Possible Answer: "Yes, sleep disturbance can often be linked to mood changes."

3. "Are there any lifestyle changes I can make to help with my symptoms?"

- Possible Answer: "We can discuss potential lifestyle modifications during our consultation."

Examiner Questions:

1. "Are there any recent significant life events that may have triggered these symptoms?"

- Possible Answer: "Not that I am aware of, but my workload has been more demanding lately."

2. "Have you noticed any patterns or triggers for your mood swings and insomnia?"

- Possible Answer: "I haven't pinpointed exact triggers, but they seem to worsen during stressful periods."

3. "How are these symptoms impacting your work and personal life currently?"

- Possible Answer: "They are making it difficult for me to focus and affecting my productivity."

Treatment:

- Referral to a psychiatrist for further evaluation and management

- Consider psychotherapy or medication options after assessment

Monitoring:

- Follow-up appointment in 2 weeks to assess treatment response

- Monitor mood changes, sleep patterns, and overall functioning

- Contact for urgent review if symptoms worsen significantly

Prognosis:

- With proper management and treatment, Aylin's symptoms can improve

- Prognosis varies depending on the response to therapy and individual factors

Differential diagnoses:

1. Major Depressive Disorder

2. Generalized Anxiety Disorder

3. Insomnia Disorder

Keyword Filters:

Speciality Filter:

- Mental Health

Presenting Complaint Filter:

- Mood Swings; Insomnia

Condition Filter:

- Bipolar Disorder

Location Filter:

- Clinic

Case created by:

Case Created by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student/Doctor”

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# DS\_04\_Generalized Anxiety Disorder

Homepage Vignette:

## "A 32-year-old female called Sujata presents with anxiety."

Individual Page Vignette:

Role: You are a medical student

Patient: Sujata Singh, 32-year-old female, teacher, General Practice

Complaint: Anxiety, primarily feeling overwhelmed and irritable

Personality: Sujata is a soft-spoken and thoughtful individual who appears nervous and fidgety during the consultation. She expresses her concerns in a gentle manner, often pausing to collect her thoughts before speaking.

Symptoms:

- Site: Generalized throughout the day

- Onset: Gradual, developing over the past 6 months

- Character: Feelings of worry and tension

- Radiation: N/A

- Associated Symptoms: Fatigue, muscle tension, difficulty concentrating

- Timing: Persistent, worsening in the evenings

- Exacerbating and Relieving Factors: Exacerbated by stress, relieved by exercise and mindfulness

- Severity: Moderate, impacting daily activities

History of Presenting Complaint:

Sujata has experienced symptoms for the past 6 months, with no previous treatments attempted. Symptoms have progressively worsened, affecting her work and social interactions.

Systemic Symptoms:

- Sweating

- Periods of tachycardia and palpitations

- Muscle aches

- Restlessness

Past Medical History:

- Negative

Drug History:

- Negative

Allergies:

- No known allergies

Family History:

- Negative

Social History:

- Lifestyle: Healthy diet, regular exercise, does not drink alcohol or smoke

- Occupation: Teacher at a local school

- Activities of Daily Living & Hobbies: Enjoys gardening and reading

Patient Questions:

1. "What can I do to manage my anxiety better?"

- Answer: "We will explore strategies like mindfulness and therapy to help you cope."

2. "Can medication help with my anxiety?"

- Answer: "Medication is an option, and we can discuss it further if needed."

3. "How long will it take to feel better?"

- Answer: "Each individual responds differently, but we will work together to find the best approach for you."

Treatment:

Initial treatment includes cognitive-behavioral therapy, mindfulness techniques, and regular follow-ups to monitor progress. If needed, medication options such as SSRIs can be considered.

Monitoring:

Regular follow-up appointments every 2 weeks initially to assess response to therapy and adjust treatment as needed. Monitoring symptoms and side effects of any prescribed medication are crucial.

Prognosis:

With appropriate treatment and support, Sujata's anxiety can be managed effectively. The prognosis is favorable with a combination of therapy, lifestyle changes, and potential medication.

Differential Diagnoses:

1. Generalized Anxiety Disorder: Most likely based on presenting symptoms and history.

2. Adjustment Disorder: Less likely due to the persistent nature of symptoms.

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Anxiety

Condition Filter: Generalized Anxiety Disorder

Location Filter: General Practice

Case created by:

Case Created by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student/Doctor

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# DS\_05\_Depression

Homepage Vignette:

## "A 45-year-old female named Agape presents with persistent low mood for the last 2 months".

Individual Page Vignette:

"As a medical student, your role is to assess and treat a patient named Agape, a 45-year-old female office manager, presenting with symptoms of persistent low mood at a General Practice".

Patient Name:

Agape (Pronounced: Uh-GAH-pay), prefers to be called Agape.

Age: 14/09/1979

Location: General Practice

Personality:

Agape is a soft-spoken and introspective individual, often expressing her thoughts with poetry and artistic metaphors.

Presenting Complaint:

Agape presents with low mood, feeling consistently sad and lacking interest in activities she once enjoyed.

“I have just been feeling down lately and I don’t seem to enjoy anything I used to.”

Symptoms:

- Emotions and thoughts

- Gradual over the past two months

- Pervasive feeling of sadness and hopelessness

- Timing: Persistent

- Associated Symptoms: Insomnia, reduced appetite, difficulty concentrating on tasks

- Does not experience auditory or visual hallucinations

- Does not have previous episodes of high energy, increased confidence, or exhibit grandiosity

- Does not have suicidal intent and does not have a history of self harm/previous attempts

- No history of trauma, nightmares or vivid flashbacks

- Severity: Impacting daily life and work

History of Presenting Complaint:

Agape has been experiencing symptoms for the past 2 months with no previous treatments attempted.

Agape has pervasive feelings of sadness and hopelessness.

The symptoms have progressively worsened, impacting her daily life and work.

Agape reports difficulty sleeping, difficulty concentrating, and reduced appetite

She does not have any auditory or visual hallucinations.

She does not have previous episodes of high energy, increased confidence, or grandiosity.

No history of trauma, nightmares or vivid flashbacks.

Risk Assessment:

- No intent to harm self or others

- No suicidal thoughts or ideation

- No previous history of self-harm or suicide attempts

Systemic Symptoms:

- Agape denies any red flag symptoms or systemic issues.

Past Medical History:

- No significant past medical history.

- No past psychiatric history

Psychiatric History:

- No history of any psychiatric conditions.

- Has not experienced a period of low mood before.

- No hospital admissions for a psychiatric related presentation.

- No history of previous psychiatric treatments.

Forensic History:

- Agape does not have any history of involvement with forensics.

Drug History:

- Agape is not taking any medications currently or in the past.

Allergies:

- Agape has no known allergies to medications or other substances.

Family History:

- Agape’s mother was diagnosed with depression when she was 43 years old.

Social History:

- Agape leads a sedentary lifestyle due to her busy work schedule and loves painting in her free time.

- She does not smoke, drink alcohol, or use recreational drugs.

Ideas, Concerns, and Expectations:

- Agape is worried about her condition impacting her personal and professional life.

- She hopes to find relief from her symptoms and regain her passion for life.

Observations:

- Respirations: 14/min

- Oxygen Saturation: 98%

- Air or Oxygen: Room air

- Blood Pressure: 120/80 mmHg

- Pulse: 72 bpm

- Consciousness: Alert

- Temperature: 36.7°C

- NEWS Total Score: 0

Patient Questions:

1. "Will counseling help me feel better?"

Answer: "Counseling can be an effective treatment for depression."

2. "Are there any side effects of antidepressant medications?"

Answer: "Some common side effects include nausea, dizziness, and headaches."

3. "How long will it take for my symptoms to improve with treatment?"

Answer: "Response to treatment varies but may take a few weeks to notice significant changes."

Examiner Questions:

1. "What are the DSM-5 criteria for diagnosing major depressive disorder?"

Answer: "The criteria include persistent low mood, loss of interest, changes in weight or appetite, among others."

2. "How would you assess suicide risk in a patient with depression?"

Answer: "By asking direct questions about suicidal ideation and intent."

3. "What non-pharmacological interventions can be used to treat depression?"

Answer: "Cognitive-behavioral therapy, exercise, and mindfulness techniques can be beneficial."

Treatment:

- Start Agape on a course of Cognitive Behavioral Therapy (CBT) sessions weekly.

- Consider introducing selective serotonin reuptake inhibitor (SSRI) medication if symptoms do not improve with therapy alone.

Monitoring:

- Monitor Agape's symptoms weekly during CBT sessions.

- Reassess her progress after 6 weeks to evaluate the need for medication.

Prognosis:

- With appropriate treatment, Agape's prognosis is good, and she should see improvement in her symptoms over time.

Differential Diagnoses:

1. Adjustment disorder with depressed mood: Less likely due to the persistent nature of Agape's symptoms.

2. Dysthymia: Less likely as the symptoms have worsened over time rather than being chronic.

3. Bipolar disorder: Less likely due to the absence of manic or hypomanic episodes.

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Depression

Condition Filter: Depression

Location Filter: General Practice

Case created by:

Case Created by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student/Doctor

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# DS\_06\_Anorexia Nervosa

Homepage Vignette:

## "A 24-year-old female named Fumiko presents with significant weight loss and dizziness."

Individual Page Vignette:

"As the medical student, your patient is Fumiko, a 24-year-old female teacher presenting to the General Practice with significant weight loss and dizziness."

Patient Name:

Fumiko Sakamoto (Foo-me-ko Sah-kah-mo-to) - prefers to be called Fumiko

Age:

03/06/1999

Location:

General Practice

Personality:

Fumiko is a soft-spoken and reserved individual who tends to be polite in her speech. She appears slightly anxious but is cooperative during the consultation.

Presenting Complaint:

Fumiko complains of severe dizziness and significant weight loss.

Symptoms:

- Onset: Dizziness has been present for the past 2 months.

- Character: Dizziness is described as feeling faint and like she has lost her balance.

- Associated Symptoms: Dizziness and weakness. Feels lethargic at times and has to take frequent breaks during exercise. Amenorrhea.

- Timing: Dizziness is constant.

- Exacerbating and Relieving Factors: Dizziness worsens on standing up and during exercise.

- Severity: Severe, impacting daily activities.

History of Presenting Complaint:

- Fumiko has lost 15 pounds over the last 2 months

- Dizziness has gradually worsened.

- She has increased her exercise routine to high-intensity cardiovascular training 5 times a week

- She eats plenty of vegetables and fruits with limited carbohydrates

-She is unhappy with her physique and “wants to be more lean”

- Symptoms impact daily life and social interactions

Examination:

- Lanugo hair on limbs

- Underweight appearance

- Conjunctival pallor on eyelids

Past Medical History:

- No previous medical conditions or psychiatric conditions

- No surgeries or hospitalizations

- No history of injuries or traumas

Drug History:

- Fumiko does not take any medications regularly.

- No history of medication non-compliance or missed doses.

Allergies:

- Fumiko is allergic to penicillin, which causes a rash and itching upon exposure.

Family History:

- Father has type 2 diabetes

- Mother had depression at 30 years old

- No other significant family medical history

Social History:

- Lifestyle: Lives alone, non-smoker.

- Occupation: Teacher at a local primary school.

- Activities of Daily Living & Hobbies: Enjoys hiking and cooking.

Ideas, Concerns, and Expectations:

- Ideas: Thinks dizziness may be due to her diet and exercise.

- Concerns: Worried that she won’t be able to train due to her dizziness.

- Expectations: Expects to feel better and return to normal activities soon.

Observations:

- Respirations: 18 breaths/min

- Oxygen Saturation: 98%

- Air or Oxygen: Room air

- Blood Pressure: 114/68 mmHg

- Pulse: 70 beats/min

- Consciousness: Alert

- Temperature: 36.8°C

- NEWS Total Score: 0 (Respirations 0, Oxygen Saturation 0, Blood Pressure 0, Pulse 0, Consciousness 0, Temperature 0)

- BMI 18.5 kg/m2

Condition:

Anorexia Nervosa

Patient Questions:

1. "Could my diet be causing my dizziness?"

- Possible answer: As you are not consuming many carbohydrates, such as bread, bananas, and potatoes, your body is relying on alternative sources of nutrition. Since carbohydrates are your body’s primary energy source, you may feel weak as you undertake strenuous exercise. However, it is important we conduct further investigations first.

2. "Will I be able to return back to my training?"

- Possible answer: Yes, but it is important we determine what is causing your dizziness first and rule out any possible medical cause.

3. "Will I need any special tests for my symptoms?"

- Possible answer: Based on your history, we may consider certain tests to investigate further.

Examiner Questions:

1. "What are the potential complications of untreated anorexia nervosa?"

- Possible answer: Complications can include heart problems, bone loss, and fertility issues.

2. "How does anorexia nervosa affect mental health?"

- Possible answer: It can lead to anxiety, depression, and social withdrawal.

3. "What treatment options are available for anorexia nervosa?"

- Possible answer: Treatment may involve therapy, nutritional support, and sometimes medication.

Treatment:

- Referral to specialist mental health services for further evaluation and management.

- Nutritional counseling and support.

- Psychotherapy to address underlying psychological factors.

- Regular monitoring of weight and psychological well-being.

Monitoring:

- Regular weight monitoring.

- Psychological assessment at each follow-up.

- Consider referral to dietitian for nutritional support.

Prognosis:

- Prognosis for anorexia nervosa varies but early intervention and comprehensive treatment can lead to recovery.

- Long-term follow-up is essential to prevent relapse.

Differential diagnoses:

1. Anxiety disorder - less likely given weight loss and specific dizziness symptoms.

2. Gastrointestinal issues - less likely given no gastrointestinal symptoms reported.

3. Hyperthyroidism - less likely based on initial evaluation and symptoms.

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Dizziness, Weight Loss

Condition Filter: Anorexia Nervosa

Location Filter: General Practice

Case created by:

Case Created by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student/Doctor

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# DS\_07\_Bulimia

Homepage Vignette:

## "A 27-year-old female named Lucy presents with a history of binge eating and purging."

Individual Page Vignette:

You are a medical student reviewing the case of Lucy, a 27-year-old female with a history of binge eating and purging. She is currently in the General Practice setting.

Patient Name:

Lucy Javdi (pronounced Loo-eee Jahv-dee), prefers to be called Lucy.

Age:

14/06/1997

Location:

General Practice

Personality:

Lucy is a soft-spoken individual with an anxious demeanor. She tends to avoid eye contact and is hesitant in her speech, often trailing off in her sentences.

Presenting Complaint:

Lucy presents with a history of binge eating episodes followed by self-induced vomiting. She reports feeling out of control during these episodes.

Symptoms:

- Site: Episodes occur in private, usually after meals

- Onset: Started 1 year ago

- Character: Feels overwhelming, followed by relief after purging

- Radiation: N/A

- Associated Symptoms: Fatigue, bloating

- Timing: Several times a week

- Exacerbating and Relieving Factors: Stress increases episodes, purging provides temporary relief

- Severity: Causing distress and impacting daily life

History of Presenting Complaint:

- Luxx has been experiencing binge eating and purging episodes for 1 year, leading to feelings of guilt and shame.

- She has not sought previous treatment.

- Symptoms have progressed in frequency and severity.

- Episodes impact her daily life, causing fatigue and bloating.

- Has associated low mood and low energy.

- Feels anxious about eating, but no generalised anxiety.

- Has difficulty falling asleep due to low mood and worrying about appearance.

- Does not have any auditory or visual hallucinations.

Systemic Symptoms:

- Fatigue and malaise

- Weight loss due to purging

- Psychological distress

- Changes in sleep patterns

Past Medical History:

- No significant medical conditions

- No previous injuries or traumas

- No psychiatric history

Drug History:

- No current medications

- No history of medication non-compliance

Allergies:

- No known allergies

Family History:

- Father diagnosed with depression at 23 years old.

Social History:

- Lifestyle: Physically active, 4 times per week

- Occupation: Office worker

- Activities of Daily Living & Hobbies: Enjoys painting and reading

Ideas, Concerns, and Expectations:

- Ideas: Lucy feels overwhelmed and out of control during episodes

- Concerns: She worries about the impact of her behaviors on her health

- Expectations: Lucy hopes to receive help and support to overcome her struggles

Observations:

- Respirations: 18/min

- Oxygen Saturation: 98%

- Air or Oxygen?: Room air

- Blood Pressure: 110/70 mmHg

- Pulse: 72/min

- Consciousness: Alert

- Temperature: 37.0°C

- NEWS Total Score: 1 (Oxygen Saturation)

Examination Findings:

- Scarring over knuckles on dorsal side of hand

- Enamel erosion

- Parotid gland enlargement

Examiner Questions:

1. How long have you been experiencing these episodes of binge eating and purging?

- Lucy: "It started about 1 year ago."

2. Have you noticed any specific triggers for these episodes?

- Lucy: "Stress and anxiety usually lead me to binge and purge."

Treatment:

- Psychotherapy, specifically Cognitive Behavioral Therapy for Eating Disorders

- Nutritional counseling

- Monitoring for medical complications

- Referral to a psychiatrist for medication management if needed (SSRI - Fluoxetine)

Monitoring:

- Monitor weight, vital signs, and psychological symptoms regularly

- Weekly therapy sessions initially, then bi-weekly

- Referral to psychiatrist if psychological symptoms worsen

Prognosis:

- With appropriate treatment and support, Lucy can experience significant improvement in her symptoms.

- Long-term prognosis is favorable with ongoing therapy and monitoring.

Differential diagnoses:

1. Gastroesophageal Reflux Disease (GERD) - less likely due to lack of typical symptoms like heartburn.

2. Functional Dyspepsia - less likely as symptoms are more psychological than GI-related.

Keyword Filters:

- Speciality Filter: Mental Health

- Presenting Complaint Filter: Eating Disorders

- Condition Filter: Bulimia

- Location Filter: General Practice

Case created by:

Case Created by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student/Doctor

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# DS\_08\_Mania

Homepage Vignette:

## "A 25-year-old female named Aisling presents with symptoms of mania."

Individual Page Vignette:

Role: You are a medical student.

Patient: Name: Aisling (pronounced ASH-ling); Age: 25-year-old; Location: Emergency Department; Presenting Complaint: Mania.

Personality:

Aisling is an energetic and fast-talking individual. She appears overly excited and grandiose in her speech, often changing topics abruptly.

Symptoms:

- Site: Aisling mentions feeling extremely happy and excited.

- Onset: Symptoms appeared suddenly over the past week.

- Character: Aisling describes her thoughts as racing and feels unstoppable.

- Radiation: Symptoms are not radiating to any specific part of her body.

- Associated Symptoms: Aisling reports decreased need for sleep and increased goal-directed activity.

- Timing: Symptoms have been progressively worsening.

- Exacerbating and Relieving Factors: Aisling reports that nothing seems to calm her down.

- Severity: Aisling describes her symptoms as alarming and exhilarating.

History of Presenting Complaint:

- Aisling has been experiencing these symptoms for the past week.

- No previous treatments attempted.

- Symptoms have been progressively worsening.

- Symptoms impacting daily life and causing distress.

- Affecting work performance and personal relationships.

- Aisling's physical and mental wellbeing affected.

- History of low mood around 6 months ago.

- No reported auditory or visual hallucinations.

- Fixed beliefs that the government is monitoring her every move.

- Believes the government can hear her thoughts.

- No thoughts of suicide or self harm; No history of self harm or suicide

Systemic Symptoms:

- No abnormal systemic symptoms noted for this case.

Past Medical History:

- No significant past medical history noted.

Drug History:

- No current medications reported.

Allergies:

- No allergies reported.

Family History:

- Father diagnosed with schizophrenia at 21 years old.

Social History:

- Lifestyle: Aisling is a full-time student.

- Occupation: Student.

- Activities of Daily Living & Hobbies: Aisling enjoys painting and hiking.

- Smoking: Non-smoker.

- Alcohol: Social drinker, 2 units per week.

- Recreational Drug Use: None reported.

- Diet: Balanced.

- Exercise: Regular exercise routine.

Ideas, Concerns, and Expectations:

- Ideas: Aisling believes she is invincible and can achieve anything.

- Concerns: Aisling worries about the impact of her symptoms on her relationships and daily life.

- Expectations: Aisling expects to be listened to and understood in the consultation.

Observations:

- Respirations: 18 Breaths/min

- Oxygen Saturation: 98%

- Air or Oxygen?: Room air

- Blood Pressure: 130/80 mmHg

- Pulse: 110 Beats/min

- Consciousness: Alert

- Temperature: 37.2°C

- NEWS Total Score: 4 (Explanation: 0 for Respiration, 0 for Oxygen Saturation, 0 for Blood Pressure, 2 for Pulse, 0 for Consciousness, 2 for Temperature)

Condition: Mania

Patient Questions:

1. "Why do I feel so fantastic all the time?"

Possible answer: "You may be experiencing symptoms of mania, which can cause an inflated sense of self-esteem and euphoria."

2. "Can these symptoms go away on their own?"

Possible answer: "Treatment can help manage your symptoms and improve your quality of life."

3. "What can I do to control these overwhelming feelings?"

Possible answer: "There are treatments available to help stabilize your mood and manage these symptoms."

Examiner Questions:

1. "What are the main clinical features of mania?"

Possible answer: "Symptoms of mania include high energy levels, reduced need for sleep, rapid speech, and grandiose beliefs."

2. "How does mania differ from hypomania?"

Possible answer: "Mania involves more severe symptoms that significantly impact daily functioning, while hypomania is milder."

3. "What are the potential consequences of untreated mania?"

Possible answer: "Untreated mania can lead to relationship problems, financial difficulties, and even hospitalization."

Treatment:

- The most appropriate treatment plan includes mood stabilizers such as lithium or antipsychotics like quetiapine.

- Psychotherapy, such as cognitive-behavioral therapy, may also be beneficial.

- Consider referral to a psychiatrist for further evaluation and management.

Monitoring:

- Monitor Aisling's mood and symptoms regularly.

- Assess for any side effects of medications.

- Follow-up visits every 1-2 weeks initially, then spaced out as symptoms improve.

- Consider psychiatric referral if symptoms persist.

Prognosis:

- With proper treatment and management, Aisling's prognosis is generally good.

- Compliance with medication and therapy is crucial for long-term stability.

- Factors such as family support and coping skills can impact the outcome.

Differential Diagnoses:

1. Bipolar disorder: more likely given the symptoms of mania.

2. Substance-induced mood disorder: less likely due to no reported substance use.

3. Schizophrenia: less likely based on the absence of psychotic symptoms.

Keyword Filters:

- Speciality Filter: Mental Health

- Presenting Complaint Filter: Mania

- Condition Filter: Mania

- Location Filter: Emergency Department

Case created by:

Case Created by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student

Reviewed by:

Reviewed by XX, XX Medical Student/Doctor

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

# DS\_09\_Depression

Homepage Vignette:

## "A 35-year-old female named Nishta presents with symptoms of depression."

Individual Page Vignette:

You are a medical student. Nishta, a 35-year-old female IT consultant, presents to the General Practice with symptoms of depression.

Patient Name:

Nishta Kaur (Nishta)

Age:

12/10/1989

Location:

General Practice

Personality:

Nishta is a soft-spoken individual with a calm demeanor. She expresses her thoughts and concerns clearly, but may appear reserved at times.

Presenting Complaint:

Nishta is experiencing persistent feelings of sadness, lack of interest in activities she once enjoyed, fatigue, and changes in her sleeping and eating habits.

Symptoms:

- Site: Mind

- Onset: Gradual

- Character: Persistent feelings of sadness

- Radiation: N/A

- Associated Symptoms: Lack of interest, fatigue, changes in sleeping and eating habits

- Timing: Ongoing

- Exacerbating and Relieving Factors: N/A

- Severity: Moderate

History of Presenting Complaint:

- Nishta has been experiencing symptoms for the past 6 months

- She has not had any previous treatments

- Symptoms have gradually worsened over time

- Symptoms impact her daily activities and overall mental well-being

- Negative for trauma or other speciality-specific histories

Systemic Symptoms:

- Normal systemic symptoms

Past Medical History:

- Negative for any significant medical conditions, surgeries, or hospitalizations

Drug History:

- N/A

Allergies:

- N/A

Family History:

- Negative for any significant medical conditions in the family

Social History:

- Lifestyle: Sedentary

- Occupation: IT consultant

- Activities of Daily Living & Hobbies: Enjoys reading and painting

- Smoking: Never smoked

- Alcohol: Occasional social drinker (2 units per week)

- Recreational Drug Use: N/A

- Diet: Balanced diet with occasional takeout

- Exercise: Minimal physical activity

Ideas, Concerns, and Expectations:

Ideas: Nishta believes her symptoms may be related to stress at work and personal life.

Concerns: She is worried about the impact of her symptoms on her daily life and relationships.

Expectations: Nishta hopes to find ways to manage her depression and improve her mental well-being.

Observations:

- Respirations: 16/min

- Oxygen Saturation: 98%

- Air or Oxygen: Room air

- Blood Pressure: 120/80 mmHg

- Pulse: 70 bpm

- Consciousness: Alert

- Temperature: 37.0°C

- NEWS Total Score: 0

Examiner Questions:

1. Can you describe the impact of your symptoms on your daily life?

Answer: "I find it hard to enjoy things I once loved and feel tired all the time."

2. Have you noticed any specific triggers for your symptoms?

Answer: "Work pressures and relationship issues tend to worsen my feelings of sadness."

3. How are you coping with your current mental state?

Answer: "I try to distract myself with hobbies, but it's becoming increasingly difficult."

4. Have you ever experienced similar symptoms in the past?

Answer: "No, this is the first time I've felt this way."

5. Is there a family history of mental health conditions?

Answer: "No, mental health issues are not common in my family."

Condition:

Depression

Treatment:

- Initial treatment: Cognitive Behavioral Therapy (CBT)

- Consider referral to a psychiatrist if symptoms persist

- Monitor progress and adjust treatment as needed

Monitoring:

- Regular follow-up appointments every 2 weeks to assess response to treatment

- Contact the practice sooner if symptoms worsen or thoughts of self-harm occur

- Consider referral for more intensive therapy if needed

Prognosis:

- With treatment, Nishta's depression is likely to improve over time

- Response to therapy can vary, but overall prognosis is positive

- Factors like compliance with treatment and support system can influence outcomes

Differential Diagnoses:

1. Adjustment disorder: Less likely as symptoms have persisted for a prolonged period.

2. Bipolar disorder: Less likely as Nishta does not report episodes of mania.

3. Seasonal affective disorder: Less likely due to lack of seasonal pattern in symptoms.

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Depression

Condition Filter: Depression

Location Filter: General Practice

Case Created by: XX, XX Medical Studentt

Reviewed by: XX, XX Medical Student

KEYWORDS = XX

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor

# DS\_10\_Alcohol use disorder

Homepage Vignette:

## "A 35-year-old female patient named Saya presents with alcohol use disorder."

Individual Page Vignette:

As a medical student, your role is to assess and manage Saya, a 35-year-old female patient with alcohol use disorder. She is currently seeking help for her alcohol consumption.

Patient Name: Saya (pronounced sah-ya)

Age: 35

Occupation: Not provided

Location: General Practice

Presenting Complaint: Alcohol use disorder

Personality: Saya is a soft-spoken individual who appears nervous and hesitant. She speaks slowly and carefully, showing signs of anxiety.

Symptoms:

- Site: Not applicable

- Onset: Gradual onset over the past few years

- Character: Saya reports feeling a constant need to consume alcohol

- Radiation: Not applicable

- Associated Symptoms: Mood swings, fatigue

- Timing: Ongoing

- Exacerbating and Relieving Factors: Alcohol consumption worsens her symptoms

- Severity: Severe, impacting her daily life

History of Presenting Complaint:

Saya has been struggling with alcohol use disorder for the past few years. She has attempted to cut down on her drinking but has not been successful. Her symptoms have progressively worsened, affecting her mood, energy levels, and overall quality of life.

Systemic Symptoms:

- Fatigue

- Changes in sleep patterns

- Mood swings

Past Medical History:

- No significant medical conditions

- No previous surgeries or hospitalizations

Drug History:

- Saya consumes alcohol regularly

Allergies:

- No known allergies

Family History:

- No significant family medical history reported

Social History:

- Not provided

Ideas, Concerns, and Expectations:

- Ideas: Saya believes that her drinking is becoming a problem and wants help.

- Concerns: Saya is worried about the impact of her alcohol consumption on her health and relationships.

- Expectations: Saya expects guidance on how to manage her alcohol use disorder.

Observations:

- Respirations (Breaths/min): 16

- Oxygen Saturation (%): 97

- Air or Oxygen?: Room air

- Blood Pressure (mmHg): 136/80

- Pulse (Beats/min): 70

- Consciousness (AVPU): Alert

- Temperature (Celsius): 37

- NEWS Total Score: 0 (all parameters within normal range)

Physical Examination:

- Not provided

Special Tests:

- Not provided

Diagnostic Tests:

- Not provided

Treatment:

- Provide counselling and support for alcohol use disorder

- Consider referral to a specialist for further management

Monitoring:

- Monitor alcohol consumption and mood regularly

- Schedule follow-up visits to track progress

Prognosis:

- With proper management and support, Saya's prognosis for overcoming alcohol use disorder is good

Differential diagnoses:

1. Substance use disorder

2. Depression

3. Anxiety disorder

Keyword Filters:

- Speciality Filter: Mental Health

- Presenting Complaint Filter: Alcohol use disorder

- Condition Filter: Alcohol use disorder

- Location Filter: General Practice

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor”

KEYWORDS = XX

# DS\_11\_Opioid use disorder

Homepage Vignette:

## “A 29-year-old female named Ananya presents with opioid use disorder.”

Individual Page Vignette:

You are a medical student at your 5th year of training. You encounter Ananya, a 29-year-old female who works as a graphic designer. She presents to the Emergency Department with opioid use disorder.

Patient Name: Ananya Kaur (pronounced Uh-NAHN-yuh KOW-er)

Age: 29

Occupation: Graphic designer

Location: Emergency Department

Personality:

Ananya is a soft-spoken and friendly individual. She speaks calmly and articulately, showing signs of nervousness. Her demeanor is polite and cooperative.

Presenting Complaint:

Ananya presents with a history of opioid use disorder.

Symptoms:

- Site: Generalized body aches

- Onset: Gradual and worsening over the past year

- Character: Dull and nagging

- Radiation: None

- Associated Symptoms: Fatigue, insomnia

- Timing: Persistent

- Exacerbating and Relieving Factors: Exacerbated by stress, relieved temporarily by opioid use

- Severity: Moderate

History of Presenting Complaint:

- Ananya has been struggling with opioid use disorder for approximately one year with no previous attempts at treatment.

- She reports worsening symptoms over time, with a significant impact on her daily life and work performance.

- She reports no difficulties sleeping, and has been eating and drinking regularly

- No previous psychiatry history

- Anaya does not have any low mood, suicidal thoughts or thoughts of self-harm

- No feelings of high energy, impulsive behaviour, or thoughts of grandiose

- Anaya does not have any auditory or visual hallucinations

Systemic Symptoms:

- Fatigue, insomnia, constipation

Past Medical History:

- No significant past medical history

Drug History:

- Currently taking opioids for pain management

Allergies:

- No known allergies

Family History:

Ananya has a family history of substance abuse and addiction.

Social History:

- Lifestyle: Ananya leads a sedentary lifestyle

- Anaya does not take any other recreational drugs

- Anaya does not drink any alcohol

- Occupation: Graphic designer

- Activities of Daily Living & Hobbies: Enjoys painting and reading

Ideas, Concerns, and Expectations:

- Ideas: Ananya is aware of her addiction and wants help to overcome it.

- Concerns: Ananya is worried about the impact of her addiction on her health and relationships.

- Expectations: Ananya expects support and guidance in her journey towards recovery.

Observations:

- Respirations: 16 breaths/min

- Oxygen Saturation: 98%

- Air or Oxygen?: Room air

- Blood Pressure: 130/80 mmHg

- Pulse: 80 beats/min

- Consciousness: Alert

- Temperature: 37.0°C

- NEWS Total Score: 0 (within normal range)

Treatment:

Ananya will undergo a comprehensive treatment plan for opioid use disorder based on evidence-based guidelines. This will include a combination of pharmacological and psychosocial interventions, tailored to her specific needs. Maintenance therapies to combat opioid addiction consist of Methadone and Buprenorphine.

Monitoring:

Regular monitoring of Ananya's progress, both medically and emotionally, will be essential in her treatment plan. Any concerning changes or lack of improvement should prompt a reassessment of her plan.

Prognosis:

With proper treatment and support, Ananya has a good prognosis for recovery from opioid use disorder. However, the road to recovery may be challenging, and ongoing support will be crucial for her long-term success.

Differential diagnoses:

1. Chronic pain syndrome

2. Depression

3. Substance abuse disorder

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Substance Misuse

Condition Filter: Opioid Use Disorder

Location Filter: Emergency Department

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor

# DS\_12\_Autism spectrum disorder

Homepage Vignette:

## "A 8-year-old child named Shiori is brought to the GP by her mother. Shiori presents with difficulty in social interactions and communication."

Individual Page Vignette:

You are a medical student working in a General Practice.

Patient Name: Shiori Aizawa

Age: 8

Location: General Practice

Presenting Complaint: Difficulty in social interactions and communication

Shiori Aizawa is a soft-spoken and reserved child who expresses her struggles in social situations with others.

Symptoms:

Site: Difficulty in social interactions

Onset: Gradual onset over the past few years

Character: Difficulty maintaining eye contact, trouble initiating conversations

Timing: Consistent in various social settings

Impact on ADLs: Struggling to make friends and build relationships

Severity: Mild to moderate

History of Presenting Complaint:

Shiori has been experiencing difficulties in social interactions for the past few years, with minimal improvements despite efforts to engage in group activities. She has not sought any previous treatments. The symptoms have progressively worsened and are impacting her ability to form connections with others.

Social Interaction - unable to interpret social cues, inability to form social attachments

Communication - minimal speech, difficulties expressing speech

Behaviours - preoccupation with interest of the piano, does not respond well to new environments

Does not have engage in any impulsive behaviours or hyperactivity

Does not have issues with hearing ability

Does not experience low mood

Demonstrates anxiety in new routines or unfamiliar environments

Systemic Symptoms:

Normal

Past Medical History:

No history of congenital malformations or genetic abnormalities

Delayed developmental and growth milestones

Normal prenatal and neonatal history

Maternal history - delivery through SVD, inconsistent pre-natal care

Drug History:

Negative

Allergies:

None

Family History:

Autism reported in a cousin on the paternal side of the family

Social History:

Lifestyle: Introverted and reserved

Activities of Daily Living & Hobbies: Enjoys playing the piano and listening to piano music

No history of trauma

Lives at home with mother and father

Ideas, Concerns, and Expectations:

Ideas: Mother is worried she may have a learning disability

Concerns: Worries about her difficulty in making friends

Expectations: Hopes to find ways to help her improve her social interactions

Observations:

Respirations: 16 breaths/min

Oxygen Saturation: 98%

Air or Oxygen: Room air

Blood Pressure: 110/70 mmHg

Pulse: 80 beats/min

Consciousness: Alert

Temperature: 36.8°C

NEWS Total Score: 0

Physical Examination:

Mental Status: Reserved and shy demeanor, minimal eye contact, limited speech

Special Tests:

Autism spectrum disorder assessment

Diagnostic Tests:

Results pending

Condition: Autism spectrum disorder

Patient Questions:

1. "Why do I find it so hard to connect with others?"

2. "Is there any treatment available for my social difficulties?"

3. "Can I improve my social skills?"

Examiner Questions:

1. "How have your social interactions impacted your daily life?"

2. "Have you noticed any specific patterns in your difficulties with social communication?"

3. "What are your expectations from this consultation?"

4. "Have you sought help for your social interactions before?"

5. "Do you have any specific goals for improving your social skills?"

Treatment:

Referral for ASD assessment and therapy sessions. Consideration of cognitive-behavioral therapy for anxiety management.

Monitoring:

Regular follow-up visits to monitor progress in therapy sessions and assess social skill improvements. Referral to a specialist if needed.

Prognosis:

With appropriate therapy and support, Shiori can improve her social skills and feel more comfortable in social settings. The prognosis depends on her response to therapy and willingness to engage in treatment.

Differential Diagnoses:

1. Social anxiety disorder: Less likely as the symptoms are more consistent with ASD.

2. Selective mutism: Less likely as Shiori does not mention mutism but struggles with communication.

3. Communication disorder: Less likely as the symptoms are more in line with ASD.

Keyword Filters:

Speciality Filter: Mental Health

Presenting Complaint Filter: Difficulty in social interactions and communication

Condition Filter: Autism spectrum disorder

Location Filter: General Practice

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Doctor

# DS\_13\_Panic attack

Homepage Vignette:

## “A 35-year-old female named Saya presents with sudden-onset chest pain.”

Individual Page Vignette:

Role: You are a 5th-year medical student involved in the care of Saya, a 35-year-old female presenting with sudden-onset chest pain.

Patient Name: Saya (pronounced "sah-yah")

Age: 35

Occupation: Not specified

Location: Emergency Department

Presenting Complaint: Sudden-onset chest pain

Personality: Saya is a calm and articulate individual, speaking clearly and expressing her symptoms in a detailed manner.

Symptoms:

- Site: Chest

- Onset: Sudden

- Character: Sharp

- Radiation: None

- Associated Symptoms: Shortness of breath

- Timing: Constant

- Exacerbating and Relieving Factors: Worsened with deep breaths

- Severity: 8/10

History of Presenting Complaint:

- Saya has been experiencing sudden chest pain for the past 30 minutes

- No previous treatments attempted

- Symptoms have worsened over time

- Impact on daily life with difficulty breathing deeply

Systemic Symptoms:

- No other systemic symptoms present

Past Medical History:

- No significant past medical history

- Diagnosis of generalised anxiety disorder

Drug History:

- No current or previous medication use

Allergies:

- No known allergies

Family History:

- Negative for any significant medical conditions in the family

Social History:

- Non-smoker, occasional alcohol drinker

- Desk job, active lifestyle

- No recent travel history

- Not sexually active

- No recent life events or exposure to hazards

Ideas, Concerns, and Expectations:

- Unsure about the cause of chest pain

- Concerned about the severity of symptoms

- Expects reassurance and treatment plan

Observations:

- Respirations: 18 breaths/min

- Oxygen Saturation: 98%

- Air/Oxygen: Room air

- Blood Pressure: 120/80 mmHg

- Pulse: 90 beats/min

- Consciousness: Alert

- Temperature: 37.0°C

- NEWS Total Score: 0

Physical Examination:

- Normal findings on auscultation of the chest

Diagnostic Tests:

- ECG normal

- Chest X-ray normal

Condition: Panic attack

Patient Questions:

- "Could this chest pain be something serious?"

GIven the results from your tests and your history, it is likely that this is a panic attack and should resolve on its own.

- "How long will these symptoms last?"

A panic attack can generally last from a few minutes up to 30 minutes.

- "What can be done to treat a panic attack?"

An acute panic attack can be managed with a medication such as benzodiazepine, which can help you to calm down and relieve your symptoms.

Examiner Questions:

- What are the common symptoms of a panic attack?

Chest pain, shortness of breath, sweating, rapid heart rate

- How would you differentiate between a panic attack and a myocardial infarction?

An ECG and relevant cardiac tests can help differentiate between a panic attack and MI

- What is the first-line treatment for a panic attack?

Benzodiazepine (Such as Lorazepam)

- How do you approach managing a patient with panic attacks in the long term?

Cognitive behavioural therapy (CBT)

Treatment:

- Reassurance and stress management techniques

- Consider referral for psychological support

Monitoring:

- Regular follow-up to monitor symptoms and response to treatment

- Reassess if symptoms worsen or new symptoms develop

- Consider referral to a psychologist if needed

Prognosis:

- Favorable prognosis with appropriate management of panic attacks

- Symptoms can improve with therapy and stress management techniques

Differential Diagnoses:

1. Myocardial infarction - less likely due to normal ECG and chest X-ray

2. Pulmonary embolism

3. Somatic symptom disorder

Keyword Filters:

Specialty Filter: Acute And Emergency

Presenting Complaint Filter: Chest Pain

Condition Filter: Panic Attack

Location Filter: Emergency Department

Case Created by XX, XX Medical Student

Reviewed by XX, XX Medical Student

Reviewed by XX, XX Medical Student/Docto

# DS\_14\_Opioid overdose

Homepage Vignette:

## “A 33-year-old individual named Rowan (pronounced ROW-un) presents with altered mental status and respiratory depression.”

Individual Page Vignette:

You are a healthcare professional in the Emergency Department. A patient named Rowan, aged 33, a freelance graphic designer, from a suburban location, presents with drowsiness and difficulty breathing.

Patient Name:

Name: Rowan Kazi (pronounced ROW-un KAHD-zee). Please refer to them as Rowan.

Age:

Date of Birth: 14/06/1991

Location:

Emergency Department

Personality:

Rowan is pleasant but minimally responsive, speaking in muffled, incoherent sentences when roused. They're usually sociable and articulate, which is incongruent with their current presentation.

Presenting Complaint:

"I can't... can't stay awake, and it's hard to... breathe…" (Rowan is noted to have a decreased level of consciousness and shallow breathing.)

Symptoms:

Site: The chest feels tight; "My chest... feels heavy."

Onset: It started "a few... hours ago..."

Character: Breathing is described as labored.

Radiation: No radiation of discomfort.

Associated Symptoms: Confusion, pinpoint pupils.

Timing: The symptoms have persisted since onset.

Exacerbating and Relieving Factors: No known exacerbating factors; no relief noted from position changes or rest.

Severity: Unable to provide a clear response due to altered mental state, but symptoms appear severe.

History of Presenting Complaint:

- Rowan has been experiencing symptoms for a few hours.

- No previous treatments have been attempted for the current episode.

- Symptoms have remained constant without fluctuation.

- Daily life is affected, with an inability to engage in usual activities.

- Work has not been impacted as symptoms started after work hours.

- Physical and mental wellbeing significantly compromised due to altered mental status.

Rowan might say:

- "It just... started this evening, haven't taken... anything for it..."

- "I can't think straight... didn't have anything like this... before."

Psychiatric History:

- Any previous instances of seeking help for mental health - Negative

- Any previous psychiatric diagnoses - Denies any previous diagnoses

- Any previous psychiatric treatments - Negative previous psychiatric treatments

Forensic History:

- Negative for any forensic history

Systemic Symptoms:

- Fatigue: Yes

- Fever: Normal

- Night sweats: Normal

- Unintended weight loss: Normal

- Generalized weakness: Normal

- Malaise: Yes

- Altered bowel habits: Constipation

- Changes in urinary habits: Normal

- Changes in sleep patterns: Normal

- Peripheral oedema: Normal

- Malaise: Present

Rowan might say:

- "I'm so... tired, more than usual..."

- "No fever... just can't catch my breath..."

Past Medical History:

- No previous medical conditions reported.

- No surgical history.

- No reported psychiatric history.

- A history of opioid use but unclear if active or in the past.

- Immunizations up to date.

- Rowan doesn’t report any allergies or significant health events.

Rowan might say:

- "I've used... pills before, but not... not now..."

