REASON FOR CONSULT:, Depression.,HPI:, The patient is an 87-year-old white female admitted for low back pain status post hip fracture sustained a few days before Thanksgiving in 2006. The patient was diagnosed and treated for a T9 compression fraction with vertebroplasty. Soon after discharge, the patient was readmitted with severe mid low back pain and found to have a T8 compression fracture. This was also treated with vertebroplasty. The patient is now complaining of back pain that fluctuates at time, acknowledging her pain medication works but not all the time. Her pain is in her upper back around her shoulder blades. The patient says lying down with the heated pad lessens the pain and that any physical activity increases it. MRI on January 29, 2007, was positive for possible meningioma to the left of anterior box.,The patient reports of many depressive symptoms, has lost all interest in things she used to do (playing cards, reading). Has no energy to do things she likes, but does participate in physical therapy, cries often and what she believes for no reason. Does not see any future for herself. Reports not being able to concentrate on anything saying she gets distracted by thoughts of how she does not want to live anymore. Admits to decreased appetite, feeling depressed, and always wanting to be alone. Claims that before her initial hospitalization for her hip fracture, she was highly active, enjoyed living independently at Terrace. Denies suicidal ideations and homicidal ideations, but that she did not mind dying, and denies any manic symptoms including decreased need to sleep, inflated self-worth, and impulsivity.

Denies auditory and visual hallucinations. No paranoid, delusions, or other abnormalities of thought content. Denies panic attacks, flashbacks, and other feelings of anxiety. Does admit to feeling restless at times. Is concerned with her physical appearance while in the hospital, i.e., her hair looking ""awful."",PAST MEDICAL HISTORY:, Hypertension, cataracts, hysterectomy, MI, osteoporosis, right total knee replacement in April 2004, hip fracture, and newly diagnosed diabetes. No history of thyroid problems, seizures, strokes, or head injuries.,CURRENT MEDICATIONS:, Norvasc 10 mg p.o. daily, aspirin 81 mg p.o. daily, Lipitor 20 mg p.o. daily, Klonopin 0.5 mg p.o. b.i.d., digoxin 0.125 mg p.o. daily, Lexapro 10 mg p.o. daily, TriCor 145 mg p.o. each bedtime, Lasix 20 mg p.o. daily, Ismo 20 mg p.o. daily, lidocaine patch, Zestril, Prinivil 40 mg p.o. daily, Lopressor 75 mg p.o. b.i.d., Starlix 120 mg p.o. t.i.d., Pamelor 25 mg p.o. each bedtime, polyethylene glycol 17 g p.o. every other day, potassium chloride 20 mEq p.o. t.i.d., Norco one tablet p.o. q.4h. p.r.n., Zofran 4 mg IV q.6h.,HOME MEDICATIONS:, Unknown.,ALLERGIES:, CODEINE (HALLUCINATIONS).,FAMILY MEDICAL HISTORY:, Unremarkable.,PAST PSYCHIATRIC HISTORY:, Unremarkable. Never taken any psychiatric medications or have ever had a family member with psychiatric illness.,SOCIAL/DEVELOPMENTAL HISTORY:, Unremarkable childhood. Married for 40 plus years, widowed in 1981. Worked as administrative assistant in UTMB Hospitals VP's office. Two children. Before admission, lived in

the Terrace Independent Living Center. Was happy and very active while living there. Had friends in the Terrace and would not mind going back there after discharge. Occasional glass of wine at dinner. Denies ever using illicit drugs and tobacco.,MENTAL STATUS EXAM:, The patient is an 87-year-old white female with appropriate appearance, wearing street clothes while lying in bed with her eyes tightly closed. Slight decrease in motor activity. Normal eye contact. Speech, low volume and rate. Good articulation and inflexion. Normal concentration. Mood, labile, tearful at times, depressed, then euthymic. Affect, mood congruent, full range. Thought process, logical and goal directed. Thought content, no delusions, suicidal or homicidal ideations. Perception, no auditory or visual hallucinations. Sensorium, alert, and oriented x3. Memory, fair. Information and intelligence, average. Judgment and insight, fair.,MINI MENTAL STATUS EXAM,: A 28/30. Could not remember two out of the three recalled words.,ASSESSMENT:, The patient is an 87-year-old white female with recent history of hip fracture and two thoracic compression fractures. The patient reports being high functioning prior to admission and says her depression symptoms have occurred while being in the hospital.,Axis I: Major depression disorder.,Axis II: Deferred.,Axis III: Osteoporosis, hypertension, hip fracture, possible diabetes, meningioma, MI, and right total knee replacement.,Axis IV: Lives independently at Terrace, difficulty walking, hospitalization.,Axis V: 45.,PLAN:, Continue Lexapro 10 mg daily and Pamelor 25 mg each bedtime monitor for adverse

effects of TCA and worsening of depressive symptoms. Discussed about possible inpatient psychiatric care.,Thank you for the consultation.