Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12609

5 - SUMMARIES

[redacted]

DISCHARGE SUMMARY
Personal and Confidential

IDENTIFICATION: Attending: [redacted] MD

Patient Name: [redacted] (Last First Middle) MR #: [redacted]

Address of Pt.: [redacted]

Phone: Home: [redacted] Work: _____

Admission Date: 9/9/97 Discharge Date: 9/12/97 Sex: F Race: WHITE

Age: 28 DOB: [redacted] Marital Status: SINGLE

Living Arrangements: Resides alone _____ or with others (specify):
RESIDES W/ ROOMMATE

Occupation: RESEARCH ASST [redacted]

Admission Legal Status: Vol X 2PC _____ EA _____ DCS _____

Source of Referral: Self _____ Other (specify) [redacted]

REASON FOR ADMISSION: (Symptoms or behavioral changes culminating in hospitalization; psychosocial stressors or precipitants; current psychiatric involvement and medications)

PT PRESENTED AT [redacted] HAVING BEEN REFERRED BY DR. [redacted] STOCK, FOR EVALUATION OF DEPRESSION AND PANIC D/O. PT WAS FEELING DEPRESSED FOR PAST 7-8 WEEKS AND C/O OF 3-4 PANIC ATTACKS. PT WAS STARTED ON XANAX IN AUGUST BY PT'S ENDOCRINOLOGIST. PT REPORTS TAKING XANAX IN THE MORNING AND NOON ON A NEED BASIS. PT UPON ADMISSION STATED SHE ~~HAD~~ (ERROR) HAS NO DESIRE TO WAKE UP IN THE MORNINGS AND USUALLY LIES IN BED W/O DOING ANYTHING. PT STATED TAKING A SHOWER IS HER HIGHEST ACCOMPLISHMENT DURING A NORMAL DAY. PT REPORTS LOSS OF WEIGHT OF 25 LBS. IN PAST 7-8 WKS., WHICH SHE STATES IS UNUSUAL BECAUSE SHE HAS A GOOD APPETITE USUALLY. PT C/O OF CRYING SPELLS THROUGH THE LAST 8 WKS AND C/O FEELING NERVOUS AND JITTERY ALL THE TIME. SHE CLAIMED HER HANDS SHAKE

(continued) to (1)

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PERSONAL/FAMILY PSYCHIATRY HISTORY: PT REPORTED ONE PRIOR HOSPITALIZATION 11 YEARS AGO FOR 2 DAYS, AFTER ATTEMPTED O/D. PT WAS DEPRESSED AND WAS GIVEN PROZAC, PAMELOR, TOFRANIL FOR A COUPLE OF YEARS. PT REPORTS SIDE EFFECTS FROM MEDS, BUT PROZAC HELPED DEPRESSION, BUT DID NOT MAKE HER HAPPY. SHE STATED SHE WAS "NOT LIVING" RATHER SHE WAS "EXISTING ONLY." PT STOPPED MEDS AND DEALT W/ DEPRESSION ON HER OWN. PT REPORTED HISTORY OF SUPERFICIAL

MEDICAL STATUS: Physical Exam; Lab studies obtained-normal or abnormal; Special tests or procedures (e.g., CT scan, EEG - list all results) (continued to ①)

PT HAS HX OF ENDOMETRIOSIS, CURRENTLY ON ORAL CONTRACEPTIVES; PT HAS THYROID NODULES TREATED WITH SYNTHROID IN JULY '97; SCLERITIS. ROUTINE + MICROSCOPIC UA ANALYSIS: 9/9/97 KET 1+; HEMATOLOGIC PROFILE: 9/9/97 WNL. DIFFERENTIAL WBC: 9/9/97 ↑LYMPH 43%, ↑ MONO 10%. GENERAL CHEMISTRY: 9/9/97 AST 60↑; 14/L ↓BUN 6 mg/dl. TFT'S: 9/9/97 WNL. URINE DRUG SCREEN: 9/9/97 WNL.

ADMISSION MENTAL STATUS EXAMINATION: PT CASUALLY DRESSED, (continued to ①) COOPERATIVE, ANXIOUS, OVERLY TALKATIVE, TEARFUL AT TIMES. SPEECH ↑ IN RATE, DYNAMICS NORMAL. THOUGHT PROCESS ORGANIZED. THOUGHT CONTENT NO DELUSIONS, NO IDEAS OF REFERENCE. NO H/I HALLUCINATIONS. MOOD DEPRESSED, ANXIOUS, C/O CRYING SPELLS, SLEEP ↓ NO SI/HI. INSIGHT JUDGEMENT FAIR.