Drug History:

- Rowan reports occasional use of prescription opioids in the past but is unclear about current use. No information on dosages or frequency can be obtained due to altered consciousness.

- No known medication non-compliance, overdoses, or use of alternative therapies reported.

- Reports no current use of over-the-counter medications or supplements.

Rowan might say:

- "I had some pills... for pain a while back, but... don't take 'em regularly..."

- "No, don't use any other... meds."

Allergies:

- No known allergies or intolerances are reported.

Rowan might say:

- “No allergies that I know of...”

Family History:

- Not obtainable at present due to the patient's altered mental status.

Social History:

Lifestyle: Freelance graphic designer, primarily sedentary work.

Occupation: Graphic designer

Activities of Daily Living & Hobbies: Rowan enjoys digital art, gaming, and occasional hiking.

Smoking: Non-smoker

Alcohol: Social drinker, approximately 2-3 units per week occasionally

Recreational Drug Use: History of opioid use, but current use is unclear

Diet: Prefers a vegetarian diet

Exercise: Light exercise, mainly walking and occasional hiking

Travel History: No recent travel

Sexual History: Not obtainable at present

Driving Status: Has a valid driver's license

Cultural or Religious Practices: Non-disclosed

Recent Life Events: Not obtainable at present

Exposure to Hazards or New Environment: No known recent exposures

Rowan might say:

- "I work from home... on my computer a lot..."

- "Just drink at parties... don't smoke or do drugs..."

- "Try to stay... active, when I... can."

Ideas, Concerns, and Expectations:

- Ideas: Rowan is unable to articulate any ideas about their current health status.

- Concerns: Expresses general distress related to breathing difficulties.

- Expectations: Unclear due to impaired communication; however, a sense of urgency for medical assistance is evident.

Rowan might say:

- "Please, just... need to breathe... fix it..."

Physical Examination:

(Include findings indicative of opioid intoxication such as respiratory depression, miosis, decreased bowel sounds)

Special Tests:

- Glasgow Coma Scale (GCS) to assess the level of consciousness.

- Naloxone challenge test to confirm opioid overdose.

Diagnostic Tests:

Blood Tests (Reference Ranges):

Given the need for urgent intervention, blood tests to confirm opioid levels may be deferred in favor of immediate treatment.

Imaging Tests:

Not indicated in this scenario unless further complications are suspected.

Condition: Opioid overdose

Patient Questions:

1. "What's happening to me?" (Reassure that they're in a safe place receiving medical care.)

2. "Will I be okay?" (Affirm that they're receiving the best possible treatment to improve their condition.)

3. "Can you tell my family?" (Confirm that staff will ensure their family is informed and involved.)

4. "Why am I so sleepy?" (Explain that their symptoms are consistent with opioid overdose affecting their alertness but will be addressed promptly.)

Examiner Questions:

1. What is the immediate management for an opioid overdose? (Administer naloxone and secure the airway.)

2. What are the signs of opioid intoxication? (Decreased respiratory rate, pinpoint pupils, altered mental state.)

3. Why is it important to check the blood glucose level in a patient with altered mental status? (To rule out hypoglycemia as a cause or contributor to altered consciousness.)

4. How do you differentiate between opioid overdose and other causes of respiratory depression? (Naloxone challenge and history.)

5. How would you monitor a patient after administering naloxone for opioid overdose? (Continuous observation, repeated doses of naloxone as needed, and considering admission for extended monitoring.)

6. What are potential complications of opioid overdose? (Aspiration pneumonia, acute lung injury, rhabdomyolysis, prolonged hypoxia effects.)

Treatment:

- Immediate administration of naloxone with the dose depending on the clinical severity and response.

- Supportive care including oxygen supplementation and airway management.

- Consider activated charcoal if the patient presents within 1-2 hours of ingestion.

- Admission to an appropriate level of care for monitoring, further evaluation, and potential additional doses of naloxone.

Monitoring:

- Continuous vital sign and respiratory status monitoring is essential.

- Re-assessment of consciousness level and naloxone efficacy.

- Consider cardiac monitoring due to the risk of arrhythmias.

- Plan for frequent naloxone administration as required due to the short half-life of naloxone compared to certain opioids.

- Follow-up visits to assess for potential complications and substance use counseling.

Prognosis:

- With timely and appropriate treatment, the immediate prognosis for opioid overdose can be good.

- The long-term outcome is dependent on the patient's engagement in substance abuse treatment programs to prevent recurrence.

- Potential for full recovery if hypoxia and other complications have not resulted in permanent damage.

Differential diagnoses:

1. Sedative-hypnotic intoxication (less likely due to pinpoint pupils and response to naloxone).

2. Hypoglycemic event (less likely due to lack of diaphoresis, tremors, or history of diabetes).

3. Stroke (less likely due to lack of focal neurological signs).

Speciality Filter: Acute And Emergency; Psychiatry; General Practice;

Presenting Complaint Filter: Altered Mental Status; Respiratory Depression;

Condition Filter: Opioid Overdose;

Location Filter: Accident & Emergency;

Case created by:

Jane Doe, Medical Student

Reviewed by:

John Smith, Medical Student

Reviewed by:

Alex Lee, Medical Student/Attending Doctor

# DS\_15\_Low mood

Homepage Vignette:

## “A 34-year-old individual named Alex Smith presents with persistent low mood.”

Individual Page Vignette:

You are a General Practitioner, and a patient named Alex Smith, a 34-year-old teacher at a local school, comes to your clinic complaining of persistent low mood and lack of interest in daily activities.

Patient Name: Alex Smith (Pronounced: Al-ex Smith). Alex prefers to be called Alex.

Age: 25/05/1989

Location: General Practice

Personality: Alex is eloquent and typically optimistic but has recently become more introspective and less talkative. Alex speaks candidly about feelings and is comfortable discussing personal matters, expressing a readiness to find solutions to the current state of low mood.

Presenting Complaint: Alex reports experiencing a persistent low mood and a lack of interest in activities that were previously enjoyable.

Quote: "I've always been the 'cheerful one', but lately, I just can't seem to find joy in anything, even the things I used to love. It's like the color has been drained from my life."

Symptoms:

- Persistent low mood

- Diminished interest in all activities

- Fatigue

SOCRATES:

Site: Not applicable; the complaint is emotional/psychological.

Onset: "This all started a few months ago, I guess. It's been getting worse, though."

Character: "It's like a heaviness, a gloom that I can't shake off."

Radiation: Not applicable.

Associated Symptoms: "I feel tired all the time, no matter how much I rest."

Timing: "It's pretty constant; I especially notice it when I try to do something I usually enjoy."

Exacerbating and Relieving Factors: "Not much seems to help, but I do feel a bit better after a decent night's sleep, which is getting rarer."

Severity: "On a scale of mild to severe, I'd say it's quite severe. It's affecting my work and my relationships."

Symptoms Negative or Positive Findings:

- No significant weight change

- No sleep disturbances reported

- No thoughts of self-harm or suicide

- Denies anxiety

- No known precipitating stressful life events

Quote:

- "I haven't lost any weight, if that's what you're asking."

- "I haven't been waking up in the middle of the night, but then again, I've never been a great sleeper."

- "No, no thoughts of hurting myself, but I understand why you'd have to ask."

- "Anxiety isn't really the issue; it's more like an absence of feeling."

- "Life's been pretty routine, nothing major happening that I can point to as a cause for this."

History of Presenting Complaint:

- Symptoms began several months ago, however has been getting worse

- Feels a “heaviness and gloom” that the patient can’t shake off

- Feels tired all the time even after periods of resting

- Eats and drinks normally

- No previous psychiatric treatment

- Daily activities and teaching affected by low mood

- No impact on physical wellbeing reported

- Still enjoys engaging in social activities with friends

- No history of high energy, thoughts of grandiose, or risky behaviour

- No auditory of visual hallucinations

- No constant worrying, restlessness, irritability

Risk:

- No suicidal thoughts or thoughts of intent

- No history of suicide attempts or self-harm

Psychiatric History:

- Any previous instances of seeking help for mental health - Negative, has never experienced this before

- Any previous psychiatric diagnoses - Denies any previous diagnoses

- Any previous psychiatric treatments - Negative previous psychiatric treatments

Forensic History:

- Negative for any forensic history

Quote:

- "It snuck up on me over a few months. At first, I thought I was just tired."

- "I've never seen anyone for mental health before."

- "I've noticed I just can't muster up the enthusiasm I once had for my job or hobbies."

- "At least physically, I feel okay, no aches or pains, just the mood stuff."

Systemic Symptoms:

- No reported fevers

- No night sweats

- No significant weight loss

- General feeling of fatigue present

- Otherwise, systemic symptoms are unremarkable

Quote:

- "I haven't had any fevers or anything."

- "No sweats during the night, just the usual tossing and turning."

- "My weight's been stable; food isn't really a comfort or a problem for me."

- "I do feel worn out a lot. It's a struggle to get through the day sometimes."

Past Medical History:

- No significant past medical history

- No previous surgeries or hospitalizations

- No psychiatric or psychological history prior to current symptoms

- No history of substance abuse

- Vaccinations up to date

Quote:

- "I've been pretty healthy, never had any surgeries or been hospitalized."

- "I've never needed to see a psychiatrist before this."

- "Drugs? No, I've never used anything except the occasional drink with friends."

- "I believe all my shots are up to date. I get the flu shot every year."

Drug History:

- Occasionally takes ibuprofen for headaches

- No regular medications

- No known history of medication non-compliance as there are no regular medications

Quote:

- "Just ibuprofen when I have a headache, which isn't very often."

- "No, I'm not on any medications regularly."

Allergies:

- No known allergies

Quote: "I've been fortunate; I don't have any allergies that I'm aware of."

Family History:

- Father has hypertension

- Mother is healthy

- No known psychiatric illnesses in immediate family

Quote:

- "Dad takes pills for high blood pressure, but that's about it."

- "Mom's well, thanks. She's always been healthy."

- "No, we don't have any history of mental illness in the family."

Social History:

Lifestyle: Alex lives alone and is socially active with friends and colleagues.

Occupation: Full-time teacher at a local school.

Activities of Daily Living & Hobbies: Enjoys reading, hiking, and participating in community theater; however, Alex reports a recent lack of interest in these activities.

Smoking: Non-smoker

Alcohol: Occasional social drinker, about 1-2 units per week

Recreational Drug Use: None

Diet: Balanced diet, includes vegetables, fruits, and lean proteins

Exercise: Regular, typically hikes on weekends

Quote:

- "Yeah, I hang out with people from work and some old college friends on weekends. Well, I used to more before all this started."

- "Teaching's been my passion. It's hard now, though; I feel like I'm just going through the motions."

- "Hiking, reading, acting—those used to really fill up my downtime. Now, not so much."

Ideas, Concerns, and Expectations:

Alex has a limited understanding of depression but suspects it could be the issue. Concerns primarily revolve around the impact of mood on professional and personal life. Alex expects to discuss potential treatment options, including therapy and medications, and is eager to start feeling better.

Quote:

- "Is this depression? I've read a bit about it and it seems to fit."

- "I'm worried about how this is affecting my teaching and how I connect with my friends and family."

- "I'm here because I need help. Whatever we need to do—medication, talking to someone—I just want to get back to my old self."

Observations: To be measured during the consultation.

Physical Examination: Normal, age-appropriate physical exam expected due to presenting with mood-related complaints.

Special Tests: Not applicable; focus is on mental health assessment.

Diagnostic Tests: May include standard blood tests to rule out organic causes for mood changes.

Condition: Low mood

Patient Questions:

- "Could this be something physical causing my mood to drop?"

- "It's a possibility. I'd like to run some tests to make sure there are no underlying medical issues contributing to your mood."

- "How long does treatment for depression usually take to start working?"

- "It can vary from person to person, but usually, medications take about 2 to 4 weeks to begin having an effect."

- "What kind of side effects can I expect from the medication?"

- "Side effects depend on the medication, but some common ones can include nausea, headache, or sleep disturbances. We'll monitor you closely for any adverse effects."

- "How often would I need to see a therapist if we go that route?"

- "Therapy typically starts with weekly sessions, and then we can adjust the frequency based on how you're responding."

Examiner Questions:

- Please outline the criteria for major depressive disorder.

- "The criteria include experiencing five or more symptoms over a two-week period, with at least one symptom being either depressed mood or loss of interest in activities."

- What initial investigations would you consider for this patient presenting with low mood?

- "I would consider ordering a complete blood count, thyroid function tests, and maybe electrolytes to rule out any physical causes of low mood such as anemia or hypothyroidism."

- Can you discuss the role of psychotherapy in the treatment of depression?

- "Psychotherapy, such as cognitive-behavioral therapy, can help a patient identify and challenge negative thought patterns, develop coping mechanisms, and work through issues contributing to depression."

- How would you monitor the progress of this patient?

- "Monitoring would include regular follow-ups to assess mood and function, as well as any side effects from medication. The use of standardized questionnaires can be helpful."

- What alternative treatments are available for patients who do not respond to first-line antidepressants?

- "Options include switching to another antidepressant, combining antidepressants, psychotherapy, and in severe cases, considering electroconvulsive therapy."

Treatment:

The treatment plan should follow NICE, CKS, BMJ, and BNF guidelines for depression, which typically involve:

- Starting SSRIs for pharmacological treatment, with fluoxetine (20 mg daily) being a common first choice; adjust dosage based on response and tolerability.

- Consider cognitive-behavioral therapy (CBT) or counseling as non-pharmacological interventions.

- Discuss potential side effects and ensure informed consent before commencement of treatment.

- Alternative options if SSRIs are contraindicated include SNRIs, bupropion, or tricyclic antidepressants.

Monitoring:

- Follow up in 2 weeks to assess initial response to medications and to monitor for side effects.

- Continue follow-ups every 4 to 6 weeks, adjusting treatment as needed.

- Conduct regular assessments of mood using standardized scales.

- Consider referral to a psychiatrist if no improvement after two different antidepressant trials.

Prognosis:

- The prognosis for depression is generally good with treatment, although some patients may experience a chronic course.

- Early initiation of treatment increases the likelihood of a favorable response.

- Factors influencing response include the presence of comorbid conditions, social support, adherence to treatment, and environmental stresses.

Differential diagnoses:

1. Bipolar disorder - less likely due to the absence of any reported manic or hypomanic episodes.

2. Hypothyroidism - can cause depressive symptoms but is less likely without other symptoms such as weight gain, cold intolerance, and fatigue.

3. Anemia - may present with fatigue but is less likely without accompanying symptoms like pallor or shortness of breath.

Speciality Filter:

General Practice; Mental Health

Presenting Complaint Filter:

Low Mood; Loss Of Interest

Condition Filter:

Depression

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_16\_ADHD

Homepage Vignette:

## A 9-year-old called Tahir presents with difficulty paying attention in class and impulsivity.

Individual Page Vignette:

You are a General Practitioner. Tahir Akram, 9 years old, a student, located at a General Practice, presents with difficulty concentrating and acting on impulse without thinking.

Patient Name: Tahir Akram (Tah-heer Ak-ram), prefers to be called Tahir.

Age: 17/09/2014 (suitable for ADHD presentation).

Location: General Practice.

Personality: Tahir is an energetic boy who speaks quickly and often jumps from topic to topic. His mother, accompanying him, describes him as bright but very fidgety and often lost in his thoughts.

Presenting Complaint:

Tahir struggles with concentrating on his tasks, whether in the academic setting or during play. He's often seen fidgeting and has difficulty sitting still. He also tends to blurt out answers and interrupts others.

"I just can't sit in one place and my teacher says I don't listen — but I really try! Sometimes I don't even think before I do things, like when I shouted out the answer in class yesterday!"

Symptoms:

- Difficulty maintaining attention: "I keep trying to focus but I get distracted real fast."

- Impulsiveness: "When I think something, I just do it or say it without waiting."

- Hyperactivity: "I feel like I always need to be moving, or my legs start feeling weird."

History of Presenting Complaint:

Onset: His mother recalls Tahir has always been quite active, even as a toddler.

Has been consistently impulsive and inattentive.

Occasional forgetfulness with tasks and belongings, disruption in class.

Tahir's symptoms are present during school hours and at home.

Activities that require a high level of attention exacerbate symptoms, while physical activity sometimes helps him to feel better.

The symptoms are significant enough to interfere with Tahir's school performance and are a cause of concern for his parents.

No difficulties with speech, reading and writing.

Does not have difficulty with eye contact and responding to social cues. Is able to adapt to routine changes.

Drug History:

- Does not take any prescription or OTC medications.

Allergies:

- No known allergies.

Past Medical History:

- No past medical history.

- Normal birth through SVD. No maternal history of drinking, smoking, or teratogenic exposure during pregnancy

- Had normal developmental and growth milestones.

Family History:

- His mother mentions her brother had similar issues in childhood, though he was never formally diagnosed or treated.

Social History:

Lifestyle: Tahir is a full-time student.

Occupation: N/A.

Activities of Daily Living & Hobbies: He struggles with organization and completing chores. Enjoys playing soccer.

Diet: Regular diet without any particular restrictions.

Exercise: Plays soccer with friends twice a week.

Lives at hope with mother and father

No history of involvement with social work

Ideas, Concerns, and Expectations:

- Tahir is worried that his inability to focus might make him fall behind in school.

- "Are there other kids like me? Can I become better at focusing?"

- He is hoping for some help so that he can do better in school.

Observations:

Respirations (Breaths/min): 18 (0 points)

Oxygen Saturation (%): 98% on room air (0 points)

Blood Pressure (mmHg): 112/75 (0 points)

Pulse (Beats/min): 88 (0 points)

Consciousness (AVPU): Alert (0 points)

Temperature (Celsius): 36.8°C (0 points)

NEWS Total Score: 0

(The NEWS score is 0, indicating no immediate physiological risk.)

Physical Examination:

The examination does not reveal any acute physical issues. Normal development for age.

Diagnostic Tests:

No specific diagnostic tests are required for ADHD diagnosis; it's a clinical diagnosis.

Condition:

Attention-Deficit/Hyperactivity Disorder (ADHD)

Patient Questions:

1. "Why can't I stay still like other kids in my class?"

- "Everyone is different, Tahir. It doesn't mean there is something wrong with you; your energy and thoughts just work a bit faster!"

2. "Will I have to take medicine for this?"

- "Medicines can help some children focus better and feel less restless. But it's not the only way we can help, and we can decide together what's best for you."

3. "Can I still play soccer?"

- "Absolutely, Tahir, soccer is great for you! Exercise can help you utilize your energy and might even help you focus better."

Examiner Questions:

1. How would you diagnose ADHD in a child like Tahir?

- "ADHD is diagnosed based on clinical criteria, which involve obtaining a detailed history of the presenting symptoms, ruling out other conditions, and often using behavior rating scales."

2. Are there any risk factors in Tahir's history that may predispose him to ADHD?

- "Family history of similar behavior could suggest a genetic predisposition to ADHD."

3. What non-pharmacological management could you recommend for Tahir?

- "Behavioral strategies, environmental modifications, psychoeducation for Tahir and his family, and a structured routine can be beneficial."

4. What are the potential side effects of medications used to treat ADHD?

- "Stimulant medications often used for ADHD can cause decreased appetite, sleep problems, headaches, and occasionally increased heart rate and blood pressure."

5. How would you monitor Tahir's progress?

- "Regular follow-up appointments to discuss his behavior at home and school, performance in schoolwork, and any side effects from the medication."

Treatment:

Treatment for ADHD is based on a multimodal approach:

1. Psychoeducation for Tahir and his parents regarding ADHD.

2. Behavioral strategies tailored to Tahir's needs.

3. Setting up a structured environment at home and school.

4. Consideration of medication, such as methylphenidate, starting with a low dose and titrating as needed based on his response and any side effects.

Monitoring:

Tahir should have regular follow-ups to monitor his behavior, academic progress, and potential medication side effects. The frequency of follow-ups could initially be monthly, then less often if he is responding well to treatment. If medications are prescribed, monitor weight, height, and blood pressure.

Prognosis:

ADHD is a chronic disorder that often persists into adulthood but symptoms may become less pronounced over time. With appropriate management, children with ADHD can lead successful lives. Maintaining a strong support system and continued behavioral strategies is essential.

Differential diagnoses:

1. Learning disorders: Less likely due to the presence of hyperactivity and impulsivity across different settings.

2. Childhood onset of mood disorder: Can present with concentration difficulties but typically has mood as the central feature.

3. Sleep disorders: Sleep disturbances can affect attention but are not associated with consistent impulsivity and hyperactivity.

Speciality Filter:

Child Health; Mental Health; General Practice.

Presenting Complaint Filter:

Difficulty Concentrating ; Hyperactivity ; Impulsivity.

Condition Filter:

Attention-Deficit/Hyperactivity Disorder.

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_17\_Bulimia

Homepage Vignette:

A 25-year-old female named Kaira presents with episodes of binge eating followed by self-induced vomiting.

Individual Page Vignette:

You are a General Practitioner and Kaira, a 25-year-old bank teller, presents in your clinic with a history of binge eating episodes and subsequent self-induced vomiting to prevent weight gain.

Patient Name: Kaira Torres (pronounced KY-rah TOHr-res; prefers to be called Kaira)

Age: 25 years old, DOB 07/02/1999

Location: Clinic

Personality: Kaira is articulate and appears well-composed. She speaks candidly about her difficulties but with a degree of embarrassment. She's generally open about her life but tends to minimize the significance of her symptoms.

Presenting Complaint: "I can't seem to stop myself from eating too much at times, but afterwards, I feel so guilty that I make myself throw up."

Symptoms:

- Binge eating

Site: Not applicable

Onset: "It started happening more often in the past year."

Character: “The binging feels uncontrollable.”

Radiation: Not applicable

Associated Symptoms: “I feel anxious and depressed at times, especially after eating too much.”

Timing: “The episodes happen a couple of times a week.”

Exacerbating and Relieving Factors: “Stress seems to make it worse; keeping busy sometimes helps distract me.”

Severity: “It’s starting to affect my life a lot.”

- Self-induced vomiting

Site: Not applicable

Onset: "Usually right after I binge eat."

Character: “It’s a forceful action; I have to do it.”

“My throat often feels sore, and I worry about my teeth.”

Timing: “It occurs almost every time I have an episode of binge eating.”

Exacerbating and Relieving Factors: “The need to vomit gets worse when I feel like I’ve eaten way too much.”

Negative Symptoms:

- No dysphagia

- No hematemesis

- No significant unintended weight changes

History of Presenting Complaint:

- Began experiencing symptoms more than a year ago

- No previous medical treatments sought for these symptoms

- Symptoms have gradually become more frequent

- Impact on daily life includes social withdrawal and a feeling of losing control

- The symptoms negatively affect her performance at work

- Kaira expresses worry about both her physical and mental well-being

- Has associated low mood and fear of weight gain

- Does not report any episodes of anxiousness or excessive worrying

- Does not have lost interest in activities and is able to sleep regularly

- Does not report any auditory or visual hallucinations

Systemic Symptoms:

- Occasional mild fatigue, otherwise none of the following are applicable:

- No fever

- No night sweats

- No significant unintended weight loss or gain

- No generalized weakness

- No significant bowel changes

- No significant urinary changes

- Sleep is sometimes disturbed post-binge episodes

Past Medical History:

- No major illnesses or surgeries

- No psychiatric history

- No substance abuse history except for occasional social drinking

- Up-to-date on immunizations

- No significant past hospitalizations

Risk:

- No suicidal thoughts or thoughts of intent

- No history of suicide attempts or self-harm

Psychiatric History:

- Any previous instances of seeking help for mental health - Negative, has never experienced this before

- Any previous psychiatric diagnoses - Denies any previous diagnoses

- Any previous psychiatric treatments - Negative previous psychiatric treatments

Forensic History:

- Negative for any forensic history

Drug History:

- No regular medications

- No history of medication allergies

- Only occasional use of over-the-counter ibuprofen for menstrual cramps

- No herbal supplements or alternative therapies used

Allergies:

- No known drug allergies

- No known food allergies

Family History:

- Mother with a history of depression

- Paternal uncle with diabetes Type 2

- No other significant family medical history

Social History:

Lifestyle: "I try to keep a balanced life, but it can be hard with my job's demands."

Occupation: "I'm a bank teller, which can be pretty stressful."

Activities of Daily Living & Hobbies: "I used to enjoy painting, but I haven't had much time or energy for it lately."

- Smoking: Non-smoker

- Alcohol: "I drink socially, maybe one or two drinks on the weekend."

- Recreational Drug Use: "I've tried marijuana a few times, but it's not a regular thing for me."

- Diet: "I try to eat healthily, but I often binge on junk food."

- Exercise: "I go for runs occasionally, but not as regularly as I'd like."

Ideas, Concerns, and Expectations:

- Ideas: "I think I might have some sort of eating disorder."

- Concerns: "I'm worried that this is going to have serious health consequences."

- Expectations: "I hope you can help me understand what's going on and find a way to get better."

Observations:

- Respirations (Breaths/min): 16

- Oxygen Saturation (%): 98%

- Air or Oxygen?: Room air

- Blood Pressure (mmHg): 120/80

- Pulse (Beats/min): 72

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.7

- NEWS Total Score: 0 (All observations are within the normal range)

Physical Examination:

- General examination is ​within normal limits: Well-nourished and well-hydrated appearance, with no acute distress noted.

- Abdominal examination is unremarkable with no tenderness, organomegaly, or masses.

- Oral examination may show signs consistent with repeated vomiting, such as dental enamel erosion.

- Skin may show signs of laxity or mild abrasions/knuckle callouses if the patient is inducing vomiting manually.

Diagnostic Tests:

- Basic blood tests may be requested to check for electrolyte imbalances commonly associated with frequent vomiting (e.g., hypokalemia, hypochloremia, metabolic alkalosis).

Condition:

Bulimia

Patient Questions:

1. "Could this be something serious like cancer? You hear about people losing weight and being sick when they have cancer."

- "Your symptoms are not indicative of cancer. They are more in line with an eating disorder called bulimia nervosa, which is serious but treatable with the right support and intervention."

2. "Are you going to put me on medication? I’ve heard about people getting medications for mental stuff but I don't want to be on pills forever."

- "Medication can be part of the treatment but we also focus on psychological support. It's important to address the underlying causes of your eating behavior. We’ll work together to find the most suitable treatment plan for you – it doesn’t necessarily mean medication forever."

3. "What happens if I can't stop myself from purging? Am I going to have long-term health issues?"

- "Chronic purging can lead to serious health issues, but many people recover completely from bulimia with proper treatment. It's essential to start treatment early to reduce the risk of long-term effects."

4. "Do I have to go to a therapist? I'm not crazy, I just can’t control my eating sometimes."

- "Seeing a therapist doesn't mean you are crazy. Eating disorders are complex conditions that benefit greatly from talking therapies, like cognitive behavioral therapy, which can help you gain control over your eating habits."

Examiner Questions:

1. What is the first-line treatment for a patient with bulimia nervosa according to NICE guidelines?

- "The first-line treatment as per NICE guidelines includes a psychological therapy, specifically cognitive behavioral therapy tailored for bulimia nervosa."

2. What are the possible medical complications of bulimia nervosa that a doctor should monitor?

- "Possible complications include electrolyte imbalances, dehydration, gastrointestinal issues, dental problems, and cardiac arrhythmias due to induced vomiting."

3. What pharmacological interventions can be considered for bulimia nervosa and when should they be initiated?

- "Selective serotonin reuptake inhibitors (SSRIs), like fluoxetine, can be used if psychological therapy is not effective or not available, and should be considered particularly if there is comorbid depression or anxiety."

4. How would you address a patient's concern about the stigma associated with mental health treatment?

- "I would validate their feelings and stress the importance of mental health as part of overall wellbeing. I'd provide education about how common and treatable eating disorders are and offer assurance that their condition is taken seriously and without judgment."

5. What factors in this patient's history support the diagnosis of bulimia nervosa?

- "The episodes of binge eating followed by compensatory behaviors such as self-induced vomiting, the patient's concerns about weight gain despite being of normal weight, and her distress about her eating habits support the diagnosis."

6. In managing bulimia nervosa, when would you refer a patient to a specialist eating disorder service?

- "A referral to a specialist eating disorder service would be made if there is no improvement with primary care management, if medical stabilisation is required, or if there are severe psychiatric or medical comorbidities."

Treatment:

- Refer to a therapist for cognitive-behavioral therapy (CBT) specific to eating disorders.

- Consideration of pharmacotherapy with an SSRI, such as fluoxetine, in adults (dose typically starts at 20mg daily and can be increased to 60mg).

- Monitor and manage any medical complications as a result of the eating disorder, such as electrolyte imbalances.

- Regular medical and psychological follow-ups to monitor the patient's response to therapy and medication.

Monitoring:

- Schedule regular follow-up appointments with the GP and/or therapist to monitor Kaira's mental and physical health.

- Vital signs and weight should be monitored at each visit.

- Monitor for signs of depression or anxiety and address these symptoms appropriately.

- If on SSRIs, monitor for side effects and response to medication.

- Referral to a dietitian may be helpful for nutritional counselling and management.

- Remain alert for symptoms of severe electrolyte imbalances or signs of physical deterioration that may require urgent intervention.

Prognosis:

- With proper treatment, including therapy and possibly medication, many patients with bulimia nervosa can recover and maintain a healthy relationship with food.

- Prognosis is better with early intervention and when the patient is highly motivated for treatment.

- Prognostic factors that may influence recovery include the presence of comorbid psychiatric conditions, the duration and severity of the eating disorder, and the patient's social support system.

Differential diagnoses:

1. Binge Eating Disorder – Less likely due to the presence of compensatory behaviors like vomiting.

2. Anorexia Nervosa, binge-purge subtype – Less likely given the patient's normal weight and primary concern over binging, not weight loss.

3. Gastroesophageal Reflux Disease (GERD) – Less likely due to the characteristic nature of self-induced vomiting.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Abnormal Eating Behaviour; Vomiting

Condition Filter:

Bulimia

Location Filter:

Clinic

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_18\_Anxiety

Homepage Vignette:

## A 27-year-old individual named Rowan presents with palpitations and excessive worry.

Individual Page Vignette:

You are a General Practitioner and Rowan, a 27-year-old accountant, has come into your clinic complaining of palpitations and feelings of excessive worry.

Patient Name: Rowan Parker (Pronounced ROW-an PAR-ker). Rowan would like to be called by their first name.

Age: 01/06/1997

Location: Clinic

Personality: Rowan is articulate and analytical, tending to provide detailed descriptions of their experiences. They speak quickly, especially when discussing their symptoms, reflecting their anxious state.

Presenting Complaint:

Rowan reports, "I keep feeling my heart racing for no reason, and I can't stop worrying about things at work and home, even though I know it shouldn't be this bad."

Symptoms:

- Palpitations

- Excessive worry

- Difficulty concentrating

SOCRATES for Palpitations:

Site: "It's in my chest, just feels like my heart is thumping away."

Onset: "It started about a couple of months ago."

Character: "Feels like my heart is pounding hard and fast."

Radiation: "Doesn't really go anywhere, just stays in my chest."

Associated Symptoms: "Sometimes I get sweaty and feel short of breath."

Timing: "It comes and goes, sometimes it's worse when I'm stressed."

Exacerbating and Relieving Factors: "Stress makes it worse. Deep breathing sometimes helps a little."

Severity: "When it's bad, it's quite scary. I'd say it's like a 7 out of 10."

History of Presenting Complaint:

- Symptoms started approximately two months ago.

- No previous treatments attempted.

- Has feelings of anxiety and persistent worrying

- Restlessness

- Sleep disturbance

- Symptoms are worsening with stress and tend to be more frequent during work hours.

- Impact on daily life includes trouble sleeping and difficulty concentrating at work.

- No history of similar symptoms.

Risk:

- No suicidal thoughts

- No history of previous suicide intent or self-harm

Rowan could say, "It's been hard to get through a full day of work without feeling on the edge. My sleep is all over the place now."

Systemic Symptoms:

- Experience of fatigue.

- No fever.

- No unintentional weight loss.

Rowan might mention, "I feel tired all the time now, but that's probably because I'm not sleeping well."

Past Medical History:

- No significant past medical history.

- No previous surgeries or hospitalizations.

- No psychiatric history apart from current symptoms.

- No history of substance abuse.

- Vaccinations up-to-date.

Psychiatric History:

- Rowan has no prior history of mental health disorders diagnosed by a healthcare professional.

- Describes experiencing periods of stress and occasional low moods in the past, associated with work deadlines.

- No previous psychiatric medication or therapy.

- No family history of significant mental illness.

Rowan might say, "I've always been a bit of a worrier, but nothing like this before. It’s like my mind won’t shut off."

Mental State Examination:

Appearance and Behavior: Rowan is alert, well-groomed, and appears their stated age. They are fidgety and restless during the examination.

Speech: Speech is rapid and articulate, with a normal tone and volume.

Mood: Rowan describes their mood as "on edge" and "anxious."

Affect: Anxious affect; mood-congruent with the reported feelings of worry and concern.

Thought Process: Thoughts are organized, goal-directed, but Rowan reports difficulty concentrating due to anxious ruminations.

Thought Content: No delusions or obsessions reported. Expresses worries about possible health issues and work-related stressors.

Perceptions: No hallucinations or misperceptions reported. Acknowledges palpitations and physiological symptoms of anxiety.

Cognition: Appears oriented to time, place, and person. Short-term memory intact, as evidenced by the ability to recall recent events.

Insight and Judgment: Rowan demonstrates insight into their condition, recognizing that their worry may be excessive. Judgment appears intact based on their decision to seek medical help.

Rowan might detail, "I've been generally healthy all my life, never really had to see a doctor for anything serious."

Drug History:

- No prescription medications.

- Occasional use of over-the-counter ibuprofen for headaches.

- No knowledge of medication allergies.

Allergies:

- No known allergies to medications, foods, or environmental factors.

Rowan could clarify, "I've never had a bad reaction to anything, as far as I know."

Family History:

- Mother has hypertension.

- Father has type 2 diabetes.

- No known genetic disorders.

Rowan might explain, "Both my parents have some chronic conditions, but nothing like what I'm feeling now."

Social History:

Lifestyle: Leads a sedentary lifestyle due to desk job.

Occupation: Accountant.

Activities of Daily Living & Hobbies: Enjoys reading and playing piano.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately two glasses of wine per week.

Recreational Drug Use: None.

Diet: Vegetarian, tries to eat balanced meals.

Exercise: Walks occasionally but does not have a regular exercise routine.

Travel History: No recent travel.

Sexual History: Not provided as not directly relevant to the condition.

Driving Status: Has a driver's license and drives daily.

Cultural or Religious Practices: Not discussed as not directly relevant to the condition.

Recent Life Events: Recently promoted at work, which has increased stress levels.

Rowan might say:

- "Work's been really crazy ever since I got this promotion, it's like I can't switch off."

- "I usually have a glass of wine on the weekends to unwind."

- "I've been trying to eat more salads and veggies since I don't really work out much."

Ideas, Concerns, and Expectations:

Rowan might express, "I'm kind of worried that there's something really wrong with my heart. I just want to make sure it's not something serious like a heart attack waiting to happen. I'm hoping we can figure out what's going on and get it under control."

Observations:

Respirations: 18 Breaths/min

Oxygen Saturation: 98%

Air or Oxygen: Room air

Blood Pressure: 138/85 mmHg

Pulse: 92 Beats/min

Consciousness: Alert

Temperature: 36.7 Celsius

NEWS Total Score: 0 (All parameters score 0 points.)

Physical Examination:

- Cardiovascular exam shows normal S1 and S2, no murmurs, rubs, or gallops.

- Respiratory exam is clear to auscultation bilaterally.

- No edema or signs of thyroid abnormalities.

Special Tests: Not applicable for this case.

Diagnostic Tests:

- ECG recommended to rule out cardiac causes of palpitations.

Condition:

Anxiety

Patient Questions:

- "Could this be something serious, like heart disease?" (Possible answer: "Your symptoms are concerning for you, but they are often associated with anxiety. However, we'll do an ECG just to be sure.")

- "How can I stop these palpitations?" (Possible answer: "We can discuss strategies to manage stress and anxiety, and if needed, medication can also be helpful.")

- "Will this anxiety affect my long-term health?" (Possible answer: "Anxiety can have various effects on health, but with proper management, you can lead a healthy life.")

Examiner Questions:

- What are common symptoms of anxiety disorder? (Palpitations, excessive worry, restlessness, difficulty concentrating, sleep disturbance).

- How would you differentiate between anxiety and other potential causes of palpitations? (Taking a thorough history, assessing associated symptoms, performing a physical examination, and conducting an ECG).

- What are the first-line treatments for anxiety disorder? (CBT (Cognitive Behavioural Therapy), lifestyle changes, and SSRIs (Selective Serotonin Reuptake Inhibitors)).

- Can you name any SSRIs? (Fluoxetine, sertraline, citalopram).

- What lifestyle modifications would you recommend to a patient with anxiety? (Regular exercise, healthy diet, adequate sleep, stress management techniques).

- What is the role of benzodiazepines in the treatment of anxiety? (They can be used for short-term relief of acute anxiety symptoms, but they are not recommended for long-term use due to the risk of dependence).

Treatment:

- Cognitive Behavioural Therapy (CBT) as the first line.

- Consider an SSRI such as sertraline 50mg once daily, can increase the dose after several weeks if needed.

- Benzodiazepines, like lorazepam, can be used short-term for acute anxiety but are not for long-term management.

- Provide guidance on relaxation techniques and refer for therapy.

Monitoring:

- Monitor response to medication after starting SSRIs every 2-4 weeks initially, then every 3-6 months.

- Advise Rowan to seek immediate medical attention if they experience severe side effects from medications or worsening symptoms.

- Schedule follow-up for therapy effectiveness after the initial few sessions and then periodically.

Prognosis:

- With appropriate treatment, many individuals with anxiety disorders can lead full, productive lives.

- Response to treatment may vary, and symptoms may recur, emphasizing the importance of ongoing therapy and adherence to treatment plans.

- Factors such as coexisting conditions, stress, and lack of social support may influence prognosis.

Differential diagnoses:

1. Hyperthyroidism: Lack of heat intolerance, weight loss, and tremors make this less likely.

2. Cardiac arrhythmia: No chest pain or history of heart disease, ECG needed for confirmation.

3. Pheochromocytoma: Rare and usually presents with headaches, sweating, and sustained hypertension.

Speciality Filter:

General Practice; Mental Health

Presenting Complaint Filter:

Palpitations; Anxiety

Condition Filter:

Anxiety

Location Filter:

Clinic

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_19\_Delirium tremens

Homepage Vignette:

A 57-year-old male called Mihailo presents with tremors and confusion.

Individual Page Vignette:

You are a doctor in the Accident & Emergency department, and Mihailo, a 57-year-old university professor, has been brought in by his colleagues. They report he has been experiencing increasingly severe tremors and seems disorientated and confused.

Full Name: Mihailo Petrović (pronounced mi-HI-lo PET-ro-vich; patient prefers to be called Mihailo)

DOB: 25/05/1967

Location: Accident & Emergency

Personality: Mihailo is a highly intellectual and articulate individual, used to speaking his mind clearly and vehemently. Despite his current condition, he attempts to converse with a semblance of his usual eloquence but is noticeably disorganized in his thoughts.

Presenting Complaint: “I can’t seem to keep my hands steady, and everything feels...off. I just don’t understand what’s happening to me.”

Symptoms:

- Tremors

- Confusion

- Agitation

- Insomnia

- Possible hallucinations

SOCRATES for tremors:

Site: "It's in my hands, mostly."

Onset: "They started a few days ago... just slight shakes, but now it's constant."

Character: "It's like a rhythmic trembling, you see?"

Radiation: "No, it doesn't go anywhere else."

Associated Symptoms: "I've been feeling quite confused and... there are times when I see things that I know aren't there."

Timing: "It’s been a few days, I think? It’s all quite muddled."

Exacerbating and Relieving Factors: "Nothing seems to calm them down; they're relentless."

Severity: "It's severe enough to make holding a pen a herculean task."

History of Presenting Complaint:

- Symptoms started a few days prior.

- No previous treatments attempted.

- Symptoms have progressively worsened.

- Frequency of symptoms is consistent.

- Impact on ADLs significant, unable to perform basic tasks or work.

- Impact on mental wellbeing with confusion and potential hallucinations.

Specialty-specific history (mental health): Negative for intentional substance use, but missed alcohol consumption could be associated with presenting symptoms.

Quote: “These shudders began as a minor annoyance, but now they've commandeered my hands. I can hardly grade my students' papers. And my thoughts... they scatter like leaves in the wind.”

Systemic Symptoms:

- No exhaustiveness, fever, night sweats, or unintended weight loss reported.

- Malaise and general weakness.

- No changes in bowel or urinary habits.

- No peripheral oedema.

- Insomnia present.

- Agitation and increased autonomic symptoms.

Quote: “I haven’t had a fever, and my weight is stable, thanks to my disciplined diet. But there’s a persistent weakness, a sort of unease in my body and mind. Sleep escapes me night after night, leaving me agitated.”

Past Medical History including Psychiatric History:

- No personal history of major medical conditions reported.

- No past psychiatric diagnoses or treatments mentioned; however, assess for previously undiagnosed or undisclosed conditions.

- No known self-harm or suicide attempts.

- No record or report of substance abuse, though habitual alcohol consumption present.

- Preventative care and immunizations are up to date.

- No significant health events or hospitalizations reported.

- Psychiatric History: Denies any prior psychiatric illnesses or hospitalizations, treatment by a psychiatrist, or use of psychotropic medication.

Quote: “My health record is as clear as my conscience, doctor. Except for the daily spirits, I lead a pretty abstemious life. My last vaccination was on schedule, as of my last physical.”

Risk and Forensic History:

- No known history of violence or criminal behavior.

- No engagement with forensic services.

- Risk Factors: Sudden cessation of regular alcohol use, history of alcohol use could imply a risk for delirium tremens. No reported risks to self or others at present.

- Risk to Self: No current suicidal ideation or attempts; however, vigilance is needed due to the risk of harm from confusion and disorientation.

- Risk to Others: No history of violence, but confusion may lead to unpredictable behavior, which should be closely monitored.

Drug History:

- No prescription medications.

- No history of medication non-compliance.

- Occasional use of OTC pain relievers for headaches.

- No herbal supplements or alternative therapies.

- Regular alcohol consumption, but stopped abruptly a few days ago.

- No known overdoses.

Quote: “Medicine cabinets are foreign territory to me; I prefer a natural existence. Although, a gin-progressively replaced my evening tea, but that ceased abruptly when my symptoms began.”

Allergies:

- No known allergies or intolerances.

Family History:

- Father passed away from a myocardial infarction.

- Mother has hypertension.

- No other known hereditary conditions.

Quote: “My father met his fate at the hands of his heart, and mother battles her blood pressure. Other than that, our family tree is as robust as an oak.”

Social History:

Lifestyle: A university professor, intellectually engaged and socially active within academic circles.

Occupation: Professor of Philosophy.

Activities of Daily Living & Hobbies: Enjoys reading, writing, and hosting intellectual debates, all of which have been impacted.

Smoking: Non-smoker.

Alcohol: Regular drinker, typically 3 glasses of wine per evening, every day until symptoms started.

Recreational Drug Use: Denied.

Diet: Balanced diet with a preference for Mediterranean cuisine.

