H&P- Parkinson's Disease Dementia

DATE: September 25, 2023

Identifying Information in narrative form

JS, born on March 1, 1948, is a 72-year-old Caucasian male, who is currently retired and married. He was referred by his family physician and is accompanied by his wife. Due to his forgetfulness and cognitive decline, JS's history is somewhat unreliable, but his wife serves as a reliable historian.

CHIEF COMPLAINT(S):

JS presents with the following chief complaint: "I'm having difficulty concentrating and making simple decisions."

HISTORY OF PRESENT ILLNESS:

JS, a 72-year-old male, was brought to the physician's office by his wife. After managing his Parkinson's diagnosis for the past year and a half, his wife noticed a significant change in his mental state. His wife reports frequent memory lapses during conversations, difficulty focusing on basic tasks, following directions, and controlling his emotions. JS reports chronic irritability and anger, though he is unsure if these are direct symptoms. He also experiences disturbed sleep patterns, daytime sleepiness, and diminished appetite. JS' resting tremor is exacerbated during emotional stress. Activities such as grooming and dressing have become increasingly challenging, contributing to mild depression.

PSYCHIATRIC REVIEW OF SYMPTOMS

Suicidality: JS denies any suicidal ideation, expressing no desire to harm himself and feeling safe to return home.

Homocidality: There is no indication of homicidal thoughts or intent.

Anxiety: JS reports moderate anxiety, rating it at 7/10 in relation to his symptoms.

Mood: JS has experienced increasing irritability over the past year, rating it at 7.5/10, and displays impatience and interruption tendencies.

SIGECAPS for Mood:

- **Sleep:** Decreased
- **Interest:** Decreased
- **Energy:** Decreased
- **Concentration:** Decreased
- **Appetite:** Decreased

Somatic: JS reports no new unexplained illnesses or symptoms.

Perceptual Alterations: JS denies any perceptual alterations.

Psychosis: JS denies any external influence on his thoughts or mind.

PRESENT MEDICATION(S): (includes vitamins and over-the-counter meds)

Carbidopa: L-Dopa (25:100 mg) PO TID
Atorvastatin 40 mg PO QD
Lisinopril 10 mg PO QD
Vitamin D 2000 IU PO QD

ALLERGIES:

None

PAST HOSPITALIZATION/SURGICAL HISTORY:

Surgical history/procedures: None
Previous Hospitalizations: None

PAST PSYCHIATRIC HISTORY - If relevant to psychiatric concern

Timeline: JS has recently (within the last 3 weeks) experienced symptoms of mild depression alongside cognitive decline.

Other mental health conditions: JS denies any other mental health concerns.

Treatment/success of treatment: JS has not sought treatment for mild depression.

FAMILY HISTORY:

- Father: Early onset Alzheimer's Disease at the age of 62, deceased at age 71.
- Mother: Died at the age of 65 due to heart failure.
- Maternal and Paternal Grandparents: Unknown
- No siblings

PERSONAL AND SOCIAL HISTORY:

JS is a 72-year-old retired male who previously worked in construction. He was exposed to various toxins and pesticides during his career. JS was a former avid smoker, mainly during work breaks, and occasionally consumes alcohol on Sunday afternoons while watching football.

JS resides with his wife of 40 years in a 2-bedroom townhouse. While they report no concerns regarding their living situation, stress related to JS's symptoms has strained their relationship. They do not have sexual concerns and have no children.

JS's diet is managed by his wife, although he has a decreased appetite and experiences sleep disturbances due to anxiety. He was raised Catholic but is not religious. JS has no legal issues.

REVIEW OF SYSTEMS:

Constitutional – No Acute Distress, but reports fatigue
Eyes – Decreased blink rate
Ears/Nose/Throat - Unremarkable
Skin – Facial Seborrheic Dermatitis
Cardiovascular – Unremarkable
Pulmonary – Unremarkable
Endocrine - Unremarkable
Gastro Intestinal - Unremarkable
Genitourinary - No increased frequency or pain on urination. Gets up once a night to urinate
Musculoskeletal:

- Muscular Rigidity (Cogwheel Rigidity)
- Bradykinesia (difficulty with movement)
- Hypokinesia (slow shuffling gait/movement)

Neurologic – Postural Instability reported while testing
Psychology – Irritability and Anxiety
Heme/Lymphatics – Unremarkable

PHYSICAL EXAMINATION:

Oral temperature: 98.6 C

HT: 176.022 cm [5’ 10”]

WT: 150 lb.
BMI: 21.5 (129-174 lbs)

TEMP: 37.0° C; 98.7° F

PULSE: 92 bpm

RESP: 16 breaths/minute

mmHG Oxygen saturation 93% (room air)

R arm supine = 130/84 mmHg

R arm sitting = 133/80 mm Hg

L arm sitting = 133/80 mm Hg

L arm standing = 130/84 mmHg

GENERAL APPEARANCE , AFFECT & INSPECTION:

Patient is appropriately groomed and well dressed. No odor emanating from his body or breath. He is conscious, sitting quietly on the exam table. His face appears expressionless. Upon discussion, he seems irritable, which becomes worse when talking with the physician. At points during the conversation, he appears to have a difficultly formulating his thoughts.

HEENT:

- No evidence of head, ear, eye, nose, mouth, or throat trauma.
- Normal scalp with no lesions or tenderness.
- Pupils are 3mm and PERRLA.
- Decreased blink rate noted.

