Psychiatry Review

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Overview

- Anxiety, Affective, and Psychotic Disorders
- Substance Use and Personality Disorders

Case 1: Trouble Sleeping

A 40 yo G2P2 woman comes to your office complaining of fatigue, low energy and insomnia. She has not been sleeping through the night, and notices that she has been having troubles with concentration and short-term memory at work (she is a bank teller). She notes that her parents were both alcohol dependent, that her father had a “nervous breakdown” at 52, and her mother had Alzheimer’s at 70. Vitals and physical exam are unremarkable.

What is the best course of action?

A. Check CBC, thyroid function and consider starting an SSRI
B. Reassure patient that nothing is wrong, as there are no physical exam findings
C. Refer her for a sleep study
D. Start Aricept (donepezil) and counsel her regarding dementia
E. Start a benzodiazepine anxiolytic agent
Steps to Make a Psychiatric Diagnosis
- Rule out Medical Mimics
- Rule out Substance Use
- Consider Primary Psychiatric Diagnoses

Major Depression Symptoms
- Depressed Mood or Anhedonia (must have at least one)
- Change in sleep
- Change in appetite/weight
- Decreased energy/fatigue
- Decreased Libido
- Difficulty concentrating
- Guilt, irritability
- Suicidal ideation or thoughts of death
>5/9 symptoms. What about <5?

Major Depressive Symptoms
- Somatic Symptoms
- Anxiety
- Anger attacks
- Alexithymia

Case 2: Pressured message
A 36 yo long-term outpatient in your clinic calls the clinic nurse reporting he has a new idea to save the clinic hundreds of dollars by offering his services as a telecommunications guru. The nurse, remembering that the patient is a plumber, routes the call to your voicemail. There are several messages from him in which he rambles about his skills, saying “That med school stuff is pretty simple, and this idea is so brilliant that you probably won’t understand it.” You note that his speech is pressured, loud, and his manner is uncharacteristically confident.
Case 2

Differential diagnosis includes all of the following EXCEPT:

A. Alcohol intoxication
B. Amphetamine abuse
C. Pancreatic Cancer
D. New onset bipolar disorder
E. Space occupying brain tumor

Bipolar Disorder (formerly Manic-Depression)

- Symptoms include:
  - Episodes of depression
  - Periods of normal mood
  - Episodes of mania (decreased need for sleep, increased spending, expansiveness, increased libido, mixed episodes with irritability)
  - Mania with psychotic features
  - High incidence of recurrent episodes (>90%)

Case 3: Stressed Out

A 32 yo African-American woman presents to your outpatient clinic complaining of “stress.” On history, you learn that she is single, works at a law firm as an administrative assistant, and has few friends. She has a remote history of date rape at age 19, for which she sought counseling for several months. Her family is on the other coast, and she lives alone. She reports that she worries about her job performance, her apartment, whether she will ever find a husband, whether there is something physically wrong with her, and that she is bothering you by coming to your office. She notes no changes in her appetite or sleep patterns, and denies nightmares or feeling depressed, stating “I’m just really worried.” She denies palpitations, SOB, panic attacks or chest pain, and PE and vitals are all within expected range.

Case 3

What is the most likely diagnosis?

A. Post-traumatic stress disorder (PTSD)
B. Generalized Anxiety Disorder
C. Panic attacks
D. Major Depressive Disorder
E. Obsessive Compulsive Disorder
Anxiety Disorders

- Acute and PTSD (<>1month)
- Generalized Anxiety Disorder
- Panic Disorder
- Social Phobia
- Obsessive Compulsive Disorder
- Phobias

Case 4: Down at the Farm

Two months after he lost 2 fingers of his left hand in a machinery accident, a farm worker comes to your office complaining of insomnia. He has difficulties falling asleep, and wakes frequently through the night. His wife notes that he has not been as involved in their children’s baseball games, and that he has stopped his weekly bowling league because “he just doesn’t have the heart.” They both agree that he has been uncharacteristically irate, and yesterday, when driving past his neighbor Frisbee’s farm, he became sweaty, short of breath, and had to pull over on the side of the road for several minutes. Sometimes he reports episodes of “reliving the whole accident” to the point that he wonders if he “is going crazy.”

Case 4

Which of the following treatment strategies is NOT indicated?

A. Prescriptions for a benzodiazepine anxiolytic and a sleep agent
B. Prescription for an SSRI and referral to a PTSD group
C. Referral for counseling regarding the loss of his fingers
D. Referral to a couples counselor focusing on family relationships
E. Prescription for a neuroleptic agent and referral for neuropsychological testing

Case 5: Loud Voices

You have been treating a 50 yo patient with schizophrenia for several years on Haldol (haloperidol), a typical neuroleptic agent. For the past several months, you have noticed he has had worsening auditory hallucinations and now seems physically restless in your office check-ups. You decide to switch his medication to Zyprexa (olanzapine), an atypical neuroleptic agent.
Case 5

Which of the following is NOT true regarding medications used to treat schizophrenia?