Exercise: Moderately active with frequent walks.

Travel History: Occasional academic conferences abroad.

Sexual History: Prefers not to discuss.

Driving Status: Drives to and from work regularly.

Cultural or Religious Practices: Not specified.

Recent Life Events: No recent significant events reported.

Quote 1: “I've always indulged in the fine bouquet of a good Merlot, yet never to excess. My daily stroll through the campus quads has been my only reprieve from the sedentary life of the mind.”

Quote 2: “Travel has always been solely for the dissemination of knowledge, rarely for leisure. And my diet? Well, let's just say I follow Hippocrates: let food be thy medicine.”

Quote 3: “Driving has become a challenge with these... tremors. Safety is paramount, hence my colleagues' insistence to escort me today.”

Ideas, Concerns, and Expectations:

Ideas: “Could it be some sort of withdrawal? I’ve read about such things.”

Concerns: “I am deeply troubled by these... hallucinations, are they a harbinger of something graver?”

Expectations: “I expect a thorough assessment and, hopefully, a quick resolution so I can return to my duties unencumbered.”

Quote: “One can’t help but conjecture... could my abrupt abstinence from the evening chalice have brought upon this plight? Prodigious concerns plague me, doctor; I implore you, let not my mind be the victim of my body's revolt.”

Observations:

Respirations (Breaths/min): 20 (0 points).

Oxygen Saturation (%): 98 on room air (0 points).

Blood Pressure (mmHg): 140/85 (0 points).

Pulse (Beats/min): 100 (1 point).

Consciousness (AVPU): Alert but confused (3 points).

Temperature (Celsius): 37.2 (0 points).

NEWS Total Score: 4.

(The NEWS score is 4: 1 point for pulse rate and 3 points for new-onset confusion.)

Physical Examination:

General: Patient appears agitated.

Neurological: Presence of fine tremors in hands, disorientation, confusion, and hallucinations may be evident upon detailed cognitive testing.

Cardiovascular: Tachycardia.

Condition: Delirium tremens

Patient Questions:

1. "What exactly is delirium tremens? How serious is it?" (Answer: "Delirium tremens is a serious form of alcohol withdrawal. It can be serious, but with proper treatment, we can manage the symptoms and prevent complications.")

2. "Will I need to be hospitalized for this condition?" (Answer: "Given the severity of your symptoms, hospitalization is usually recommended to monitor your condition and provide supportive care.")

3. "Can this condition affect my brain permanently?" (Answer: "There can be long-term effects if not managed properly, which is why we're addressing it promptly to minimize any potential risks.")

4. "How long before I can return to my normal life?" (Answer: "Recovery varies, but with treatment, you could start to see improvement within a few days. Complete recovery may take longer, and we will guide you through it.")

Examiner Questions:

1. What are the key diagnostic criteria for delirium tremens?

(Answer: Signs of alcohol withdrawal with severe tremors, confusion, agitation, hallucinations, and autonomic instability.)

2. How is the severity of alcohol withdrawal assessed medically?

(Answer: Through scoring systems like the CIWA-Ar and clinical judgment considering the patient's symptoms and history.)

3. What is the first-line treatment for delirium tremens?

(Answer: Benzodiazepines are typically the first-line treatment for managing symptoms and preventing complications.)

4. What potential complications should you monitor for in a patient with delirium tremens?

(Answer: Seizures, cardiac arrhythmias, aspiration pneumonia, and other metabolic disturbances.)

5. Name one non-pharmacological intervention that could be helpful in this case.

(Answer: A quiet, safe environment and reassurance are important to help reduce agitation and confusion.)

6. Why is thiamine administration important in patients with suspected alcohol withdrawal?

(Answer: To prevent Wernicke-Korsakoff syndrome, a serious neurological disorder associated with thiamine deficiency.)

Treatment:

The treatment plan for delirium tremens would include:

- Admission to a hospital for close monitoring and treatment.

- Administration of benzodiazepines such as lorazepam or diazepam for symptom control, dosed appropriately for the patient’s age and condition.

- Thiamine supplementation to prevent Wernicke-Korsakoff syndrome.

- IV fluids and electrolyte replacement as necessary.

- Anti-seizure prophylaxis if there is a history of seizures.

- Other supportive measures like ensuring a calm environment and adequate nutrition.

- If allergic to benzodiazepines or if they are ineffective, use of alternatives such as phenobarbital or propofol may be considered, under specialist supervision.

Monitoring:

Continual observation for signs of worsening withdrawal symptoms, seizures, and delirium is essential. The dosing of medications may need adjustment according to symptom response. Frequent reassessment of mental status, vital signs, electrolyte levels, and hydration status is crucial. Consideration for tapering down benzodiazepines as symptoms improve to avoid sedation and dependency. Follow-up with addiction services and consideration for long-term therapy may be needed to prevent relapse into alcohol use.

Prognosis:

With appropriate medical treatment, the prognosis for delirium tremens is generally good, although there is a fatality rate of 1-5%. Continuous abstinence and avoidance of alcohol are crucial for long-term recovery. Prognostic factors include age, comorbidities, and adherence to treatment and follow-up care.

Differential diagnoses:

1. Alcohol withdrawal seizure (less likely due to presence of autonomic disturbances and hallucinations).

2. Wernicke-Korsakoff syndrome (absence of ophthalmoplegia or ataxia makes this less likely).

3. Other causes of delirium (e.g., metabolic disturbances, infection, which are less likely given the history of sudden alcohol cessation).

4. Substance-induced psychotic disorder (less likely due to the temporal relationship between symptom onset and cessation of alcohol intake).

Speciality Filter:

Acute And Emergency; Medicine Of Older Adult; Mental Health

Presenting Complaint Filter:

Tremor; Confusion

Condition Filter:

Delirium Tremens

Location Filter:

Accident & Emergency

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_20\_Delusional disorder

Homepage Vignette:

## A 42-year-old individual called Morgan presents with conviction in unusual beliefs.

Individual Page Vignette:

You are a psychiatrist in a mental health clinic, and today you will be assessing Morgan, a 42-year-old editor. Morgan expresses a strong conviction in beliefs that are considered unusual and not based in reality.

Patient Name: Morgan Belanger (Pronunciation: Mor-gan Bell-an-jey; likes to be called Morgan)

Age: 14/05/1980

Location: Mental Health Clinic

Personality: Morgan is articulate and presents in a manner that is both self-assured and serious. They speak deliberately and are keen on details, often providing lengthy explanations on matters they perceive as significant. Morgan is respectful but may become agitated when their beliefs are challenged.

Presenting Complaint: Morgan reports experiencing persistent thoughts that others consider to be out of touch with reality.

Quote: "I'm here because I know things that others seem to ignore or are just oblivious to, and I need someone to acknowledge that my findings are significant."

Symptoms:

- Firmly-held beliefs perceived as delusional by others

History of Presenting Complaint:

- Symptoms present for several years, but have become more profound recently

- Attempts to share beliefs and insights have led to increased isolation and tension in personal relationships. "I’ve been experiencing some tension with family and friends who don't believe me."

- Impact on daily life includes time spent researching and defending beliefs

- Work impact: Morgan may struggle to concentrate on tasks unrelated to their beliefs

- Physical and mental wellbeing affected by stress and conflicts with others

Quote: "For years I've been piecing everything together, you have to understand that it occupies a lot of my time. It's been tough with my partner and colleagues who just dismiss it all."

Systemic Symptoms:

- Stress-related symptoms such as tension headaches and difficulty sleeping

Quote: "The stress of it all gives me headaches, and yes, I’ve been sleeping poorly; the thoughts just don’t stop."

Past Medical History:

- Reports no significant past medical history

Psychiatric History:

- No prior formal psychiatric evaluation or treatment

- Reports instances of stress-related insomnia

Quote: "This is my first time talking to a psychiatrist. I usually manage on my own, although I sometimes have trouble sleeping because of my racing thoughts."

Risk Assessment:

- No history of harm to self or others

- Strong conviction in beliefs could lead to potential conflicts

Quote: "I would never hurt anyone. My work is about unveiling truths, not creating conflicts. But, people can get heated when they're challenged."

Forensic History:

- No previous criminal activity or legal issues

- No involvement with law enforcement related to current beliefs

Quote: "No, I've never been in trouble with the law. I'm careful to ensure my research stays within legal bounds."

Drug History:

- No current medications

- Denies any history of non-compliance, herbal supplements, or overdose incidents

Quote: "No, I don't take any medications. I've never needed to."

Allergies:

- No known allergies

Quote: "Allergies? No, I’m not allergic to anything as far as I know."

Family History:

- No known family history of psychiatric conditions

Quote: "My family has always been relatively healthy, mentally and physically."

Social History:

Lifestyle: Independent, detail-oriented, spends time researching

Occupation: Editor

Activities of Daily Living & Hobbies: Prefers solitary activities related to research and analysis

Smoking: Non-smoker

Alcohol: Drinks occasionally, about 3 units per week

Recreational Drug Use: Denies use

Diet: Primarily plant-based

Exercise: Walks regularly, about 30 minutes per day

Quote: "I keep to myself mostly, and I’m an editor by trade. I don’t smoke or do drugs, and I only drink socially. My diet is mainly vegetarian, and I like to stay active by walking."

Ideas, Concerns, and Expectations:

- Morgan has developed an elaborate personal explanation for their beliefs

- Worried that their insights are being ignored or dismissed

- Expects validation of their beliefs or an explanation why they perceive things differently

Quote: "I expect you to at least consider that what I'm saying has merit. I'm concerned that nobody is willing to admit that what I know could be true."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98%

Air or Oxygen?: Room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 70

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8

NEWS Total Score: 0

Physical Examination:

General examination unremarkable.

Special Tests:

Not applicable for this case.

Diagnostic Tests:

Mental State Examination: In-depth assessment of current mental status, including mood, thought content, and perceptions.

Condition:

Delusional Disorder

Patient Questions:

1. "Can you actually believe me, or are you going to dismiss me like everyone else?"

Possible Answer: "I'm here to listen to you and understand your perspective. Let's talk about your experiences, and we'll work together from there."

2. "What if my beliefs are true and everyone else is wrong?"

Possible Answer: "Our beliefs are our realities. It's important for us to discuss them so we can understand how they fit into the wider context of our lives."

3. "Are you going to give me medication to stop these thoughts?"

Possible Answer: "Our first step is to discuss all possible approaches and find what works for you. Medication is just one option that we can consider."

Examiner Questions:

1. How would you approach a patient presenting with delusional beliefs in a non-confrontational manner?

Possible Answer: I would establish rapport, listen empathetically, and validate the patient's feelings without necessarily confirming the delusional content.

2. What differentiates delusional disorder from other psychotic disorders?

Possible Answer: Delusional disorder features the presence of one or more non-bizarre delusions without other hallmark symptoms of schizophrenia like hallucinations, disorganized speech, or significantly disorganized or catatonic behavior.

3. What is the importance of history-taking in assessing someone with possible delusional disorder?

Possible Answer: A comprehensive history allows us to understand the onset and course of symptoms, rule out medical conditions or substance use, and assess the impact on the patient's functioning.

4. How might you address Morgan's expectation for validation of their beliefs?

Possible Answer: By explaining that my role is to provide support and care, and that we can work on strategies to help them manage the impact of their beliefs on daily functioning.

5. Can delusional disorder evolve into a more severe psychotic disorder?

Possible Answer: While delusional disorder is typically a stable condition, continuous assessment is necessary as it can, though rarely, progress to schizophrenia or another psychotic disorder.

6. What are some psychotherapeutic approaches for treating delusional disorder?

Possible Answer: Cognitive-behavioral therapy to challenge and reframe delusional beliefs, and supportive psychotherapy to promote functional coping strategies.

Treatment:

1. Psychoeducation: Explaining the nature of the disorder to Morgan.

2. Psychological interventions: Considering Cognitive Behavioral Therapy to address delusional thoughts.

3. Pharmacological interventions:

- If necessary, treatment with antipsychotics such as risperidone 0.5 to 2 mg daily, titrating up with consideration of side effects and therapeutic response.

- If risperidone is ineffective or not tolerated, alternatives like olanzapine or aripiprazole can be considered.

4. Monitor for side effects and treatment adherence.

Monitoring:

- Regular follow-up appointments to assess mental state and any medication side effects.

- Adjust treatment based on the response and tolerability.

- Long-term therapy may be necessary for maintaining stability and functionality.

Prognosis:

- Delusional disorder has a variable prognosis. Some patients experience remission of symptoms while others may have a chronic course.

- Early intervention and adherence to treatment can improve outcomes.

- Prognostic factors include age of onset, the presence of triggering stressors, and the patient's insight into their condition.

Differential diagnoses:

1. Schizophrenia: Less likely due to absence of hallucinations, disorganized speech, and behavior.

2. Major Depressive Disorder with Psychotic Features: Absence of a major depressive episode makes this diagnosis less likely.

3. Bipolar Disorder: No history of manic or hypomanic episodes.

4. Substance-Induced Psychotic Disorder: No evidence of substance misuse in this case.

5. Delirium: Morgan is alert and oriented, making delirium unlikely.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Belief in Delusions

Condition Filter:

Delusional Disorder

Location Filter:

Mental Health Clinic

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_21\_Depersonalisation

Homepage Vignette:

A 35-year-old individual named Alexei presents with feelings of being detached from themselves.

Individual Page Vignette:

You are a General Practitioner evaluating Alexei Kuznetsov, a 35-year-old journalist, who is visiting your clinic complaining of persistent feelings of detachment from their body and surroundings.

Patient Name: Alexei Kuznetsov (Pronunciation: Ah-LEK-say Kooz-NET-sov, prefers to be called Alexei)

Age: 15/06/1988

Location: General Practice Clinic

Personality: Alexei is an articulate and inquisitive individual, accustomed to seeking thorough answers in their work as a journalist. They maintain a composed demeanor during the consultation but exhibit an undercurrent of anxiety and introspection, possibly due to the distressing nature of their symptoms.

Presenting Complaint: Alexei reports experiencing persistent feelings of being detached from their own body and surroundings as if they are observing themselves from outside.

Quote: "It's like I'm not really here, you know? As if I'm watching myself in a movie."

History of Presenting Complaint:

- Duration: Months

- Treatment History: None attempted

- Progression: No change in symptom intensity or frequency

- Impact on ADLs: Significant, particularly affecting work concentration

- Impact on Work: Difficulty focusing, reduced productivity

- Mental Wellbeing: Experiences distress due to symptomatology

- No impact on physical wellbeing reported, but mental wellbeing is affected due to the distressing nature of the sensations

Quote: "It's been a few months with this odd feeling... I've tried to shake it off, thinking it's just stress. But it's making work harder than it should be."

- Negative findings: No reports of pain, specific physical discomfort, vision changes, or loss of consciousness.

Quote: "I don't have pain or anything like that, just these episodes where I feel disconnected from myself."

Quote: "It started out of nowhere a while back. At first, I thought it was just stress or lack of sleep, but it's been getting in the way of my focus at work."

Psychiatric History:

- No reported history of psychiatric illnesses prior to current symptoms

- Denies previous episodes of mood or anxiety disorders

- No known history of psychosis or severe mental illness

Quote: "No, I've never had any mental health issues before this, at least nothing diagnosed or that needed treatment."

Risk Assessment:

- No expressed or implied risk of harm to self or others

- No history of suicidal ideation or attempts

- No engagement in self-harming behaviors

Quote: "I don't want to harm myself; I'm just really looking for a solution to these unsettling feelings."

Forensic History:

- No known history of criminal behavior or legal issues

- Denies any encounters with law enforcement or the criminal justice system

Quote: "I've always played it safe and kept on the right side of the law, so no trouble with that, thankfully."

Systemic Symptoms:

- No reports of fatigue, fever, night sweats, unintended weight loss, or generalised weakness

- All reported systemic symptoms are normal

Quote: "Other than what I've told you, I feel physically healthy. It's just this weird mental state that's bothering me."

Past Medical History:

- No history of significant medical conditions, surgeries, or hospitalizations

- No reported psychiatric history previous to current complaint

- No history of substance abuse or significant health events

Quote: "I've been lucky with my health so far; nothing like this has ever happened to me before."

Drug History:

- No regular medications, no history of medication non-compliance or overdose incidents

- Occasional use of over-the-counter pain relief for headaches

- No known use of herbal supplements or alternative therapies

Quote: "I don't take any medications regularly, just an Advil here and there for a headache."

Allergies:

- No known allergies or intolerances

Quote: "I don't have any allergies that I'm aware of."

Family History:

- Non-contributory with no known genetic conditions or significant family health issues

Quote: "My family is pretty healthy overall; nothing that I think might relate to this."

Social History:

Lifestyle:

- Single, lives alone

Occupation:

- Journalist

Activities of Daily Living & Hobbies:

- Enjoys reading, biking, and meditation

Smoking: Non-smoker

Alcohol: Consumes alcohol socially, approximately 3-4 units per week

Recreational Drug Use: Denies any use

Diet: Balanced diet with occasional indulgences

Exercise: Bikes to work most days and occasionally on weekends

Quote: "I try to stay healthy. I bike, eat well, you know, the usual stuff. I drink a bit on the weekends with friends but nothing crazy."

Ideas, Concerns, and Expectations:

- Alexei believes their symptoms might be related to stress or psychological factors

- Concerned that the detachment may indicate a more serious mental health issue

- Expects to receive information and guidance on managing their symptoms and possibly a referral to a specialist if needed

Quote: "I've been wondering if this is all in my head, or if it's something serious. I'm here because I need some answers and help to get over this."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7

NEWS Total Score: 0

Physical Examination:

- General examination unremarkable

- Neurological examination does not reveal any focal deficits

- Mental state examination demonstrates good insight and cognition with no evidence of hallucinations or delusions

Special Tests:

- No specific special tests

Diagnostic Tests:

- May consider referral for psychiatric evaluation

Condition:

Depersonalisation

Patient Questions:

1. "Can this detachment feeling be a sign of something like a brain tumour?"

- Answer: "Depersonalisation typically isn't associated with brain tumours. However, if you're concerned, we can discuss further investigations."

2. "Will I need medication for this? I'd really rather not take anything."

- Answer: "Medication can be helpful in some cases, but there are also other therapeutic options we can explore."

3. "Could this be something that lasts forever? What if I don't get back to normal?"

- Answer: "Many people with depersonalisation do improve over time, especially with appropriate treatment. It's variable, but we'll work together to find the best approach."

Examiner Questions:

1. What is the first-line management for a patient presenting with depersonalisation?

- Answer: Psychological therapies, such as cognitive-behavioral therapy, are considered first-line. Medications may also be prescribed if symptoms are severe or persistent.

2. How would you differentiate between depersonalisation and psychotic disorders?

- Answer: Depersonalisation does not involve the loss of touch with reality like hallucinations or delusions seen in psychotic disorders. Insight into the unreal nature of the experience is maintained in depersonalisation.

3. What other conditions should be considered in the differential diagnosis for depersonalisation?

- Answer: Conditions such as anxiety disorders, dissociative disorders, side effects of drugs, and less commonly, seizure disorders or migraines might also present with similar symptoms.

4. How do you approach a patient's concerns about potential serious underlying causes for their symptoms, such as a brain tumour?

- Answer: Reassuring the patient that their symptoms are consistent with depersonalisation, which isn't typically caused by brain tumours. Consider further investigations if indicated by the presence of other symptoms or red flags.

5. What are some triggers or exacerbating factors commonly associated with depersonalisation?

- Answer: Stress, anxiety, substance abuse, and significant trauma are common triggers for depersonalisation episodes.

Treatment:

- Provide education regarding the nature of depersonalisation

- Cognitive-Behavioral Therapy (CBT) as first-line treatment

- Consider Selective Serotonin Reuptake Inhibitors (SSRIs) like sertraline (50-200 mg daily) or fluoxetine (20-60 mg daily) if symptoms are severe or do not improve with therapy

- Referral to psychiatry for further assessment and management if necessary

Monitoring:

- Regular follow-up appointments to monitor symptoms and treatment response

- Monitor for new symptoms or side effects of medication

- Adjust treatment plan as needed based on response and tolerability

- Referral to a psychiatrist if initial measures are ineffective

Prognosis:

- Prognosis of depersonalisation can vary; some patients experience remission of symptoms with treatment, while others may have persistent symptoms

- Prognosis is more favorable with early intervention and management

- Treatment response usually develops over weeks to months

Differential diagnoses:

1. Generalised anxiety disorder

2. Panic disorder

3. Seizure disorders

4. Migraine with aura

5. Side effects of medication or drug use

Speciality Filter: Mental Health

Presenting Complaint Filter: Feelings of Being Detached

Condition Filter: Depersonalisation

Location Filter: General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_22\_Borderline personality disorder

Homepage Vignette:

## A 26-year-old individual named Kai presents with emotional instability and fear of abandonment.

Individual Page Vignette:

You are the general practitioner assessing Kai, a 26-year-old graphic designer who has come to your clinic complaining of intense mood swings and a persistent fear of being left alone. Kai prefers to use their first name during the consultation.

Patient Name: Kai [Pronunciation: K-eye; Patient prefers to be called Kai]

Age: 15/07/1997

Location: General Practice Clinic

Personality:

Kai is articulate and expressive about their feelings, often speaking with an animated tone. They appear introspective and self-aware, sometimes prone to rapid mood changes during the conversation.

Presenting Complaint:

"I feel like I'm on an emotional rollercoaster, and I'm terrified that people are going to leave me."

Symptoms:

- Emotional instability

"One minute I'm okay, the next it's like a switch flips and I'm just plummeting."

- Persistent fear of abandonment

"It's like there's this constant voice in my head warning me that everyone I care about is going to leave."

History of Presenting Complaint:

- Kai has been experiencing mood swings for several years.

- They have not yet sought professional mental health treatment.

- Symptoms have been progressively getting worse.

- Episodes occur multiple times a day.

- Strong negative impact on daily life, relationships, and work.

- Kai frequently feels empty and struggles with self-identity.

"It's been years, and it's only getting worse. I can’t count the number of times I’ve felt this way every day."

Systemic Symptoms:

- Intermittent moments of feeling empty or lacking self-identity

- Occasional episodes of anger that are difficult to control

- No reported significant weight change, unexplained fevers, or night sweats

Past Medical History:

- No significant medical history reported.

- No past hospitalizations or surgeries.

Psychiatric history: Kai has experienced mood swings and emotional instability for several years without seeking professional psychiatric help.

"I've felt this up-and-down for a long time, but I’ve never talked to a psychiatrist about it."

Risk assessment: Kai has engaged in impulsive behavior in the past but denies current suicidal ideation or self-harm. An assessment of protective factors and current stressors is important.

"Sure, I've done some reckless stuff when I felt desperate. I don't want to hurt myself, though - I'm more scared of being left alone."

Forensic history: No reported legal issues or encounters with law enforcement.

"I've never been in trouble with the law or anything like that."

Drug History:

- Kai does not take any prescription medications.

- They occasionally use over-the-counter pain relievers.

"Never been on any meds. I use ibuprofen sometimes for headaches."

Allergies:

- Kai reports no known allergies.

"No allergies that I'm aware of."

Family History:

- Kai is not aware of any mental health issues in their family.

"As far as I know, there's nothing like this in my family history."

Social History:

Smoking: Non-smoker

"Smoking? No, I never picked up that habit."

Alcohol: Social drinker, approximately 4 units per week

"I only drink socially, not more than a glass or two in one sitting."

Recreational Drug Use: Denies any recreational drug use

"Drugs? No, never been my thing."

Diet: Kai tries to maintain a balanced diet.

"I try to eat healthy, you know, balance everything out."

Exercise: Regular exercise, attends gym three times a week.

"I hit the gym regularly, about three times a week."

- Kai has a small network of close friends and values these relationships highly. The fear of losing them can lead to intense emotional reactions.

"Sometimes I freak out at the thought of losing my friends, even if there's no real reason to worry."

Ideas, Concerns, and Expectations:

Kai has read about borderline personality disorder and believes they might have it.

They are concerned about how it could affect their future relationships and work.

Kai expects to get professional help and possibly therapy to manage their symptoms.

"I've heard of borderline personality disorder, and it kind of clicks, you know? I just really need help dealing with all of this."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: On room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 75

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7

NEWS Total Score: 0

(No additional points scored as all observations are within normal ranges.)

Physical Examination:

- General examination does not reveal any acute distress or physical abnormalities.

- Focused mental health assessment needed.

Diagnostic Tests:

- Kai's presentation does not require immediate medical testing.

- Referral to mental health specialists for diagnostic interviews and psychological assessments may be indicated.

Condition:

Borderline personality disorder

Patient Questions:

- "How common is borderline personality disorder, and why haven't I been diagnosed before?"

"Borderline personality disorder is fairly common, affecting about 1-2% of the population. It can sometimes be challenging to diagnose due to overlap with other mental health conditions."

- "Are there any treatments available, and what if they don't work for me?"

"There are several treatments available including psychotherapy like dialectical behavior therapy, and sometimes medications. Everyone's response to treatment is different, and we will work closely to find the best approach for you."

- "Will I have to deal with this for the rest of my life?"

"Borderline personality disorder can be a long-term condition, but with appropriate treatment, many people see significant improvement in their symptoms over time."

Examiner Questions:

- "What symptoms are commonly associated with borderline personality disorder?"

"Symptoms include emotional instability, fear of abandonment, feelings of emptiness, and difficulties in relationships."

- "Why might a general practitioner refer a patient to a mental health specialist in this case?"

"A referral may be necessary for specialized diagnostic assessment, psychotherapy, and ongoing management of borderline personality disorder."

- "What evidence-based psychotherapies are recommended for borderline personality disorder?"

"Dialectical behavior therapy (DBT), cognitive-behavioral therapy (CBT), and schema-focused therapy are commonly recommended."

- "How can you differentiate borderline personality disorder from bipolar disorder?"

"While both can present with mood instability, bipolar disorder typically has distinct manic or hypomanic episodes, whereas borderline personality disorder features chronic instability in relationships and self-image."

- "What is the role of pharmacotherapy in the treatment of borderline personality disorder?"

"Medications are not the first-line treatment but can be used to manage specific symptoms such as mood swings, depression, or anxiety."

Treatment:

- Referral to mental health services for comprehensive assessment.

- Consideration of psychotherapeutic interventions such as dialectical behavior therapy (DBT) or cognitive-behavioral therapy (CBT).

- Short-term pharmacotherapy may be considered for symptom management, such as SSRIs for depressive symptoms or mood stabilizers for mood swings.

Monitoring:

Kai should be monitored for engagement in therapy and response to any prescribed medications. Regular follow-ups with the general practitioner and/or mental health specialist should be scheduled. Any worsening of symptoms or crisis should prompt immediate medical attention.

Prognosis:

With appropriate psychotherapy and sometimes medication, many individuals with borderline personality disorder experience significant improvements. Factors such as support systems, insight, and adherence to treatment will influence prognosis.

Differential diagnoses:

1. Bipolar disorder - Less likely due to the absence of distinct manic episodes.

2. Major depressive disorder - Does not fully account for the chronic pattern of interpersonal issues.

3. Post-traumatic stress disorder (PTSD) - May share symptoms but typically has a history of trauma and distinct re-experiencing symptoms.

Speciality Filter:

Mental Health;

Presenting Complaint Filter:

Mood Swings; Fear of Abandonment;

Condition Filter:

Borderline Personality Disorder;

Location Filter:

General Practice Clinic;

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_23\_PTSD

Homepage Vignette:

## A 38-year-old individual named Zi Chen presents with vivid flashbacks and avoidance behavior after a traumatic event.

Individual Page Vignette:

You are a general practitioner. Your patient, Zi Chen, a 38-year-old software developer, arrives at your clinic complaining of vivid flashbacks and avoidance behavior following a traumatic event.

Patient Name: Zi Chen (pronunciation: Zee Chen), prefers to be called Chen.

Age: 24/07/1985

Location: General Practice

Personality: Chen is articulate and analytical, often approaching conversations with precision. Preference for direct communication, occasionally seeming aloof but generally cooperative.

Presenting Complaint:

"I can't seem to get the images out of my head, and I go out of my way to avoid anything that reminds me of that day."

History of Presenting Complaint (extended):

- Onset correlated with the traumatic event.

- Presence of re-experiencing symptoms such as flashbacks and nightmares.

- Avoidance of reminders and triggers related to the trauma.

- Negative alterations in cognition and mood, possibly experiencing memory issues or distorted beliefs about oneself or others.

- Marked alterations in arousal and reactivity, with symptoms like hypervigilance and an exaggerated startle response.

- Details regarding the traumatic event, including personal involvement, response at the time, and subsequent changes in perception and behavior.

- Adherence to recommended therapeutic activities, if any were previously advised.

- Impact on ADLs: avoidance of social events and difficulty maintaining normal work routines.

- Impact on work: decreased productivity and avoidance of specific tasks.

- Mental wellbeing is significantly affected with increased anxiety.

- No auditory or visual hallucinations reported

- Negative for headaches, chest pain, shortness of breath, abdominal pain.

- Positive for insomnia, increased startle response, hypervigilance.

"Ever since that car accident, I've been having these intense nightmares. I can't even drive anymore or watch car chase scenes in movies. I keep thinking I'm back in that moment and that I’ll get hurt, even though I know it’s not real."

Psychiatric History:

- Previous episodes of psychiatric illness, treatment received, and outcomes.

- Family history of psychiatric conditions.

- Screening for symptoms of other mental health disorders, such as depression or anxiety.

- History of self-harm or suicidal thoughts, attempts, and related hospital admissions.

"No, I've never been to a psychiatrist before this. But my sister has been treated for depression, it runs in our family."

Risk Assessment:

- Current risk of harm to self, including any suicidal ideation, plans, or intent.

- Assess for risk of harm to others, including any hostile or aggressive feelings.

- Exploration of current coping mechanisms and support networks.

- Evaluation of insight and judgment regarding the need for treatment and safety.

"I get so overwhelmed by these flashbacks sometimes that I start thinking I can't live like this. But I wouldn't do anything, I know I need help."

Forensic History:

- Any history of legal issues or offenses. - Negative

- Involvement with law enforcement as a victim or perpetrator. - Negative

- Any other interactions with the forensic or criminal justice system. - Negative

- Consideration of the traumatic event's relationship to criminal activity or legal consequences.

"No criminal record; I've always stayed out of trouble. The accident wasn't my fault, but it did involve a court case for the damages."

"I've practically turned into a recluse, avoiding things that used to be normal for me. I'm not spiritually inclined, and there haven't been many changes except for the accident and its aftermath."

"I try to keep to myself because I feel like I'm always on high alert, and small things can trigger a memory or a sense of panic."

"I toss and turn at night and frequently wake up from nightmares. There are many nights when I wake up sweating."

Past Medical History:

- No chronic illnesses or significant health events.

- No significant previous injuries or traumas other than the recent traumatic event.

- Not currently on any medications.

- No known substance abuse or addiction.

- Immunizations up to date.

Drug History:

- No regular medications.

- No history of medication non-compliance.

- No use of herbal supplements or alternative therapies.

- No history of overdoses.

"I don't even take painkillers usually; I try to avoid medications if I can."

Allergies:

- No known allergies or intolerances.

"I'm lucky, I guess; I've never had a bad reaction to anything."

Family History:

- Mother with hypertension.

- Father had type 2 diabetes.

- No known family history of mental health disorders.

"My folks have the usual health issues that come with age, but nothing mental health-related as far as I know."

Social History:

Lifestyle:

- Lives alone in an urban apartment.

Occupation:

- Software developer, currently working from home.

Activities of Daily Living & Hobbies:

- Enjoys reading and coding projects, has reduced social outings significantly.

- Hobbies include playing chess and occasional hiking.

Smoking: None

Alcohol: "A glass of wine occasionally, maybe once a week."

Recreational Drug Use: None

Diet: "I'm vegetarian and try to eat healthily."

Exercise: "I used to jog regularly, but it's been hard to get out lately."

Sexual History:

"Currently single, not really interested in dating with everything going on."

Driving Status:

"I can't bring myself to drive after the accident; it's part of the avoidance."

Cultural or Religious Practices:

"I don't follow any specific traditions, though I was raised in a non-religious family."

Recent Life Events:

"The car accident was the biggest thing. Otherwise, life's been pretty uneventful."

Exposure to Hazards or New Environment:

"No exposure to anything dangerous; I work as a software developer from home, so my environment hasn't changed much."

"I've become quite a hermit, avoiding the places I used to love–like the community chess club and the local trails."

Ideas, Concerns, and Expectations:

"I've read about post-traumatic stress, but I'm hoping it's something less serious. I'm really worried I won't be able to shake this off. I just want to get back to normal, whatever that takes."

Observations:

((As no specific vital signs are given, all observations will be assumed normal until otherwise indicated within the case.))

Physical Examination:

- General: Appears anxious and alert.

- Cardiovascular: Normal rate and rhythm, no murmurs.

- Respiratory: Clear to auscultation bilaterally.

- Abdominal: Soft, non-tender, no masses palpated.

- Neurological: Alert and oriented, no focal deficits.

Special Tests:

- No special tests indicated at initial assessment.

Diagnostic Tests:

- No diagnostic tests are indicated at initial general practice assessment for PTSD.

Condition:

Post-Traumatic Stress Disorder (PTSD)

Patient Questions:

1. "Is what I'm going through normal?"

- "Experiencing such symptoms after a traumatic event can be a common response, but it's important to address them so they don't become more severe."

2. "Will I need medication for this?"

- "Treatment is personalized, and it may include therapy, medications, or a combination. We'll discuss what's best for your situation."

3. "How long will it take for me to feel better?"

- "Recovery can vary for each person, but with proper treatment, many people find significant improvement within a few months."

Examiner Questions:

1. What are the diagnostic criteria for PTSD?

- "PTSD is diagnosed when a patient experiences symptoms such as flashbacks, nightmares, avoidance, mood changes, and increased reactivity for more than a month following a traumatic event."

2. Which first-line treatments are recommended for PTSD?

- "Cognitive Behavioral Therapy (CBT), specifically trauma-focused CBT, and Eye Movement Desensitization and Reprocessing (EMDR) are considered first-line treatments for PTSD."

3. What pharmacotherapy can be considered for PTSD?

- "Selective Serotonin Reuptake Inhibitors (SSRIs) like sertraline and paroxetine are commonly prescribed for PTSD."

4. How would you monitor a patient's progress with PTSD treatment?

- "Progress can be monitored through regular follow-up appointments, evaluation of symptom severity, and assessment of impact on daily functioning."

5. What factors can influence the prognosis of PTSD?

- "Factors include the severity of the traumatic event, the presence of a support system, co-occurring mental health conditions, and the patient's engagement with treatment."

Treatment:

- Referral for cognitive-behavioral therapy, specifically trauma-focused CBT.

- Consider Eye Movement Desensitization and Reprocessing (EMDR) if available and appropriate.

- For pharmacotherapy, consider SSRIs like sertraline (50-200 mg daily) or paroxetine (20-50 mg daily).

- If an SSRI is not tolerated or ineffective, consider alternative antidepressants such as venlafaxine or mirtazapine.

Monitoring:

- Schedule regular follow-up appointments to monitor symptom severity and treatment adherence.

- Adjust treatment plan based on the patient's response and any side effects experienced.

- Consider psychiatric referral if symptoms are severe or do not improve with initial treatment.

Prognosis:

- Prognosis for PTSD varies; many individuals respond favorably to therapy and/or medication.

- Early intervention generally leads to a better prognosis.

- Chronic symptoms may persist for some individuals, requiring longer-term management.

Differential diagnoses:

1. Generalized Anxiety Disorder (less likely due to the presence of trauma-specific symptoms like flashbacks).

2. Major Depressive Disorder (less likely without dominant symptoms of depressed mood or anhedonia).

3. Acute Stress Disorder (less likely as symptoms have been present for several months, beyond the acute phase).

4. Adjustment Disorder (less likely due to the severity and duration of symptoms).

Specialty Filter:

Mental Health

Presenting Complaint Filter:

Vivid Flashbacks; Avoidance Behavior

Condition Filter:

Post-Traumatic Stress Disorder

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_24\_Visual hallucinations

Homepage Vignette:

## A 70-year-old individual called Morgan presents with visual hallucinations.

Individual Page Vignette:

You are a General Practitioner. Morgan, a 70-year-old retired teacher, has come to your clinic complaining of recent episodes of visual hallucinations.

Patient Name: Morgan Taylor, prefers to be called Morgan. [Pronunciation: MOR-guhn TAY-lur]

Age: 19/06/1948

Location: General Practice

Personality: Morgan is a retired educator, articulate, and accustomed to speaking in an organized manner. They value clear communication and are attentive to details when describing their experiences.

Presenting Complaint:

"I've been seeing things that aren't really there, and it's starting to worry me."

History of the Presenting Complaint:

- Morgan has been experiencing visual hallucinations for several weeks.

- They have not sought any previous treatments for these hallucinations.

- The frequency of hallucinations varies but tends to occur multiple times throughout the day.

- These episodes have caused concern but have not significantly impacted Morgan's daily routines.

- No associated auditory hallucinations, thought insertion or broadcasting.

- No low mood, lack of interest in activities.

- No vivid flashbacks, history of trauma, or nightmares.

- Is eating and drinking regularly, no impact on sleep.

- No effect on work as Morgan is retired.

- An underlying worry about the potential implications on mental health is present.

"The episodes started out of the blue a few weeks ago. They haven't gotten worse, but they aren't getting better either."

Risk Assessment:

- No current suicidal ideation or intent.

- No history of self-harm or harm to others.

- No reported feelings of hopelessness or despair.

- Denies any recent significant stressors or triggers.

"The thought of hurting myself or anyone else has never crossed my mind. I just want to make sure these visions aren't dangerous."

Forensic History:

- No history of criminal activity or legal issues.

- No history of violent behavior.

- No involvement with the criminal justice system.

"I've never been in trouble with the law, and I don't have any history of violence."

Systemic Symptoms:

- No reports of fatigue, fever, night sweats, unintended weight loss, or generalised weakness.

- Normal bowel and urinary habits.

- Sleep patterns and appetite remain unchanged.

- No report of peripheral oedema.

"My sleep is fine, and I don't feel tired or weak. I've had no weight loss, no night sweats, nothing like that."

Past Medical History:

- Managed hypertension for the past 10 years.

- Underwent cataract surgery 5 years ago.

- No history of substance abuse or addiction.

- Up-to-date with age-appropriate vaccinations.

"I have high blood pressure, but I keep it under control. Other than that, just the usual health issues that come with age, like when I had my cataracts removed."

Psychiatric History:

- No known personal history of psychiatric illness.

- No previous psychiatric hospitalizations or outpatient treatments.

- No history of psychosis or mood disorders.

- Mental well-being has been stable throughout life.

"I've never needed help for my mental health before; this is the first time I am dealing with such a peculiar issue."

Drug History:

- Amlodipine 5mg once daily for hypertension.

- No history of medication non-compliance or missed doses.

- No use of herbal supplements or alternative therapies.

- Currently not taking any OTC medications.

"I'm on a blood pressure pill, amlodipine, I think it's called. I take it every morning without fail."

Allergies:

- No known allergies or intolerances.

"I've never had a problem with allergies, thankfully."

Family History:

- Mother had Alzheimer's disease.

- Father had a history of atrial fibrillation.

- No known family history of hallucinations or psychiatric disorders.

"My mother had Alzheimer's later in life. My father had some heart rhythm issue. Nothing like what I'm experiencing now, though."

Social History:

Lifestyle:

- Leads a quiet, retired life.

Occupation:

- Retired school teacher.

Activities of Daily Living & Hobbies:

- Enjoys reading, taking daily walks, and gardening.

Smoking: Non-smoker.

Alcohol: Drinks wine occasionally, approximately 2 units per week.

Recreational Drug Use: None.

Diet: Mediterranean-style diet.

Exercise: Walks daily for 30 minutes.

"I've never smoked. A glass of wine with dinner a couple of times a week. I like to keep active with my walks and gardening."

Travel History: "No recent travel."

Sexual History: "Not relevant at the moment."

Driving Status: "I drive, but I haven't had any episodes while behind the wheel."

Cultural or Religious Practices: "I attend church services regularly."

Recent Life Events: "Nothing significant, just enjoying my retirement."

Exposure to Hazards or New Environment: "Nothing unusual, I've lived in the same house for 40 years."

"I've had a pretty stable life, no big changes recently. I keep myself busy with hobbies and occasional social outings."

Ideas, Concerns, and Expectations:

Morgan expresses concern over the new-onset visual hallucinations and their implications on cognitive health, especially given the family history of Alzheimer's. They hope the hallucinations do not suggest a decline in mental faculties or the onset of a degenerative disease. Morgan seeks clarity about the potential psychiatric interpretations and expects advice regarding a safe course of action, including whether any lifestyle adjustments are necessary.

"I hope my mind isn't slipping away with these strange visions. I would like to know if there's anything I need to start doing differently now."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98 on room air

Blood Pressure (mmHg): 135/85

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8

NEWS Total Score: 0

Physical Examination:

(Examinations will be based on general health and neurological status, including mental state and ocular examination)

Diagnostic Tests:

Blood tests and imaging such as MRI may be indicated to rule out neurological causes

Include assessment by a psychiatrist if indicated and consider the need for cognitive tests such as the Mini-Mental State Examination (MMSE) to assess cognitive function. Review current medications for potential side effects causing hallucinations

Treatment:

(Depending on underlying cause - may involve referral to neurology, adjustment in current medication, initiation of specific therapies)

Monitoring:

(Instructions for Morgan to monitor the frequency and severity of the hallucinations and to report any new or worsening symptoms)

Prognosis:

(Discussion about the potential causes of hallucinations at Morgan's age and the usual progression depending on the underlying cause)

Differential Diagnoses:

1. Charles Bonnet syndrome

2. Neurodegenerative disorders (e.g., Alzheimer's disease)

3. Medication or substance-induced hallucinations

4. Delirium

5. Psychiatric disorders (e.g., schizophrenia)

Patient Questions:

1. "Could these hallucinations be a sign I'm developing Alzheimer's like my mother?"

- "It's understandable you're concerned given your family history, but hallucinations alone aren't diagnostic of Alzheimer's. We'll need to consider other symptoms and possibly conduct more tests to understand what's happening."

2. "Are there any treatments to stop these hallucinations?"

- "Treatment will depend on the underlying cause. Sometimes, adjusting medications or treating an underlying condition can reduce or eliminate hallucinations."

3. "Should I stop driving because of these incidents?"

- "For now, continue as you are but please be cautious. If the hallucinations become more frequent or occur while you're driving, we may need to reassess."

Examiner Questions:

1. How would you conduct a psychiatric assessment in a patient presenting with hallucinations?

- "I would evaluate their mental status, inquire about mood, thought content, and any psychotic symptoms. A thorough history of the hallucinations, any associated factors, and past mental health history should be included."

2. How would you differentiate between a hallucination and a delusion?

- "Hallucinations are sensory perceptions without external stimuli, while delusions are fixed, false beliefs not based on reality."

3. How might you assess the potential for harm in a patient with hallucinations?

- "I would directly ask about any thoughts of self-harm or harm to others, consider the content of the hallucinations, and assess for associated factors like delusions or severe agitation."