(1)

[redacted]

ADDENDUM:

(REASON FOR ADMISSION continued):

SO MUCH THAT SHE HAS TO HAVE HER FRIENDS DRIVE HER TO THE PSYCHIATRIST, UPON ADMISSION PT DENIED SUICIDAL/HOMICIDAL IDEATION, BUT WAS UNSURE OF WANTING TO HURT HERSELF IN THE FUTURE, ~~BECAUSE~~ ERROR SHE FEELS ~~THE~~ A ERROR HER CONDITION IS GETTING WORSE, AND FEELS SHE MAY GOT TO A POINT WHERE SHE WOULD NOT KNOW HOW TO DEAL WITH IT. PT IS CURRENTLY IN TREATMENT W/ DR. [redacted] PER PT CHART, PT WAS PRESCRIBED UP TO 5 MG DAILY OF XANAX FOR ANXIETY. PT RECENTLY STOPPED PAXIL ON PAST FRI. 9/5/97 GIVEN TO HER FOR DEPRESSION. PT REPORTED NO IDENTIFIABLE PRECIPITATING FACTORS TO THIS DEPRESSION OTHER THAN TRYING AN HERBAL DIET (NOV '96 - JULY '97), DEVELOPING THYROID NODULES IN FEB '97 AND SYNTHROID IN JULY '97.

(PERSONAL/FAMILY PSYCHIATRIC HX continued):

CUTTING 11 YEARS AGO "TO FEEL PHYSICAL PAIN, RATHER THAN EMOTIONAL PAIN." DENIES CUTTING EVER SINCE. PT REPORTED POSITIVE FAMILY HISTORY OF DEPRESSION ON MOTHER'S SIDE, INCLUDING HER MOTHER.

(MEDICAL STATUS continued):

MICROBIAL ANTIBODIES: RPR NONREACTIVE

[redacted]

HOSPITAL COURSE: (including all [redacted] problems and resolutions of goals/objectives at time of discharge) PT WAS ADMITTED TO [redacted] UNDER CLOSE OBS ON 9/8/97 AND WAS GIVEN ATIVAN 2MG po prn FOR AGITATION q6°. PT SLEPT ONLY 1 HRR ON 9/8/97. ON 9/9/97, PT WAS INTERVIEWED BY TEAM. PT WAS ANXIOUS, JITTERY, UNHAPPY WITH ROOM ARRANGEMENTS. PT WAS GIVEN KLONOPIN 0.5mg po bid BECAUSE IT WAS BELIEVED SHE WAS IN WITHDRAWAL STATE, AND WELLBUTRIN 100mg po b.i.d FOR DEPRESSION; ATIVAN PRN WAS DISCONTINUED. BY AFTERNOON, PT WAS CALMER AND ABLE TO SHOWER AND DRESS. PT STATED THAT HER PRESENT CONDITION MAY HAVE BEEN DUE TO, ORIGINALLY, HER HERBAL DIET (NOV '96-JULY '97), SYNTHROID TX (JULY '97) FOR THYROID NODULES (FEB '94). PT BELIEVED THIS WAS ALL "COINCIDENCE." ON NIGHT OF 9/9/97, PT WAS ANXIOUS, TREMULOUS, NAUSEOUS. PT WAS GIVEN KLONOPIN 0.5MG PO, AND FELT CALMER. EARLY MORNING 9/10/97 PT VOMITED SMALL AMOUNT OF FLUID. PT UNABLE TO SLEEP, RECEIVED BENEDRYL 50 MG PO WITHOUT EFFECT UNTIL 6:30 AM. ON MORNING 9/10/97, PT WAS ~~STILL~~ ERROR ANXIOUS, SHAKING, AND REFUSED WELLBUTRIN BECAUSE SHE FELT IT HAD MADE HER NAUSEOUS. LATER IN AM MORNING, PT BECAME CALMER. KLONOPIN WAS INCREASED TO 0.5 mg QID. BENEDRYL 100mg po QHS WAS ORDERED FOR SLEEP, AND KLONOPIN BID prn FOR AGITATION. WELLBUTRIN WAS HELD FOR 3 DAYS. PT APPETITE WAS NOTED TO BE DISTURBED. ON AFTERNOON OF 9/10/97, PT EXPERIENCED "ATTACK," PT SAID "IT'S HAPPENING AGAIN." PT WAS SHAKY, TEARY, FRIGHTENED. PT WAS GIVEN KLONOPIN 0.5mg AND CALMED DOWN WITH AID OF NURSE. ON 9/10/97, PT SLEPT 3.5 HRS WITH 50 mg BENEDRYL po. PT SAID NEXT DAY SHE FELT BETTER BECAUSE SHE HAD GOTTEN SOME SLEEP. PT DENIED FEELING DEPRESSED ON 9/11/97, BUT FELT SAD BECAUSE SHE WAS HOMESICK. HOWEVER,

