CASE REPORT IN PSYCHIATRY

GENERAL INFORMATIONS

a.) The case report should contain information from and about the patient. It should also demonstrate that the person who wrote it was able to get in contact with the patient and relatives and therefore could get proper information and also could write about it in an official way.
b.) The case report is to reflect that the person who wrote it is familiar with psychiatric technical terms in describing the symptoms, the status and in illustrating the illness.
c.) case report should demonstrate that the examiner has basic informations to express symptoms according the investigation of the patient, is able to make differential diagnosis between separate illnesses and can establish a therapeutic plan.
d.) informations from other medical documents or those gained by the examiner himself should be separated in the case report. It is to note that personal experiences are essential..

Structure and build-up of the case report

Data of the patient (beginning letters of the name, age, sex)

Circumstances of present admission (please note that You must use Your own words according to exploration and previous data)
Date of admission, name of doctor who referred the patient to the hospital. Way of hospitalization (if it happened), diagnosis, state, event or symptom as a reason of hospitalization. Was the hospitalisation because of emergency or according to an advance. Was the hospitalization according to the patients own wish or the patent accepts it because of the pressure of the environment or if there was a need for an emergency provision. Was there a need for a judiciary survey ? Is the patient under guardianship?
First meeting, first impressions (Impact of circumstances of the first meeting and of the patient on the examiner, human reactions)

Present complaints:
Complaints (psychical and physical) that already have been present in the preceding period and temporal changes. Answers to the question „What kind of complaints have You had before Your admission and what changes occurred according to Your opinion, that made Your admission necessary? (You need to record the conformation of the cross-sectional picture and a maximum of 1-2 weeks period of complaints. Use the phasing of the patient. If the patient tells details about previous medical attendance connecting to his complaint, this should be also mentioned here. If the patient does not speak about it spontaneously, write about it rather in the part of the psychiatric history).

Exploration:
Word-for-word editing words of the patient, that could illustrate either the illness by the patient or the symptoms and also presents the way how the student can manage a conversation with a psychiatric patient.

History of illness:
Somatic: infectious diseases during childhood, important medical problems, investigations, hospitalizations. Facts told by the patient and collected out of medical records should be listed here.

Psychiatric:
1. Conformation of present complaint. Basically events or happenings that are supported by medical reports. If there are no previous data, make efforts to detail temporal, diagnostic and symptomatic changes.
2. Other psychiatric events, which have no connection with the present complaints or state
3. Detailed summary on previous treatments (if was /were) on the Clinic.
4. Drug, alcohol, nicotine, caffeine

Biographical assay, important life events: perinatal history and circumstances, original construction of family and relationship towards family members. Early childhood, developmental data (mental and physical). Schools, school performance. Working, working performance. Conformation of personal relationships, psychosexual development. Interest(s), way of spending leisure time, hobbies. Development and build up of own family. Also collect information by asking about possible psychic traumas: losses, deaths, changes (divorce, work changes or changing place of living). Important details determining actual living circumstances.
Try to evaluate those values, motivations, relationship to self and to others that are important in the life of the patient. Also try to evaluate, what role does the illness have in the life development of the patient, what life events should play a role in conformation of the illness.

Heteranamnesis (history of illness told by relatives or close friends): Description of data or opinion of relatives of the patient (if they are present and are ready to tell details).Try to get information and details that are important from the point of the patient and the illness (e.g. if anything told by the patient had happened really or not, if the patient's judgement is realistic or not in connection with particular details).
When taking the heteroanamnesis, one must consider personal right and obligation secrecy.

Status:
Internal:
The patient is in a good state. No pallor, cyanosis or jaundice. Blood pressure, pulse.
Head and neck: Normal conjunctiva. No palpable lymph nodes. Faces are pale. The thyroid gland is not enlarged, and there are no palpable lymph nodes on the neck.
Chest: normal shape, symmetric breathing movements.
Lungs: normal breathing sounds.
Heart: Regular heart beats, normal heart sounds, no murmurs.
Abdomen: Smooth, non tender. No palpable liver or spleen. Normal peristalsis was auscultatet. No palpable tumours. No rebound tenderness. No tenderness in the back.
Extremities: warm, dry. Good inguinal pulse bilaterally. Palpates the artery dorsalis pedis bilaterally.

Neurological:
Skull and spine: The shape of the skull is normal; there are no scars, protrusions or impressions on it. There is no pain on percussion. The shape of the spinal columns is normal, the physiological curvatures are preserved. The tone of the paravertebral muscles is normal. There is no tenderness over the vertebral bodies and in the paravertebral regions by palpation and percussion. The movements of the spine are normal. Las gue sign is absent.

Meningeal signs: The neck is not stiff. Kernig and Brudzinski signs are not present.