4. What should be included in a risk assessment for a geriatric patient?

- "A geriatric risk assessment should include the patient's ability to independently undertake daily activities, their social support system, any cognitive decline signs, and risks for falls or accidents."

Treatment:

(Based on NICE, CKS, BMJ Best Practice, and BNF guidelines)

Speciality Filter:

General Practice; Neurosciences; Mental Health

Presenting Complaint Filter:

Visual Hallucinations

Condition Filter:

Charles Bonnet Syndrome; Visual Hallucinations

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_25\_Suicidal thoughts

Homepage Vignette:

## A 24-year-old individual called Sam Jha presents with suicidal thoughts.

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Individual Page Vignette:

You are a general practitioner, and you have a patient named Sam Jha, born 26/06/2000, a university student, who has come to your clinic reporting persistent suicidal thoughts.

Patient Name: Sam Jha (Pronunciation: Sahm Jha), prefers Sam.

Age: Born 26/06/2000

Location: Clinic

Personality: Sam is introspective and speaks in a measured, thoughtful manner. They have a background in literature, often using rich metaphors to describe feelings. Sam is articulate but shows signs of distress when discussing emotional topics.

Presenting Complaint: Sam reports experiencing persistent suicidal thoughts.

"When it gets really dark in my head, I just feel like maybe it would be easier if I wasn't around, you know?"

Symptoms:

- Persistent sadness

- Hopelessness

- Feelings of worthlessness

- Social withdrawal

- Anxiety

Site: "It's like a darkness in my mind that won't lift."

Onset: "I've been feeling down for several months, but these scary thoughts started around two weeks ago."

Character: "It's more emotional than physical, a sinking feeling, always there."

Radiation: "My anxiety sometimes feels like chest tightness, but it's all really in my head."

Associated Symptoms: "I can't concentrate anymore, and I've lost interest in things I used to love."

Timing: "It's pretty constant, some days are slightly better, but it never completely goes away."

Exacerbating and Relieving Factors: "The nights are the worst. Sometimes talking to my friend helps a bit."

Severity: "It's really intense, enough to make me think about ending things. I'd say it's pretty severe."

"I barely eat these days, I'm just not hungry... and sleep, what's that? I toss and turn every night."

History of Presenting Complaint:

- Symptoms started several months ago: "I've been feeling down for several months, but these scary thoughts started around two weeks ago."

"It's more emotional than physical, a sinking feeling, always there."

- Lack of appetite, disturbed sleep

- Decreased energy levels

- Difficulty concentrating: "I can't concentrate anymore, and I've lost interest in things I used to love."

- Symptoms have progressively become worse.

- Experiencing thoughts daily.

- Impact on daily life is significant, making academics and social life very difficult.

- Impact on work is severe, affecting grades and attendance.

- Mental wellbeing severely affected with suicidal ideation.

"Reading and writing, which I love, have become just impossible tasks. I can't focus, let alone keep up with my studies."

Risk Assessment:

- Suicidal ideation

- No previous treatments attempted or history of self-harm

- No active plan for suicide, reports no advanced directives (will, letter)

Systemic Symptoms:

- Fatigue

- General malaise

- Altered bowel habits

- Altered sleep patterns

- Weight loss due to decreased appetite

"All I do is stay in bed. I feel so tired but then sleep never comes, and I've noticed my jeans getting loose."

Past Medical History:

- No significant previous medical history.

- No known surgeries or hospitalizations.

- No psychiatric history formally diagnosed.

- No history of substance abuse or addiction.

"I've never had to deal with anything like this before. I'm usually the organized one."

Drug History:

- Not on any medications currently.

- No known history of medication non-compliance.

- Not using any over-the-counter or herbal supplements.

"No pills or supplements. I thought about getting sleeping pills, but never actually did."

Allergies:

- No known allergies or intolerances to medications, foods, or environmental factors.

"Nope, no allergies that I know of."

Family History:

- Mother with a history of depression.

- Father with hypertension.

- No other significant family medical history.

"My mom went through a tough time, mental health-wise, a few years back."

Social History:

Lifestyle: University student, sedentary lifestyle.

Occupation: Part-time library assistant.

Activities of Daily Living & Hobbies: Enjoys reading and writing, but currently not engaging in hobbies due to symptoms.

"I used to love going out with friends, to readings and open mics, but now I just can't find the energy."

Smoking: Non-smoker.

Alcohol: Infrequent alcohol use, less than 2 units per week.

Recreational Drug Use: No history of recreational drug use.

Diet: Previously balanced, but currently poor due to appetite loss.

Driving Status: Non-driver.

Cultural or Religious Practices: Engages in cultural literary events.

Recent Life Events: Increased academic pressure.

Exposure to Hazards: No recent exposure.

"My world has become these four walls, and my laptop screen is my only window out."

Ideas, Concerns, and Expectations:

Ideas: "Maybe I have what my mom had, depression or something?"

Concerns: "I'm really scared that one of these days, I might actually do something... to myself."

Expectations: "I don't know what you can do, but I hope there's a way to make these thoughts stop."

"I remember mom going through this, and she got help... is that what's happening to me now?"

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 120/80

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8

NEWS Total Score: 0

Physical Examination:

- General appearance of fatigue.

- No acute distress.

- Vital signs within normal limits.

Special Tests: N/A

Diagnostic Tests:

Mental Health Assessment:

- Beck Depression Inventory (BDI).

- Hamilton Depression Rating Scale (HDRS).

Condition: Suicidal thoughts

Patient Questions:

- "What does it mean if I am diagnosed with depression?"

- "Depression is a treatable medical condition characterized by persistent feelings of sadness, loss of interest, and other emotional and physical symptoms."

- "Can you tell me what kind of treatments are available?"

- "Treatments include medication, such as antidepressants, and talking therapies, like cognitive behavioral therapy. A combination is often most effective."

- "Is there anything I should be doing on my own to feel better?"

- "Staying connected with friends and family, maintaining a routine, and regular exercise can help, but it's crucial to seek professional help."

Examiner Questions:

1. What are the red flags in this patient's history that indicate an immediate need for intervention?

- "Red flags include suicidal ideation, significant changes in mood and behavior, and depression in family history."

2. How would you assess the risk of suicide in this patient?

- "Assessing the risk involves exploring the patient's thoughts, specific plans, means, and intent of suicide, as well as any previous attempts."

3. What are the criteria for diagnosing major depressive disorder?

- "The criteria include experiencing five or more symptoms during the same 2-week period, at least one of which should be either (1) depressed mood or (2) loss of interest or pleasure."

4. What is the role of the biopsychosocial model in managing this patient?

- "The biopsychosocial model helps us understand how biological factors, psychological state, and social environment all play a role in the patient's mental health, and guides a comprehensive treatment approach."

5. What factors would you consider before prescribing antidepressants to this patient?

- "Factors include severity of symptoms, past medical history, potential side effects, patient preference, and any contraindications to medication."

Treatment:

- Immediate risk assessment for safety and hospitalization if required.

- Psychiatrist referral for urgent evaluation.

- Initiate antidepressant therapy (e.g., selective serotonin reuptake inhibitors (SSRIs)) under the guidance of mental health professionals, with monitoring for side effects.

- Initiate talking therapy, such as cognitive behavioral therapy (CBT) or psychotherapy.

- Consideration of adjunctive medications for insomnia or anxiety if needed.

Monitoring:

- Regular follow-up visits to monitor medication efficacy and side effects.

- Regular mental health evaluations to assess response to therapy and adjust treatment as needed.

- Monitoring for emergence of any suicidal thoughts or behaviors, particularly in the early stages of treatment or during dose changes.

- Psychoeducation about recognizing warning signs and having a plan for seeking help in emergencies.

Prognosis:

- With proper treatment, many individuals with depression see a significant improvement in symptoms.

- Protracted treatment and repeated assessments may be necessary to find the most effective medication and therapy combination.

- Prognosis may vary based on the individual's response to treatment, support system, and adherence to the treatment plan.

Differential diagnoses:

1. Severe depression

2. Bipolar disorder - ruled out due to the lack of manic or hypomanic episodes.

3. Substance-induced mood disorder - no substance use reported.

4. Thyroid disorders - would need blood tests to rule out but less likely given presentation and absence of physical symptoms.

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Speciality Filter: Mental Health; General Practice;

Presenting Complaint Filter: Suicidal Thoughts; Low Mood; Depression;

Condition Filter: Suicidal Thoughts;

Location Filter: Clinic

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_26\_Specific phobia

Homepage Vignette:

## A 28-year-old individual named Taran Ngozi presents with an intense, irrational fear of heights.

Individual Page Vignette:

You are a General Practice Doctor examining Taran Ngozi, a 28-year-old office administrator, at your clinic. Taran has come in today reporting a crippling fear of heights that is impacting daily functioning.

Patient Name:

Taran Ngozi (Pronunciation: Tah-ran N-goh-zee), prefers to be called Taran.

Age:

DOB: 14/07/1996

Location:

General Practice Clinic

Personality:

Taran is noticeably tense and has a habit of speaking quickly when anxious. Taran is well-spoken and expressive about feelings and experiences.

Presenting Complaint:

"I just can't seem to shake this overwhelming terror whenever I'm anywhere high up. It's starting to interfere with my life."

Symptoms:

- Intense fear specifically related to heights

- Avoidance of situations involving heights

History of Presenting Complaint:

- Symptoms since childhood, worsening over the past year

- "It happens every time I'm at a height, even thinking about it can trigger the feelings."

- "I get dizzy, sweaty, my heart races, and sometimes I feel like I'm about to pass out."

- No previous treatments attempted

- Avoids situations involving heights whenever possible

- Daily life increasingly impacted due to avoidance

- Reports no generalised anxiety or excessive worrying

- No obsessive thoughts or compulsions to alleviate anxieties

- No fixed and firmly held beliefs

- No visual or auditory hallucinations

"I always hated being up high, even as a kid. Lately, though, it's just impossible to deal with."

Systemic Symptoms:

- No reported fatigue, fever, night sweats, or unintended weight loss

- No change in general physical functioning aside from anxiety-related symptoms

"All that's really wrong is this fear. Otherwise, I'm healthy."

Past Medical History:

- No significant past medical history

- No known surgeries or hospitalizations

Risk Assessment:

- Risk to self: Taran does not exhibit any suicidal ideation or intent.

- Risk to others: No history or indication of harm to others.

- Risk from others: No reports of feeling unsafe or at risk from others.

- Risk of neglect: Taran is maintaining self-care and daily responsibilities.

- Risk of vulnerability: There is an increased risk of avoidance of situations that might cause distress due to the phobia.

Quote:

- "I've never thought about hurting myself or anything like that. It's just this fear that I want to deal with."

- "I don't have any problems with other people; I'm not a threat or anything."

- "I feel safe where I am, just not when I have to be high up."

- "I've been keeping up with my work and personal care, so no worries there."

- "I do find myself avoiding certain things more and more, like visiting friends in their high-rise apartments."

Psychiatric History:

- No history of hospitalization for mental health issues

- Denies any past or current use of psychiatric medications

- No known history of counseling or therapy

Drug History:

- Occasionally uses over-the-counter analgesics for headaches

- No history of medication non-compliance or overdose incidents

"Just the odd ibuprofen for a headache now and then is all I take."

Allergies:

- No known allergies

"I'm lucky, I guess. No allergies that I know of."

Family History:

- Unknown medical history of biological family (adopted)

"I don't really have any info on my biological family's health history."

Social History:

Lifestyle: Office Administrator

Occupation: Currently working from home due to fear impacting commute across a bridge

Activities of Daily Living & Hobbies: Enjoys reading and video gaming indoors

Smoking: (pack years: 0) Non-smoker

Alcohol: (<1 unit/week) Drinks socially, very rarely

Recreational Drug Use: None

Diet: Balanced diet

Exercise: Moderate exercise, mostly indoors

"I work from home mostly, which is nice but also kind of a result of this whole situation. In my free time, I'm usually gaming or with a book."

"I've pretty much stuck to ground level my whole life, and I'm not seeing anyone right now."

Ideas, Concerns, and Expectations:

"I guess I'm mostly worried that this'll limit me for the rest of my life. I'm hoping there's some way to treat this, so I can live normally without having these panic attacks."

Observations:

Respirations (Breaths/min): 18

Oxygen Saturation (%): 98% on room air

Air or Oxygen?: Room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 82

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8°C

NEWS Total Score: 0

Physical Examination:

General examination is unremarkable with no signs of acute distress while at ground level.

Special Tests:

Not applicable for specific phobia diagnosis.

Diagnostic Tests:

Not indicated for specific phobia diagnosis.

Condition:

Specific phobia

Patient Questions:

"Why can't I just shake this fear off like normal fears?"

- "Fear reactions can be complex, especially phobias. They are not a sign of weakness, and with the right treatment, we can work on managing and potentially overcoming them."

"How is talking to a therapist going to help me with my fear of heights?"

- "Therapists can use various techniques, like cognitive-behavioral therapy, to address the root cause of your fear and teach you coping strategies."

"Do I have to face my fear directly, because that sounds terrifying?"

- "Exposure therapy is one method that involves gradual exposure under controlled conditions, but we'll take it one step at a time based on what you're comfortable with."

Examiner Questions:

1. Can you describe how you would differentiate between a specific phobia and other anxiety disorders?

- "Specific phobias are characterized by an intense, irrational fear of a particular object or situation that is clearly avoidable, whereas other anxiety disorders, such as generalized anxiety disorder, involve a more diffuse anxiety."

2. What are the main criteria for diagnosing a specific phobia in a patient?

- "The primary criteria include a marked and persistent fear that is excessive or unreasonable, instant anxiety upon exposure to the fearful stimulus, recognition that the fear is excessive, and significant impairment in normal routine."

3. Which therapy modality is considered first-line for specific phobias?

- "Cognitive-behavioral therapy (CBT) is often the first line of treatment for specific phobias, particularly because of its effectiveness in changing thought patterns and behaviors."

4. When should pharmacotherapy be considered in the treatment of specific phobias?

- "Pharmacotherapy is usually considered if CBT alone is insufficient, or if the patient has comorbid conditions like generalized anxiety or depression that also need treatment."

5. How would you address a patient's reluctance to engage in exposure therapy for their phobia?

- "I would explore the patient's fears and concerns, provide education on the gradual nature and effectiveness of exposure therapy, and ensure their consent and comfort in each step of treatment."

Treatment:

- Cognitive-Behavioral Therapy (CBT) as the first-line treatment.

- Consider relaxational strategies, biofeedback, or hypnotherapy.

- Short-term use of benzodiazepines or SSRIs for severe anxiety related to exposure.

- Referral to a psychologist for structured desensitization and exposure therapy.

Monitoring:

- Regular follow-up appointments to evaluate progress with CBT and any pharmacotherapy.

- Monitor for treatment adherence and response, adjusting the plan as necessary.

- Refer to a mental health specialist if no improvement is seen or if the phobia worsens.

Prognosis:

- With appropriate CBT and possible exposure therapy, the prognosis for specific phobias is generally good.

- Patient motivation and adherence to therapy play a significant role in treatment success.

- Duration and complexity of the phobia may affect the treatment timeline.

Differential diagnoses:

1. Panic Disorder: Less likely due to the absence of recurrent unexpected panic attacks.

2. Agoraphobia: Less likely as the fear is specific to heights rather than open spaces or leaving home.

3. Generalized Anxiety Disorder: Less likely given the situational nature of the fear.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Fear of heights; Intense, irrational fear related to heights; Avoidance of situations involving heights.

Condition Filter:

Specific Phobia

Location Filter:

General Practice

Case created by:

NAME, Medical Student

Reviewed by:

NAME, Medical Student

Reviewed by:

NAME, Medical Student/Doctor

# DS\_27\_Nightmares

Homepage Vignette:

## A 28-year-old individual called Avery presents with recurrent nightmares.

Individual Page Vignette:

You are the General Practitioner evaluating Avery, a 28-year-old librarian, who has come to your clinic concerned about chronic nightmares disrupting their sleep.

Patient Name: Avery Kuznetsov (Pronunciation: AY-və-ree Kooz-NET-sov); Avery prefers to be called by their first name.

Age: 14/06/1995

Location: General Practice

Personality: Avery is an introverted and thoughtful person with a soft-spoken demeanor. They choose their words carefully and exhibit a respectful attitude towards others.

Presenting Complaint:

"I've been having really bad dreams almost every night, and they're starting to affect my day."

Symptoms:

- Nightmares that cause distress or anxiety

- Difficulty falling back to sleep after waking up from a nightmare

Avery reports no additional significant symptoms like changes in appetite, weight fluctuations, mood disturbances, physical pains or aches, or changes in their daily routine.

History of Presenting Complaint:

- Symptoms have been present for several months

-"Sometimes I wake up sweating, and my heart is pounding."

-Onset: "Almost every night, especially in the early morning hours."

- No treatments attempted

- Symptoms are consistent and frequent

- No history of trauma or vivid flashbacks

- No low mood, loss of interest in activities, feelings of guilt and worthlessness

- No generalised anxiety or excessive worrying

- The nightmares disrupt Avery's sleep and affect their mood the next day

- There has been no impact on work performance yet, but Avery is concerned it could start affecting them if it continues

"There are times when I dread going to bed, knowing that I'll probably end up waking from a nightmare."

Systemic Symptoms:

Avery denies experiencing any systemic symptoms such as fatigue, fever, night sweats (unrelated to nightmares), unintended weight loss, or generalized weakness.

Past Medical History:

- No history of chronic medical conditions

- No previous surgeries or hospitalizations

- No psychiatric or psychological history

- Avery has never smoked, used illicit substances, or had issues with alcohol

- Up to date with immunizations and vaccinations

Psychiatric History:

- Avery reports no history of mental health disorders, no prior diagnosis or treatment for psychiatric conditions.

- There have been no periods of increased stress, anxiety, or depression beyond normal day-to-day experiences.

Risk Assessment:

- Avery denies any current or past thoughts of self-harm or suicide.

- There is no evidence of risk-taking behaviors or substance misuse that could contribute to psychiatric conditions or affect safety.

- Avery lives in a stable home environment and has a supportive social network.

- Avery reports feeling safe at home and in their community.

Drug History:

- Occasional use of non-prescription ibuprofen for headaches, 400mg as needed.

Allergies:

Avery denies any known allergies to medications, foods, or environmental factors.

Family History:

No known family history of sleep disorders or significant medical conditions.

Social History:

- Avery leads a sedentary lifestyle

- Occupation: Librarian

- Hobbies include reading, writing, and playing board games

- No smoking history

- Drinks alcohol socially, about 2 units per week

- Uses no recreational drugs

- Diet is balanced and varied

- Limited physical activity

Ideas, Concerns, and Expectations:

"I've read online that stress can cause nightmares; maybe that's what's going on? I'm worried that there's something else behind these dreams, or that they'll never stop. I'm hoping you can help me find a way to get better sleep."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 120/80

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.5

NEWS Total Score: 0 (All observations within normal ranges)

Physical Examination:

General physical and neurological examinations are within normal limits.

Diagnostic Tests:

Polysomnography (sleep study) may be considered if treatment is ineffective or if there's the suspicion of a sleep disorder.

Condition:

Nightmares

Patient Questions:

"Why do I keep having these nightmares?"

- "There can be many reasons for nightmares, including stress, anxiety, and sleep disruption. We will look into it further if necessary."

"Do you think I need medication?"

- "We can consider options for stress reduction and improving sleep hygiene first. If those aren't effective, we could look into other treatments, including medications."

"Could this be something serious?"

- "Most of the time, nightmares are not a sign of something more serious. However, we'll monitor your situation closely and take appropriate steps if needed."

Examiner Questions:

1. What lifestyle changes would you recommend to Avery to help with their nightmares?

- "I'd recommend practicing good sleep hygiene, reducing stress through relaxation techniques or therapy, and maintaining a regular sleep schedule."

2. What could be the underlying causes of Avery's nightmares?

- "Potential causes could include stress, anxiety disorders, sleep deprivation, or certain medications."

3. When would you consider referring Avery to a specialist?

- "If there's no improvement with initial management or if Avery exhibits signs of a sleep disorder such as sleep apnea or narcolepsy."

4. What are some potential adverse effects of sleep deprivation?

- "They include cognitive impairment, mood disturbances, and increased risk of cardiovascular disease."

5. How would you differentiate between nightmares and night terrors?

- "Nightmares usually occur during REM sleep and are often remembered, while night terrors happen during non-REM sleep and aren't typically recalled."

Treatment:

- Reassure Avery that nightmares are common and can be managed.

- Advise on sleep hygiene practices: maintaining a regular sleep schedule, making the bedroom comfortable and free from distractions, avoiding stimulants before bed.

- Consider cognitive-behavioral therapy (CBT) for stress and potential anxiety contributing to the nightmares.

- If nightmares persist, medications such as prazosin might be considered under specialist advice.

Monitoring:

Instruct Avery to maintain a sleep diary to monitor the frequency and severity of nightmares. Follow-up appointment in 4-6 weeks to assess the effectiveness of sleep hygiene improvements and consider referral to a sleep specialist if no progress is made.

Prognosis:

With appropriate lifestyle changes and potentially CBT, many individuals see an improvement in the frequency and intensity of nightmares. The prognosis is generally good, but the condition can be chronic if underlying issues like stress or anxiety are not addressed.

Differential diagnoses:

1. Stress-related disorders: Less likely due to the lack of other stress markers in Avery's life.

2. Sleep apnea: No reported symptoms of snoring, daytime sleepiness, or pauses in breathing during sleep.

3. Medication side-effects: Avery is not currently taking any medications known to cause nightmares.

4. Substance abuse: Avery reports no substance abuse.

5. Mood disorders: No reported mood disturbances.

Speciality Filter: Mental Health; General Practice

Presenting Complaint Filter: Sleep Disturbance; Psychological Disorder

Condition Filter: Nightmares

Case Created by: John Doe, Medical Student

Reviewed by: Jane Smith, Medical Student

Reviewed by: Alex Taylor, Medical Student/Doctor

# DS\_28\_Alzheimer’s Dementia

Homepage Vignette:

## A 72-year-old woman called Seo-yun presents with memory loss.

Individual Page Vignette:

You are a General Practitioner. Your patient, Seo-yun, a 72-year-old retired librarian, presents to your clinic complaining of progressive memory loss and difficulty performing daily tasks.

Patient Name:

Seo-yun Park (Pronunciation: SUH-yuhn PAHRK); She prefers being called Seo-yun.

Age:

Birthday: 15/06/1952

Location:

General Practice Clinic

Personality:

Seo-yun is a methodical and articulate individual, displaying an engaging warmth in conversation. She takes great pride in her attention to detail, acquired from her many years as a librarian, and she speaks in clear, measured sentences, often pausing to find the precise word she wants to use.

Presenting Complaint:

Seo-yun has come to the clinic because she has been experiencing progressive memory issues over the past year, which now seem to be affecting her daily activities.

"I've always prided myself on my memory and organizational skills, but lately, I've been forgetting appointments and misplacing things more often than ever."

History of Presenting Complaint:

- The memory loss has been progressive for about a year.

- No previous treatments have been attempted.

- The memory issues are becoming more frequent and severe.

- Impact on daily life includes misplacing items and missing appointments.

- Work is not applicable as she is retired, but she mentions difficulties with tasks requiring concentration and organization.

- Physical wellbeing has not been notably impacted but she mentions increasing mental strain.

"I thought it would just pass, but it's been a year and it's getting harder to manage my own affairs."

Systemic Symptoms:

- Fatigue: Occasionally feels more tired than usual but attributes it to age.

"I suppose I get tired more easily, but isn't that normal for someone my age?"

- Fever: Negative

- Night Sweats: Negative

- Unintended weight loss: Negative

- Generalized weakness: Has not experienced any notable weakness.

- Malaise: Occasionally feels less motivated.

"There are days I just don't feel like myself, less motivated to start the day."

- Bowel habits: Normal

- Urinary habits: Normal

- Changes in sleep patterns: Experiencing some difficulty sleeping.

"Lately, I find myself waking up at night. My mind just won't settle down."

- Peripheral oedema: Negative

Past Medical History:

- Hypertension, controlled with medication.

- No surgical history.

- Complete immunizations including a flu vaccine annually.

"I've never been one to neglect my health, I've got my blood pressure under control and never miss my flu shot."

Psychiatric History:

- Mood and Affect: Seo-yun denies any history of significant mood disturbances but admits to feeling more anxious lately about her memory: "I've never had any sort of depression, but this memory thing does have me feeling a bit on edge."

- Psychotic Symptoms: There is no history of hallucinations or delusions.

- Cognitive Changes: Progressive memory loss, with difficulty concentrating and some executive dysfunction.

"It's the memory loss that's worrying me, not just day-to-day, but sometimes I second-guess if things happened at all."

- Suicidal Ideation: Seo-yun denies any thoughts of self-harm or suicide.

"No, no, I've never thought about hurting myself. I just want to understand what's happening to me."

- Past Psychiatric Treatment: None reported.

Drug History:

- Amlodipine 5mg once daily for hypertension.

"Just my blood pressure pill every morning. Never miss it."

- Occasional over-the-counter pain relievers for headaches.

"Sometimes I take a painkiller if I have a headache, but that's rare."

Allergies:

- Penicillin causes a rash.

"I avoid penicillin ever since it gave me a rash years ago."

Family History:

- Mother had Alzheimer's disease.

"My mother went through something similar, I believe. It was Alzheimer's for her."

- Father had a history of coronary artery disease.

- No siblings.

Social History:

Lifestyle:

- Enjoys reading and gardening.

Occupation:

- Retired librarian.

Activities of Daily Living & Hobbies:

- She lives alone and is largely independent but admits that her hobbies and daily activities are becoming more challenging.

Smoking: Non-smoker.

Alcohol: Occasional glass of wine with dinner.

Recreational Drug Use: None.

Diet: Balanced diet, mainly home-cooked meals.

Exercise: Walks daily in the park.

"I've always loved a good book and tending to my garden. A glass of wine at dinner, that's my only indulgence."

Ideas, Concerns, and Expectations:

- Ideas: Worried it might be Alzheimer's, acknowledges family history.

"With my mother's history, I can't help but wonder if I'm headed down the same path."

- Concerns: Fear of becoming dependent and loss of independence.

"I am terrified of the day I might not be able to look after myself."

- Expectations: Hopes for an assessment and guidance on how to manage her symptoms and maintain independence.

"I hope you can tell me what's going on and how to keep my independence as long as possible."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 140/85

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 36.5

NEWS Total Score: 0 (All parameters within normal range.)

Physical Examination:

- General: Alert and oriented, no distress.

- Neurological: Cranial nerves intact, no focal deficits.

- Cognitive: Mild impairment noticed on testing memory and executive function.

Special Tests:

- Mini-Mental State Examination (MMSE) indicates mild cognitive impairment.

Diagnostic Tests:

- Complete blood count, electrolytes, liver and thyroid function tests normal, vitamin B12 and folate levels within the reference range.

- Neuroimaging with CT or MRI head to assess for any structural abnormalities - pending.

Treatment:

Follow NICE guidelines for management of Alzheimer's disease:

1. Establish a working diagnosis and consider potential reversible causes of dementia.

2. Refer to a specialist for confirmation of the diagnosis as required.

3. Cholinesterase inhibitors, such as donepezil, rivastigmine, or galantamine, may be appropriate for symptom management, depending on the patient's suitability.

4. Treat any comorbid conditions and review current medications for potential cognitive impact.

5. Supportive therapies, including cognitive stimulation therapy.

If the patient is allergic to cholinesterase inhibitors or if treatment is ineffective, consider memantine.

Monitoring:

Regular follow-up appointments to assess the progression of symptoms and the efficacy of treatment. Monitoring of medication side effects and routine assessment of the need for additional support services or adjustments in living arrangements. Referral to a memory clinic or specialist services as symptoms progress.

Prognosis:

Alzheimer's disease is a progressive neurodegenerative disease with variable rates of progression. Education on the typical course of Alzheimer's and support for family and caregivers is important. Prognostic factors include age at onset, overall health, and support systems.

Differential diagnoses:

1. Age-related cognitive decline (less severe and does not typically progress to affect daily functioning).

2. Vascular dementia (often has a sudden onset or stepwise deterioration, with associated vascular risks).

3. Depression (can mimic signs of dementia but has different treatment and prognosis).

Examiner Questions:

1. What are the common diagnostic criteria for Alzheimer's disease and how do they apply to Seo-yun's case?

- Answer: The diagnostic criteria for Alzheimer's disease typically include evidence of progressive memory impairment, along with at least one other area of cognitive decline, such as language disturbance, executive dysfunction, or apraxia, that interferes with daily life activities. A medical history, cognitive tests such as the MMSE, and neuroimaging can support the diagnosis. In Seo-yun's case, there is a history of progressive memory loss, difficulty performing complex tasks, and a family history suggestive of Alzheimer's disease, aligning with these criteria.

2. How might you differentiate between Alzheimer's dementia and other possible causes of cognitive impairment in the elderly?

- Answer: Differentiating Alzheimer's dementia from other causes involves a thorough assessment including a patient's medical, psychiatric, and medication history, along with a physical and neurological examination. Cognitive testing can differentiate between normal age-related changes and pathological dementia. Neuroimaging can rule out other causes like tumors or vascular contributions to cognitive impairment. Lab tests can exclude reversible causes such as vitamin deficiencies or thyroid dysfunction. In Seo-yun's case, the slow progression and family history point more towards Alzheimer's.

3. What role do cholinesterase inhibitors play in the treatment of Alzheimer's disease, and what would be the next steps if Seo-yun does not respond to this treatment?

- Answer: Cholinesterase inhibitors work by increasing the levels of acetylcholine in the brain, thereby improving cognitive function or slowing cognitive decline in some Alzheimer’s disease patients. If Seo-yun does not respond, we could consider prescribing memantine, which works by regulating glutamate activity, or discuss non-pharmacological interventions such as cognitive stimulation therapies.

4. Explain the potential importance of discussing Power of Attorney and advance care planning in patients with Alzheimer's disease.

- Answer: Discussing Power of Attorney (POA) and advance care planning early in the disease process is important as the patient's ability to make informed decisions could deteriorate. It ensures that the patient's wishes are respected and that there is a clear decision-maker for healthcare and financial decisions when they can no longer make these decisions themselves. For Seo-yun, it would also provide peace of mind and a sense of control over her future care.

5. How would you address Seo-yun's concerns about her increasing memory loss and its impact on her independence?

- Answer: To address Seo-yun’s concerns, it's important to provide empathetic support, clear information about her condition, and discuss management strategies to maintain her independence, such as organizing daily tasks, using reminders, and ensuring she has a safe living environment. We should also discuss available community support, adult day care programs, and the potential future benefit of caregiver involvement.

6. Can you name some of the support services available for patients with Alzheimer’s disease and their families?

- Answer: Support services for Alzheimer's patients and their families include Alzheimer's associations that provide education and support groups, respite care services, home care assistance, adult day care programs, legal and financial planning assistance, and local community and charity

Treatment:

(Based on NICE, CKS, BMJ Best Practice, and BNF guidelines)

Speciality Filter:

General Practice; Neurosciences; Mental Health

Presenting Complaint Filter:

Visual Hallucinations

Condition Filter:

Charles Bonnet Syndrome; Visual Hallucinations

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_29\_Memory loss

Homepage Vignette:

## “A 70-year-old individual called Rowan presents with memory loss and confusion.”

Individual Page Vignette:

You are a General Practitioner. Rowan, a 70-year-old retired school teacher, has come to your clinic accompanied by their adult child. They express concern over Rowan’s recent episodes of forgetting conversations and appointments. It seems like Rowan has been growing more forgetful over the past six months, and it's starting to interfere with their daily life.

Patient Name: Rowan Pereira (Pronunciation: ROH-uhn Puh-RAIR-uh; prefers to be called Rowan)

Age: 23/04/1954

Location: General Practice Clinic

Personality: Rowan is a retired school teacher, articulate and usually detail-oriented. They are somewhat reserved but open up when discussing topics of interest, particularly education and literature. Recently, Rowan seems more subdued and occasionally frustrated when unable to recall certain details.

Presenting Complaint:

Rowan is concerned about their memory loss, especially since it's affecting their ability to handle daily tasks. “It’s just not like me to forget things this way,” Rowan might say.

History of Presenting Complaint:

- Has been experiencing worsening memory loss for about six months.

- No previous treatments attempted for this issue.

"Sometimes, I can't seem to get the words out, even though I know what I want to say."

- The symptoms have been progressively getting more frequent.

- Impact on daily life: forgetting appointments and misplacing items.

- Impact on work: Retired, but becomes easily fatigued during activities that require concentration.

- Impact on physical and mental wellbeing: The memory issues are starting to cause frustration and avoidance of social situations.

Systemic Symptoms:

- Fatigue: "I feel more tired than usual."

- Sleep changes: "My sleep hasn't been the greatest lately."

- All other systemic symptoms are normal.

Past Medical History:

- Hypertension controlled with medication.

- Previous knee replacement surgery with good recovery.

- Negative for diabetes, cardiac diseases, and cancer.

Psychiatric history: Negative for any diagnosed psychiatric conditions or treatments.

Patient Risk Assessment:

- Suicide Risk: No current or past history of suicidal ideation or attempts. "I've never thought about hurting myself, even with all this going on."

- Self-Harm Risk: No history of self-harm behaviors. "No, I've never done anything like that."

- Vulnerability to Abuse or Neglect: Currently lives independently, with a supportive family network. "My family's been really helpful, always checking in on me."

- Risk of Fall: Due to memory issues and age, there is an increased risk of falls. "I've been careful around the house, especially since my memory's been acting up."

- Medication Overuse or Misuse: Takes medication as prescribed, without history of overuse or misuse. "I take my blood pressure pill every day, just like the doctor told me."

- Alcohol or Substance Misuse: Denies misuse of alcohol or substances. "I enjoy a glass of wine now and then but never overdo it."

- Capacity to Make Decisions: Currently capable but might need reassessment if cognitive decline progresses. "I think I'm still good at making decisions, though this situation does worry me."

Drug History:

- Amlodipine 10 mg daily for hypertension.

- No history of medication non-compliance.

- Occasionally takes over-the-counter ibuprofen for knee pain.

Allergies:

- No known allergies or intolerances to medications or foods.

Family History:

- Mother had Alzheimer's disease.

- Father died of a heart attack.

- One sibling living with Type 2 diabetes.

- No other significant family medical history to note.

Social History:

Lifestyle:

- Rowan enjoys reading and gardening.

Occupation:

- Retired school teacher.

Activities of Daily Living & Hobbies:

- Independent with all activities of daily living, although they have been more forgetful lately.

Smoking:

- Does not smoke.

Alcohol:

- Drinks wine occasionally, about 2 units a week.

Recreational Drug Use:

- None.

Diet:

- Generally balanced diet, with a preference for home-cooked meals.

Exercise:

- Takes daily walks for about 30 minutes.

Travel History:

- No recent travel.

Sexual History:

- Not relevant to present condition.

Driving Status:

- Limiting driving due to recent forgetfulness.

Cultural or Religious Practices:

- Occasionally attends a local community book club.

Recent Life Events:

- No significant recent life events.

Exposure to Hazards or New Environment:

- No exposure to significant hazards or changes in living environment.

Ideas, Concerns, and Expectations:

- Rowan has heard about dementia and Alzheimer's disease and is worried that they might be developing one of these conditions. "Could this be something like what my mother had?"

- They are concerned about the future and the impact it might have on their independence.

- Rowan expects a thorough assessment, clarification about their symptoms, and a clear plan of action. "I need to know what's going on, so I can prepare for whatever comes next."

Observations:

Respirations (Breaths/min): 16 (0 points)

Oxygen Saturation (%): 98 on room air (0 points)

Blood Pressure (mmHg): 138/86 (0 points)

Pulse (Beats/min): 72 (0 points)

Consciousness (AVPU): Alert (0 points)

Temperature (Celsius): 36.7 (0 points)

NEWS Total Score: 0 (“Rowan’s NEWS score is 0, indicating they are currently stable.”)

Physical Examination:

- General: Appears well, no acute distress.

- Neurological: Cranial nerve examination normal, no focal deficits.

- Cognitive: Mild difficulty with short-term memory recall.

Special Tests:

- Mini-Mental State Examination (MMSE) indicates mild cognitive impairment.

Diagnostic Tests:

- Pending further evaluation, including blood work and possibly imaging to assess for potential causes of memory loss.

Patient Questions:

- "Could stress be the reason I'm forgetting things?" (Answer: Stress can contribute to memory problems, but it’s important we rule out other medical conditions too.)

- "What will happen if you find out it's something serious like dementia?" (Answer: If it's dementia, we have many ways to support you, including medications and lifestyle adjustments.)

- "Are there things I should be doing at home to help with my memory?" (Answer: Staying mentally and physically active can help, as well as keeping a regular routine and using tools to help with memory, like calendars and notes.)

- "Will I be able to live on my own, or will I need someone to take care of me?" (Answer: We'll work on plans to keep you safe and independent as long as possible, and if needed, we’ll discuss support options.)

Examiner Questions:

- What conditions should be considered in the differential diagnosis of memory loss in an elderly patient? (Answer: Possibilities include Alzheimer's disease, other dementias, depression, medication side effects, thyroid disorders, and vitamin deficiencies among others.)

- How would you distinguish between normal age-related memory changes and pathological memory loss? (Answer: Normal aging might involve slower recall and occasional forgetfulness, while pathological loss includes significant impairments that affect daily activities.)

- What are the risk factors for Alzheimer's disease? (Answer: Age, family history, genetics, and possibly lifestyle and heart health factors.)

- What initial investigations would you order for Rowan's reported symptoms? (Answer: Full blood count, electrolytes, liver function tests, thyroid function tests, vitamin B12, folate levels, and possibly a CT head scan.)

- Why is it important to determine if a patient with memory loss is able to drive safely? (Answer: Memory impairment can affect driving ability, posing a risk to the patient and others on the road.)

Treatment:

The treatment plan should start with a full medical evaluation to rule out treatable causes of memory loss. If a diagnosis of a degenerative condition like Alzheimer's disease is made, treatment options include:

- Cholinesterase inhibitors such as Donepezil, which may help with cognitive symptoms in early to moderate cases.

- Memantine for moderate to severe cases.

Other aspects of management include:

- Supporting mental and physical activity.

- Assisting with strategies for memory support.

- Addressing legal and safety considerations, such as driving and living arrangements.

- Referral to a specialist, such as a neurologist or geriatrician, may be necessary for further management and support.

Monitoring:

- Regular follow-up visits to monitor cognitive function and any medication side effects.

- Assess the need for increased support or changes in living arrangements as the condition progresses.

Prognosis:

The prognosis depends on the underlying cause of the memory loss. Degenerative conditions like Alzheimer's have a progressive course, with gradual decline in memory and function. Early diagnosis and intervention can provide the best outcome for maintaining quality of life.

Differential diagnoses:

1. Major depression - Less likely due to absence of depressive symptoms.

2. Thyroid dysfunction - Can be ruled out with normal thyroid function tests.

3. Vitamin B12 deficiency - Would see improvement with supplementation if this were the cause.

4. Normal pressure hydrocephalus - Would expect gait disturbances and urinary incontinence, which are not present.

Speciality Filter:

General Practice; Neurosciences; Medicine Of Older Adult;

Presenting Complaint Filter:

Memory Loss; Confusion;

Condition Filter:

Memory Loss;

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_30\_Body dysmorphia

Homepage Vignette:

A 23-year-old individual named Alexei presents with excessive concern over physical appearance.

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Individual Page Vignette:

You are a doctor in a General Practice setting. Alexei, a 23-year-old Graphic Designer, located in a clinic, presents to you expressing an extreme level of concern and distress regarding their physical appearance.

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Patient Name: Alexei Kuznetsov (Ah-lek-say Kooz-neht-sov), prefers to be called Alexei.

Age: 23/05/2001

Location: Clinic

Personality: Alexei is articulate and detail-oriented, often seeking reassurance from friends and professionals alike about their appearance. They speak in a meticulous and somewhat anxious manner, reflecting their underlying concerns about how they look.

Presenting Complaint: "I just can't stop thinking about the way my nose looks. It's like it's all I see when I look in the mirror. People keep telling me I look fine, but I just don’t believe them. I think I might need surgery to fix it."

Symptoms:

- Preoccupation with perceived flaws in physical appearance (Site: the nose, Quote: "My nose is just too big, it's all I notice when I look in the mirror.")

- Excessive mirror checking or avoidance (Timing: several hours a day, Quote: "I either spend hours looking at my reflection to find a good angle or I avoid mirrors completely.")

- Repeated requests for reassurance (Character: persistent, Quote: "Do you think my nose really looks okay? Be honest, I can take it.")

- Emotional distress impacting daily life (Severity: high, Quote: "It's starting to affect everything, my job, my relationships, I just can't shake off these thoughts.")

History of Presenting Complaint:

- Duration of symptoms: Noticed escalating over the past 2 years

- Previous treatments: None

- Progression: Increasing preoccupation particularly in the last 12 months

- Frequency of symptoms: Daily

- Impact on daily life: High, causing significant distress and inability to focus on work

- Impact on work: Reduced productivity as a graphic designer due to loss of concentration and esteem

Quote: "It started a couple of years ago but it's just gotten worse. I can’t focus on my designs because all I can think about is how I look."

Systemic Symptoms:

- Anxiety: Yes, particularly social anxiety regarding appearance

- Sleep disturbances: Yes, difficulty falling asleep due to anxiety

- Unintended weight changes: No

- Fatigue: Yes, due to poor sleep

Quote: "I'm always anxious about how I look, I lose sleep over it, too. But my weight is stable and I don't feel weak or anything."

Past Medical History:

- General health: Generally healthy

- Psychiatric history: Anxiety diagnosed at age 19

- Previous surgeries: None

- Medication history: Occasional use of over-the-counter anxiolytics

Quote: "Well, I've always been a bit of an anxious person. Needed some over-the-counter stuff to calm me down sometimes, but that's about it."

Psychiatric history: Diagnosed with generalized anxiety disorder at age 19, receiving occasional counseling, no history of inpatient psychiatric treatment, no history of self-harm or suicidal ideation.

Quote: "I've always been kind of wound up and worried about stuff. I saw a therapist for a while when I was 19 because I couldn't handle the stress."

Risk Assessment:

- Risk to self: Currently no evidence of self-harm or suicidal ideation. Suffers from low self-esteem related to appearance concerns which should be monitored.

- Risk to others: No current or historical evidence of risk to others.

- Vulnerability: The patient's preoccupation with appearance may make them vulnerable to exploitation or hasty decisions about cosmetic interventions.

- Suicidality: No current ideation, plan, or intent; however, the presence of body dysmorphia increases the risk of future suicidal ideation if not treated effectively.

Quote on Risk Assessment:

- "No, I've never thought about hurting myself or anyone else. But sometimes I just feel really down because of how I look, like I want to disappear."

- "I know I need help so I don't make a crazy decision about changing my face or something."

- "I've never been suicidal, but there are days I just don't want to leave the house or be seen, it's that bad."

Drug History:

- Prescriptions: No ongoing prescription medication

- Over-the-counter: Occasional use of herbal anxiolytics

- Compliance: N/A

Quote: "I sometimes take these herbal calm pills I got at the pharmacy when I'm feeling super anxious."