(continued)

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PSYCHOLOGICAL TESTING: Yes ____ (attached) No X

CONDITION UPON DISCHARGE: Improved ____ Not Improved X

FINAL DIAGNOSIS: (Including DSM IV Codes):

AXIS I: GENERALIZED ANXIETY D/O 300.02

II: NONE V71.09

III: THYROID NODULES, ENDOMETRIOSIS, SCLERITIS

IV: PANIC ATTACKS, HEALTH CONDITION

V: 60/0

RECOMMENDATION:

Disposition: (Where discharged to): HOME W/ FAMILY.

Outpatient Appointments: NONE - (PT'S MOTHER CONTACTED DR. [redacted] PT'S OUTPT PROVIDER ON 9/12/97 - DATE OF DISCHARGE.)

Medication: (Prescriptions with # of refills): ~~D/C AT NO~~ ERROR NONE BECAUSE PT DISCHARGED AGAINST MEDICAL ADVISE

Diet: NONE

Activity Restrictions: NONE

[redacted]
Primary Therapist Signature

9/15/97
Date

[redacted]
Attending Physician Signature

9/17/97
Date

[redacted]

[redacted]

[redacted]

ADDENDUM:

(HOSPITAL COURSE continued):

PT WAS UNSURE IF DEPRESSION WOULD COME BACK LATER, EVEN AFTER DISCHARGE. PT WORRIED ABOUT GETTING PANIC ATTACKS WHILE ON JOB AND INTERVIEWING PEOPLE. PT WAS TAUGHT DEEP BREATHING/RELAXATION TECHNIQUES. ON 9/11/97, PT SAID THAT HER ANXIETY LEVEL WAS BACK TO WHEN SHE HAD STARTED ON XANAX. PT SLEPT 7.5 HRS ON NIGHT OF 9/11/97, WITH BENEDRYL 50mg p.o. ON 9/12/97, CLOSE OBS WERE DISCONTINUED, PT RELEIVED OFF FLOOR PRIVELEGES WITH STAFF AND FAMILY. KLONOPIN WAS DECREASED TO 0.5mg p.o. TID. WELLBUTRIN WAS DISCONTINUED. PT NOW BELIEVED THAT HER SLEEP HAD IMPROVED. PT WISHED TO BE DISCHARGED 9/12/97 OR 9/13/97. HOWEVER, WHEN PT TOLD SHE WOULD HAVE TO STAY ADDITIONAL DAYS TO TAPER KLONOPIN, PT WAS NONCOMPLIANT, AND DISSATISFIED, AND DISCHARGED HERSELF ON 9/12/97 AMA.

COMPREHENSIVE TREATMENT PLAN PROBLEMS WERE AS FOLLOWS UPON DISCHARGE:

1. MOOD/AFFECT DISTURBANCE: UNRESOLVED. PT DID NOT DEMONSTRATE IMPROVED, STABLE MOOD.
2. ANXIETY DISTURBANCE: UNRESOLVED. PT IMPROVED SOMEWHAT BUT DID NOT FULLY DEMONSTRATE MANAGEMENT LEVEL OF ANXIETY UPON DISCHARGE.
3. IMPAIRED PHYSICAL STATUS: UNRESOLVED. PT SLEEP AND APPETITE HAD SLIGHTLY IMPROVED, BUT WAS STILL DISTURBED UPON DISCHARGE.
4. DISCHARGE PLANNING NEEDS: UNRESOLVED. PT DISCHARGED HERSELF AMA.

[redacted]

HISTORY SHEET

9/8/97 11 PM · [redacted] Resident admit note :

C.C 28 year old single fema[redacted] referred by Dr. [redacted] for c/o depression and panic attacks.