CARDIOVASCULAR:

- Regular heart rate and rhythm with no abnormal heart sounds.
- No S3 or S4.
- No cardiac murmurs.
- No carotid bruits.
- No cranial bruits.
- No subclavian bruits.

- No abnormal splitting of S1 or S2.
- No pulsus paradoxes or alternans.
- No pedal edema.

PULMONARY:

- Unlabored breathing with normal rate.
- No retractions.
- Respiratory rate is 13 breaths/minute.
- No cyanosis or clubbing.

ABDOMEN & PELVIS

- Flat and symmetrical abdomen with no bulges.
- No mass, scars, striae, hematoma, jaundice, or vascular changes.
- Umbilicus is inverted without inflammation or discharge.
- Normoactive bowel sounds.
- No bruits heard at major arteries.
- Tympanitic note with occasional dullness on percussion.
- Abdomen is soft, non-tender, and non-guarding.
- No mass or organomegaly noted.

MUSCULOSKELETAL:

- Difficulty initiating gait (freezing).
- Stooped posture with kyphosis.
- Falls forward or sideways while turning.
- Limited cervical spine flexion, extension, and lateral bending.
- Bradykinesia and pill-rolling tremor observed.
- Tremor disappears while writing.
- Extremities are symmetrical with 3/5 strength (active movement against gravity).

NEUROLOGICAL:

- **Appearance**- JS is a healthy-appearing 72- year-old male, who appears his stated age. His weight is proportional to his height and he is appropriately groomed, with clean hair and clothing.
- **Behavior** - HS is sitting upright and appears tense. He is able to make eye contact but not consistently. JS seems visibly irritable.

- **Speech** - His speech is appropriate in quantity, rate, and volume, and is spontaneous. His speech is clear and he was coherent when describing his symptoms.
- **Mood** - JS describes his mood as irritable and fatigued on most days. He rates his irritability as a 7.5/10 and is snappy and impatient during the exam.
- **Affect** – JS display irritable affect. When questioned about what he occasionally shows lapses in forming ideas but also appears irritable at points during the interview.
- **Thought Content** - No signs of delusions, compulsions, obsessions, depersonalization, feeling unreal, or phobias
- **Thought Process** – No signs of abnormalities in thought process.
- **Perceptual Alterations** - No evidence of hallucinations, derealization, or other perceptual alterations
- **Judgement** – Diminished ability to understand a situation correctly and act appropriately
- **Insight** – Patient admits possible change in behavior

Mental Status Exam

Date Orientation	**3**	**-2 for date and day**
Place Orientation	**4**	**-1**
Register 3 Objects	**3**	
Serial Sevens	**3**	**-2**
Recall 3 Objects	**0**	**-3**
Naming	**2**	

Repeating a Phrase	**1**	
Verbal Commands	**3**	
Written Command	**1**	
Writing	**1**	
Drawing	**1**	
Total	**22/30**	

Interpretation: Mild cognitive impairment

CRANIAL NERVES I - XII:

- CN I: Unremarkable
- CN II: Visual Acuity is 20/20 bilaterally, full visual fields, normal fundoscopic exam.
- CN III, IV, VI: Extraocular movements intact. Pupils constrict to accommodation, decreased blink rate noted.
- CN V: Facial sensation intact. Motor intact. Corneal responses not tested.
- CN VII: Normal facial symmetry and movements.
- CN VIII: Normal hearing, Weber and Rinne tests.
- CN IX, X: Normal palate elevation and phonation.
- CN XI: Intact head turning and shoulder shrug.
- CN XII: Normal tongue movements and no atrophy.

CEREBELLUM:

- Patient exhibits a shuffling gait upon movement, bradykinesia, and tends to fall forward or to the side.

PERIPHERAL NERVES, MOTOR AND SENSORY FINDINGS:

- Motor examination reveals weakness and resting tremor (3/5 strength with active movement against gravity).
- No evidence of asterixis, chorea, dystonia, myotonia, or myoclonus.
- Sensory examination reveals no major abnormalities.
- Romberg's sign, graphesthesia, and stereognosis are normal.

Deep Tendon Reflexes:

	Biceps	Triceps	Brachioradialis	Patellar	Ankle	Babinski	Clonus
Right	1+	1+	1+	1+	1+	Negative	Negative
Left	1+	1+	1+	1+	1+	Negative	Negative

IMPRESSION:

Our initial impression of this patient is that he is suffering from Parkinson's Disease Dementia

PLAN:

1. Confirm Diagnosis:

- Further neurological evaluation and testing to confirm the diagnosis of Parkinson's Disease Dementia (PDD) and assess disease severity.
- Consider a DaTscan or SPECT imaging for dopamine transporter abnormalities to aid in diagnosis.

2. Medication Management:

- Optimize current medication regimen (Carbidopa: L-Dopa).
- Evaluate the need for adjunct medications such as anticholinergics or dopamine agonists for symptom control.
- Monitor for potential medication side effects and adjust as necessary.

3. Address Mood and Cognitive Symptoms:

- Initiate treatment for depression and anxiety, which may include psychotherapy, counseling, or pharmacological interventions.
- Consider cognitive-enhancing medications (e.g., cholinesterase inhibitors) to address cognitive impairment.
- Collaborate with a psychiatrist for ongoing management of mood and cognitive symptoms.