Allergies:

- Known allergies: None reported

Quote: "No allergies that I know of, everything seems fine with what I’ve taken before."

Family History:

- No known genetic disorders

- Parents in good health

- No known psychiatric history in the family

Quote: "My parents are fit and healthy, and we don't have any history of mental health issues as far as I'm aware."

Social History:

Lifestyle:

- Occupation: Graphic Designer

- Activities of Daily Living & Hobbies: Enjoys drawing and digital art

Smoking: Non-smoker

Alcohol: Rarely, less than 2 units per month

Recreational Drug Use: Denies any use

Diet: Balanced diet with a preference for organic food

Exercise: Goes to the gym twice a week

Quote:

"I work as a graphic designer, and I love anything and everything that has to do with art."

"I really don't drink or smoke, and I've never touched drugs."

"I try to eat healthily, and I work out when I can, helps clear my mind a bit."

Ideas, Concerns, and Expectations:

- Ideas: Believes that cosmetic surgery may be the only solution to their concerns

- Concerns: Worried about the inability to control their thoughts and the impact on life

- Expectations: Seeks a referral for cosmetic surgery and reassurance regarding appearance

Quote:

"I think I might need surgery, it feels like the only thing that will help me stop obsessing."

"I'm really scared that these thoughts are never going away, it's consuming me."

"I'm hoping you can tell me I look fine or refer me to a surgeon who can fix what's wrong."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98%

Air or Oxygen?: Room air

Blood Pressure (mmHg): 128/85

Pulse (Beats/min): 83

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7°C

NEWS Total Score: 0 (All observations are within normal ranges)

Physical Examination:

- General appearance: Well-groomed individual showing signs of anxiety, such as mild hand tremors.

- Skin: No visible lesions or scars on the face

- ENT: Symmetrical nasal structure with no evident deformities

- Psychiatric: Affect is congruent with stated mood, showing heightened anxiety.

Special Tests:

- No specific special tests indicated at this stage.

Diagnostic Tests:

- Assessment with validated body dysmorphia questionnaires may be indicated.

Condition:

Body Dysmorphia

Patient Questions:

1. "What if you just don't see it, but there's really something wrong with my nose?"

- "I understand your concern, but after a thorough examination, I didn't find any abnormalities regarding your nose's appearance.”

2. "Can you refer me for a surgery right now?"

- "Before considering surgery, it’s important to explore other treatments that address body dysmorphia, which might help relieve your concerns without needing surgery.”

3. "Am I going to feel like this forever?"

- "Many people with body dysmorphia see a marked improvement with the right treatment plan, including therapy and sometimes medication. We will work together to find the best approach for you.”

4. "What if people are just lying to me and I do look as bad as I think?"

- "It’s common for people with body dysmorphia to doubt reassurance from others. Therapy can help you develop healthier perceptions and ease your distress.”

Examiner Questions:

1. What is the diagnostic criteria for body dysmorphia?

- "The diagnostic criteria include an obsessive preoccupation with a perceived defect in appearance, repetitive behaviors or mental acts in response to appearance concerns, and significant distress or impairment in social, occupational, or other areas of functioning."

2. What other conditions should be ruled out before diagnosing body dysmorphia?

- "Other conditions such as an eating disorder, social anxiety disorder, or obsessive-compulsive disorder should be considered and ruled out."

3. What are the first-line treatments for body dysmorphia?

- "First-line treatments include cognitive-behavioral therapy (CBT) specifically designed for body dysmorphia and selective serotonin reuptake inhibitors (SSRIs)."

4. How would you manage a patient with body dysmorphia who is seeking cosmetic surgery?

- "It’s important to address the underlying body dysmorphia first, as cosmetic surgery may not relieve the distress and can sometimes worsen the condition. A multidisciplinary approach involving mental health professionals is key."

5. What factors may increase the risk of developing body dysmorphia?

- "Risk factors can include a family history of body dysmorphia or other psychiatric conditions, societal pressure or influences around appearance, and personal characteristics such as perfectionism."

Treatment:

- First-line treatment begins with cognitive-behavioral therapy (CBT) that's tailored to body dysmorphia.

- Consider the introduction of SSRIs, such as fluoxetine, which can be started at 20 mg daily and titrated up to a therapeutic dose as needed. If the patient doesn't tolerate or respond to SSRIs, other antidepressants like clomipramine can be considered.

- A referral to a psychiatrist or a mental health specialist with experience in treating body dysmorphia for a comprehensive approach that may include medication management.

Monitoring:

- Regular follow-up appointments should be scheduled to monitor progress, ideally every 4-6 weeks initially.

- Evaluate the effectiveness of therapy and medication, adjust the treatment plan as necessary.

- Monitor for any signs of worsening symptoms or the development of related issues, such as depression or anxiety disorders.

- Referral to a psychiatrist or mental health specialist if symptoms persist or worsen.

Prognosis:

- The outcome of body dysmorphia can vary but is generally considered chronic, with fluctuations in symptom severity.

- Early intervention with appropriate treatment can lead to significant improvements.

- Some patients might experience persistent symptoms but can learn to manage them effectively.

- Prognostic factors include the presence of comorbid psychiatric conditions, the severity of symptoms at the onset of treatment, and the patient's level of insight.

Differential diagnoses:

1. Obsessive-Compulsive Disorder: Less emphasis on physical appearance and more varied obsessions and compulsions.

2. Social Anxiety Disorder: Social avoidance is not specifically focused on appearance concerns.

3. Eating Disorder: Body concerns primarily focused on weight and shape, rather than specific perceived flaws.

4. Major Depressive Disorder: Preoccupation with appearance might happen, but it’s not typically obsessive or the main focus.

Speciality Filter:

Mental Health;

Presenting Complaint Filter:

Excessive Concern Over Physical Appearance;

Condition Filter:

Body Dysmorphia;

Location Filter:

General Practice;

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_31\_OCD

Homepage Vignette:

## A 34-year-old individual named Morgan presents with intrusive thoughts and ritualistic behaviors.

Individual Page Vignette:

You are a General Practitioner, and Morgan, a 34-year-old office manager, has come to your clinic complaining of persistent, intrusive thoughts and engaging in repetitive behaviors.

Patient Name: Morgan Taylor (Pronunciation: MOR-guhn TAY-luhr). Morgan prefers to be called by their first name.

Age: 20/06/1990

Location: Clinic

Personality: Morgan is meticulous and detail-oriented, often speaking in an organized and precise manner. They express themselves clearly and are direct about their concerns, but they become visibly anxious when discussing their symptoms.

Presenting Complaint: "I can't stop thinking these upsetting thoughts, and I have to do certain things over and over again to make them stop."

Symptoms:

Site: Non-applicable.

Onset: "I first noticed these problems during college, but it's been getting worse over the past few months."

Character: "It's like a loop of thoughts that I can’t break out of, and then I have to do things a certain way to feel okay."

Radiation: Non-applicable.

Associated Symptoms: "Sometimes I feel really anxious if I don’t complete my routines."

Timing: "It happens multiple times every day. It's exhausting."

Exacerbating and Relieving Factors: "Stress makes it worse, but when I complete my routines, I feel a bit better for a while."

Severity: "It feels like it's taking over my life."

Negative or positive findings for full questioning around obsessive-compulsive disorder include persistent and unwanted thoughts, urges, or images that are intrusive and cause distress (obsessions), along with repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly (compulsions).

History of Presenting Complaint:

- Experiencing symptoms for several years with worsening over the past few months.

- No previous psychiatric treatments attempted.

- Symptoms are persistent and frequent, interfering daily with work and social life.

- Impact on ADLs: significant, with Morgan spending hours on routines.

- Morgan expresses, "I've tried to stop, but it just makes me feel worse."

Systemic Symptoms:

- Fatigue: "I'm always tired from dealing with this."

- All other systemic symptoms are normal.

Past Medical History:

- Psychiatric or psychological history: No previous diagnosis of psychiatric illnesses. Morgan has not engaged in therapy or counseling prior to this consultation.

- Any previous injuries or traumas are not reported.

Risk Assessment:

- No current suicidal ideation or self-harm behaviors have been expressed or evidenced by Morgan.

- Morgan does not report any previous attempts at self-harm or suicidal ideation.

- There is no indication of immediate risk to self or others based on Morgan's presentation and history. However, obsessive-compulsive disorder can be associated with significant distress, and the potential for future risk should be evaluated continuously.

- A plan should be established for Morgan to seek immediate help if feelings of depression worsen or suicidal thoughts occur.

Quote for history and risk assessment:

- "I've never seen a psychiatrist or been diagnosed with anything, but I feel like this has been building up for a while."

- "Sometimes, I feel hopeless because of these constant thoughts and rituals, but I've never thought about hurting myself."

- "I can promise you that I'm not a risk to myself or anyone else; I just want to figure out how to manage these symptoms."

Drug History:

- Occasional acetaminophen for headaches, no regular medications.

- No history of medication non-compliance or overdose.

Allergies:

- No known allergies or intolerances.

Family History:

- A parent with a history of anxiety, otherwise non-contributory.

Social History:

Lifestyle: Meticulous and organized in both personal and work life.

Occupation: Office manager.

Activities of Daily Living & Hobbies: Enjoys reading and puzzles, but rituals consume significant time.

- Smoking: non-smoker.

- Alcohol: social drinker, 2-3 units per week.

- Recreational Drug Use: none.

- Diet: balanced with some specific food preferences due to rituals.

- Exercise: walks daily, 30 minutes.

Travel History: No recent travel.

Sexual History: Not sexually active currently.

Driving Status: Has a valid license, no issues with driving.

Cultural or Religious Practices: Non-religious, rituals are not based on cultural or religious beliefs.

Recent Life Events: Increased workload might be contributing to stress.

Exposure to Hazards or New Environment: None reported.

Ideas, Concerns, and Expectations:

- Ideas: "I think I might have what they call OCD, seen someone talking about it online."

- Concerns: "What if I can't control this? It’s embarrassing."

- Expectations: "I hope there's a treatment. Maybe therapy or medication?"

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98%

Air or Oxygen?: Room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8°C

NEWS Total Score: 0 (as all observations are within normal range)

Physical Examination:

- General inspection does not reveal any abnormalities.

- Evidence of mild anxiety (e.g., hand wringing) may be observed.

Special Tests: Not applicable for OCD.

Diagnostic Tests: Given Morgan's presentation, the primary diagnosis of OCD is clinical. Further psychiatric evaluation and possibly neuropsychological testing may be indicated for diagnosis confirmation and to rule out other mental health conditions.

Condition: Obsessive-compulsive disorder

Patient Questions:

Q1: "What exactly is OCD, and why do I have it?"

Possible Answer: "OCD is a common disorder characterized by unwanted repetitive thoughts and behaviors. It's caused by a combination of genetic, neurobiological, behavioral, cognitive, and environmental factors."

Q2: "Can OCD be cured?"

Possible Answer: "There's no cure for OCD, but treatment can help manage symptoms so you can live a full, productive life."

Q3: "Is medication necessary, or can I manage this with therapy alone?"

Possible Answer: "It can vary from person to person. Some do well with therapy, especially cognitive-behavioral therapy, while others may need medication to help manage their symptoms."

Q4: "Are there any side effects to the treatments?"

Possible Answer: "All treatments can have side effects. For therapy, they are minimal, but medications can have various side effects that we can discuss and monitor closely."

Examiner Questions:

Q1: What are the DSM-5 criteria for OCD?

Possible Answer: "The DSM-5 criteria for OCD include the presence of obsessions, compulsions, or both; the obsessions or compulsions are time-consuming or cause clinically significant distress or impairment; they're not attributable to substance use or another medical condition; and they're not better explained by another mental disorder."

Q2: How would you distinguish between OCD and obsessive-compulsive personality disorder (OCPD)?

Possible Answer: "OCD involves true obsessions and compulsions, while OCPD is characterized by a pervasive pattern of preoccupation with orderliness, perfectionism, and control, without the presence of true, intrusive obsessions or compulsions."

Q3: Can OCD present with tics or Tourette syndrome?

Possible Answer: "Yes, there's a subset of OCD associated with Tourette syndrome, particularly in pediatric populations, where tics and OCD symptoms may present concurrently."

Q4: What first-line pharmacotherapy is recommended for OCD?

Possible Answer: "Selective Serotonin Reuptake Inhibitors (SSRIs) are the first-line medication for treating OCD."

Q5: Which cognitive-behavioral therapy technique is most effective for OCD?

Possible Answer: "Exposure and Response Prevention (ERP) is considered the most effective CBT technique for treating OCD."

Q6: How might OCD impact a patient's daily functioning?

Possible Answer: "OCD can severely disrupt daily routines, work, social activities, and relationships due to the time spent on obsessions and compulsions, as well as the distress caused by these symptoms."

Treatment:

According to NICE guidelines, the treatment approach for OCD includes:

- First-line treatment with cognitive-behavioral therapy, specifically Exposure and Response Prevention (ERP).

- If therapy alone is insufficient or not available, consider the addition of a selective serotonin reuptake inhibitor (SSRI), such as sertraline (starting dose 50 mg daily, can increase to a maximum of 200 mg daily).

- For those who do not respond or tolerate SSRIs, consider trying a different SSRI or clomipramine (a tricyclic antidepressant).

- Always consider therapy in conjunction with medication, if possible.

- Other options if SSRIs are ineffective or not tolerated include SNRIs like venlafaxine or other medications as per psychopharmacology guidelines.

Monitoring:

Morgan should be regularly monitored for symptomatic improvement, side effects of medication, and adherence to treatment. Follow-up appointments should be scheduled every 2-4 weeks initially when starting medications and at reasonable intervals during CBT. Treatment should be reviewed and potentially adjusted every 3-4 months.

Prognosis:

The prognosis varies as OCD is a chronic condition, but with appropriate treatment, symptoms can be managed effectively. The degree of improvement may depend on the severity of the disorder, the patient's ability to adhere to treatment, and the presence of co-existing conditions.

Differential diagnoses:

1. Generalized Anxiety Disorder: Less likely due to the presence of specific obsessions and compulsions rather than generalized worry.

2. Major Depressive Disorder: May be comorbid but does not explain the repetitive rituals or intrusive thoughts specific to OCD.

3. Hoarding Disorder: Distinguished by the specific symptomatology involving the accumulation of possessions.

4. Body Dysmorphic Disorder: Focus is specifically on perceived body flaws, which is not the case here.

Speciality Filter:

Mental Health;

Presenting Complaint Filter:

Obsessions and/ or compulsions;

Condition Filter:

Obsessive-compulsive disorder;

Location Filter:

Clinic;

Case created by:

XX, Medical Student

Reviewed by:

XX, Medical Student

Reviewed by:

XX, Medical Student/XX Doctor

# DS\_32\_Borderline personality disorder

Homepage Vignette:

A 27-year-old individual named Avery presents with mood swings and unstable interpersonal relationships.

Individual Page Vignette:

You are a general practitioner, and Avery, a 27-year-old office worker, comes to your clinic seeking help for mood swings and difficulty maintaining stable relationships with friends and family.

Patient Name: Avery (Pronunciation: EH-vuh-ree)

Age: 27 years old, Birthday: 26/09/1997

Location: General Practice

Personality: Avery is articulate and introspective, frequently sharing detailed descriptions of their emotions and experiences. They express themselves passionately, often displaying a spectrum of intense emotions within a brief period.

Presenting Complaint:

"I feel like I'm on a roller coaster with my emotions, and it's ruining my relationships. I either love someone intensely or can't stand them, and there's no in-between."

Symptoms:

- Mood swings ranging from intense happiness to severe depression

- Difficulty maintaining stable relationships

- Impulsive behaviors

- Chronic feelings of emptiness

- Explosive anger

Site: "The emotional pain feels like it's in my chest and stomach."

Onset: "This has been happening since my late teens, but it's getting worse."

Character: "It's like a deep ache inside, so intense it's physical."

Radiation: "It doesn't really 'radiate' but it takes over everything."

Associated Symptoms: "When I'm upset, I sometimes spend recklessly or eat too much."

Timing: "It can be any time; there are days that are okay, but then suddenly, it's too much."

Exacerbating and Relieving Factors: "Stress at work or fights with friends make it worse. Sometimes, writing or going for a walk helps."

Severity: "On a scale from one to ten, it's often a nine or ten."

History of Presenting Complaint:

- Symptoms have been present for nearly a decade.

- Past counseling with some temporary improvements.

- Mood swings are unpredictable and affect daily functioning.

- Interpersonal conflicts occur frequently, impacting work and personal life.

- Feelings of emptiness persist despite changes in circumstances.

Avery might say: "I've tried talking to some therapists before, and it helps a bit, but nothing really changes for long. I can't seem to control how I feel or connect with people without chaos."

Systemic Symptoms:

- Reports occasional insomnia related to stress.

- Explains poor appetite when feeling depressed.

- Denies fever, night sweats, or unintended weight loss.

Avery might elaborate: "When I'm stressed, I can't sleep, and I either don't eat or just eat junk. But I don't have fevers or anything."

Past Medical History:

- Mental health history of anxiety diagnosed at age 22.

- Previous intermittent counseling sessions for emotional distress.

- No significant past medical or surgical history.

- Immunizations up to date.

They might state: "I've dealt with anxiety before, had my ups and downs, you know? No other major health issues. I'm pretty good with keeping my vaccines current."

Psychiatric History:

- Intermittent anxiety treatment.

- No record of inpatient psychiatric treatment.

- Denies any previous psychiatric medications besides sertraline.

Avery might say: "Yeah, I've been to therapy off and on for my anxiety, took Zoloft once. Never had to be hospitalized or anything serious like that, though."

Risk Assessment:

- Denies current suicidal ideation, plans, or attempts.

- Reports impulsive behaviors which may pose potential risks to self.

- History of intense, unstable relationships could indicate the risk of self-harm during interpersonal stress.

Drug History:

- Previously used sertraline with limited benefit; currently not on any medications.

- Occasionally takes ibuprofen for headaches.

- No known history of medication non-compliance.

Avery might comment: "I was on Zoloft a while back. It didn't do much, so I stopped. Now I just take Advil when needed."

Allergies:

- No known allergies to medications, foods, or environmental factors.

Avery could confirm: "Luckily, no allergies to worry about."

Family History:

- Mother with treated depression; no known history of BPD.

- Denies mental health issues in other family members.

Avery might mention: "Mom has been dealing with depression for years. She’s on medication for it. As far as I know, nobody else in the family has mental stuff going on—at least not like me."

Social History:

Lifestyle: Engages in social activities but struggles to maintain relationships.

Occupation: Office worker, often feels stressed by job demands.

Activities of Daily Living & Hobbies: Enjoys painting and writing poetry as outlets for self-expression.

Smoking: Non-smoker.

Alcohol: Consumes alcohol socially, about 4 units per week.

Recreational Drug Use: Denies any recreational drug use.

Diet: Variable, often affected by mood.

Exercise: Walks regularly for exercise.

Avery might share: "I try to keep busy with work, art, and poetry. I don't smoke or do drugs, but I'll have a drink now and then. My eating and exercise can be all over the place, depending on how I feel."

Ideas, Concerns, and Expectations:

Avery believes that they might have a psychological problem that requires professional help, expresses concern over the impact of the mood swings on life and relationships, and hopes to gain strategies to manage emotions and improve relationships.

They could convey: "I think there's something wrong with how I handle feelings. I'm scared I'll end up alone because of it. I really want to get better at managing this and have steady relationships."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98%

Air or Oxygen?: Room air

Blood Pressure (mmHg): 120/78

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.5°C

NEWS Total Score: 0 (All observations within normal range)

Physical Examination:

Full physical examination yields unremarkable findings with no evidence of physical illness.

Special Tests:

Mental state examination indicates signs consistent with borderline personality disorder, such as affective instability and impulsive behavior.

Diagnostic Tests:

Diagnostic assessment is primarily based on clinical interview and psychological evaluation. No blood tests or imaging are indicated for this diagnosis.

Condition:

Borderline Personality Disorder

Patient Questions:

"How can you tell it's not just me being too sensitive or overreacting?" (Possible answer: "The patterns of your emotions and behaviors fit a recognized condition. It's not about being 'too sensitive'; it's about how your emotions are regulated.")

"Will I have to be on medication forever?" (Possible answer: "Treatment for BPD often focuses on therapy, but medication may be used to manage specific symptoms. It's personalized to each individual.")

"What if I can't control my anger or impulses?" (Possible answer: "Therapy, especially dialectical behavior therapy, can be very effective at helping you learn to control these feelings and impulses.")

Examiner Questions:

Can you explain the criteria for diagnosing borderline personality disorder? (Possible answer: BPD is diagnosed based on criteria that include patterns of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.)

How might borderline personality disorder affect a person's social functioning? (Possible answer: Individuals with BPD might struggle to maintain relationships due to their intense emotional responses and fears of abandonment, impacting their ability to function socially.)

What types of therapies are effective for borderline personality disorder? (Possible answer: Dialectical behavior therapy and cognitive behavioral therapy have been shown to be effective in treating BPD.)

How do you differentiate borderline personality disorder from bipolar disorder? (Possible answer: BPD is characterized by ongoing patterns of instability in moods and interpersonal relationships, while bipolar disorder involves distinct episodes of mania and depression.)

What role does family history play in borderline personality disorder? (Possible answer: Family history may be a risk factor, as relatives of individuals with BPD are more likely to have the disorder.)

Treatment:

Psychoeducation about the disorder and discussion of treatment options.

Referral to a psychologist for dialectical behavior therapy (DBT), which is the mainstay of treatment for BPD.

Consideration of cognitive-behavioral therapy (CBT) or schema-focused therapy as adjunctive treatments.

Medications may be considered for comorbid conditions or specific symptoms, such as SSRIs for depression or mood stabilizers for anger.

Regular follow-up appointments to monitor progress and adjust the treatment plan.

Monitoring:

Monitor the patient's engagement with therapy and symptom changes over time. Look out for signs of comorbid conditions such as depression, which may require additional treatment. Frequent follow-up initially (e.g., monthly), with adjustments made based on the patient's progress.

Prognosis:

The course of BPD can be variable, with some individuals experiencing a reduction in symptoms over time, especially with effective treatment. Long-term commitment to therapy can lead to significant improvements, although symptoms may persist to some degree. Early intervention and adhering to treatment plans positively influence prognosis.

Differential diagnoses:

1. Bipolar Disorder: Episodic mood changes rather than the persistent instability seen in BPD.

2. Depression: Does not typically feature the pattern of unstable relationships and identity disturbance characteristic of BPD.

3. Histrionic Personality Disorder: Less impulsivity and self-destructive behavior compared to BPD.

4. Narcissistic Personality Disorder: Stability of self-esteem differentiates it from the identity disturbance in BPD.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Personality Change; Emotional Lability

Condition Filter:

Borderline Personality Disorder

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_33\_Loss of libido

Homepage Vignette:

## A 32-year-old female named Kirana presents with loss of libido.

Individual Page Vignette:

You are a General Practitioner. Your next patient, Kirana, a 32-year-old lawyer, has come in due to concerns about a significant loss in sexual desire.

Patient Name: Kirana Sadiq (Keer-ah-nah Sah-deeq). Kirana would like to be called by her first name.

Age: 15/07/1992

Location: General Practice

Personality: Kirana is articulate and well-informed, often conducting her own research before consultations. She speaks candidly but maintains a professional demeanor.

Presenting Complaint:

Kirana reports, "Over the past few months, I've noticed that my sexual desire has significantly decreased, and it's starting to affect my relationship."

Symptoms:

Site: Not applicable

Onset: Kirana mentions, "It's been a gradual thing, but I really started noticing it around three or four months ago."

Character: Not applicable

Radiation: Not applicable

Associated Symptoms: Not applicable

Timing: No specific timing, continuous issue

Exacerbating and Relieving Factors: Kirana confesses, "I haven't found anything that makes a difference either way."

Severity: Kirana admits, "It's not like physical pain, but it's quite distressing for me emotionally."

- All other specialty-specific and general signs and symptoms are negative.

History of Presenting Complaint:

- Kirana has been experiencing a decreased sexual desire for approximately 3-4 months.

- No previous treatments have been sought for this issue.

- Symptoms have been gradual and persistent without acute exacerbations.

- The decrease in libido has started to affect her personal relationship, causing emotional distress and anxiety.

- No significant impact on her ability to function at work has been noted.

- The condition has not affected her physical wellbeing but has impacted her mental wellbeing due to concerns about her relationship and self-perception.

Kirana may articulate her experience as follows: "It started off so subtly that I barely noticed, but over the last few months, it's been inescapable. I've not done anything about it yet, no medications or therapy. It's weird because it's not affecting my job - I'm able to work just fine. But inside, it's really troubling, especially because it's not like me, and I worry about what it means for my partner and me."

Systemic Symptoms:

- No fatigue, fever, or night sweats.

- No unintended weight loss or general weakness.

- Sleep and appetite are normal.

- No evidence of peripheral oedema.

Kirana clarifies, "Aside from what I've mentioned, I feel physically fine. No fevers, no weight changes, and I'm sleeping well."

Past Medical History:

- No known chronic illnesses or previous surgeries.

- No previous psychiatric or psychological history.

- No known substance abuse or addiction.

- Up to date on recommended immunizations.

Kirana recounts, "I've been pretty healthy all my life, no serious illnesses or surgeries. And I'm not on any regular medication."

Psychiatric History and Risk Assessment:

- No history of psychiatric illness.

- Currently, there is no evidence of depression, anxiety, or other mood disorders as per the patient's self-report.

- No known risk factors present for mental health issues such as a family history of psychiatric illness, past personal history, or high-stress life events.

- No reports of self-harm or suicidal ideation.

- The patient does not exhibit signs of active psychosis, mania, or significant cognitive impairment.

Kirana might express, "I've always been pretty good at managing stress and haven't had issues with anxiety or depression. I've never thought about harming myself, and I don't have any family history of mental illness."

Kirana could comment, "Despite the stress at work, I've been coping well and haven't noticed any changes in my mood or thoughts that would concern me."

Drug History:

- No current medications.

- No known history of medication non-compliance.

- Does not use any herbal supplements or alternative therapies.

Kirana says, "I don't take any medications regularly, and I'm not big on supplements or alternative treatments."

Allergies:

- No known allergies or intolerances.

Kirana assures, "I've never had any allergic reactions to medications or foods that I'm aware of."

Family History:

- No significant family history of chronic illnesses.

- Parents are alive and well with no known medical conditions.

Kirana explains, "Both my parents are healthy for their age, and there's no history of genetic diseases in the family as far as I know."

Social History:

Lifestyle: Eats a balanced diet and leads a generally healthy lifestyle.

Occupation: Lawyer with a reputable firm.

Activities of Daily Living & Hobbies: Enjoys yoga and reading, manages all activities of daily living independently.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Predominantly plant-based diet with occasional fish.

Exercise: Regular yoga and attends a gym twice a week.

Kirana shares, "I lead an active lifestyle, I like to stay fit with yoga and the gym. I don't smoke, and I only drink socially. My diet is mostly vegetarian, and I make sure to include plenty of veggies and fruits."

Travel History: No recent travel.

Sexual History: In a monogamous relationship for the past 5 years.

Driving Status: Drives regularly without any recent incidents.

Cultural or Religious Practices: Does not follow any specific practices that would affect her medical care.

Recent Life Events: No recent significant life events.

Exposure to Hazards or New Environment: No known exposures.

Kirana reflects, "I've not traveled anywhere exotic recently, and there haven't been any big changes in my life or environment. I drive to work every day without any issues."

Ideas, Concerns, and Expectations:

Kirana believes her loss of libido may be due to recent stress at work but is open to exploring other causes. She is concerned that this may signify an underlying health issue or could have a lasting impact on her relationship. As for expectations, she is looking for reassurance and a plan to address her concerns.

Kirana mentions, "I thought it might just be stress, but I'm beginning to worry it's something more serious. I am hoping we can figure out what's wrong and find a way to fix it."

Observations:

Respirations (Breaths/min): 14

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.9

NEWS Total Score: 0

(Kirana's vital signs are within normal ranges, resulting in a NEWS score of 0.)

Physical Examination:

General examination is within normal limits.

Special Tests:

No special tests are indicated for this condition at this time.

Diagnostic Tests:

Based on Kirana's presentation of loss of libido, the following tests may be considered:

- Full Blood Count (FBC): Within normal limits.

- Thyroid Function Tests: Within normal limits.

- Hormonal assays (as appropriate for gender): Results within normal limits.

- Liver Function Tests: Within normal limits.

- Serum electrolytes: Within normal limits.

- Urinalysis: No abnormalities detected.

Condition:

Loss of libido

Patient Questions:

1. "Could this be something serious, like a hormonal problem?"

- "It's certainly possible that hormonal issues can impact libido, but let's run some tests to rule out any concerns and discuss other factors that can contribute."

2. "Is there anything I can do at home to improve this situation?"

- "Improving sleep, managing stress, and maintaining a healthy lifestyle can be beneficial. We can also explore if there are any psychosexual factors that can be addressed."

3. "Could my diet be affecting my sex drive?"

- "While a plant-based diet is generally healthy, we can review it to ensure you are getting all the nutrients needed that can impact libido, like zinc and vitamin D."

4. "Will you be prescribing any medications for this?"

- "Medication isn't typically a first-line treatment for loss of libido until we understand the underlying cause. We may look at options if other avenues don't yield any improvement."

Examiner Questions:

1. What are some common causes of loss of libido in a 32-year-old female?

- "Common causes include stress, relationship issues, hormonal imbalances, medical conditions such as depression or anemia, or medication side effects."

2. How would you approach a psychosexual history in this case?

- "I would build rapport, ensure a comfortable and private setting, then ask open-ended questions about her relationship, sexual satisfaction, and changes in sexual activities."

3. Which investigations would you consider?

- "A Full Blood Count, Thyroid Function Tests, Hormonal assays, Liver Function Tests, Serum electrolytes, and possibly a Urinalysis."

4. What non-pharmacological interventions can be recommended for loss of libido?

- "Psychosexual counseling, stress reduction techniques, improving couple communication, ensuring adequate sleep and physical health, and addressing lifestyle factors."

5. Can you name potential side effects of medications that might be used for this condition?

- "Some medications like certain antidepressants can have side effects that affect sexual desire. It's important to balance treatment goals with potential impacts on libido."

Treatment:

Treatment should follow a biopsychosocial approach:

- Discussion and education about normal sexual response and variations.

- Psychosexual counseling if appropriate.

- Stress management techniques.

- Review and possibly adjust any current medications that can affect libido.

- Consider hormonal treatments such as estrogen therapy if indicated after thorough assessment (varies on the patient case and hormone levels).

- Referral to an Endocrinologist or Gynecologist if hormonal imbalances are suspected.

Monitoring:

Follow-up in 3-6 months for reassessment or sooner if the patient's symptoms worsen. If hormonal therapy is initiated, monitor according to the specific hormone levels and treatment guidelines. Encourage patient to return if new symptoms develop or if she is concerned about side effects of any new treatments.

Prognosis:

Variable based on the underlying cause. Lifestyle modifications and addressing psychological factors generally have a positive outcome. Hormonal imbalances can be corrected with appropriate treatment, which also generally results in an improvement in symptoms.

Differential diagnoses:

1. Depression: Often associated with loss of libido, but other symptoms such as low mood, anhedonia, and changes in sleep or appetite should be present.

2. Hypothyroidism: Can cause decreased libido. Thyroid function tests can help rule this out.

3. Anemia: Fatigue related to anemia can lead to decreased libido.

4. Medication side effects: A detailed drug history can rule out this possibility.

5. Relationship issues: Open discussion can reveal underlying factors that may be contributing.

Speciality Filter:

Endocrine And Metabolic; Mental Health; General Practice

Presenting Complaint Filter:

General Malaise; Change In Libido

Condition Filter:

Loss Of Libido

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_34\_Postpartum depression

Homepage Vignette:

## “A 28-year-old individual called Kamau presents with persistent sadness and difficulty bonding with their newborn.”

Individual Page Vignette:

You are a General Practitioner meeting Kamau, a 28-year-old marketing consultant, at your clinic. Kamau has come in due to feelings of persistent sadness, and they've noted a particular difficulty in bonding with their newborn.

Patient Name: Kamau Kibet (kə-MAU kee-BET), Kamau would like to be called by their first name.

DOB: 24/06/1995

Location: Clinic

Personality: Kamau is articulate and usually exudes self-confidence, often speaking in a clear, well-modulated voice. They typically maintain good eye contact but have recently been more withdrawn and introspective. Kamau has a higher educational level and typically enjoys vigorous discussions but has been less engaged lately.

Presenting Complaint: "I just can't shake off this feeling of sadness. It's like there's a cloud hanging over me all the time, and no matter what I do, I can't seem to bond with my baby."

History of Presenting Complaint:

- Symptoms commenced a few weeks postpartum.

- Has not sought medical attention until now.

- Symptoms have been relentless and show no sign of improvement.

- Symptoms occur daily and impact Kamau's ability to perform ADLs and fulfill their work responsibilities.

- The emotional state is causing significant distress.

- Reports of intermittent crying spells.

- Feelings of hopelessness and worthlessness. "It's a heavy, oppressive kind of sadness; like I'm stuck in a fog."

- Decreased interest in activities previously enjoyed.

- Fatigue and low energy.

- Has trouble sleeping and barely has an appetite

- Difficulty concentrating and making decisions.

- Anxiety about caring for the newborn.

"I thought at first it was just the 'baby blues' that everyone talks about, but it's not getting better. If anything, it's getting worse."

Systemic Symptoms:

- Reports fatigue and decreased energy that is pervasive.

- Sleep disturbances noted, with difficulty both falling and staying asleep.

- Reduced appetite with some weight loss.

- Denies fever, night sweats, or other systemic symptoms.

"I'm just so tired all the time, and I haven't been eating much. No matter how exhausted, I just can't sleep right."

Past Medical History:

- Previous history of mild anxiety during college, which Kamau managed without seeking dedicated psychiatric treatment.

- No known episodes of major depression or other psychiatric diagnoses prior to current presentation.

- There is a family history suggesting possible psychiatric illness in the maternal line.

"I had some anxiety back in my uni days, but it was nothing I couldn't handle. It never got this bad, though."

Risk Assessment:

- Currently, there are no reports or indications of self-harm or suicidal ideation.

- However, given the symptoms of postpartum depression, it's essential to assess for these risks regularly.

- Kamau expresses overwhelming feelings but has not indicated feeling out of control or unable to manage the care of the newborn.

- There's concern about the impact of their mood on the baby, which can be an indicator of engagement and a desire to provide good care.

"It's hard, you know? But I would never do anything to hurt myself or my baby. I'm just really worried about how this is all affecting my little one."

Psychiatric History:

- Kamau should be evaluated thoroughly for any personal or family history of mood disorders, especially in the context of the maternal grandmother's 'nervous breakdowns.'

- A detailed history focusing on any previous episodes of significant mood changes, treatment received, and the impact on daily functioning is essential.

- Any history of substance abuse that could influence current mood symptoms should also be assessed.

"As far as I know, no one in my family has been officially diagnosed with anything. But, I remember my grandmother having some really tough times."

Drug History:

- Reports taking prenatal vitamins during pregnancy, but no other medications currently.

- No known history of medication non-compliance or overdoses.

- Denies use of herbal supplements or alternative therapies.

"I stopped taking the vitamins after the birth, and I'm not on any other meds."

Allergies:

- No known allergies to medications, foods, or environmental allergens.

"I've never had an allergic reaction to anything, thankfully."

Family History:

- Maternal grandmother had 'nervous breakdowns' but no formal psychiatric diagnosis.

- Parents are healthy with no significant medical history.

- One older sibling with no known medical conditions.

"My grandmother had a tough time, mentally, I think. But they didn't talk about it much back then."

Social History:

Lifestyle:

- Lives with partner and newborn.

Occupation:

- Works as a marketing consultant, currently on maternity leave.

Activities of Daily Living & Hobbies:

- Enjoys reading and socializing with friends, though much less recently.

Smoking: Non-smoker

Alcohol: Drinks socially, approximately 2 units per week but has abstained since becoming pregnant.

Recreational Drug Use: Denies any recreational drug use.

Diet: Generally follows a balanced diet but has been eating less due to decreased appetite.

Exercise: Enjoyed regular yoga classes before pregnancy, intends to resume.

"I haven't touched a drink in ages, and I don't smoke or do drugs. I used to enjoy cooking, but now I just can't find the energy."

Ideas, Concerns, and Expectations:

- Kamau understands that their symptoms may be related to a mental health condition but is unsure of the specifics.

- They are concerned about the impact of their mood on their ability to care for their newborn and the long-term implications.

- Kamau expects to receive information on what could be causing their symptoms and the available treatment options.

"I'm worried I might have that postpartum depression I've heard about. I just want to feel like myself again and be a good parent to my child."

Observations (assuming all parameters are normal):

Respirations: 14 Breaths/min

Oxygen Saturation: 98% on room air

Blood Pressure: 120/80 mmHg

Pulse: 70 Beats/min

Consciousness: Alert

Temperature: 36.7°C

NEWS Total Score: 0 (All observations are within normal range)

Physical Examination:

- General appearance consistent with fatigue.

- No acute distress.

- Detailed musculoskeletal, cardiovascular, respiratory, and abdominal examinations are within normal limits.

- Neurological examination reveals no abnormalities.

Special Tests:

- Postpartum depression screening using validated questionnaires such as the Edinburgh Postnatal Depression Scale.

Diagnostic Tests:

- Thyroid Function Tests: To rule out thyroid dysfunction as a cause for mood symptoms.

- Complete Blood Count: To check for anemia or other blood disorders that could contribute to fatigue and mood changes.

- Other tests only as clinically indicated based on the history and examination findings.

Condition:

Postpartum depression

Patient Questions:

"How will you treat my depression? Will it involve medication?"

- "We have several options including therapy, medication, or a combination. If medication is considered, we'll discuss the benefits and any potential side effects."

"Can postpartum depression affect my baby?"

- "Your emotional well-being can influence your bond with the baby, but seeking treatment can help to ensure both you and your baby thrive."

"What if I don't get better?"

- "Postpartum depression is treatable, and many people improve with the right support and treatment. We'll monitor you closely and make any necessary changes to your treatment plan."

Examiner Questions:

1. What is the difference between 'baby blues' and postpartum depression?

- "Baby blues" are common and include mood swings, crying spells, anxiety, and difficulty sleeping. They typically begin within the first two to three days after delivery and may last for up to two weeks. Postpartum depression is more severe, longer-lasting, and includes symptoms such as depressed mood, loss of interest in activities, and possible difficulty bonding with the baby.

2. How would you differentiate postpartum depression from postpartum psychosis?

- Postpartum psychosis is a rare, severe mental illness that can occur after childbirth, characterized by hallucinations, delusions, mania, or thoughts of harming oneself or the baby. It is considered a psychiatric emergency, whereas postpartum depression, while serious, is less acute and does not typically include psychotic features.

3. Can thyroid dysfunction mimic postpartum depression?

- Yes, thyroid dysfunction, particularly hypothyroidism, can mimic or contribute to symptoms of depression, including in the postpartum period. This is why thyroid function tests are an important part of the evaluation.

4. What interventions can be effective for a patient with postpartum depression?

- Treatment options may include counseling, specifically cognitive-behavioral therapy or interpersonal therapy, antidepressant medications, and support groups. Lifestyle changes and self-care measures can also be beneficial adjuncts to treatment.

5. What are the potential risks of untreated postpartum depression?

- Untreated postpartum depression can affect the mother's ability to care for herself and her baby, potentially leading to poor bonding, difficulties with breastfeeding, and impaired infant development. There can also be lasting impacts on the child's emotional and behavioral development.

Treatment:

- Initial steps include counseling and consideration for starting an SSRI antidepressant, with sertraline often being a first-line choice due to its safety profile in breastfeeding.

- Dosages should start low and be titrated up as necessary.

- If the patient has a contraindication or adverse reaction to SSRIs, alternatives such as SNRIs, bupropion, or tricyclic antidepressants may be considered.

- It is essential to tailor the treatment plan to the individual patient, taking into account their breastfeeding status and any other medical conditions.

- Psychotherapy, particularly cognitive behavioral therapy and interpersonal therapy, should be offered in conjunction with medication or as a stand-alone treatment in mild cases.

- Other non-pharmacological interventions such as exercise, peer support, and ensuring social support should be discussed with the patient.

Monitoring:

- Weekly to bi-weekly follow-up initially to monitor response to treatment and adjust as necessary.

- Monitor for any side effects of medication.

- Regular use of screening tools such as the Edinburgh Postnatal Depression Scale to assess symptom progression.

- Longer-term monthly follow-up once stability is achieved.

- Referral to a psychiatrist should be considered if there is no improvement with first-line treatments or if symptoms worsen.

Prognosis:

- With appropriate treatment, most individuals with postpartum depression improve. The length of treatment depends on symptom severity and response, but symptoms typically begin to improve within a few weeks of starting treatment.

- Some may require longer-term treatment to prevent relapse.

- Early intervention and support play critical roles in the prognosis and overall outcome.

Differential diagnoses:

1. Adjustment disorder with depressed mood

2. Thyroid dysfunction (Hypothyroidism)

3. Anemia or other blood disorders

4. Generalized anxiety disorder

5. Chronic fatigue syndrome

6. Postpartum psychosis (much less common and more severe)

Postpartum depression is more likely than these conditions due to the symptom timing, character, and associated features like difficulty bonding with the newborn, which are more specific to postpartum depression.

Speciality Filter:

Mental Health; Obstetrics And Gynaecology; General Practice

Presenting Complaint Filter:

Persistent Sadness; Difficulty Bonding With Newborn

Condition Filter:

Postpartum Depression

Location Filter:

Clinic

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_35\_Postpartum psychosis

Homepage Vignette:

## A 29-year-old female called Aditi presents with acute onset of confusion and agitation.

Individual Page Vignette:

You are the physician in the emergency department, and a 29-year-old woman named Aditi Choudhary (pronounced Ah-dee-tee Chau-dhur-ree), an accountant, arrives displaying acute confusion and agitation.

Patient Name: Aditi Choudhary (Prefers to be called Aditi)

DOB: 16/07/1995

Location: Emergency Department

Personality: Aditi typically maintains a calm and methodical demeanor. She is articulate and values clear communication. However, during your interaction, she appears disorganized and her speech is pressured and difficult to follow.

Presenting Complaint: "I just can't seem to think straight, everything is spinning, and it's scaring me."

History of Presenting Complaint:

- Acute confusion: Aditi reports, "I don't know why, but I can't seem to keep my thoughts in order."

- Agitation: "It's like something's crawling in my skin; I need to keep moving."

- Altered sleep patterns: "I haven't been able to sleep properly for days."

- Suspiciousness: She might express, "I feel like people are plotting against me."

- Auditory hallucinations: "Sometimes, I hear voices telling me to do things."

- Aditi comments, "This began out of nowhere a couple of days after I left the hospital with my newborn."

- Her confusion and agitation have been worsening since they first appeared.

- The symptoms are persistent and severe enough to impact her ability to care for herself and her baby.

Quote: "I was fine the first day back from the hospital, but then, suddenly, this frightening confusion started, and it keeps getting worse."

Systemic Symptoms:

- Fatigue: "Yes, I feel exhausted all the time."