A. Atypical neuroleptic agents have a more tolerable side effect profile.
B. Atypical neuroleptic agents more effectively treat the “negative” symptoms of schizophrenia (i.e. affective flattening, amotivation, asociality).
C. Atypical neuroleptic agents more effectively treat the “positive” symptoms of schizophrenia (i.e. paranoid ideations, auditory hallucinations).
D. In long-term use, atypical neuroleptic agents have lower risk of tardive dyskinesia than typical neuroleptics.
E. Atypical neuroleptic agents are more expensive than typical neuroleptic agents.

Psychotic Symptoms

- Positive Symptoms
  - Disorg thought/behav
  - Hallucinations (A/V)
  - Paranoia
  - Delusions

- Negative Symptoms
  - Decreased affect
  - Decreased motivation
  - Decreased spontaneous thought
  - Social withdrawal

Antipsychotics

- Mesolimbic, mesocortical, basal ganglia, and pituitary/hypothalamic pathways
- Novel antipsychotics
  - Block dopamine and serotonin
  - Preserve dopaminergic transmission in mesocortical tract to reduce negative sx’s
- Older antipsychotics (eg Haldol)
  - Block dopamine

Case 6: Suicidal Thoughts

A 47 yo man presents to the emergency room reporting he is feeling like killing himself by jumping in front of traffic. He says he cannot be safe unless he is hospitalized. He appears somewhat restless or agitated. On exam, you note he is disheveled and malodorous. He has a bulbous nose, is ataxic, and is slurring his speech. His vitals are: BP = 146/90, HR= 110, RR = 18, Temp = 38.5. Urine tox screen is negative for any illicit drug use.
Case 6
What is the best management strategy?
A. Call psychiatry consult for hospitalization for suicidal ideation
B. Provide patient with resources for shelter beds
C. Counsel patient regarding health effects of chronic alcohol abuse
D. Admit patient to a medical service and administer benzodiazepines, IV thiamine and fluids to prevent alcohol withdrawal

Alcohol Withdrawal and Delirium
Delirium is characterized by:
- Rapid onset (hours-days)
- Waxing and waning course
- Cognitive deficits
- Problems with attention and orientation
- May be agitated or “hypoactive”
Emphasis should be to define and treat cause

Case 7: They’re after me!
A 24 yo man is brought into the emergency room by police after causing a public disturbance outside a nightclub. He reports he had been at a club for several hours with his friends, and they had argued about which club to go to next, and he insisted on staying there. His friends left him there, and he noticed several men at the bar who seemed to be pointing to him and laughing. He proceeded to another bar, but again saw different people across the room talking about him. As he attempted to leave, he got in a fight with another patron, yelling “You people can’t threaten me!”

Differential diagnosis includes all of the following EXCEPT:
A. Acute amphetamine intoxication
B. First break schizophrenia
C. Acute alcohol intoxication
D. Dehydration and hyponatremia
E. Social phobia

Case 7
Differential Diagnosis
Psychosis
- Medical mimics (thyroid, meds, CNS lesion)
- Substance use (esp stimulants--cocaine or methamphetamines; hallucinogens)
- Primary psychiatric disorders:
  - Schizophrenia
  - Schizoaffective disorder
  - Bipolar or MDD with psychotic features
  - Brief Psychotic episode

Case 8: They’re still there!
The same patient presents in your outpatient clinic approximately 1 month later. He expresses remorse for his behavior in the night club last month, stating that a friend convinced him to use some methamphetamines to help him get over his inhibitions with asking women out. He denies having used any drugs since that night, though he continues to smoke ½ ppd, and drinks beers on weekends. However, he has also noticed that people continue to talk about him from across the room, and he now worries that the federal government has been tracking his movements.

Case 8
Which of the following statements is true?
A. Antabuse (disulfiram) is an effective treatment for chronic opiate abuse and dependence
B. Cognitive and behavioral effects of substance abuse can last for weeks to months after the last use by a patient
C. Amphetamine dependence generally leads to paranoia, whereas cocaine dependence leads to chronic mania
D. Marijuana is considered a “gateway” drug, because most users will progress to use heroin over the course of their lifetimes
E. Cocaine is the most frequently used substance of abuse

Question 9: Only the Best
You are contacted by a 30 year old woman who wants you to be her primary care physician because “my closest friend says that you’re the best doctor in the state.” She says that she has multiple medical problems and that “other doctors never understood me--they were all idiots.” She also wants to be on SSI for chronic abdominal pain but has multiple negative tests in the past. She endorses depression but says that although intense her depressive symptoms last for hours to days, and she appears to have periods of hypomania and impulsivity. Her physical exam is notable for multiple linear scarring on her left forearm and abdomen.
Case 9

Which of the following are true?

- A. OCD and Obsessive-Compulsive PD are the same
- B. Personality disorders can be dx’d in single interview or contact
- C. Borderline PD responds well to SSRIs +/- a mood stabilizer
- D. Cognitive Behavioral Therapy is contraindicated in Borderline PD
- E. Patients with Borderline PD have low rates of substance use and completed suicide

GOOD LUCK!