Cranial nerves:

I. Olfaction is normal on both sides.
II. Visual acuity is preserved: the patient can count fingers from 6 meters. The border of the optic disc is sharp on fundoscopy. Physiological excavation is preserved.
Visual fields are intact.Pupils are symmetric and normally wide. Their borders are sharp and their shape is round. They are located in the center of the iris. Direct and consensual light reflexes, accommodation and convergence reflexes are normal.
III, IV, VI. Palpebral fissures are equal. The eyeballs are conjugated and their movements are free and conjugated. No diplopia is reported by the patient. There is no nystagmus.
V. Sensation in the territories of the trigeminal nerves is normal. Exit points of the ophthalmic, maxillary and mandibular nerves are not painful upon pressing. The corneopalpebral reflex is symmetric. The innervation of the masticatory muscles is normal. Masseter reflex is absent.
VII. The face is symmetric, palpebral fissures are equal, wrinkles of the forehead and closure of the eyes are symmetric. The corners of the mouth are at the same level, and they are symmetrically innervated. The patient identifies tastes on the anterior two thirds of the tongue on both sides. Lacrimation is normal. There is no hyperacusis.
VIII. Whispered words are identified by the patient from 2 meters.
Tuning fork tests are normal
IX, X. Gag reflex can be equally elicited from both sides. The pharynx is lifted up during phonation. The palatal arches are symmetric on both sides. The uvula is in the midline. The soft palate reflex is normal on both sides. There is no dysphonia or dysarthria. Swallowing is normal.
XI. The strength of both trapezius and sternocleidomastoid muscles are normal.
XII. The protruded tongue is in the midline. The movements of the tongue are free.
No atrophy, fasciculation or fibrillation is seen.

Motor system:
Muscle tone and muscle bulk are normal. No fasciculation is seen.
Muscle power is normal in all four limbs. Pronator drift test on the upper limbs and leg holding test are normal. Deep reflexes are normal and symmetric.
Hoffmann and Trömner signs are negative on both sides. There is no Babinski sing on either side. Abdominal skin reflexes are present and symmetric.
Cremaster and anal reflexes can be evoked.

Sensory system:
Normal tactile, pain and thermal sensation. Vibration and joint position sensation on the extremities is normal.

Vestibulo-cerebellar functions and gait:
Eudiadochokinesis on both sides. Finger-to-nose and heel-to-knee tests are precise, ataxia or intention tremor is seen. Romberg's test is normal, there is no falling to either side. Stance and gait are normal, with preserved synkinesis of the arms.
No deviation during walking with closed eyes is observed.
In Bárány's test there is no past-pointing. In pulsion tests there is normal compensation.
Babinski synergy is present.

Hyperkinesia:
No tremor or other types of hyperkinesia are seen.

Autonomic functions:

Micturition and defecation are normal.
During Schellong's test the blood pressure does not drop. Sweating is normal.

Psychiatric: *example for a negative status*: clear consciousness, oriented for time, place, self and examiner. Attention can be drawn, directed, keeps the target idea and can change the subject. No direct or indirect sign of perceptual disturbance. Ideas, concepts fit to educational level. No disturbance in the form and content of thought. Remarking, keeping and evoking functions of memory are intact. Mood in a middle range. Emotional reactions are appropriate to the situation either in quality or in intensity. No subjective or behavioural or vegetative signs of anxiety (or: appropriate to medical examination). No change in activity, and contractual capacity state according to history of illness compared to previous, adequate to the patients personality and expectations. Appetite average. Sexual activity adequate to age, situation and personality. Pace of psychomotorium average, no functional disturbance. General quick speech, no disturbance in form, logic, directed. Keeps eye-contact normally, mimic, gestures are adequate to situation, no disturbances observed. Behaviour adequate to situation, normal level of critical judgement. According to anamnestical data, personality change is observed (detailed explanation of it). Personality according to available data is preserved (or changed). Social connections are ordered. Self judgement is preserved. Insight of illness is adequate, realistic. Value orientation, goals are adequate to situation and level of socialization. Intellectual functions are adequate to age, situation and educational level. Suicidal ideation, inclination or intention can not be explored.

Summary: try to use ICD 10 and also write diagnoses according to the different Axis of the DSM.IV.
Collect all possible diagnoses, arguments for and against. According these arguments, take a stand on the most possible basic diagnosis and on the main diagnosis which is the reason for the present treatment.
If there can not be a diagnosis defined, emphasis should be put on the most powerful symptom(s) that made the admission necessary.

Opinion, diagnosis: Try to establish diagnoses (basic diagnosis and the diagnosis on which's basis treatment is indicated) according to ICD-10 and all axis of DSV-IV. Detail all possible diagnoses as well as arguments for and against. If there is no diagnosis, You should emphasize symptoms or group of symptoms that are the most important from the point of the present treatment.

Plan of investigation: first of all those psychological, radiological and other investigation and consultations, laboratory blood tests that help in establishing the diagnosis or confirm it should be listed here. Explain why do You order each of the investigations and what do You want from the results.

Plan of treatment: according to the main diagnosis, list all the possible pharmacological and non-pharmacological therapeutic interventions. Indicate main ways of therapy according to type of medicine or chemical agents. More detail is only required in special cases, e.g. reason for admission was adjusting a new medicine because previous ones (more types of SSRI, RIMA) were not effective, so dual action drugs will be given.