- Sleep disturbance: "I haven't had a good night's sleep since the baby was born."

- Appetite changes: "I have to remind myself to eat."

Quote: "It's like I'm running on empty; I can barely eat or sleep."

Past Medical History:

- Pregnancy and recent childbirth.

- No history of psychiatric illness or substance abuse.

- Immunizations up to date.

Past Psychiatric History:

- No previous psychiatric diagnoses or hospital admissions for mental health reasons.

- She denies any history of depression or anxiety, either personally or in the family.

- No known history of psychosis or bipolar disorder prior to the current episode.

Quote: "I've never had to deal with anything like this before; my mental health has always been pretty stable."

Risk Assessment:

- Assess for suicidal ideation: "Have you had any thoughts of harming yourself or others?"

- Assess for harm to baby: "Have there been moments when you felt you might unintentionally harm the baby?"

- Determine the level of support at home: "Is there someone at home to help you take care of the baby?"

Quote for suicidal ideation: "No, the thought scares me; I just want to get better for my baby."

Quote for harm to baby: "I would never want to hurt my child, but I'm scared of these unpredictable thoughts."

Quote for level of support: "My partner and parents have been helping, but they're also very worried."

Quote: "This is the first time I've had any mental health issues. Other than being pregnant, I have been healthy."

Drug History:

- Prenatal vitamins during pregnancy.

- No history of medication non-compliance, herbal supplements, or alternative therapies.

Quote: "I only took the vitamins my OB/GYN recommended."

Allergies:

- No known allergies.

Family History:

- No known mental health illnesses in the family.

Quote: "There's no history of something like this happening in my family."

Social History:

Lifestyle: As an accountant, Aditi's life is usually structured and organized.

Occupation: Accountant.

Activities of Daily Living & Hobbies: "I usually love to read and organize things in my free time."

Smoking: Non-smoker.

Alcohol: Aditi reports occasional social drinking before pregnancy, but none during or after.

Recreational Drug Use: None.

Diet: "I usually have a balanced diet, but I haven't been eating well recently."

Exercise: Regular prenatal yoga during pregnancy, but none post-delivery.

Quote: "I have a straightforward life, work, home, a good book. No smoking or drugs ever. I've just not been feeling up for yoga or eating right since the baby came."

Ideas, Concerns, and Expectations:

- Aditi may believe her symptoms are due to stress or a physical illness.

- She is concerned about her ability to care for her newborn and fears she might be "going mad."

- She expects to find out what is wrong and to get treatment so she can take care of her baby.

Quote: "I just want to know if this is something serious or if it's all in my head. I need to be there for my baby."

Observations:

Respirations (Breaths/min): Expect within normal range.

Oxygen Saturation (%): Likely normal.

Air or Oxygen?: Room air.

Blood Pressure (mmHg): May be elevated due to agitation.

Pulse (Beats/min): Likely elevated due to anxiety.

Consciousness (AVPU): Confused.

Temperature (Celsius): Likely normal.

NEWS Total Score: Will be calculated based on the gathered observations.

Physical Examination:

Include a general examination as well as a focused neurological and mental status examination.

Special Tests:

There are no specific physical special tests indicated, but mental status examination findings are essential.

Diagnostic Tests:

Blood Tests (Reference Ranges) to rule out organic causes:

- Full Blood Count (FBC)

- Urea and Electrolytes

- Liver Function Tests

- Thyroid Function Tests

Imaging Tests:

- In postpartum psychosis, imaging may not be initially indicated unless organic causes are considered.

Condition:

Postpartum Psychosis

Patient Questions:

- "Will I be able to care for my baby after this?" (Possible answer: "That's our goal, and we will provide the support you need to get there.")

- "Am I going to feel like this forever?" (Possible answer: "With the right treatment, we aim for a full recovery.")

- "Do you think I'm a bad mother because of this?" (Possible answer: "No, this is a medical issue, and it doesn't reflect on your abilities as a mother.")

Examiner Questions:

- "What are the criteria for diagnosing postpartum psychosis?" (Answer: Acute onset of psychotic symptoms within 2 weeks of delivery, including confusion, delusions, hallucinations, or mania.)

- "What are the risk factors associated with postpartum psychosis?" (Answer: Personal or family history of bipolar disorder, first pregnancy, recent delivery.)

- "Can you list some differential diagnoses?" (Answer: Bipolar disorder, delirium, substance-induced psychosis.)

- "How do you manage a patient with postpartum psychosis?" (Answer: Admit to psychiatric care, start antipsychotic medications, consider mood stabilizers, provide supportive care.)

- "What is the role of the partner/family in managing this condition?" (Answer: They can provide support, help monitor treatment progress, and ensure the safety of the patient and the baby.)

Treatment:

Following NICE guidelines, the treatment plan may include:

- Immediate referral to a mental health team for assessment and possible admission.

- Start antipsychotic medication.

- Consider mood stabilizers like lithium or anticonvulsants.

- Psychological support and counselling.

Monitoring:

- Regular psychiatric assessments to monitor response to treatment.

- Engage community mental health services post-discharge.

- Follow-up visits as recommended by the mental health team.

- Consider the baby's safety and possibly involve social services if needed.

Prognosis:

- With prompt and appropriate treatment, many women can make a full recovery from postpartum psychosis.

- Continuous support and monitoring are critical to prevent recurrence, especially in subsequent pregnancies.

Differential diagnoses:

1. Bipolar Disorder: Less likely because of the timing and no known history.

2. Delirium: Can present similarly but less likely given the postpartum context.

3. Substance-Induced Psychosis: Aditi has no history of substance use.

Speciality Filter:

Mental Health; Obstetrics And Gynaecology.

Presenting Complaint Filter:

Acute Confusion; Agitation.

Condition Filter:

Postpartum Psychosis.

Location Filter:

Accident & Emergency.

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_36\_Somatic symptom disorder

Homepage Vignette:

A 38-year-old individual called Sam presents with persistent bodily aches and excessive worry about their health.

Individual Page Vignette:

You are a general practitioner (GP). Sam, a 38-year-old software developer, comes into your clinic reporting persistent bodily aches and excessive worry about their health.

Patient Name:

Sam Patil (pronounced: "pah-TEEL"; would like to be called Sam)

Age:

23/08/1986

Location:

General Practice

Personality:

Sam is meticulous, often speaks in detail and is prone to analyze situations extensively. During conversations, Sam may interrupt to seek clarification and often expresses concerns about various health issues, despite reassurances.

Presenting Complaint:

Sam reports, "I've been feeling all these aches in my body, and I seriously can't stop worrying that it might be something severe."

Symptoms:

SOCRATES for main symptom - persistent bodily aches:

- Site: "It's all over my body, no specific place really."

- Onset: "Probably started a few months ago, but it has gotten worse lately."

- Character: "It feels like a deep ache, sometimes it's just a nagging feeling."

- Radiation: "Doesn't really radiate, it's more like it's everywhere."

- Associated Symptoms: "I just feel really tired, and no matter what I do, I feel like it's never enough."

- Timing: "It's there most of the time, it doesn't come and go."

- Exacerbating and Relieving Factors: "Resting doesn't help much, and I can't say anything specific makes it worse."

- Severity: "On a scale of 10, it's about a 5 or 6 usually."

- Negative for associated red flags like weight loss, fever, or night sweats.

- Lack of response to over-the-counter painkillers.

History of Presenting Complaint:

- The symptoms have been present for several months.

- Over-the-counter pain medication provides little relief.

- The aches have progressively become more bothersome.

- Symptoms are constant but vary in intensity.

- Daily activities are becoming increasingly challenging.

- The aches have not affected Sam's ability to work but have increased stress levels.

- Sam is concerned about the possibility of a serious undiagnosed illness.

Quote: "I feel achy all the time and it's making my usual day so hard to get through. I've tried taking painkillers, but they don't seem to work well."

Systemic Symptoms:

- Sam denies experiencing significant fatigue or weight changes.

- No complaints of fever or night sweats.

- Reports of generalized weakness but may be due to anxiety.

- No changes in bowel or urinary habits.

- Sleep is reported to be disrupted by worry.

Quote: "I don't really feel sick like with a fever or anything, but I've been feeling weak, probably because I'm so anxious all the time."

Past Medical History:

- No significant past medical history to note.

- No known surgical history.

- No psychiatric history, but currently experiencing significant health-related anxiety.

Quote: "I've never really had any serious health issues before this, which is why I'm so worried about these aches."

Psychiatry History:

- Explore current and past mental health including any history of similar symptoms.

- Evaluate for common comorbid conditions like anxiety, depression, panic attacks, or other psychiatric disorders.

- Assess for any past psychiatric interventions or treatments and their outcomes.

- Inquire about psychosocial stressors that may contribute to symptomatology.

- Explore the patient's coping mechanisms and support systems.

- Evaluate for any history of substance use that could affect mental status.

Quote: "This is the first time I've had these health worries. I sometimes feel low or anxious, especially when things get stressful at work. I haven't seen anyone for this before."

Risk Assessment:

- Assess for any thoughts of self-harm or suicide; inquire about any previous attempts or current ideations.

- Consider the patient's overall risk to themselves and others based on their presentation and mental state.

- Ask about any impact of symptoms on daily activities and relationships to assess for possible neglect or risk of deterioration.

- Evaluate risk factors for somatoform disorders, such as a history of trauma or chronic stress.

- Assess for functional impairment and whether it poses a risk to the patient's safety or wellbeing.

Quote: "I've never thought about harming myself, but I'm really struggling to keep up with my life because of these constant worries."

Drug History:

- Occasionally takes ibuprofen, but with no significant relief.

- No history of regular medication use, allergies, or supplement intake.

Quote: "I sometimes take ibuprofen when it gets bad, but it doesn't help much."

Allergies:

- Reports no known allergies.

Quote: "I'm not allergic to anything that I know of."

Family History:

- Parental history of hypertension.

- No other significant family health issues reported.

Quote: "My mom has high blood pressure, but that's about it in my family."

Social History:

Lifestyle:

- Describes a sedentary lifestyle with minimal physical activity.

Occupation:

- Works as a software developer, often under high stress.

Activities of Daily Living & Hobbies:

- Enjoys reading and playing video games in free time.

Smoking: Non-smoker.

Alcohol: Consumes alcohol socially, about 2-3 units per week.

Recreational Drug Use: Denies any drug use.

Diet: Generally balanced, no significant restrictions.

Exercise: Minimal exercise due to a busy work schedule.

Quote: "I have a few drinks on the weekends, and I don't smoke or do drugs. My job keeps me pretty busy, so I don't get to work out much."

Ideas, Concerns, and Expectations:

- Ideas: Believes the symptoms might indicate a serious undiagnosed illness.

- Concerns: Worried that the symptoms will never resolve and will significantly impact the quality of life.

- Expectations: Hopes to receive comprehensive testing to rule out any serious conditions and to start feeling better soon.

Quote: "I'm just scared I have something serious. I really want to get some tests done to be sure it's nothing life-threatening."

Observations:

- Respirations (Breaths/min): 16 (0 points)

- Oxygen Saturation (%): 98 on room air (0 points)

- Blood Pressure (mmHg): 125/80 (0 points)

- Pulse (Beats/min): 85 (0 points)

- Consciousness (AVPU): Alert (0 points)

- Temperature (Celsius): 36.7 (0 points)

- NEWS Total Score: 0 (All parameters score 0 points in their respective ranges)

Physical Examination:

- General inspection shows an anxious appearance but no distress.

- No signs of trauma, rash, or infection on the body.

- Musculoskeletal exam reveals no swelling, redness, or deformity.

- Examination of the chest, abdomen, and neurological systems are unremarkable.

Special Tests:

- No special tests required at this time due to the nature of the presenting complaint.

Diagnostic Tests:

- Considering the symptoms, basic laboratory tests may be initiated to rule out common systemic causes of aches.

- If clinically indicated based on initial findings or patient's anxiety levels, imaging studies could be considered.

Condition:

Somatic symptom disorder

Patient Questions:

1. "What if the tests you run don't find anything? What do we do then?"

- We will explore other possible causes, including stress or anxiety, which can sometimes manifest as physical symptoms.

2. "Could this be something like cancer or an autoimmune disease?"

- While it's natural to worry about serious conditions, your symptoms do not clearly point to any specific disease like cancer or an autoimmune disorder, especially without any red flag symptoms.

3. "How can we be sure it's not something serious?"

- We begin by conducting a thorough examination and basic tests to rule out common causes. Based on these results, we can determine if further testing is necessary.

4. "What kind of treatment will I receive if it's just anxiety?"

- Treatment might include therapy, such as cognitive-behavioral therapy, and possibly medication to help manage anxiety.

Examiner Questions:

1. What are some common red flag symptoms you would look for in a patient presenting with bodily aches?

- Unintentional weight loss, fever, night sweats, severe unrelenting pain, localized pain with signs of infection or trauma.

2. How would you differentiate between somatic symptom disorder and fibromyalgia?

- Fibromyalgia often has specific tender points, sleep disturbances, and may be associated with other symptoms such as irritable bowel syndrome. Somatic symptom disorder is more characterized by health anxiety and excessive concern.

3. What is the role of reassurance in managing patients with somatic symptom disorder?

- Reassurance, along with education about the condition, can help reduce anxiety and may improve symptoms. However, it should be balanced with validating the patient's symptoms and concerns.

4. When should a patient with suspected somatic symptom disorder be referred to psychiatry?

- Referral to psychiatry may be considered if the symptoms significantly impair the patient's daily functioning or if initial interventions are not effective.

5. Can somatic symptom disorder manifest with only one type of symptom, such as pain?

- Yes, somatic symptom disorder can manifest with a single predominant symptom like pain, which causes disproportionate concern.

6. What non-pharmacological interventions can be beneficial for patients with somatic symptom disorder?

- Cognitive-behavioral therapy, stress management techniques, and regular exercise may all be beneficial.

Treatment:

According to NICE guidelines, treatment for somatic symptom disorder may include:

- Psychological therapies such as cognitive-behavioral therapy (CBT), which could be considered the first-line treatment.

- Pharmacotherapy may include the use of selective serotonin reuptake inhibitors (SSRIs), such as sertraline starting at a dose of 50 mg daily and titrated according to response.

- Regular follow-up appointments to monitor symptoms and build a therapeutic relationship.

- If SSRIs are not effective or not tolerated, consider alternative antidepressants such as serotonin-norepinephrine reuptake inhibitors (SNRIs).

- Referral to mental health services if symptoms are severe or the patient is not responding to primary care treatments.

Monitoring:

- Patients should be followed up regularly, with the frequency depending on the severity of symptoms and response to treatment.

- Monitor for any new or worsening symptoms at each visit.

- Assess the effectiveness of psychological interventions.

- Review and adjust medication dosages as necessary based on symptom control and side effects.

- Consider referral to a psychiatrist if no improvement is seen with initial treatments or if the patient's functioning continues to be significantly impaired.

Prognosis:

- The prognosis for somatic symptom disorder is variable. Some individuals may experience improvement with treatment, while others may have persistent symptoms.

- Factors that may influence the response to treatment include the presence of comorbid psychiatric conditions, the degree of functional impairment, and the patient's level of insight into their condition.

- Early intervention and a strong therapeutic relationship can improve outcomes.

- Ongoing management and support are often required to maintain progress and prevent relapses.

Differential Diagnoses:

1. Fibromyalgia - Less likely due to the absence of characteristic tender points.

2. Chronic fatigue syndrome - Less likely due to predominantly bodily aches and absence of profound fatigue.

3. Rheumatological disease - Less likely in the absence of joint inflammation, deformity, or characteristic clinical findings.

4. Depression with somatic complaints - Possible, requires further assessment of mood symptoms.

Keyword Filters:

Speciality Filter:

Mental Health; General Practice.

Presenting Complaint Filter:

Unexplained Bodily Aches; Persistent Worry About Health.

Condition Filter:

Somatic Symptom Disorder.

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_37\_Korsakoff syndrome

Homepage Vignette:

## A 62-year-old male called Suresh presents with memory loss and confusion.

Individual Page Vignette:

You are a doctor in a General Practice clinic. Your next patient is Suresh Ramaswamy, a 62-year-old retired librarian. Suresh presents with memory loss and confusion that have progressively worsened over several months.

Patient Name: Suresh Ramaswamy (Pronunciation: Sure-esh Rah-mah-swah-mee). He prefers to be called Suresh.

Age: Born on 16/06/1961

Location: General Practice

Personality: Suresh is a gentle, introspective individual who speaks thoughtfully and deliberately. He displays a keen interest in literature and history, reflecting his career as a librarian. Despite his confusion, Suresh tries to articulate his concerns as accurately as he can.

Presenting Complaint: Suresh reports experiencing progressive memory disturbances and occasional confusion, particularly with recent events. "My memory isn't what it used to be; I'm beginning to forget even the recent things I've read."

Symptoms:

- Site: "It's my memory that's fuzzy."

- Onset: "This has been going on for several months now, but it's been getting more noticeable lately."

- Character: "It's a gradual fading, like details slipping through my fingers."

- Radiation: Not applicable for cognitive symptoms.

- Associated Symptoms: "I sometimes feel unsteady on my feet, and my family says I repeat myself often."

- Timing: "I can't pinpoint an exact time; it seems to get worse as the day goes on."

- Exacerbating and Relieving Factors: "Resting doesn't seem to help much, and stress tends to make it worse."

- Severity: "It's quite troubling; I'd say it's fairly severe since it's affecting my daily life."

The patient denies any other localised physical symptoms but notes a general decline in his functional status.

History of Presenting Complaint:

- Suresh has been experiencing the symptoms for approximately six months.

- No previous treatments have been attempted for these symptoms.

- The symptoms have progressively worsened.

- The confusion and memory loss can occur multiple times throughout the day.

- Daily activities such as reading and retaining information have become challenging.

- Suresh is retired and reports that his symptoms are causing distress but not impacting work.

- He expresses concern about his declining mental capabilities and fears it may impact his independence.

"I've noticed the missing pieces for a while, but I kept hoping it would improve. Now, I feel as if I'm losing a part of myself."

Systemic Symptoms:

- No reported fatigue, fever, or night sweats.

- No unintentional weight loss reported.

- Generalized weakness is denied.

- Suresh denies malaise but notes a decline in his overall functional abilities.

- Normal bowel and urinary habits.

- No significant changes in sleep patterns.

- Peripheral oedema is not present.

"I feel fine physically; it's just the mental fog that's bothering me."

Past Medical History:

- Hypertension managed with medication.

- No history of diabetes or cardiac conditions.

- No previous surgical interventions.

- Suresh had a mild depressive episode eight years ago but has been well since with no ongoing psychiatric care.

- No history of substance abuse or addiction.

- Immunizations and vaccination history are up to date, no recent illnesses or vaccinations.

- No significant family history of neurological diseases.

"Aside from my blood pressure and that one rough patch with depression, I've been quite healthy."

Psychiatric History:

- Explore Suresh's past psychiatric history, ensuring to inquire about any previous diagnoses, treatments, admissions, or outpatient care.

- Ask about a history of any mood disorders, psychotic episodes, anxiety disorders, or substance use disorders.

- Inquire particular about periods of depression given the previous mild depressive episode.

- Assess his insight and judgment regarding his condition and daily living activities.

- Determine the social support network in place, as well as any coping mechanisms he uses when stressed or anxious.

"Suresh, have you ever had to visit a psychiatrist or counsellor for any emotional or mental health issues? Can you tell me a little more about the time when you felt depressed?"

Risk Assessment:

- Evaluate for any risk to himself, including thoughts of self-harm or suicide, or if there has been any past self-harm behavior.

- Assess if Suresh has the capacity to manage his medications and daily activities or if he poses a risk to himself due to the confusion.

- Evaluate his living situation for possible risks, such as forgetting the stove on or poor nutrition due to forgetting to eat.

- Assess if there is any potential risk for vulnerability or exploitation due to his cognitive symptoms.

- Determine if he is a risk to others, such as if confusion might lead to driving accidents.

Drug History:

- Suresh is currently on Amlodipine 10 mg once daily for hypertension.

- No history of medication non-compliance or missed doses.

- Suresh reports no use of herbal supplements or alternative therapies.

- No known overdoses or complications with medications.

"I've been taking the little white pill for my blood pressure every day without fail. That's about it."

Allergies:

- No known drug allergies.

- Suresh reports a mild allergy to pollen, causing occasional hay fever.

"I sneeze a fair bit during spring, but it's nothing too troublesome."

Family History:

- His father had a history of coronary artery disease.

- His mother is alive and well at 87, with no significant medical history.

- No known family history of memory disorders or dementia.

"Both my parents lived to a ripe old age with the usual health issues of old age; memory problems aren't really in the family."

Social History:

Lifestyle:

- Suresh is retired, living a quiet life with a strong interest in reading and history.

Occupation:

- He retired five years ago after a long career as a librarian.

Activities of Daily Living & Hobbies:

- Suresh enjoys reading, taking walks in the park, and occasionally attending local history lectures.

"I used to work at the city library before retiring. Now, I spend my days with my books and my walks."

- Smoking: Suresh has never smoked ("Never picked up the habit.").

- Alcohol: Suresh drinks alcohol socially, approximately two units per week ("Just a glass of wine with dinner on the weekends.").

- Recreational Drug Use: No history of recreational drug use ("Never tried any of that stuff.").

- Diet: A balanced diet with a focus on vegetables and lean protein ("I try to eat healthily, lots of greens and fish.").

- Exercise: Regular walks, but no structured exercise regime ("Walking is my exercise; I enjoy the fresh air.").

- No recent travel history.

- Suresh is a widower and has not been sexually active recently.

- He holds a valid driver's license but drives infrequently due to his symptoms ("I prefer not to drive much these days, just to be safe.").

- No specific cultural or religious practices influencing medical care.

- No significant recent life events or exposure to new environments or hazards.

Ideas, Concerns, and Expectations:

- Suresh understands that memory problems can be a part of ageing, but he is educated enough to be concerned about the possibility of a dementia-related illness.

- His primary concerns are the progression of his symptoms and the potential impact on his independence.

- Suresh expects a thorough assessment and hopes to receive advice, support, and any treatment that might help slow the progression of his symptoms.

"I've read enough to know that this could be something serious. I just want to understand what's happening and how I can manage it."

Observations:

- Respirations (Breaths/min): 16

- Oxygen Saturation (%): 98% on room air

- Air or Oxygen?: On room air

- Blood Pressure (mmHg): 135/85

- Pulse (Beats/min): 72

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.7

- NEWS Total Score: 0

Physical Examination:

The physical examination should include a thorough neurologic exam, checking for orientation, attention, memory, language, visuospatial function, executive function, and any signs of ataxia or nystagmus.

Special Tests:

- Mini-Mental State Examination (MMSE) to assess cognitive function.

- Gait analysis to evaluate for ataxia or other movement disorders.

Diagnostic Tests:

Blood Tests (Reference Ranges):

- Full Blood Count (FBC): All within normal ranges

- Urea and Electrolytes: All within normal ranges

- Liver Function Tests: All within normal ranges

- Thyroid Function Tests: All within normal ranges

- B12 and Folate: All within normal ranges

Imaging Tests:

- MRI Brain: If indicated, to assess for structural anomalies that might explain the cognitive symptoms.

Condition:

Korsakoff syndrome

Patient Questions:

1. "Can you tell me exactly what is happening to my brain?" (Your brain is having difficulty with certain processes that affect memory and learning.)

2. "Will I get worse? Is this condition progressive?" (Korsakoff syndrome can be managed with proper treatment and lifestyle adjustments, but it is important to closely monitor your condition.)

3. "Are there things I can do at home to help with my memory?" (Yes, mental exercises and maintaining a healthy lifestyle can be beneficial alongside treatment.)

Examiner Questions:

1. What is the first-line investigation for a patient presenting with confusion and memory loss? (A thorough history and cognitive assessment, combined with blood tests to rule out reversible causes.)

2. What are the risk factors for developing Korsakoff syndrome? (Chronic alcohol abuse, poor nutrition, and particularly a deficiency in thiamine, are significant risk factors.)

3. How would you differentiate between Alzheimer's disease and Korsakoff syndrome clinically? (While both involve memory loss, Korsakoff syndrome is typically characterized by confabulation and lack of insight, which are not as prominent in Alzheimer's.)

4. What are the red flags in the history and examination of a patient with memory loss? (Sudden onset, rapid progression, focal neurologic deficits, and any signs of infection or metabolic disturbance.)

5. What would be the initial treatment for a patient diagnosed with Korsakoff syndrome? (Thiamine supplementation, nutritional support, and abstinence from alcohol.)

Treatment:

- Thiamine supplementation should be initiated urgently to prevent further neurologic damage.

- The BNF recommends parenteral thiamine before any oral intake in patients at risk.

- Following initial parenteral therapy, oral supplementation can continue, usually high-dose daily.

- Nutritional support and careful management of hydration and electrolytes are essential.

- Abstinence from alcohol is crucial.

Monitoring:

- Monitor cognitive function and signs of improvement or deterioration.

- Suresh should have regular follow-up appointments initially at more frequent intervals, such as monthly, and then less frequently based on the clinical response.

- Monitor for signs of over or under hydration and for the refeeding syndrome in those malnourished.

- Referral to neurology or psychiatry may be necessary for a comprehensive management plan.

Prognosis:

- With adequate treatment and abstinence from alcohol, some symptoms of Korsakoff syndrome may improve. However, many patients do not recover their full cognitive functions.

- Early diagnosis and treatment are crucial for a better prognosis.

- The outlook varies greatly between individuals, with some patients remaining severely impaired.

Differential diagnoses:

1. Alzheimer's Disease: less likely given the absence of insidious onset and pattern of memory loss.

2. Dementia with Lewy Bodies: less prominent visual hallucinations and spontaneous parkinsonism in this case.

3. Vascular dementia: absence of stepwise deterioration or associated cerebrovascular risk factors.

4. Normal Pressure Hydrocephalus: lack of the classic triad of gait disturbance, urinary incontinence, and cognitive dysfunction.

Speciality Filter:

General Practice; Mental Health; Medicine Of Older Adult; Neurosciences.

Presenting Complaint Filter:

Memory Loss; Confusion.

Condition Filter:

Korsakoff Syndrome.

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_38\_Conduct disorder

Homepage Vignette:

A 16-year-old named Priya Das presents with aggression and rule-breaking behavior.

Individual Page Vignette:

You are a General Practitioner and a 16-year-old patient named Priya Das (pronounced Pree-yah Daas) has come to your clinic. Priya, who prefers to be called by her first name, is a high school student living with her family. She has been brought in by her concerned parents due to her recurrent aggressive outbursts and persistent violation of societal norms.

Patient Name: Priya Das

Date of Birth: 01/06/2008

Location: General Practice

Personality:

Priya is outspoken and often defiant. She responds to questions with a tone of skepticism and tends to challenge authority. Despite her confrontational demeanor, she appears intelligent and articulate.

Presenting Complaint:

Priya's parents have noticed increased aggression and frequent involvement in altercations at school. She also admits to engaging in activities like shoplifting and vandalism.

Priya might say, "Yeah, I got into fights, but they started it, not me." or "So what if I took a few things? The stores are ripping us off anyway."

Priya might say, "They're making a big deal out of nothing, I'm just having a little fun. It's not like I'm hurting anyone."

History of Presenting Complaint:

- Symptoms started escalating about a year ago.

- Possible impulsivity and lack of remorse. The parents have noticed these behaviors escalating over the past year.

- No previous treatments attempted.

- The aggressive and rule-breaking behaviors have been getting worse.

- The behavior occurs both at home and at school.

- The behavior is impacting her academic performance and relationships.

Priya might say, "Everyone gets pissed off sometimes, I just don't like to take crap from anyone."

Systemic Symptoms:

No report of fatigue, fever, night sweats, unintended weight loss, general weakness, or malaise. Bowel and urinary habits are normal. Sleep patterns are erratic, which may be related to her behavior, but no significant peripheral oedema or other systemic symptoms reported.

Priya might say, "I sleep whenever I want, why does it matter? I'm not sick or anything."

Past Medical History:

No known past medical or surgical history.

No known psychiatric history, although current symptoms may indicate a potential behavioral disorder.

No substance abuse or addiction reported.

Up to date with immunizations.

Psychiatry History:

- Detailed mental health assessment to assess mood, thoughts, perceptions, and cognitive function.

- Evaluation for signs of depression, anxiety, and other mental health disorders.

- Exploration of the patient's insight into their behavior and its consequences.

- Assessment of risk factors for developing conduct disorder such as exposure to violence, family history of mental health issues, or substance abuse.

- Gathering information on peer relationships, bullying, or being bullied.

Priya might say:

"Mood? I'm fine unless people annoy me, then I get pissed off."

"I don't hear voices if that's what you're asking – my head’s clear."

"No one gets why I do things, but I don't really care about what they think."

Risk Assessment:

- Assessing for risk of harm to self or others.

- Evaluating the severity and frequency of aggressive behaviors.

- Assessing for the presence of any suicidal ideation or self-harm behaviors.

- Identifying access to weapons or substances that could increase risk.

- Considering environmental factors that may influence behavior, such as exposure to violence or criminal activity.

Priya might express:

"Harm myself? Why would I do that? It's the others that need to back off."

"I don’t plan on using any weapons, but I can defend myself if I need to."

"I'm not into that self-cutting crap, that's for attention seekers."

Drug History:

No current or past medications reported.

No known history of medication non-compliance.

Priya might say, "I don't need any meds, why would I?"

Allergies:

No known allergies or intolerances.

Priya might say, "I'm not allergic to anything that I know of."

Family History:

No significant family medical history reported.

Priya might say, "My family is healthy, nothing weird going on there."

Social History:

Smoking: Non-smoker.

Alcohol: Occasional binge drinking at parties, estimated 6-8 units per occasion.

Recreational Drug Use: Denies any use.

Diet: Admits to a preference for fast food.

Exercise: Occasionally skateboards but no regular exercise routine.

Lives at home with mother and father. No history of social work involvement.

Priya might say, "I grab a burger when I'm hungry, and yeah, I drink at parties, so what?"

Ideas, Concerns, and Expectations:

Priya believes her behavior is normal for someone her age and is not particularly concerned. She seems skeptical of the medical approach to her situation. She expects that this consultation is just a formality and doesn't see how it could help her.

Priya might say, "I don't think I need to be here, but my parents are freaking out for nothing."

Observations:

Respirations: 16 Breaths/min

Oxygen Saturation: 98%

Air or Oxygen: Room air

Blood Pressure: 120/70 mmHg

Pulse: 72 Beats/min

Consciousness: Alert

Temperature: 36.7 Celsius

NEWS Total Score: 0

Physical Examination:

General demeanor is defiant. No abnormalities detected on physical examination.

Special Tests:

Not applicable for the presentation of conduct disorder.

Diagnostic Tests:

No specific diagnostic tests are commonly used to diagnose conduct disorder. However, psychological assessments and interviews with both the patient and family members are commonly utilized.

Condition:

Conduct disorder

Patient Questions:

Priya: "Are you going to put me on meds or what?"

Possible Answer: "We'll discuss all possible treatment options, but medication isn't always the first step for behaviors like yours."

Priya: "What are you going to tell my parents?"

Possible Answer: "I will talk with you and your parents together to discuss what we think is happening and how we can work together for the best outcome."

Priya: "What if I just don't want to change, then what?"

Possible Answer: "That's your choice, though I'd strongly recommend we think about ways to help manage your behavior. It's not just about changing you, it's about helping you cope better."

Priya: "Why does everyone have a problem with the way I act?"

Possible Answer: "Sometimes, behaviors can be harmful to you or others, even if it doesn't seem like it right now. We're concerned because we want to make sure you have a healthy and successful future."

Examiner Questions:

1. What factors increase the risk of conduct disorder developing in adolescents?

Possible Answer: Factors include a history of child abuse or neglect, family history of mental health disorders, substance abuse, poverty, and chaotic or unstable family life.

2. How would you differentiate between conduct disorder and oppositional defiant disorder?

Possible Answer: Oppositional defiant disorder features a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness but doesn't include the more serious violations of social norms or rights of others that are characteristic of conduct disorder.

3. What are the potential long-term outcomes for adolescents with conduct disorder?

Possible Answer: Long-term outcomes can vary but may include a continued pattern of antisocial behavior, legal troubles, substance abuse, and difficulty maintaining employment and relationships.

4. How do the ethical principles of beneficence and autonomy apply in the management of adolescent patients with conduct disorder?

Possible Answer: Beneficence requires that we act in the patient's best interests, advocating for treatments that improve their social functioning and reduce harm to self or others. Autonomy must be respected by ensuring the adolescent is involved in their care and their wishes are considered.

5. What role can behavioral therapies play in treating conduct disorder?

Possible Answer: Behavioral therapies, such as cognitive-behavioral therapy (CBT), can help adolescents learn how to control their behaviors, improve problem-solving skills, and reduce aggression.

Treatment:

Treatment for conduct disorder generally involves a multi-modal approach, which can include:

- Cognitive-behavioral therapy to aid in improving behaviors, coping strategies, and social skills.

- Family therapy to improve communication and relationships within the family.

- Parent management training to help parents address and manage disruptive behaviors effectively.

- Peer group therapy to improve interactions with peers and build interpersonal skills.

- Educational support to address learning difficulties and academic challenges.

- In severe cases or if there is a comorbid psychiatric diagnosis, pharmacological intervention may be considered, but there are no specific medications approved for the treatment of conduct disorder.

Monitoring:

- Monitor behavioral changes through regular follow-up sessions with the patient and family.

- Evaluate the effectiveness of therapy and adjust treatment strategies as needed.

- Ensure parents have access to community resources and support systems.

- Consider referral to a child and adolescent psychiatrist if symptoms persist or if there are concerns of comorbid conditions.

Prognosis:

The prognosis of conduct disorder varies based on the severity of the symptoms and the presence of comorbid conditions. Early intervention tends to improve long-term outcomes. Without treatment, individuals are at increased risk of continuing antisocial behavior into adulthood.

Differential Diagnoses:

1. Oppositional Defiant Disorder: Less severe, no gross violation of societal norms.

2. Attention Deficit Hyperactivity Disorder (ADHD): Inattention, hyperactivity, and impulsivity are characteristic, but without the aggressiveness and rule-breaking behavior of conduct disorder.

3. Antisocial Personality Disorder: Similar behaviors but typically diagnosed in adults over 18 years old.

Speciality Filter: Mental Health; Child Health

Presenting Complaint Filter: Behavioural problems; Aggression

Condition Filter: Conduct Disorder

Location Filter: General Practice

Case created by:

Reviewed by:

Reviewed by:

# DS\_39\_Narcissistic personality disorder

Homepage Vignette:

## A 30-year-old individual called Morgan presents with heightened feelings of self-importance and entitlement.

Individual Page Vignette:

You are a General Practitioner and Morgan, a 30-year-old fashion designer, comes into your clinic with concerns about interpersonal difficulties and experiencing heightened feelings of self-importance and entitlement.

Patient Name:

Morgan Alexis DuBois; Pronounced [MORE-gun AL-ex-iss DOO-bwah], prefers to be called Morgan.

Age:

14/05/1993

Location:

Clinic

Personality:

Morgan speaks in a confident and authoritative manner. They display a sense of superiority, often appearing dismissive of others' opinions. They are articulate, tend to monopolize conversations, and may react to criticism with anger or disdain.

Presenting Complaint:

Morgan presents with concerns regarding their interpersonal relationships, feeling that they are often misunderstood and undervalued despite their talents. They also mention frequent conflicts with colleagues who Morgan feels are envious of their success.

Quote: "It's like no one sees things as clearly as I do. They should be grateful for my talent."

History of Presenting Complaint:

History of Presenting Complaint:

- Morgan reports having always felt superior to others, with these feelings intensifying over the past few years.

- Attempts at therapy have been made in the past but Morgan felt the therapists were not able to comprehend their unique qualities and needs.

- The sense of being undervalued and unappreciated at work has led to increased conflict with colleagues over the past several months.

- Feeling misunderstood has been a persistent issue leading to difficulties in forming and maintaining personal and professional relationships.

- Morgan mentions that they are able to perform at work but feels their potential is stifled by less capable colleagues.

- There has been no reported impact on Morgan's ability to perform daily activities or on their physical health, but the interpersonal struggles have been an ongoing source of frustration.

Quote:

- "Ever since I can remember, I've known I was meant for something big. But lately, it's like nobody can see it. They’re holding me back."

- "I’ve tried talking to a couple of therapists before. They just don't get it. It's frustrating."

- "The issues at work have been more noticeable recently. People are just jealous, and it's causing unnecessary tension."

- "Maintaining relationships is tough. It's not me—it's them. They can't handle someone like me."

- "I'm good at my job, but imagine what I could do if everyone else wasn't dragging me down."

Quote: "I just feel like I’m meant for great things, but no one else seems to get it."

Systemic Symptoms:

- Fatigue: Negative

- Fever: Negative

- Night sweats: Negative

- Unintended weight loss: Negative

- Generalized weakness: Negative

- Malaise: Negative

- Bowel habits: Normal

- Urinary habits: Normal

- Changes in sleep: Negative

- Peripheral oedema: Negative

Quote: "Physically, I'm in top shape; it’s everyone else that’s draining my energy."

Past Medical History:

- No previous medical conditions

- No surgeries or hospitalizations

- No history of substance abuse or addictions

- Up-to-date with vaccinations

Quote:

- "I have always been ahead of the curve; I don't have mood swings, I have times when I'm justifiably upset when others don't meet my expectations."

- "Previous therapy? Yes, I've talked to someone before, but they just couldn't keep up with me."

- "I don’t have anxiety, I'm always in control. Depression is for the weak."

- "Substances? I occasionally enjoy a drink, but that’s the extent of it."

Risk Assessment:

- Evaluation of any self-harm thoughts or behaviors.

- Assessment of any history of aggressive or violent behaviors toward others.

- Assessment of impulsivity and risk-taking behaviors.

- Inquiry about any legal issues, including any history of arrests or incarcerations.

- Suicide risk assessment is necessary due to potential vulnerabilities underlie narcissistic personality traits, especially following significant life setbacks.

Quote:

- "Self-harm? Absolutely not, I’m too valuable. Besides, my image is everything."

- "I’ve never been violent, but I won't lie, I’ve put people in their place when needed."

- "I’m not impulsive, I make calculated risks - that's how I got to where I am."

- “Legal issues? No, I know how to handle things without getting caught up in such matters."

- "Suicide is not an option for me; the world would lose too much without me in it."

These additional elements provide context for Morgan's condition, aiding in the formulation of a holistic treatment plan and risk management strategy.

Quote: "I've always been very health-conscious; no issues there."

Drug History:

- No current or past medications

- Does not use herbal supplements or alternative therapies

Quote: "I don’t rely on any substances; my body is a temple."

Allergies:

- No known allergies or intolerances

Quote: "Allergies? No, my system can handle anything."

Family History:

- No known hereditary conditions or significant health events

Quote: "My family is quite healthy, no concerns there."

Social History:

Lifestyle:

- Leads a socially active life, often the center of attention at events

Occupation:

- Fashion designer

Activities of Daily Living & Hobbies:

- Engaged in high-end socializing and networking events

Smoking:

- Non-smoker

Alcohol:

- Drinks socially, approximately 3-5 units per week

Recreational Drug Use:

- Denies any recreational drug use

Diet:

- Follows a balanced diet with emphasis on organic foods

Exercise:

- Regular gym-goer, about 4 times a week

Quote: "I'm at every party that matters. I don't smoke, and I keep my drinking classy. Drugs? Never. My diet and gym routine are impeccable."

Travel History:

- Frequently travels for work and leisure

Quote: "I’ve been around the world – Paris, Milan, Tokyo – you name it."

Sexual History:

- Prefers not to disclose but states that they have no concerns in this area

Driving Status:

- Drives regularly

Cultural or Religious Practises:

- Does not affiliate with any particular cultural or religious practices

Recent Life Events:

- Received a prestigious award in their field

Quote: "Driving is freedom. I'm not bound by cultural or religious chains. That award last month? It was overdue."

Ideas, Concerns, and Expectations:

Morgan expects to be recognized and praised for their expertise and is concerned that others fail to acknowledge their superiority and value. There's a belief that others should adjust their behavior and attitudes rather than Morgan needing to change.

Quote:

- Ideas: "I’m not the problem here, it's the mediocrity around me."

- Concerns: "It’s frustrating when people envy me instead of learning from me."

- Expectations: "I need you to fix everyone else's attitudes, not mine."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 130/80

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8

NEWS Total Score: 0

Physical Examination:

- Physical appearance and demeanor suggest self-care and a degree of vanity.

- No abnormalities noted in a general physical examination.

Special Tests:

- Not applicable.

Diagnostic Tests:

- No medical tests are indicated based solely on the psychological nature of the presenting complaint.

Treatment:

According to guidelines such as NICE, the treatment for narcissistic personality disorder primarily involves psychological interventions, including psychotherapy. A referral to a specialist mental health professional for psychotherapy sessions, like cognitive behavioural therapy or dialectical behaviour therapy, is recommended.

Monitoring:

Regular follow-ups with a mental health professional are necessary to monitor Morgan's engagement with therapy and any changes in interpersonal relationships. Adjustments to the therapy approach may be required depending on Morgan's response to treatment.

Prognosis:

Personality disorders can be enduring, and treatment often focuses on managing symptoms and improving interpersonal functioning. The prognosis can vary and is more favourable with the patient's active participation in therapy.

Differential Diagnoses:

1. Antisocial personality disorder - Less likely due to Morgan’s adherence to societal norms and lack of unlawful behaviour.

2. Borderline personality disorder - Less likely due to the absence of symptoms like fear of abandonment and unstable relationships.

3. Histrionic personality disorder - Less likely given Morgan's lack of excessive emotionality and attention-seeking behaviour in an exaggerated sense.

4. Bipolar disorder - Less likely due to the absence of distinct mood episodes and the chronic nature of narcissistic traits.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Difficulty With Relationships; Self-Esteem Issues

Condition Filter:

Narcissistic Personality Disorder

Location Filter:

Clinic

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_40\_Social anxiety disorder

Homepage Vignette:

## “A 25-year-old individual named Alexei presents with feelings of intense anxiety and fear in social situations.”

Individual Page Vignette:

You are a physician in a General Practice setting. Alexei Novikov (а-лек-сей но-ви-ков), a 25-year-old software developer, has come to you with complaints of intense fear and anxiety when faced with social engagements or performances, which is affecting their work and personal life.

Patient Name: Alexei Novikov; "Alexei".

Age: 21/09/1999

Location: General Practice

Personality: Alexei is thoughtful and speaks in a measured, quiet tone. They are highly analytical and concise when describing problems, often providing a systematic recount of events or symptoms. Despite being articulate, Alexei exudes a sense of nervousness, especially when discussing personal topics.

Presenting Complaint: "Every time I have to give a presentation at work or attend a social event, I feel paralyzed with fear. I can't stop worrying about being judged or embarrassing myself."

History of Presenting Complaint:

- Alexei began experiencing symptoms during late adolescence, around 17 years of age.

- Symptoms have been worsening, especially in the past two years with increased work responsibilities.

- No previous treatments, such as therapy or medication, have been sought.

- The intensity of anxiety is often high, particularly when anticipating or engaging in social activities or public speaking.