[redacted] patient was diagnosed with thyroid nodules in Feb 1997; biopsies were done which were inconclusive patient was started on synthyroid in the last wk of July to induce shrinkage of the nodules.

patient gives h/o feeling depressed since the past 7-8 weeks and c/o 3-4 panic attacks — patient was started on Xanax in dng by her endocrinologist 2mg QHS ± 50 mg Benadryl. patient reports taking Xanax in the morning and noon on a need basis. patient says she has no inclination to wake up in the mornings and usually lies in bed without doing anything. patient says taking a shower in the morning is all that she can say is her highest accomplished task during a normal day. patient reports loss of weight of 25 lbs in the past 7-8 weeks which she claims is highly unusual because she usually has a good appetite. patient has taken a leave of absence from her job @ the [redacted] for about 2 wks which would be up tomorrow. patient denies hearing voices, seeing images or having unusual

[redacted]

Notes should be **numbered and titled** by problem. The note can be subdivided into any or all of these headings: Subjective, (Sx:). Objective, (Obj:). Interpretation, (Int:). Plans. Treatment, (Rx:).

Use both sides of sh

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[redacted]

[redacted]

HISTORY SHEET

experiences. patient has had crying spells through the last 8 weeks and c/o feeling nervous and jittery all the time — she claims her hands shake so much that she has to ask her friends to drive her to the even [redacted] her psychiatrist. patient denies suicidal or homicidal ideation @ this time but says she is not sure about not wanting to hurt herself in the future as according to her she is getting more worse and given a breaking point she wouldn't know how to deal with it. patient given a rating scale of 1-10 c 10 being best, patient said her current level of functioning would be 3-4.

past psych hx: patient gives h/o depression 11 years ago culminating in a suicide attempt c drug overdose and a 2 day stay at a hospital. patient apparently was on prozac / Xanax for a couple of years then. No other hx of psych. hospitalisations

past medical + surgical hx: patient was diagnosed with thyroid nodules in Feb. She had an ovary removed due to endometriosis and has been on orthocyclene since then. Her appendix was removed during the ovariectomy

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Med hx: As in HOPI.

[redacted]

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Use both sides of sheet

[redacted]

HISTORY SHEET

[redacted]

Family hx: patients' mother lives in [redacted] and has come down from [redacted] to after she got concerned by her telephone calls. patients mother has hx of depression and was on Elavil.

personal/social hx: patient lives with her friend who she claims is very supportive. patient is gay and says that her mother is unaware about the same; however mentions that this could be a stressful situation in the future. patient is worked on her dissertation for her PhD @ [redacted]

[redacted]

28 year old female patient is well dressed and groomed with good ADL's. patient is cooperative and maintains good eye contact. patient does not show any abnormal psychomotor activity. Speech is normal in rate with good response time. Thought processes are ~~goal~~ error [redacted] logical and organised. Mood "jittery" Affect appropriate and blunted. No delusional material elicited patient does not demonstrate suicidal or homicidal ideation. No patient denies A/V hallucinations. patient is oriented to time 9/8/97 place ([redacted]) and person. Concentration and memory are good as per pt. cogn. tests - patient able to spell "WORLD" backwards able to remember the last 3 presidents

000010

[redacted] Notes should be numbered and titled by problem. The note can be subdivided into any or all of these headings: Subjective, (Sx:). Objective, (Obj:). Interpretation, (Int:). Plans. Treatment, (Rx:). Use both sides of

[redacted]

HISTORY SHEET

able to do serial 7's ; 3 object recall (table, tgiv; daffodil) good after 5 mins; Able to abstract "All that glitters is not gold" — "Whatever appears good on the shrface need not necssarily be so." Insight and jidgement fair

Imp: patient demonstrates dysthymic mood with error [redacted] congruent affect ; no Evidence of any disorgn. of thought processes. patient claims she feels she's getting 'worse and would feel safer amongst people and in a ward.

Diagnosis: Axis I Major depressive disorder NOS

II Deferred

III Thyroid nodules, Endometriosis, Sclerotis

IV Dealing with the thyroid condn other stressors to be identified

V 40/0

Plan: Admit to [redacted]
Close obs
Routine labs as ordered.
Further diagnostic workup
To ct. synthyroid
To start antidepressants after being reviewed by treatment team.

000011

[redacted]

Notes should be **numbered and titled** by problem. The note can be subdivided in[redacted] these headings: Subjective, (Sx:). Objective, (Obj:). Interpretation, (Int:). Plans[redacted]

[redacted] 9/8/97