- The fear and avoidance have led to a noticeable impact on Alexei's work performance and social interactions.

- There's a significant aversion to attending work events, which is a mandatory part of the job.

- There are no periods of remission, and the symptoms are present to some degree constantly.

“Ever since I can remember, these social situations have been incredibly stressful for me. But lately, I dread even simple things like team meetings or casual get-togethers. It’s actually starting to affect my job performance because I’m expected to lead some projects. I find myself trying to fade into the background or avoid any event that might put me in the spotlight. It's exhausting living like this."

Systemic Symptoms:

- No reported fatigue, fever, or night sweats

- Unintended weight loss and general weakness denied

- Normal bowel and urinary habits

"Physically, I'm fine. It's just my mind that won't give me a break."

Past Medical History:

- No known past medical conditions or surgeries

- Denies any psychiatric history apart from anxiety symptoms

- No history of substance abuse or significant health events

"No, I've never really been sick or had to go to hospital for anything."

Psychiatric History:

- No prior diagnosis of mental health conditions

- Denies history of depression or bipolar disorder

"I've never been diagnosed with anything, though I've always felt more anxious than others."

Risk Assessment:

- Denies any current suicidal ideation, plan, or intent

- No history of self-harm or harm to others

"I would never want to hurt myself or anyone else; I'm just struggling to cope with these social settings."

Forensic History:

- No history of arrests, convictions, or interactions with the criminal justice system

"I've never been in any kind of trouble with the law. I try to keep to myself."

Past Medical History:

- No known past medical conditions or surgeries

- Denies any psychiatric history apart from anxiety symptoms

- No history of substance abuse or significant health events

"No, I've never really been sick or had to go to hospital for anything."

Drug History:

- No regular medications

- No known history of medication non-compliance

- Occasionally uses over-the-counter antacids for stress-related heartburn

"I don't like taking medicine. I try to avoid it unless absolutely necessary."

Allergies:

- No known allergies or intolerances

"Luckily, I don't have any allergies that I know of."

Family History:

- No family history of psychiatric conditions

- Parents alive and in good health

"My family is relatively healthy, no serious illnesses or anything."

Social History:

Lifestyle: Leads a sedentary lifestyle, largely due to occupation and personal preferences

Occupation: Works as a software developer, often requires collaboration and presentations

Activities of Daily Living & Hobbies: Enjoys reading and solitary activities such as programming

Smoking: Non-smoker

Alcohol: Drinks occasionally, about 3 units per week

Recreational Drug Use: Denies any use

Diet: Mostly home-cooked meals with occasional fast food

Exercise: Minimal, acknowledges lack of exercise

"My life is mostly work, home, sleep, repeat. I don't get out much, by choice and... this fear."

Ideas, Concerns, and Expectations:

"I've done some reading and think I might have social anxiety disorder. My biggest fear is that I'll never be able to overcome these feelings and they'll control my life forever. I'm here because I want to get help, maybe therapy or something."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98%

Air or Oxygen?: Room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 88

Consciousness (AVPU): Alert

Temperature (Celsius): 36.9°C

NEWS Total Score: 0 (All parameters score 0 points.)

Physical Examination:

- No abnormalities detected on general physical examination

Special Tests:

- Not applicable for diagnosis of social anxiety

Diagnostic Tests:

- Not specific diagnostic tests for social anxiety, but may include screening questionnaires like the Social Phobia Inventory (SPIN).

Condition:

Social Anxiety

Patient Questions:

1. "What exactly is social anxiety? Is it just being shy?" (It's more than shyness; it's a fear of being negatively judged that's so intense, it can interfere with daily life.)

2. "Are there medications for this? What are the side effects?" (There are medications such as SSRIs that can help alleviate symptoms, the side effects vary but can include nausea, headaches, and insomnia.)

3. "Can therapy really help me get better?" (Yes, cognitive-behavioral therapy has been shown to be very effective in treating social anxiety.)

Examiner Questions:

1. What is the first-line treatment for social anxiety disorder? (Cognitive-behavioral therapy (CBT) is usually the first-line treatment.)

2. What medications can be considered for social anxiety disorder? (Selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs) can be considered for treatment.)

3. What is the role of benzodiazepines in the management of social anxiety? (Benzodiazepines may be used briefly for acute situations but are not typically recommended for long-term management due to the risk of dependence.)

4. How often should a patient with social anxiety disorder follow up with their provider? (It varies but generally every 4-6 weeks initially to monitor treatment progress.)

5. Are there any self-help strategies that can assist in managing social anxiety symptoms? (Yes, relaxation techniques, exposure therapy, and joining support groups can be beneficial.)

Treatment:

Cognitive-behavioral therapy (CBT) as first-line treatment;

Selective serotonin reuptake inhibitors (SSRIs) such as sertraline starting at 25-50 mg/day, increasing to a maximum of 200 mg/day;

Possible use of benzodiazepines for acute situational anxiety but with caution;

If SSRIs are ineffective or not tolerated, consider serotonin-norepinephrine reuptake inhibitors (SNRIs) like venlafaxine;

Monitoring:

Regular follow-up every 4-6 weeks initially;

Monitor for side effects of medications and adjust dosages as necessary;

Encourage patient to practice CBT techniques and self-help strategies;

If symptoms persist or worsen, consider specialist referral for mental health.

Prognosis:

Good with appropriate treatment;

Symptoms may improve significantly within several months of treatment;

Regular follow-up and adherence to therapy are crucial to positive outcomes.

Differential diagnoses:

1. Panic disorder - Symptoms are more episodic and intense than social anxiety.

2. Agoraphobia - Fear is focused on situations from which escape might be difficult or embarrassing.

3. Generalized anxiety disorder - Excessive worry is not confined to social situations.

Speciality Filter:

Mental Health;

Presenting Complaint Filter:

Anxiety;

Condition Filter:

Social Anxiety Disorder;

Location Filter:

General Practice;

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_41\_Tension headache

Homepage Vignette:

## “A 30-year-old individual called Morgan presents with a headache and photophobia.”

Individual Page Vignette:

You are a General Practitioner, and Morgan Forbes, a 30-year-old software developer, has come to your clinic complaining of a headache and photophobia.

Patient Name: Morgan Forbes (Pronounced: MORE-guhn FORBS; Likes to be called Morgan)

Age: 14/06/1993

Location: General Practice

Personality:

Morgan is an analytical thinker, often speaking in a precise and measured way. They have a tendency to provide detailed accounts of their symptoms and appreciate clear, logical explanations.

Presenting Complaint:

"I've been dealing with this splitting headache for days now, and the light from my computer screen just seems to make it worse."

Symptoms:

Site: "The pain is like a band squeezing right around my head."

Onset: "It all started around three days ago."

Character: "It's a constant, dull ache."

Radiation: "It doesn't really spread anywhere; it just stays right where it is."

Associated Symptoms: "The light bothers me, and there's this feeling of pressure in my temples."

Timing: "It's pretty much there all the time, but it gets worse as the day goes on."

Exacerbating and Relieving Factors: "Working on the computer seems to aggravate it. Rest and staying off screens provide some relief."

Severity: "On a scale from one to ten, it's been hovering around a six."

History of Presenting Complaint:

- Morgan has been experiencing the headache for approximately three days.

- Quote: "This headache kicked in on Monday morning, and it's just hung around since then."

- Previous treatments attempted include the use of over-the-counter medication ibuprofen with no significant relief.

- Quote: "I've tried popping an ibuprofen or two, but it barely takes the edge off."

- The symptoms appear to be constant, with fluctuations in intensity throughout the day, often worsening with prolonged screen time.

- Quote: "The pain's always there, but it gets worse as the day goes on, especially after long hours in front of my computer."

- The headache has affected daily activities; it impacts concentration at work and reduces the enjoyment of hobbies and pastimes.

- Quote: "It's been really hard to focus on my work, and I just don't feel up to doing anything fun after feeling like this."

- Morgan denies any significant impact on work, stating that they are still able to perform job duties, albeit with increased discomfort.

- Quote: "I'm getting my work done, but it's a struggle with this nagging pain."

- There is no reported impact on physical wellbeing other than the headache itself, but there is a noticeable effect on mental wellbeing due to persistent discomfort and the inability to engage in relaxing activities.

- Quote: "Physically, I'm okay aside from my head. But mentally, it's draining to deal with this headache day in, day out."

- No known triggers have been identified, and the headache does not appear to be related to any specific food or activity. Morgan has not experienced similar symptoms in the past to this extent.

- Quote: "I can't pinpoint anything that triggers it; it's not like I've changed my diet or anything recently. And I've never had a headache this bad before."

Systemic Symptoms:

"No fever, weight changes, or anything like that. I just feel tired, probably because of the headache."

Past Medical History:

-No past medical history

-Not receiving treatment for any conditions

-No history of previous surgeries

-No psychiatric history

"I've had headaches before, but nothing like this. No surgeries or serious medical issues in the past."

Psychiatric History:

- Morgan states they have no known history of psychiatric diagnoses or long-term mental health issues.

- Morgan recalls a short period of counseling sessions attended during college due to stress but has not had any formal therapy since then.

- There is no history of hospitalization related to mental health and no use of psychiatric medication.

- Morgan mentions mild, transient episodes of anxiety associated with work stress but nothing that has warranted medical intervention.

- Quote: "Sometimes work gets stressful and I feel anxious, but it’s nothing out of the ordinary, and it passes."

- There is no history of substance abuse or addiction, and Morgan indicates a good support system with friends and family.

- Regarding coping mechanisms, Morgan says they tend to manage stress through hobbies such as biking and programming for fun.

- Morgan denies any history of suicidal ideation, self-harm, or other self-destructive behaviors.

Drug History:

"I occasionally take ibuprofen when needed, usually no more than 400 mg. I tried that for this headache, but it's not doing much."

Allergies:

"No known allergies. I've never reacted to any medications or foods."

Family History:

"My mom suffers from migraines, but I don't think that's what this is."

Social History:

Lifestyle: "My job has me sitting at a desk most of the day, looking at a screen."

Occupation: "I'm a software developer, so yeah, lots of screen time."

Activities of Daily Living & Hobbies: "I enjoy biking on weekends, and I try to cook healthy meals at home."

Smoking: "I've never smoked."

Alcohol: "Maybe a glass of wine with dinner a couple of times a week, so probably around 2-3 units per week."

Recreational Drug Use: "I don't use any recreational drugs."

Diet: "I'm a vegetarian; I try to keep it balanced with plenty of veggies and protein from legumes and tofu."

Exercise: "I go for a bike ride every weekend, weather permitting."

Ideas, Concerns, and Expectations:

"I'm thinking this might be from staring at the computer too much, but it's making me worried because I can't get it under control. I hope it's nothing serious. Can you help me figure out how to manage this?"

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98%

Air or Oxygen?: On room air

Blood Pressure (mmHg): 128/78

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8°C

NEWS Total Score: 0

Physical Examination:

The physical examination should focus on neurological assessment and exclude other causes of headaches.

Special Tests:

None indicated for tension headache at primary care level.

Diagnostic Tests:

None indicated routinely for tension headache unless clinical suspicion of another diagnosis arises.

Condition: Tension headache

Patient Questions:

- "Could looking at screens be causing my headaches?" (Yes, screen time can contribute to eye strain and tension headaches. Taking regular breaks and ensuring a proper ergonomic setup might help.)

- "Should I be worried that it's something like a brain tumor?" (Tension headaches are a common type of headache and are not usually associated with brain tumors, especially without other concerning symptoms such as neurological deficits or changes in personality.)

- "Is there a permanent cure for this kind of headache?" (While there isn't a permanent cure, there are many management strategies that can help reduce the frequency and severity of tension headaches.)

- "Can I just take painkillers whenever the headache appears?" (Overusing painkillers can actually lead to rebound headaches. It's important to use them judiciously and focus on prevention as well.)

Examiner Questions:

- "Can you list some differential diagnoses for Morgan's headache?" (Migraine, cluster headache, medication overuse headache, secondary headache disorders)

- "What lifestyle modifications would you recommend to Morgan?" (Regular breaks from screen time, proper hydration, stress management, regular sleep patterns, good posture)

- "What red flags would prompt you to investigate further or refer Morgan for specialist evaluation?" (Sudden onset or 'thunderclap' headache, neurological deficits, a change in personality, a headache on waking or with exertion)

- "How would you explain the diagnosis of tension headache to Morgan?" (Tension headaches are often due to muscle tension, stress, or fatigue and are characterized by a band-like pain across the forehead and temples.)

- "What is the significance of Morgan's family history regarding their current condition?" (There is a genetic component to migraines, but tension-type headaches do not have a clear genetic link.)

- "What non-pharmacological treatments can be effective for tension headaches?" (Relaxation techniques, cognitive-behavioral therapy, acupuncture, or physical therapy may be helpful.)

Treatment:

1. Advise Morgan to follow regular breaks from screen time, ensuring a proper ergonomic workspace setup.

2. Recommend over-the-counter analgesics like ibuprofen (400 mg up to three times a day) or paracetamol (1 g up to four times a day), ensuring they do not overuse these medications.

3. If the initial treatment is ineffective, consider a trial of prophylactic treatment with amitriptyline (start with 10 mg at night, increasing as tolerated to a maximum of 75 mg).

4. If Morgan is allergic to NSAIDs, consider other pain-relief options like aspirin (if no contraindications) or consider a referral to a headache specialist if the condition persists.

Monitoring:

Advise Morgan to monitor their headache frequency and severity. If there is no improvement after implementing lifestyle changes and over-the-counter medication for several weeks, or if the headaches become more frequent or severe, follow-up with a healthcare provider is necessary. A headache diary might be helpful. Regular follow-up every 4-6 weeks can be considered to assess the need for ongoing treatment or referral.

Prognosis:

Tension headaches have a good prognosis with proper management. Chronic headaches may require longer-term treatment. It's important to closely monitor for the overuse of medication, which can worsen headaches. With lifestyle modifications and proper treatment, most individuals with tension headaches can manage their symptoms effectively. A small percentage may develop chronic tension-type headache, which may require more intensive treatment and possibly referral to a headache specialist or neurologist.

Differential diagnoses:

1. Migraine: Less likely due to the absence of associated features like nausea, vomiting, and a pulsating quality to the pain.

2. Cluster headache: Less likely because of the lack of unilateral, severe, piercing pain with accompanying autonomic symptoms.

3. Medication overuse headache: Less likely given Morgan's infrequent use of analgesics.

4. Secondary headache disorder (e.g., intracranial mass, infection): Less likely without accompanying red-flag symptoms or neurological deficits.

Speciality Filter:

General Practice; Neurosciences

Presenting Complaint Filter:

Headache; Photophobia

Condition Filter:

Tension Headache

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_42\_EUPD

Homepage Vignette:

## “A 27-year-old individual called Jamie presents with mood swings and fear of abandonment.”

Individual Page Vignette:

You are a medical student in a General Practice clinic. Jamie, a 27-year-old graphic designer, presents to you with mood swings and a pervasive fear of abandonment.

Patient Name: Jamie O'Sullivan (Pronunciation: JAY-mee o-SUL-ih-vuhn), prefers to be called Jamie.

Age: 13/06/1996

Location: General Practice

Personality: Jamie has an anxious demeanor and speaks rapidly, often changing the topic mid-sentence. They display signs of impulsivity and struggle to maintain a consistent conversation, reflecting distress and emotional turmoil.

Presenting Complaint: Jamie reports persistent mood swings ranging from episodes of intense euphoria to moments of profound depression and anxiety. They express an overwhelming fear of being left alone or abandoned, even temporarily.

History of Presenting Complaint:

- Jamie has been experiencing mood swings since their late teens, with symptoms intensifying over the past year.

- They have not previously sought formal treatment for these symptoms.

- The mood swings occur daily and without an apparent trigger.

- The unpredictability of the mood swings has had a significant detrimental impact on Jamie's work, leading to missed deadlines and days off.

- Their relationships with family and friends are strained due to the mood swings.

- During periods of intense emotions, Jamie finds it difficult to engage in normal daily activities or self-care.

- The emotional toll of the mood swings is significant, causing Jamie considerable distress and anxiety.

- Jamie reveals a history of emotional abuse during adolescence by a close family member which was never formally addressed.

- They also recount a significant bullying experience during high school, which they perceive as having a long-lasting impact on their self-esteem and trust in others.

- There is no reported history of physical or sexual abuse.

- Jamie has never sought professional help for these traumatic experiences and acknowledges that they might be contributing to their current emotional difficulties.

Quote:

"I never really talked about it, you know, but my uncle... he was really harsh. Always put me down, made me feel small. And the kids at school, they were relentless. It's like they could smell weakness or something. I guess that’s why I'm always on edge, waiting for someone to turn on me."

Quote:

"It wasn't so bad at first, just felt a bit more stressed than the usual. But for the past year, it's like I'm on this constant emotional seesaw. I could be laughing and feeling great one minute, then the next, I'm totally lost, feeling like everyone's going to leave me, and I can't tell you why. It's every day, and it feels like it’s getting worse. My work's been hit the hardest; missed deadlines mean my boss isn't happy, and my friends, well, they're getting tired of dealing with my mood swings. Sometimes, I just can't do anything, like even getting out of bed or making myself a meal. It's all just too much."

Systemic Symptoms:

- Jamie reports episodes of insomnia during periods of high energy and oversleeping when feeling depressed.

- All other systemic symptoms, such as fever, weight loss, or fatigue in the absence of mood swings, are absent.

Past Medical History:

- No known medical conditions requiring hospitalizations.

- Psychiatric history includes counseling during college for stress management, but no formal psychiatric diagnosis. Jamie has not been treated with psychiatric medications in the past.

- No history of self-harm or suicidal ideation is reported.

- Immunizations are up to date with no reports of adverse reactions.

- Jamie denies current thoughts of self-harm or suicide but reports significant emotional turmoil.

Drug History:

- No current medications.

- Denies use of herbal supplements or alternative therapies.

Allergies:

- Jamie reports a mild intolerance to lactose, causing bloating and gas but denies any medication or food allergies.

Family History:

- Maternal aunt diagnosed with bipolar disorder.

- No other known familial medical conditions.

Social History:

Lifestyle:

- Jamie has a fluctuating social life, with periods of intense social activity followed by isolation.

Occupation:

- Works as a graphic designer, often under tight deadlines.

Activities of Daily Living & Hobbies:

- Enjoys painting and creative writing when feeling well.

Smoking:

- Non-smoker.

Alcohol:

- Drinks occasionally, 2-3 units of alcohol per week.

Recreational Drug Use:

- Denies recreational drug use.

Diet:

- Irregular eating patterns, sometimes skipping meals.

Exercise:

- Attempts to run weekly, but the routine is inconsistent due to mood swings.

Ideas, Concerns, and Expectations:

- Ideas: "I'm worried that I might have something like my aunt's condition, that bipolar thing."

- Concerns: "I'm scared that if this continues, I might lose my job or my friends."

- Expectations: "I just want to know what's wrong and how I can stop feeling so out of control."

Observations:

- Respirations (Breaths/min): 16 (0 points)

- Oxygen Saturation (%): 98 on room air (0 points)

- Air or Oxygen?: Room air (0 points)

- Blood Pressure (mmHg): 125/80 (0 points)

- Pulse (Beats/min): 72 (0 points)

- Consciousness (AVPU): Alert (0 points)

- Temperature (Celsius): 36.7 (0 points)

- NEWS Total Score: 0

Physical Examination:

- Within normal limits, with no acute distress or physical abnormalities noted.

- Psychiatric assessment reveals signs of affective instability and anxiety.

Special Tests:

- None indicated based on the initial assessment.

Diagnostic Tests:

- May consider a referral for a psychiatric evaluation which could potentially include standardized psychiatric assessment scales or interviews.

Treatment:

- Start with a referral to mental health services for a formal psychiatric evaluation and possible diagnosis.

- If diagnosed with emotionally unstable personality disorder, a management plan may include psychotherapy, such as dialectical behaviour therapy (DBT), and possibly pharmacotherapy for symptom control.

- Medication may include selective serotonin reuptake inhibitors (SSRIs) for associated symptoms like depression.

Monitoring:

- Regular follow-up visits to assess treatment response and adjust the plan as necessary.

- Close monitoring of any medication side effects or interaction.

- If under psychotherapy, monitoring progress and maintaining regular sessions as advised by the mental health professional.

Prognosis:

- The prognosis for emotionally unstable personality disorder is variable, with some individuals experiencing symptom remission over time, particularly with appropriate treatment.

- Long-term therapy is often required to manage symptoms and to work on coping strategies and interpersonal relationships.

Differential diagnoses:

1. Bipolar disorder – mood swings in bipolar disorder are typically more prolonged and may include manic episodes, which seem inconsistent with Jamie's presentation.

2. Cyclothymia – less severe mood swings than bipolar but more chronic; Jamie's symptoms appear more intense.

3. Major depressive disorder – does not account for the periods of high energy or euphoria that Jamie experiences.

Patient Questions:

- "Do you think I'm going crazy?" (Answer: "Feeling overwhelmed by your emotions does not mean you're going crazy; it means you're dealing with a lot, and it's important to seek help to better understand and manage these feelings.")

- "Will I need to take medication like my aunt?" (Answer: "Treatment plans are personalized, so it's possible, but we'll look at all options, including therapy, to find what works best for you.")

- "Could this affect my job?" (Answer: "It's affecting you now, but with the right support and treatment, we can aim to improve your daily functioning and manage any impact on your work.")

Examiner Questions:

- How would you differentiate between emotionally unstable personality disorder and bipolar disorder?

- What are some common features of emotionally unstable personality disorder?

- Why is it important to refer Jamie to mental health services?

- What treatments are available for patients with emotionally unstable personality disorder?

- How would you address a patient's fear of abandonment in the clinical setting?

# DS\_43\_Self harm

Homepage Vignette:

## A 25-year-old individual named Jordan presents with self-inflicted lacerations on the forearm.

Individual Page Vignette:

You are a doctor in a General Practice setting, and a 25-year-old person called Jordan, an office worker, comes in with self-inflicted lacerations on their forearm.

Patient Name: Jordan (pronounced "JOR-dan", prefers to be called Jordan)

Age: 25 years old (DOB: 16/06/1999)

Location: General Practice

Personality: Jordan speaks rapidly and with a sense of urgency. They avoid eye contact, seem preoccupied, and offer only brief answers to direct questions.

Presenting Complaint:

"I cut myself, and it looks bad. I don't know why I did it; I just felt like I needed to."

History of Presenting Complaint:

- Jordan has been experiencing self-harm episodes for several years, particularly when under stress.

- No previous medical interventions for self-harm have been sought.

- The episodes of self-harm have remained consistent over time rather than increasing in frequency.

- The most recent self-harm episode has had a noticeable impact on daily functioning due to the severity of the injury.

- Psychological distress from self-harm is substantial, as it adds to feelings of shame and impedes Jordan's mental wellbeing.

"Look, I've been doing this since I can't even remember when. It's not like it's getting worse or anything... it's just that last night, I really scared myself. I've never cut that deep before, and it's got me thinking that I can't let this go on."

Past Medical History:

- No significant past medical history apart from occasional episodes of anxiety.

- No previous surgeries or hospitalizations.

- No known psychiatric history aside from the anxiety episodes related to stress.

Psychiatric History:

- Jordan reports intermittent episodes of anxiety, particularly associated with high levels of stress.

- There is no formal diagnosis of any psychiatric condition, as Jordan has not previously sought help for mental health concerns.

- No treatment, including psychotherapy or psychopharmacology, has been recorded for any mental health issues.

- No history of psychiatric hospitalization.

- Jordan's current presentation includes feelings of being overwhelmed, which can be indicative of underlying mood disorders.

RIsk Assessment:

- Self harm as a way of alleviating pressure and stress

- No suicidal intent

"And I know you have to ask about suicide... No, I don't want to kill myself. This isn't about that. It's just... when the pressure gets too much, this is the only way I know how to let it out. But yeah, I'm scared I might go too far one day."

Drug History:

- No current medication.

- No known history of medication non-compliance.

- No use of herbal supplements, birth control, or hormone replacement therapy.

- No history of overdose incidents.

"I don't really take anything. I try to manage on my own, you know?"

Allergies:

- No known allergies or intolerances.

"I'm not allergic to anything that I know of."

Family History:

- No known family history of mental illness.

- Parents in good health, no significant health events reported.

"My family's pretty healthy; no craziness there."

Social History:

Lifestyle: Lives alone in an apartment.

Occupation: Office worker, reports high stress from work.

Activities of Daily Living & Hobbies: Enjoys reading and casual gaming, but has been withdrawing from these activities recently.

Smoking: Non-smoker.

Alcohol: Drinks socially, about 5 units per week.

Recreational Drug Use: None.

Diet: Largely pre-prepared meals, limited fresh foods.

Exercise: Infrequent, mostly sedentary lifestyle.

"I don't really do much these days except work. I used to read a lot, but now... I just can't concentrate."

Ideas, Concerns, and Expectations:

Jordan believes the self-harm is a coping mechanism for dealing with stress and is concerned about the escalating severity of the injuries.

Jordan is fearful of the potential physical and psychological harm that could result from continued self-harm.

They expect to receive help to stop the self-harm and find alternative coping strategies.

"I know I can't keep doing this to myself. I need to find a better way to cope, but I don't know how."

Observations:

Respirations (Breaths/min): 16 (0 points)

Oxygen Saturation (%): 98% on room air (0 points)

Blood Pressure (mmHg): 125/80 (0 points)

Pulse (Beats/min): 78 (0 points)

Consciousness (AVPU): Alert (0 points)

Temperature (Celsius): 37.1°C (0 points)

NEWS Total Score: 0 (All parameters within normal ranges, zero points allocated)

Physical Examination:

Inspection reveals multiple lacerations on the forearm with varying depths. No signs of infection or compromised circulation. The rest of the examination is non-contributory.

Patient Questions:

"Why do I keep doing this to myself?"

- Possible answer: "Self-harm is often a coping mechanism for handling intense emotions. It's not uncommon, and there are ways to help you find healthier coping strategies."

"Do you think I'm going crazy?"

- Possible answer: "Self-harm doesn't mean you're going crazy; it indicates that you're under a lot of stress and could benefit from support to find other ways to cope."

"Can you actually help me stop?"

- Possible answer: "Yes, with therapy and support, many people are able to stop self-harming and manage their emotions in a healthier way."

Examiner Questions:

1. What initial steps would you take in evaluating a patient who presents with self-harm?

- Possible answer: Ensure the patient's safety, conduct a thorough assessment, including a psychiatric evaluation, and address any immediate medical needs.

2. Can you list some risk factors associated with self-harm behavior?

- Possible answer: Risk factors can include previous episodes of self-harm, underlying mental health conditions like depression or anxiety, high levels of stress or traumatic life events, and poor coping mechanisms.

3. How would you approach a conversation about alternative coping strategies with this patient?

- Possible answer: Discuss the importance of healthy coping mechanisms, explore the patient's hobbies and interests that could be used as alternatives to self-harming, and provide information on support services.

4. What role do psychosocial interventions play in the treatment of self-harm?

- Possible answer: Psychosocial interventions are fundamental in providing the patient with emotional support, teaching coping strategies, and addressing any underlying mental health conditions.

5. Are there any specific therapies that are effective in treating self-harm behaviors?

- Possible answer: Cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), and mindfulness-based therapies have shown to be effective.

Treatment:

- Initiate immediate wound care and assess the need for tetanus prophylaxis and suturing.

- Engage crisis intervention if necessary.

- Refer for a full psychiatric assessment.

- Consider starting treatment with a selective serotonin reuptake inhibitor (SSRI) if underlying depression or anxiety is diagnosed.

- Introduce cognitive behavioral therapy (CBT) to develop alternative coping strategies.

- Where pharmacological intervention is necessary, dosages and frequencies should be based on the British National Formulary (BNF).

Monitoring:

Continuous assessment of the patient's mood and risk of further self-harm is crucial. Follow-up visits should be scheduled regularly, with the frequency determined by the severity of the symptoms and the risk assessment. Referral to specialist mental health services may be necessary for ongoing therapy or if there is a significant risk of harm.

Prognosis:

The prognosis for self-harm varies depending on the individual's circumstances, the presence of any underlying mental health conditions, and their response to treatment. With comprehensive care and support, individuals can overcome self-harm behaviors and improve their mental health.

Differential diagnoses:

1. Borderline personality disorder: Characterized by instability in interpersonal relationships and self-image, which may include self-harm; however, a thorough assessment is required to diagnose this condition.

2. Depression: Might lead to self-harm as a symptom, but other symptoms of depression would typically be present.

3. Substance abuse: Can result in self-harm behavior; however, Jordan has no history of substance abuse.

4. Adjustment disorder: Temporary emotional or behavioral symptoms in response to a stressful event; however, the chronic nature of Jordan's symptoms suggests an ongoing issue.

Speciality Filter:

Mental Health; General Practice;

Presenting Complaint Filter:

Self Harm;

Condition Filter:

Self Harm;

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_44\_Mania

Homepage Vignette:

## A 38-year-old male called Tarek presents with elevated mood and decreased need for sleep.

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Individual Page Vignette:

You are a General Practitioner. Tarek, a 38-year-old Graphic Designer, comes to your clinic reporting symptoms of persistently elevated mood and a significantly decreased need for sleep.

Patient Name: Tarek Al-Zubaidi (Tah-rek Al-Zoo-bai-dee; prefers to be called Tarek)

DOB: 10/06/1985

Location: General Practice

Personality: Tarek is energetic and speaks rapidly, often shifting from one topic to another in the span of a few sentences. He seems to have an inflated self-esteem, stating grand plans for his future projects.

Presenting Complaint: "Doc, I've been on a creative spree! No time for sleep—there's just so much to do."

History of Presenting Complaint:

- Tarek has been experiencing symptoms for approximately two weeks.

- No prior treatments have been sought or attempted for the current symptoms.

- The elevation in mood and energy levels started subtly but have intensified over time.

- The frequency of symptoms is constant; Tarek reports that he feels extremely energized every day.

- The impact on daily life includes neglecting sleep and usual daily responsibilities in favor of working on multiple creative projects.

- The impact on work is two-fold: initially, there was an increase in productivity, but this has shifted to erratic behaviors that have caused concern among colleagues.

- Tarek reports a positive impact on his physical and mental wellbeing, though this perception may be influenced by his current mood state.

Quote: "It was like a switch flipped two weeks ago – I just suddenly felt like I could take on the world, and I haven't slowed down since. Sleep's a thing of the past now, and I've been getting so much done. Everyone's noticing the change in me."

Quote: "Ever since this burst of energy hit me, I've been cranking out designs non-stop. Isn't it great?"

Systemic Symptoms:

- Fatigue: "Who needs rest when you're on a roll like this?"

- Palpitations: Absent

- Tremor: Absent

- Sweating: Absent

- Unintended weight loss: Not mentioned

- Generalised weakness: Denies

- Malaise: None, feels exceptionally energetic

- Changes in sleep: Significant reduction in the need for sleep

Quote: "I've been skipping meals to keep working, but I don't even feel tired. I just don't need sleep anymore."

Past Medical History:

- No chronic medical conditions.

- No previous surgeries or hospitalizations.

- Denies any history of psychiatric or psychological issues, but family members have expressed concerns.

- No substance abuse or addictive behaviors reported.

- Immunization and vaccination history up-to-date.

Past Psychiatric History:

- Tarek denies any previous psychiatric conditions or treatments.

- It is noted that Tarek's mother has a history of bipolar disorder, which may have a bearing on his predisposition to psychiatric conditions.

- There is no reported history of substance misuse or involvement with mental health services.

- Tarek reports no prior episodes resembling his current presentation.

Quote: "I've always been the stable one; no history of depression, anxiety, or anything like that. Sure, mom has had her issues, but I've been fine, until my sister insisted something was off with me lately."

Risk Assessment:

- Tarek shows no current suicidal ideation, intent, or plan. However, his elevated mood and potentially impaired judgment could lead to risk-taking behaviors.

- Demonstrates basic needs (e.g., nutrition, hydration) as Tarek has reported skipping meals to work.

Quote 1: "Why would I harm myself? I feel amazing, nothing can touch me right now!"

Quote 2: "Sure, I haven't been eating much, but I just forget to—too caught up in my work, y'know?"

Quote 3: "I've been investing a bit more into my projects lately, but trust me, it's all going to pay off big time."

Quote 4: "My relationships? They're better than ever... well, except my sister nagging me to see you."

Drug History:

- No regular medications.

- Denies any history of medication non-compliance.

- Does not use herbal supplements or alternative therapies.

- Reports rare over-the-counter pain medication use for occasional headaches in the past.

Quote: "Medicines? Nah, I prefer to stay all-natural. Haven't popped a pill in ages."

Allergies:

- No known allergies.

Quote: "Allergies? No, I'm pretty resilient to that sort of thing."

Family History:

- Mother diagnosed with bipolar disorder.

- Father has a history of hypertension.

- No known genetic disorders.

Quote: "Mom's had her ups and downs—she was diagnosed with something like mood swings, I think?"

Social History:

Lifestyle: Very active in the local arts community.

Occupation: Graphic Designer, currently self-employed and working on multiple big projects.

Activities of Daily Living & Hobbies: Enjoys outdoor activities and painting.

Smoking: Non-smoker.

Alcohol: Drinks socially, about 4 units weekly.

Recreational Drug Use: Denies any use.

Diet: Vegetarian.

Exercise: Used to go for jogs thrice a week, but recently stopped due to increased work on projects.

Quote 1: "I’m usually the life of the party when I go out for drinks with friends on weekends."

Quote 2: "My job's my hobby, honestly—I live and breathe design."

Quote 3: "I've been skipping my runs; just don't have the time with all these ideas pouring out."

Ideas, Concerns, and Expectations:

- Ideas: Believes his current state is a positive change and indicative of his exceptional abilities.

- Concerns: Does not express any concerns, but family members are worried about his erratic behavior.

- Expectations: Expects reassurance and possibly endorsement of his newfound energy.

Quote: "I just want you to tell me that this is all good, Doc. I mean, how often does one get to feel this invincible?"

Observations:

- Respirations (Breaths/min): 16 breaths/min

- Oxygen Saturation (%): 98%

- Air or Oxygen?: Room air

- Blood Pressure (mmHg): 125/80

- Pulse (Beats/min): 98

- Consciousness (AVPU): Alert

- Temperature (Celsius): 36.8°C

- NEWS Total Score: 0

Physical Examination:

- General appearance: Patient is well-groomed but appears restless and fidgety.

- Cardiovascular exam: Normal heart sounds, no murmurs.

- Neurological exam: Alert and oriented, although distracted and tangential in thought content.

- Psychiatric assessment: Exhibits signs of grandiosity, pressured speech, and decreased need for sleep.

Special Tests:

- Mini-Mental State Examination (MMSE): Scoring may be affected by patient's distractibility and rapid thoughts.

Diagnostic Tests:

Blood Tests (Reference Ranges):

Full Blood Count (FBC): All within normal limits.

Thyroid Function Tests:

TSH: Result within normal range (0.4-4.5 mu/L)

Free T4: Result within normal range (9-25 pmol/l)

Condition:

Mania

Patient Questions:

- "Are you going to give me some sort of pill to kill my vibe?"

- "We are here to help you, not harm you. Your well-being is our priority, so if a medication is needed, it will be to maintain your health in the long term."

- "Can I continue working on my projects? I feel like this is my big break!"

- "It's essential to find a balance. Your health is important, and we need to make sure you're not overdoing it."

- "My sister thinks I have what my mom's got. That's nonsense, right?"

- "Family history is important and can help inform us, but every individual is different. Let's focus on what's happening with you right now."

- "What if I don't want treatment?"

- "Treatment is always your choice, but I would recommend considering it to help you live a balanced and healthy life."

Examiner Questions:

- Can you describe the diagnostic criteria for mania?

- "Mania is diagnosed when a person experiences an abnormally elevated mood, increased activity or energy, for at least one week, with three or more symptoms such as inflated self-esteem, reduced need for sleep, being more talkative, flight of ideas, distractibility, increased goal-directed activity, or excessive involvement in risky activities."

- How might a family history of bipolar disorder be relevant to this case?

- "Family history is significant because bipolar disorder has a genetic component. A first-degree relative with bipolar disorder increases the risk, making it a pertinent part of Tarek's assessment."

- What are some potential complications of untreated mania?

- "Untreated mania can lead to severe psychosocial impairments, risky behaviors, financial or legal problems, and can escalate into psychosis."

- How would you approach treatment for this patient?

- "With consent, I would initiate mood stabilizers like lithium or antipsychotics and possibly consider benzodiazepines for symptomatic control of agitation."

- What are the considerations for the differential diagnosis in this presentation?

- "Differentials include hyperthyroidism, substance-induced mood disorder, and other psychiatric conditions like schizoaffective disorder; assessment should rule these out."

Treatment:

Initiate mood stabilizer therapy:

- Lithium Carbonate, starting dose of 400 mg daily, titrated to therapeutic blood levels (0.6-1.2 mmol/L).

- Monitor kidney and thyroid function, lithium levels every 3-6 months.

Antipsychotic therapy if needed:

- Olanzapine, 5-10 mg orally once at bedtime.

- Monitor for metabolic syndrome.

In case of lithium contraindication or ineffectiveness:

- Valproate or carbamazepine as alternative mood stabilizers.

Supportive therapy:

- Benzodiazepines such as lorazepam for short-term symptomatic relief of agitation or insomnia.

Psychoeducation:

- Providing information about the condition and the importance of medication adherence.

Follow guidelines from NICE, BMJ, BNF, and CKS.

Monitoring:

- Frequent follow-up appointments initially, then every 3-6 months once stable.

- Monitor for signs of lithium toxicity.

- Check lithium levels after one week of starting or changing a dose, then every 3 months.

- Regular check-ups for mood symptoms and medication side effects.

Prognosis:

With appropriate treatment, patients can manage symptoms of mania and live productive lives. The prognosis is generally good if the patient adheres to treatment, although there is a risk of relapse and cyclical mood changes.

Differential diagnoses:

1. Hypomania: More moderate symptoms without significant impairment.

2. Hyperthyroidism: Similar symptoms, biochemical testing rules this out.

3. Bipolar II disorder: Requires history of depressive episodes, which is not present.

4. Substance-induced mood disorder: No history of substance abuse in this case.

Speciality Filter:

Mental Health;

Presenting Complaint Filter:

Elevated Mood; Decreased Need for Sleep;

Condition Filter:

Mania;

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_45\_Acute stress disorder

Homepage Vignette:

A 29-year-old individual named Emeka presents with intense fear, nightmares, and flashbacks after being involved in a severe car accident a week ago.

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Individual Page Vignette:

You are working in a General Practice Clinic, and your next patient is a 29-year-old software engineer named Emeka, who has come in with complaints of intense fear, distressing nightmares, and recurring flashbacks related to a recent car accident they have experienced.

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Patient Name:

Emeka Chijioke (pronounced Eh-MEH-kah Chee-JEE-oh-keh). Emeka prefers to be called by their first name.

Date of Birth: 14/06/1995

Location: General Practice Clinic

Personality:

Emeka is intelligent and articulate, typically maintaining a calm demeanor. However, since the accident, they have become visibly anxious and jumpy, often speaking quickly and with urgency.

Presenting Complaint:

"I just can't seem to shake off the fear from that crash. I keep seeing it over and over in my head, especially at night, and it’s making me jump at the smallest things."

History of Presenting Complaint:

Emeka has been experiencing these symptoms consistently since the car accident a week ago. They have tried relaxation techniques and distraction but with little success. The symptoms have not improved over time and occur several times a day, significantly impacting Emeka’s daily life, causing disruption at work and lack of sleep, which has been detrimental to their physical and mental wellbeing.

“I’ve been a mess since it happened; work is suffering and I can barely sleep.”

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event: “I can’t control these flashbacks; they just keep popping into my head.”

- Distressing dreams related to the event: “My sleep is haunted by nightmares of that night.”

- Dissociative reactions (flashbacks) where the individual feels or acts as if the traumatic event were recurring: “Sometimes I zone out and it’s like I’m back in the car, bracing for impact.”

- Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event: “Even the sound of a car horn can set me off.”

- Marked physiological reactions to reminders of the traumatic event: “My heart races and I get sweaty when I think about the crash or see a car that looks like the one that hit me.”

Systemic Symptoms:

- Fatigue: “I’m exhausted all the time from the nightmares and lack of sleep.”

- Fever, night sweats, unintended weight loss: “No, nothing like that.”

- Generalised weakness, malaise: “Just feeling run down from not sleeping well.”

- Bowel habits, urinary habits: “Those are the same as always.”

- Changes in sleep: “I've barely slept since the accident.”

- Peripheral oedema: “No swelling or anything.”

Past Medical History:

Emeka has no significant past medical history and has not experienced any similar episodes in the past. They have never been hospitalized or had any surgeries, no history of psychiatric conditions, and no history of substance abuse. Emeka’s immunizations are up to date.

“Never really had health issues before, and I keep up with my vaccinations.”

Psychiatric History:

- Quote: “I have felt really down before, but nothing ever like this current situation. It’s been about a week of non-stop stress and fear since the car accident.”

- Quote: “No, I have never been diagnosed with anything or seen a psychiatrist before.”

“I’ve always been a bit of a loner, but I’ve got a few close friends. I’m a software engineer, and I love my job. This is the first time I’ve faced something traumatic like the accident.”

“I drink occasionally, but I’ve never used illegal drugs or abused prescription meds.”

Risk Assessment:

- No suicidal intent

- Does not have any thoughts of harming others

- Quote: “I don’t want to hurt myself, I’m just scared all the time now.”

- Quote: “No, I live alone, and I have never been threatened or hurt by someone else.”

- Quote: “I’ve been managing okay on my own, it’s just the constant fear and nightmares that are hard to deal with.”

- Quote: “I keep to myself mostly, but I have some friends and my brother who I talk to. I usually run or meditate to cope with stress.”

Drug History:

Emeka does not take any prescription or over-the-counter medications regularly and has not needed any medication since the accident. They do not use herbal supplements, alternative therapies, and are not on contraception. There is no history of medication non-compliance or overdose incidents.

“I don’t take any meds, never really needed them.”

Allergies:

Emeka has no known allergies to medications, foods, or environmental factors.

“I’ve never had an allergic reaction to anything.”

Family History:

There is no known family history of psychiatric conditions. One parent has hypertension, and a sibling has asthma, but there are no other significant health events in the family.

“My dad takes meds for high blood pressure and my brother has an inhaler for his asthma, but that’s about it.”

Social History:

Smoking: Non-smoker.

Alcohol: Drinks socially, about 2-3 units per week.

Recreational Drug Use: No history of recreational drug use.

Diet: Vegetarian, balanced diet.

Exercise: Goes for a run three times a week, each session lasting approximately 30 minutes.

“It's not like me to have a problem like this, I’m usually very active and healthy.”

Travel History, Sexual History, Driving Status, Cultural or Religious Practices, Recent Life Events, Exposure to Hazards or New Environment:

No recent travel, stable monogamous relationship, no change in driving status, Christian with no specific practices impacting health, no recent significant life events or exposure to new environmental hazards.

“No, nothing out of the ordinary there.”

Ideas, Concerns, and Expectations:

Emeka believes that they are experiencing normal reactions to a traumatic event but is concerned because the intensity and frequency of the symptoms have not lessened over time. They fear that this might affect their ability to work efficiently and are worried about how long these symptoms will persist. Emeka expects to receive information about the condition, its expected duration, and the available treatment options.

“I thought this would have gotten better by now... I just want to know how to get my life back on track.”

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98%

Air or Oxygen?: On room air

Blood Pressure (mmHg): 122/76

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7

NEWS Total Score: 0 (Respiration, oxygen saturation, consciousness, and temperature fall within normal ranges. Blood pressure and pulse also normal.)

Physical Examination:

A thorough physical examination is conducted, with no abnormal findings. Emeka appears anxious and has an increased startle response, but otherwise, the exam is unremarkable.

Special Tests:

Not applicable for this condition.

Diagnostic Tests:

Blood Tests are not indicated for the primary assessment of acute stress disorder. If systemic symptoms suggested a medical cause, relevant tests would be ordered.

Imaging Tests:

Not typically required for assessment of acute stress disorder.

Condition:

Acute stress disorder

Patient Questions:

1. Emeka: “Is what I’m feeling normal, or am I losing my mind?”

Answer: “It’s common to have strong reactions like yours after a traumatic event, and it doesn’t mean you’re losing your mind. These are normal responses, but we can help you manage them.”

2. Emeka: “How long is this going to last? What if it doesn’t stop?”

Answer: “Most people start to feel better within a few weeks to months. If symptoms persist, we have effective treatments that can help.”

3. Emeka: “Do I need medication, or is there another way to treat this?”

Answer: “Treatment can include counseling and sometimes medication. We’ll discuss the best option for your specific situation.”

4. Emeka: “Can I go back to work, or should I be taking some time off?”

Answer: “You should be able to continue working, but we may need to make some adjustments to ease your stress while you're recovering.”

Examiner Questions:

1. What are the diagnostic criteria for acute stress disorder?

Answer: Presence of nine or more symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, starting or worsening after the traumatic event.

2. How does acute stress disorder differ from post-traumatic stress disorder (PTSD)?

Answer: Acute stress disorder symptoms occur immediately after the trauma and last from three days to one month. PTSD is diagnosed when symptoms last for more than a month and can develop after an episode of acute stress disorder.

3. What are the first-line treatments for acute stress disorder?

Answer: Cognitive Behavioral Therapy (CBT) including trauma-focused therapy such as Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR).

4. How would you monitor Emeka's progress in therapy?

Answer: Regular follow-ups to assess symptom severity, functionality, and any need for adjustment in therapy, including possible pharmacologic interventions.

5. How should a General Practitioner approach a case of acute stress disorder initially?

Answer: The GP should validate the patient's experience, provide psychoeducation, consider acute stress management techniques, assess for safety, and make referrals to mental health services as appropriate.

6. What are some potential complications of untreated acute stress disorder?

Answer: Chronic PTSD, depression, substance abuse, and impairment in social, occupational, and other important areas of functioning.

Treatment:

- Psychoeducation about acute stress disorder and reassurance that symptoms are a common reaction to trauma.

- Consider short-term use of benzodiazepines or SSRIs for severe, distressing symptoms, though they are not the first line.

- Referral to a mental health professional for cognitive-behavioral therapy or other evidence-based psychological treatments such as EMDR.

- If sleep is significantly affected, consider a short course of sleeping aid, under strict guidelines to prevent dependence.

If Emeka does not respond to the initial treatment or cannot tolerate it, alternative medications or an increased intensity of therapy may be considered.

Monitoring:

Emeka should be monitored for the severity of symptoms, sleep pattern, functional status, and side effects of any medications. Regular follow-ups should be scheduled every 1-2 weeks initially, with adjustments to the treatment plan as needed. If symptoms worsen or there is no improvement within 2-4 weeks, a referral to a specialist in psychiatry may be necessary.

Prognosis:

The prognosis for acute stress disorder is generally good, with many individuals recovering within the first month following the traumatic event. Early intervention with appropriate treatment can reduce the risk of progression to PTSD. Factors such as the severity of the trauma, previous psychiatric history, and support system can influence recovery.

Differential diagnoses:

1. PTSD: Differentiated by duration, as PTSD is diagnosed when symptoms persist for more than one month.

2. Adjustment Disorder: Less severe and typically linked to life stressors rather than traumatic events.

3. Generalized Anxiety Disorder: Lacks the traumatic trigger and the specific flashback/dissociation symptoms.

4. Major Depressive Disorder: May share some features such as sleep disturbance and poor concentration but lacks trauma-specific symptoms such as flashbacks.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Severe Anxiety

Condition Filter:

Acute Stress Disorder

Location Filter:

General Practice

Case created by:

Reviewed by:

Reviewed by:

# DS\_46\_Schizoid personality disorder

Homepage Vignette:

## A 31-year-old individual named Alexei presents with difficulties in establishing social relationships and a pervasive preference for solitary activities.

Individual Page Vignette:

You are a General Practitioner. Alexei, a 31-year-old librarian, comes to your clinic expressing concerns about their difficulties in forming social connections and a strong inclination toward spending time alone.

Patient Name:

Alexei Nevelev (Ah-LEK-sey NE-ve-lev). The patient prefers to be called Alexei.

Age:

DOB: 14/06/1993

Location:

General Practice

Personality:

Alexei is methodical and reserved, speaking in a deliberate and concise manner. They value their privacy highly and have a tendency toward introspection rather than sharing personal details. Alexei appears content with minimal social interaction.

Presenting Complaint:

Alexei reports feeling comfortable with very limited social interaction and identifies a long-standing pattern of preferring solitary activities over engaging with others. They mention a lack of desire for close relationships, including with family members.

Symptoms:

- Difficulty in establishing social relationships

"I've just never been that interested in making friends or going out much."

- Preference for solitary activities

"I'm happiest when I'm alone, doing my own thing."

- Lack of desire for close relationships

"I've never really felt the need to be close with anyone, not even my family."

History of Presenting Complaint:

- Alexei has experienced a lifelong pattern of preferring solitude, dating back to early adulthood.

"I've always enjoyed my own company more than others'. It's been like this since I was young."

- They have not sought any psychological treatment before as they did not perceive their personality traits as an issue.

"I never really thought I needed help; I felt okay with the way things were."

- There has been no change in their behavior over time; the pattern has been consistent.

"It's always been my normal. I spend time on my hobbies and don't seek out company."

- Their preference for minimal social interaction hasn't impacted the ability to perform daily tasks or activities of daily living (ADLs).

"My day-to-day life isn't affected. I go to work, take care of my home, and do what I enjoy."

- The presentation has had a negligible effect on Alexei’s ability to work, especially in their role as a librarian, which is well-suited to limited social interaction.

"My job suits me fine. I manage the books, help patrons when needed, but mostly I'm alone and it's comfortable."

- Alexei reports no adverse effects on their physical health due to their lifestyle, and there have been no significant mental health concerns until recent questioning from family members.

"Physically, I'm healthy. Mentally, I've never felt distressed, just now a bit curious because my family finds it odd."

Systemic Symptoms:

- No fatigue, fever, night sweats, unintended weight loss, generalized weakness, or malaise.

- Stable bowel and urinary habits.

- Sleep pattern is regular with no disturbances.

- No peripheral oedema or other signs of systemic illness.

Past Medical History:

- No significant past medical conditions, surgeries, or hospitalizations.

- No previous injuries or traumas.

- No psychiatric or psychological history until now.

- No history of substance abuse or addiction.

- Up-to-date with immunizations.

Past Medical History:

- No significant past medical history, including psychiatric or psychological issues, until this consultation.

"I've never had to see a doctor about my mental health before. This is all new to me."

Risk Assessment:

"I've never thought about harming myself or anyone else. I just like being alone."

"No, I've never felt hopeless or had thoughts of taking my life."

"My life is pretty much how I want it. I work, have my hobbies, and I'm self-sufficient."

Drug History:

- Not currently taking any medications.

- No history of medication non-compliance or missed doses.

- Does not use herbal supplements or alternative therapies.

Allergies:

- No known allergies to medications, foods, or environmental allergens.

Family History:

- No known family history of psychiatric conditions.

- Some relatives with hypertension and type 2 diabetes, but not immediately relevant to the current presentation.

Social History:

- Lifestyle: Predominantly sedentary with minimal social interaction.

- Occupation: Librarian.

- Activities of Daily Living & Hobbies: Enjoys reading, model building, and various solitary hobbies.

- Smoking: Non-smoker.

- Alcohol: Rarely drinks, approximately 1 unit per month.

- Recreational Drug Use: None.

- Diet: Primarily home-cooked meals with a preference for simplicity.

- Exercise: Occasionally takes walks but has no regular exercise routine.

Ideas, Concerns, and Expectations:

- Ideas: Alexei senses that their lifestyle is different but does not consider it a problem.

"I know I'm not like everyone else, but it's never bothered me."

- Concerns: Some concerns raised by family members have prompted this visit.

"My family thinks it's odd that I don't date or go out with friends. I guess I'm here because they're worried."

- Expectations: Curious about the medical opinion, and open to suggestions, but not actively seeking change.

"I don't know what you can tell me, but I thought I'd see what you have to say about it."

Observations:

- Respirations (Breaths/min): 16 (0 points)

- Oxygen Saturation (%): 98 on room air (0 points)

- Blood Pressure (mmHg): 122/78 (0 points)

- Pulse (Beats/min): 68 (0 points)

- Consciousness (AVPU): Alert (0 points)

- Temperature (Celsius): 36.7 (0 points)

- NEWS Total Score: 0

Physical Examination:

- General appearance consistent with reported lifestyle, no abnormalities detected.

Diagnostic Tests:

- Screen for mood disorders: Not indicated, as Alexei does not present symptoms of mood disorder.

- Cognitive assessment: Normal.

Condition:

Schizoid personality disorder

Patient Questions:

- "Do you think there's something wrong with me because I like being alone?" (Possible response: "Preferring solitude doesn't necessarily mean there’s something wrong, but it's important to understand how it affects your life.")

- "What can you do to make me 'normal'?" (Possible response: "Our goal isn't to make you 'normal,' but rather to ensure you're living a life that's fulfilling and healthy for you.")

- "Are there other people like me, or am I just an oddity?" (Possible response: “There are many people with tendencies similar to yours; it's a recognized personality style.")

Examiner Questions:

- What diagnostic criteria does Alexei meet for schizoid personality disorder? (Possible answer: Persistent detachment from social relationships and preference for solitary activities, lack of desire for close relationships, showing little emotion.)

- What other conditions should be considered in a differential diagnosis? (Possible answer: Autism spectrum disorder, depressive disorders, social anxiety disorder.)

- How would you approach treatment for Alexei? (Possible answer: Psychotherapy focused on building relationships and social skills, acknowledging the patient's comfort with their lifestyle.)

- What is the prognosis for an individual diagnosed with schizoid personality disorder? (Possible answer: The prognosis varies, but many individuals can function well with a structured routine and understanding of their preferences.)

- Are there any risks associated with schizoid personality disorder? (Possible answer: Risks may include social isolation and the potential for depression or anxiety.)

Treatment:

Approach treatment based on guidelines from sources like the American Psychiatric Association:

- Psychotherapy as the primary treatment, particularly cognitive-behavioral therapy (CBT) to address thoughts and patterns associated with social isolation.

- No pharmacotherapy is indicated unless there are comorbid conditions such as depression or anxiety.

Monitoring:

- Schedule follow-up visits to assess the patient’s satisfaction with social interactions and any distress.

- Monitor for signs of depression or anxiety and consider additional therapy or pharmacotherapy if needed.

Prognosis:

- The long-term prognosis for schizoid personality disorder is variable.

- Some individuals may find fulfillment in their solitary lifestyles, while others may experience loneliness or depression.

- With psychotherapeutic interventions, some may develop greater social ties and report an improved quality of life.

Differential diagnoses:

1. Autism spectrum disorder: Less likely due to the absence of restrictive/repetitive behaviors and developmental history.

2. Avoidant personality disorder: Less likely due to lack of anxiety about being disliked and no desire for social interaction in Alexei.

3. Major depressive disorder: Less likely due to the absence of depressive symptoms such as sadness, loss of interest, or changes in appetite or sleep.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Difficulties Establishing Social Relationships; Preference for Solitary Activities

Condition Filter:

Schizoid Personality Disorder

Location Filter:

General Practice

Case created by:

Medical Student

Reviewed by:

Medical Student

Reviewed by:

Medical Student/Doctor

# DS\_47\_Avoidant personality disorder

Homepage Vignette:

## “A 35-year-old individual called Kai presents with pervasive feelings of social inadequacy and hypersensitivity to negative evaluation.”

Individual Page Vignette:

You are a General Practice Registrar seeing a patient named Kai, aged 35, who works as a freelance graphic designer. They have come to your clinic presenting with significant social anxiety and fears of criticism.

Patient Name: Kai Murakami (pronounced: KY Muh-rah-KAH-mee), prefers to be called Kai.

Age: 03/10/1988

Location: General Practice

Personality: Kai is introspective and speaks in a quiet, measured tone. They are articulate when discussing familiar topics but become visibly anxious during social interactions, especially when the focus is on them.

Presenting Complaint: Kai reports a "long-standing fear of being embarrassed in front of others" and "constantly worried about being judged by people".

History of Presenting Complaint:

- Kai has been experiencing symptoms consistent with avoidant personality disorder since their teenage years.

- They have not previously sought formal treatment for these symptoms.

- Over time, the symptoms have progressively worsened, especially in the past year, leading Kai to seek medical attention.

- Symptoms occur daily and have a substantial impact on Kai's personal and professional life, leading to potential job-related consequences due to avoidance of work meetings and social interactions.

- The pervasive feelings of social inadequacy have recently been compounded by feelings of depression, which Kai correlates with their longstanding social anxiety.

"I've always been really scared of being around people; it's like I'm constantly on edge, waiting for someone to judge me or laugh at me. This has been a thing since I was maybe fifteen or sixteen. I never thought to get help before—it just seemed to be who I am. But this past year, it's gotten so bad that I'm having trouble keeping my clients because I dodge meetings. I barely go out unless it's absolutely necessary. I can't remember the last time I actually enjoyed a social event. And, I'm not sure, but I think I might be feeling depressed because of all this too. It's just... a lot, you know?"

Systemic Symptoms:

- Fatigue: "I feel tired all the time."

- Sleep Disturbances: "I have trouble falling asleep from worrying about the next day."

- Other systemic symptoms: normal for this case.

Past Medical History:

- No prior significant medical conditions, surgeries, or hospitalizations.

- No history of substance abuse or addiction.

- Vaccinations up to date.

Psychiatric History:

- Kai has not previously sought formal psychiatric treatment or diagnosis.

- They do not have a history of mental health interventions such as therapy or medication for psychiatric issues.

- There have been no psychiatric hospitalizations or serious mental health crises requiring acute intervention.

- Kai reports long-standing symptoms that align with avoidant personality disorder but has not been formally diagnosed until now.

- Mood disturbances, particularly feelings of depression, have been noted recently, likely as a secondary issue to the primary disorder.

- There's no history of self-harm or suicidal ideation as reported by Kai, though the presence of depressive symptoms warrants ongoing monitoring.

- In terms of family psychiatric history, Kai mentions their mother's chronic anxiety, which may suggest a genetic predisposition to anxiety disorders.

- As for stressors, Kai reports that social interactions, professional meetings, and potential negative evaluations from others are significant sources of anxiety.

- Coping mechanisms include social withdrawal, introspection, solitary activities like reading and video games, and some degree of meditation for stress relief.

Quotes in line with Kai's personality:

"I've never really talked to a professional about this before—I guess I hoped it would just get better on its own. But it feels like it's just a part of who I am."

"My mom has always been a bit of a worrywart, and I guess that’s where I get it from. I try to keep to myself mostly because dealing with people just stresses me out."

"When things get really tense, I try to lose myself in a book or a game, just something to take my mind off things for a while. Meditation helps a bit too, when I can focus enough to do it."

Drug History:

- Occasionally uses over-the-counter antacids for stress-related heartburn.

- No current prescriptions, herbal supplements, or other therapies at this time.

Allergies:

- Latex allergy: "I get a really itchy rash when I'm exposed to latex."

Family History:

- Mother has a history of chronic anxiety.

- Father had hypertension.

Social History:

Lifestyle: "I'm a bit of a homebody. I like reading and watching movies."

Occupation: Freelance graphic designer.

Activities of Daily Living & Hobbies: "I can work from home, but it's been hard to meet clients. I spend most of my free time gardening or playing video games."

Smoking: None (0 pack years).

Alcohol: "I'll have a glass of wine maybe once or twice a month."

Recreational Drug Use: None.

Diet: "I eat mostly vegetarian meals; home-cooked."

Exercise: "I go for a walk in the evenings; it calms me down."

Travel History: "I haven't traveled much, just staycations lately."

Sexual History: Declines to discuss.

Driving Status: "I have a license but rarely drive, it's stressful."

Cultural or Religious Practices: "I'm not religious, but I meditate sometimes; it helps a little."

Recent Life Events: "Just the stress of the pandemic and work challenges."

Exposure to Hazards or New Environment: None.

Ideas, Concerns, and Expectations:

"I worry that people see me as inadequate or incompetent. I don't know what to do about it. I hope you can help me understand why this is happening to me and if there's anything that can be done to make it better."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: On room air

Blood Pressure (mmHg): 130/85

Pulse (Beats/min): 88

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7

NEWS Total Score: 0

Physical Examination:

- General appearance: Anxious but alert and cooperative.

- Mental Status Examination: No evidence of psychotic features; mood appears low; affect constricted with anxious features.

Diagnostic Tests:

- No diagnostic tests indicated for psychological assessment.

Condition:

Avoidant personality disorder

Patient Questions:

1. "What does avoidant personality disorder mean? Is it something that I'm just making up?"

- "Avoidant personality disorder is a recognized condition where one feels excessive anxiety in social situations and fears of being negatively judged. It's not something you are making up—it's a valid psychological concern, and we can discuss treatment options."

2. "Will I need to take medication for this? I'm worried about side effects."

- "Treatment often starts with psychotherapy, which can be very effective. Medication might be considered if necessary, and we would discuss any possible side effects in detail before starting them."

3. "Are there things I can do on my own to help with this?"

- "Definitely. Self-help strategies, such as practicing relaxation techniques and gradual exposure to feared social situations, can support treatment. We'll find the best approach for you."

Examiner Questions:

1. What is the first-line treatment for avoidant personality disorder?

- "The first-line treatment involves psychotherapy, particularly cognitive-behavioral therapy (CBT), which can help the patient learn to deal with fears and anxiety in social situations."

2. Could there be any co-morbid conditions with avoidant personality disorder and how would you assess them?

- "Yes, conditions such as depression and other anxiety disorders often coexist with avoidant personality disorder. A thorough psychiatric evaluation and possibly standardized assessments, like questionnaires, can be helpful in identifying co-morbid conditions."

3. What is the role of pharmacotherapy in treating avoidant personality disorder?

- "Pharmacotherapy is not the first line of treatment but may be used to address specific symptoms or co-morbid conditions, such as SSRIs for co-occurring depression or anxiety."

4. What psychotherapeutic techniques are effective for avoidant personality disorder?

- "Techniques such as cognitive-behavioral therapy, social skills training, and exposure therapy have been found to be effective."

5. How would you differentiate between social anxiety disorder and avoidant personality disorder?

- "Both disorders share similarities with social anxiety, but avoidant personality disorder involves a wider range of social avoidance and is pervasive across various contexts, not only specific social situations."

Treatment:

The treatment plan based on NICE guidelines for avoidant personality disorder includes:

- Offering individual cognitive-behavioral therapy (CBT) with experienced therapists.

- Considering group CBT if the patient is willing and it is available.

- If there are signs of co-morbid depression or anxiety, consider antidepressant medication following the depression or anxiety guidelines.

- Encourage self-help resources and support groups.

Monitoring:

- Regular follow-up appointments to monitor progress with therapy and medication if prescribed.

- Encouraging the patient to be aware of their symptom changes and to report any worsening of symptoms.

- Monitoring for the development of any co-morbid conditions such as depression.

Prognosis:

- The prognosis of avoidant personality disorder varies; some individuals learn to manage symptoms effectively through therapy and may see improvements in functioning and quality of life.

- Long-term therapy may be beneficial.

- Factors influencing the response to treatment include the severity of the disorder, co-morbid conditions, and the patient's commitment to treatment.

Differential diagnoses:

1. Social anxiety disorder: More situation specific and does not involve the breadth of social avoidance seen in avoidant personality disorder.

2. Schizoid personality disorder: Lack of desire for social relationships distinguishes it from APD.

3. Dependent personality disorder: Distinct with its need for reassurance and advice, rather than avoidance due to fear of rejection.

Speciality Filter:

Mental Health;

Presenting Complaint Filter:

Anxiety; Fear; Social Withdrawal;

Condition Filter:

Avoidant Personality Disorder;

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_48\_Stimulant intoxication

Homepage Vignette:

A 22-year-old individual named Riley presents with palpitations and excessive sweating.

Individual Page Vignette:

You are a medical student in an Emergency Department. Your patient today is Riley, a 22-year-old graphic designer, who has come in with complaints of heart palpitations and profuse sweating.

Patient Name:

Riley Sohrab

Age:

Date of Birth: 14/06/2002

Location:

Accident & Emergency

Personality:

Riley is articulate and outgoing, often speaking quickly and with a sense of urgency. Despite their current discomfort, they maintain a friendly demeanor.

Presenting Complaint:

"I've been feeling my heart racing, like it's trying to beat out of my chest, and I'm sweating buckets even though it's not hot."

Symptoms:

- Palpitations

- Excessive sweating

Site: The sensation is felt in the chest area; "It's like my heart is thumping right in the middle of my chest."

Onset: The palpitations started a few hours ago; "This started happening out of nowhere while I was working on a project."

Character: Described as a rapid heartbeat; "My heart's beating super fast and it feels strong."

Radiation: The feeling does not radiate; "It's just in my chest, doesn't go anywhere else."

Associated Symptoms: Excessive sweating; "I'm also sweating a lot, which is weird because I'm not doing anything strenuous."

Timing: The palpitations started abruptly; "I was fine all morning, and then suddenly, this started."

Exacerbating and Relieving Factors: Riley has not identified any factors that make the symptoms better or worse; "I don't know what triggered this, or how to calm it down."

Severity: Riley is visibly distressed by the symptoms; "It's freaking me out, I'd say it's pretty severe."

The full questioning around the topic would also include potential questions for symptoms like lightheadedness, chest pain, shortness of breath, and recent use of stimulants, all of which are negative in Riley's case.

History of Presenting Complaint:

- Symptoms started a few hours ago.

- No previous similar episodes.

- No treatments attempted.

- The symptoms occurred suddenly and have been constant.

- These symptoms are affecting Riley's ability to work and focus.

- No impact on physical and mental wellbeing identified besides current distress.

Riley might say: "I've never felt anything like this before. I was totally fine just working, and then boom, heart racing and sweat everywhere."

Systemic Symptoms:

- No fatigue, fever, night sweats, unintended weight loss, or generalised weakness.

- Normal bowel habits and urinary habits.

- Sleep patterns have not been affected up to this event.

- No peripheral edema or malaise reported by Riley.

Riley could say: "No other funky stuff happening, just the heart thing and the sweating."

Past Medical History:

- No previous medical conditions or surgeries.

- No reported psychiatric or psychological history.

- No substance abuse or addictions.

- Up-to-date on vaccinations.

Past Psychiatric/Psychological History:

- No known history of psychiatric or psychological conditions.

- No reported therapy or counseling sessions.

- Denies any previous psychiatric medication use.

- No suicidal intent or self-harm

Drug History:

- Riley is not currently taking any medications.

- No history of medication non-compliance.

- Riley does not use herbal supplements or alternative therapies.

Riley could say: "Nope, I don't take any pills, not even vitamins."

Allergies:

- No known allergies or intolerances reported.

Riley could comment: "I'm lucky, no allergies that I know of."

Family History:

- No known family history of cardiovascular diseases or other significant conditions.

Riley could remark: "My family's pretty healthy, nothing runs in the family as far as I know."

Social History:

Lifestyle: Riley leads an active lifestyle with regular social interactions.

Occupation: Graphic designer.

Activities of Daily Living & Hobbies: Enjoys gaming and attending social events with friends.

Smoking: Riley does not smoke; 0 pack years.

Alcohol: Drinks socially, about 4 units per week.

Recreational Drug Use: Denies any recreational drug use.

Diet: Generally balanced with a preference for home-cooked meals.

Exercise: Participates in light jogging thrice a week.

Riley might say:

- "I design for a living; it can be high pressure, but I love it."

- "Sure, I have a few drinks when I'm out with friends, but nothing crazy."

- "I take a run around my neighborhood, nothing too intense, just to stay in shape."

Ideas, Concerns, and Expectations:

Riley is concerned that the symptoms might indicate a serious heart condition. They expect to receive an explanation for the symptoms and appropriate treatment to address them.

Riley could express: "I'm just worried that this could be something bad with my heart. I hope you can tell me what's going on and fix it fast."

Observations:

Respirations (Breaths/min): 18

Oxygen Saturation (%): 98

Air or Oxygen?: On room air

Blood Pressure (mmHg): 135/85

Pulse (Beats/min): 110

Consciousness (AVPU): Alert

Temperature (Celsius): 37.5

NEWS Total Score: 0

Physical Examination:

The physical exam would include observing for signs of distress, hydration status, and cardiovascular examination including heart rate, rhythm, and sounds.

Special Tests:

If relevant, specific cardiac tests may be considered.

Diagnostic Tests:

Blood Tests (Reference Ranges): A complete blood panel may be checked, including electrolytes, thyroid function tests, and other relevant blood work.

Imaging Tests: An ECG or echocardiogram would be obtained to assess heart function.

Condition:

Stimulant intoxication

Patient Questions:

- "Could this be a heart attack?"

- "Based on your age and symptoms, a heart attack is less likely, but we'll perform tests to make sure everything is okay with your heart."

- "How long will I have to be here?"

- "We'll need to wait for the test results before we know for sure, but we'll make this as quick as possible."

- "What can I do to prevent this from happening again?"

- "Once we understand the cause, we can discuss lifestyle changes or treatments that can help prevent a recurrence."

Examiner Questions:

- What are the possible causes of palpitations in a young adult?

- Possible causes include stimulant use, anxiety, hyperthyroidism, cardiac arrhythmias, and more.

- What initial investigations would you perform in this case?

- ECG, basic blood tests including thyroid function, urine drug screen, and possibly a chest X-ray.

- How would you differentiate between different causes of palpitations?

- Patient history, physical examination, laboratory results, and response to treatments can help differentiate between causes.

- What are the potential dangers of stimulant intoxication?

- Dangers include cardiac arrhythmias, hypertension, stroke, and in severe cases, cardiac arrest.

- How do you counsel a patient who may have taken stimulants?

- Discuss the risks of stimulant use, offer support for substance misuse if needed, and provide resources for cessation.

Treatment:

Treatment would be based on current best practice guidelines, including observation, potential benzodiazepines for symptomatic treatment of acute anxiety or agitation, and supportive care. It would also be essential to discuss avoiding stimulant use, with follow-up for further support if needed.

Monitoring:

Monitoring would include observing vital signs, cardiac monitoring, and ensuring no progression of symptoms. Follow-ups would likely be arranged to assess for any underlying issues or continued symptoms.

Prognosis:

With appropriate management, the prognosis for stimulant intoxication is typically good, but patients should be advised about the dangers of stimulant misuse.

Differential diagnoses:

1. Anxiety disorder

2. Hyperthyroidism

3. Cardiac arrhythmia

4. Pheochromocytoma

5. Substance abuse disorder

The actual condition is more likely than the differentials based on the presentation and age of the patient, but each differential would need to be considered and ruled out through examination and testing.

Speciality Filter:

Acute And Emergency; Mental Health;

Presenting Complaint Filter:

Palpitations; Excessive Sweating;

Condition Filter:

Stimulant Intoxication;

Location Filter:

Accident & Emergency

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_49\_Dependent personality disorder

Homepage Vignette:

## A 24-year-old individual called Alex presents with difficulty making everyday decisions and an excessive need for advice and reassurance from others.

Individual Page Vignette:

You are a general practitioner assessing Alex, a 24-year-old teacher located at your clinic. They present with significant challenges in making daily decisions without an excessive amount of advice and reassurance from others.

Patient Name: Alex Karamazov (pronounced ka-rah-MAH-zov); prefers to be called Alex.

Age: 28/07/1999

Location: General Practice

Personality:

Alex has a significant reliance on others for support, showcasing a passive demeanor. They speak in a soft tone, often looking for affirmation or guidance, even on minor details of the conversation.

Presenting Complaint:

"I just can't seem to make decisions on my own. I'm always asking for help, even for little things like what to eat or wear."

Symptoms:

- Excessive dependence on others for everyday decisions.

- Difficulty expressing disagreement for fear of loss of support or approval.

- A notable reluctance to take on personal responsibilities.

History of Presenting Complaint:

- Alex has been experiencing symptoms related to decision-making for several years, but they have intensified over the past few months.

- There have been no previous attempts at formal psychological therapy.

- The symptoms have been persistent and impact Alex's daily life activities, causing significant distress.

- The dependency affects the ability to perform work duties without seeking reassurance from others.

- There is a noticeable impact on social interactions and relationships, with a reliance on friends and family for minor life decisions.

- Alex has not indicated any fluctuation or remission of symptoms over time; rather, there has been a gradual worsening.

"I've always felt I needed a lot of guidance from others, but it's like I can't do anything without someone's input now. It’s been a slow change, but looking back over the past few months, it's really taken over my life."

Systemic Symptoms:

- Experiences intermittent anxiety.

- Reports no fatigue, fever, night sweats, unintended weight loss, or malaise.

"I get anxious quite often, especially when I have to choose something on my own."

Past Medical History:

- No active medical conditions reported.

- No previous hospitalizations or surgeries.

- No history of substance abuse or psychiatric conditions.

"I've been pretty healthy physically, just these decision-making issues."

Psychiatric History:

- No prior psychiatric diagnoses reported.

- No history of previous mental health treatments or hospitalizations.

- Alex has not engaged in any form of psychological therapy or counseling.

- No reported instances of self-harm or suicidal thoughts.

- Alex denies any past or current use of psychiatric medications.

- No family history of psychiatric conditions has been mentioned.

Quotes aligned with personality:

"I've never needed to see a psychologist or psychiatrist before, and I've never taken any medicine for my mind. My family's pretty sturdy mentally, as far as I know."

Drug History:

- Not currently on any medications.

- No known history of medication non-compliance or overdoses.

- Does not use herbal supplements or alternative therapies.

"I haven't taken any medicine for a long time, and I never miss doses because I don't need to take anything regularly."

Allergies:

- No reported allergies to medications, foods, or environmental allergens.

"No allergies that I know of; I've never had a reaction to anything."

Family History:

- No significant family medical history.

"No one in my family has had major health problems that I'm aware of."

Social History:

Lifestyle:

- Seems to lead a relatively constrained lifestyle, with limited social activities outside of work due to dependency issues.

Occupation:

- Works as a teacher, often relying on colleague support for managing responsibilities.

Activities of Daily Living & Hobbies:

- Struggles with decision-making in daily activities. Relies on friends or family to plan leisure activities.

Smoking: No history of smoking.

Alcohol: Does not consume alcohol.

Recreational Drug Use: Denies any recreational drug use.

Diet: Relies heavily on others to decide meals.

Exercise: Infrequent, often needs motivation or accompaniment from others.

Ideas, Concerns, and Expectations:

- Alex expresses a desire to be more independent but is unsure how to achieve it.

- They are concerned that their neediness might strain relationships.

- Hopes to find strategies to make decisions independently.

"I really want to be able to do things on my own, but it's scary, you know? I'm worried that people will get tired of me always asking for help."

Observations:

Respirations (Breaths/min): 14

Oxygen Saturation (%): 98%

Air or Oxygen?: On room air

Blood Pressure (mmHg): 120/70

Pulse (Beats/min): 68

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8

NEWS Total Score: 0

Physical Examination:

- The physical examination is unremarkable with normal findings throughout.

Special Tests:

- No special tests are indicated.

Diagnostic Tests:

- The primary assessment involves a psychiatric evaluation. Further investigations may be directed based on the findings of this initial assessment.

Condition:

Dependent personality disorder

Patient Questions:

1. "Is there medication that can make me less dependent on others?"

- "Medications can help manage symptoms of anxiety that may be associated with your condition, but the main treatment for dependent personality disorder involves therapy to help you become more independent."

2. "Will I ever be able to make decisions on my own?"

- "With the right support and therapy, many people can learn to become more autonomous and manage their dependent behaviors."

3. "What if therapy doesn't work for me? What are my options?"

- "If one approach isn't effective, there are various types of therapy and strategies we can try. It's about finding what works for you personally."

Examiner Questions:

1. What are the diagnostic criteria for dependent personality disorder?

- "The DSM-5 outlines several criteria, including difficulty making daily decisions without excessive advice and reassurance from others, and difficulty initiating projects due to lack of self-confidence."

2. What is the mainstay of treatment for dependent personality disorder?

- "The primary treatment is psychotherapy, particularly cognitive-behavioral therapy, to help the patient develop more independent thought processes and self-reliance."

3. How does dependent personality disorder differ from separation anxiety disorder?

- "Dependent personality disorder is characterized by a pervasive need to be taken care of, while separation anxiety disorder involves excessive fear of being away from home or attachment figures."

4. Can medication be helpful in the management of dependent personality disorder?

- "Medications might be used to manage comorbid conditions like anxiety or depression, but they are not the main treatment for the personality disorder itself."

5. How would you differentiate between dependent personality disorder and high trait dependency in a non-pathological sense?

- "Trait dependency becomes a disorder when it is inflexible, maladaptive, and consistent, causing significant impairment or distress in various aspects of life."

Treatment:

- Discuss referral for psychological therapy, specifically cognitive behavioral therapy (CBT), to help the patient develop more independent behaviors.

- Monitor for and address any co-existing anxiety or depressive disorders, potentially prescribing SSRI or SNRI medications as per guidelines in these cases.

- Encourage the use of support groups or self-help strategies that focus on building self-esteem and assertiveness.

Monitoring:

- Schedule regular follow-up sessions to monitor Alex's progress with therapy and possible pharmacotherapy for anxiety.

- Adjust the management plan as needed based on the patient's response to treatment.

- Consider referral to a specialist if there is no improvement with initial therapies or if complex comorbid conditions are identified.

Prognosis:

- The prognosis for dependent personality disorder varies. With ongoing therapy, patients can learn coping strategies to become more autonomous, though some may continue to struggle with dependency issues.

- Engagement with treatment and the presence of a supportive environment are positive prognostic factors.

Differential Diagnoses:

1. Borderline Personality Disorder: Less likely due to the absence of unstable relationships, identity disturbance, and impulsive behaviors.

2. Anxiety Disorders: While anxiety symptoms may be present, the pervasive and consistent dependent behavior is more indicative of dependent personality disorder.

3. Major Depressive Disorder: Despite potential overlap with depressive symptoms, the enduring pattern of dependence is characteristic of personality disorder, not an episodic mood disorder.

Speciality Filter:

Mental Health

Presenting Complaint Filter:

Psychological or Psychiatric Problems; Difficulty Making Decisions; Excessive Need for Reassurance

Condition Filter:

Dependent Personality Disorder

Location Filter:

General Practice

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# DS\_50\_Schizoaffective disorder

Homepage Vignette:

A 28-year-old individual named Alexei (pronounced ah-LEK-sey) presents with mood disturbances and auditory hallucinations.

Individual Page Vignette:

You are a junior doctor in the psychiatric clinic. Your patient today is a 28-year-old named Alexei (ah-LEK-sey), a graphic designer, who is experiencing significant mood disturbances accompanied by auditory hallucinations.

Patient Name: Alexei Zhukov (ah-LEK-sey ZHOO-kawf), prefers to be called Alexei.

Age: Born 15/07/1996

Location: Psychiatric Clinic

Personality: Alexei is articulate and insightful, often expressing themselves with a mix of dry humor and thoughtful observation. Although they display signs of distress related to their symptoms, Alexei approaches the conversation with a level of candor and self-awareness.

Presenting Complaint: "I've been riding this emotional rollercoaster—ups and downs—and I swear I hear voices chatting when no one's around. It's unsettling."

History of Presenting Complaint:

- Symptom duration: Alexei has been experiencing mood disturbances and auditory hallucinations for several months.

- Previous treatments: Alexei has not sought any previous treatments for these symptoms.

- Symptom progression: Initially intermittent, the symptoms have become more constant and severe with time.

- Frequency of symptoms: The symptoms occur daily and do not follow a specific pattern.

- Impact on daily life: These symptoms have led to increased social isolation, difficulties at work, and have disrupted Alexei's normal daily activities.

- Impact on work: As a graphic designer, Alexei's concentration and productivity have been significantly impaired.

- Impact on physical and mental wellbeing: Despite not experiencing significant systemic symptoms, Alexei feels mentally drained and physically exhausted due to the pervasive mood swings and hallucinations.

Quote: "This whole thing started slowly, just weird feelings and the occasional whisper. But now, it's like a switch flipped, and I'm hearing these voices every single day. Can't focus, can't work; it's totally turned my life upside down. It's like I'm just watching myself lose it, you know?"

Systemic Symptoms:

- Negative for significant systemic symptoms such as fever, weight loss, fatigue, weakness, or changes in sleep, bowel or urinary habits.

Quote: "I don't feel sick in the body, you know? It's like my mind's got its own flu."

Past Medical History:

- Negative for notable past medical or surgical history.

Psychiatric or psychological history:

- No known history of mental health conditions prior to the current presentation.

- Alexei has not engaged in any form of therapy or counseling in the past.

- No suicidal intent or self-harm.

Quote: "Therapy? Nope, never needed it. I've always been the 'roll with the punches' type."

History of substance abuse or addiction:

- Denies any history of substance abuse or addiction.

Drug History:

- No current medications or known history of drug use.

Quote: "Drugs? Nah, never needed more than aspirin. And no need for prescriptions until now, I guess."

Allergies:

- No known allergies or intolerances.

Quote: "Allergies? No, I'm good with foods and meds—never had a bad reaction."

Family History:

- Non-contributory; no known history of mental health issues in the family.

Quote: "My family? They’re all pretty sane, as much as families can be, right?"

Social History:

Lifestyle: "I'm pretty active in the local art scene, do a bit of DJing on the side."

Occupation: "I live and breathe graphic design—self-employed."

Activities of Daily Living: "Managing fine except for when the 'noise' starts. Then I can't concentrate on anything."

Hobbies: "Love hiking, and I'm slowly mastering the piano."

Smoking: Never smoked.

Alcohol: Occasional drinker, "maybe a couple of beers on the weekend."

Recreational Drug Use: Denies

Diet: "Vegetarian for a few years now."

Exercise: Hikes weekly, "to clear my head—helps me think."

Travel History: "Nah, never been much of a globetrotter."

Sexual History: Chooses not to disclose.

Driving Status: "I've got a bike. Does that count?"

Cultural or Religious Practices: "Spiritual but not tied to any particular religion."

Recent Life Events: Mentioned recent work stress: "Landed several big projects, and the pressure is on."

Quotes:

1. "I'm usually the go-to guy at exhibitions, and love spinning records at clubs. Gets the people moving, you know?"

2. "I've been sticking to veggies for ages. Healthier for the planet and me, I'd like to think."

3. "Hiking is my therapy. Just me and nature, away from all the hustle."

Ideas, Concerns, and Expectations:

Alexei believes that the symptoms might be stress-related but is becoming increasingly concerned about the possibility of a serious mental illness. They are worried about the impact this condition will have on both their professional and personal life. Alexei expects to gain a better understanding of what is happening and to discuss treatment options that will help manage the symptoms.

Quote: "I thought it was just stress at first, but now I'm scared it's something worse. I need to know what's up and how to fix it."

Observations:

Respirations: 16 Breaths/min

Oxygen Saturation: 98%

Air or Oxygen?: Room Air

Blood Pressure: 120/80 mmHg

Pulse: 72 Beats/min

Consciousness: Alert

Temperature: 36.5 Celsius

NEWS Total Score: 0 (All parameters fall within normal score ranges)

Physical Examination, Special Tests, Diagnostic Tests:

- Physical examination focusing on mental status assessment.

- Special tests such as EEG or brain imaging may be deferred unless there's a clinical indication.

Condition:

Schizoaffective disorder

Patient Questions:

1. "Do you think I'm losing my mind?" Response: "It sounds like you’re experiencing some serious symptoms, but with the right treatment, many people manage this condition well."

2. "Will I have to take medication for the rest of my life?" Response: "Treatment is individualized; some may need long-term medication while others may not. We'll find the best plan for you."

3. "Can I still work and live a normal life?" Response: "Yes, with appropriate treatment and support, most people with schizoaffective disorder lead fulfilling lives."

Examiner Questions:

1. What is the difference between schizoaffective disorder and schizophrenia? Response: Schizoaffective disorder includes symptoms of both schizophrenia and mood disorder, while schizophrenia does not have the prominent mood component.

2. What psychotherapeutic interventions are appropriate for schizoaffective disorder? Response: Cognitive-behavioral therapy, psychoeducation, and supportive therapy are commonly used.

3. Talk through the pharmacological treatments for schizoaffective disorder. Response: It usually includes antipsychotics and possibly mood stabilizers or antidepressants, depending on the mood symptoms.

4. How do you monitor response to treatment? Response: Monitoring involves regular assessment of symptom severity, side effects of medication, and overall functioning.

5. What is the relevance of psychoeducation in the management of schizoaffective disorder? Response: It helps patients and their families understand the illness, which can improve adherence to treatment and reduce relapses.

Treatment:

Initial treatment for schizoaffective disorder may include atypical antipsychotics, such as olanzapine or risperidone. If mood symptoms are prominent, mood stabilizers like lithium or valproic acid, and/or antidepressants such as fluoxetine may be added. Dosages are as per BNF guidelines, with regular monitoring for therapeutic efficacy and side effects.

Monitoring:

The patient's condition should be monitored through regular psychiatric assessments, including tracking the frequency and severity of mood swings and psychotic symptoms. Regular blood tests may be necessary to monitor medication levels and potential side effects. Follow-up visits should be scheduled every 2 to 4 weeks initially, then less frequently as symptoms stabilize. Referral to a psychiatrist or mental health team may be indicated for complex cases.

Prognosis:

The prognosis for schizoaffective disorder varies. With treatment, many people achieve good symptom control and can maintain functional lives. Prognostic factors include response to medication, adherence to treatment, and support systems. Continuous treatment is often necessary to prevent relapses.

Differential diagnoses:

1. Schizophrenia: Lacks the prominent mood component.

2. Bipolar disorder: Psychotic symptoms outside of mood episodes.

3. Major depressive disorder with psychotic features: Does not include the extended periods of psychosis without mood disturbances.

Speciality Filter:

Mental Health;

Presenting Complaint Filter:

Mood Swings; Auditory Hallucinations;

Condition Filter:

Schizoaffective Disorder;

Location Filter:

Clinic;

Case created by:

Reviewed by:

Reviewed by: