Psychiatry Society of Monash

2022 Year 4C Psychiatry OSCE Night

STATION 2: Gerald the Gardener

CANDIDATE INSTRUCTIONS

*You have been provided with the following candidate instructions. You have **4 minutes** to read and prepare for your station. Please read the instructions carefully.*

CANDIDATE INSTRUCTIONS

You are the registrar working in a GP clinic and are about to review Gerald Johnson, a 63 year old gentleman who presents with memory loss.

Gerald's family history includes Alzheimer's dementia, which his father was diagnosed with at age 75. His past medical history includes hypertension and hypercholesterolaemia for which he takes atorvastatin and candesartan. Gerald is an ex-smoker with a 20 pack year history. He usually drinks one to two glasses of wine on weekend nights, however recently this has increased to half a bottle a night as his wife Cheryl unexpectedly passed away 6 months ago in a motor vehicle accident.

This patient does not identify as being Aboriginal or Torres Strait Islander.

In 8 minutes, your tasks are as follows:

1. Take a history from Gerald. (6 minutes)
2. Please present your management plan for this patient. (2 minutes)

SIMULATED PATIENT INSTRUCTIONS

You are Gerald Johnson, a **63-year-old landscape gardener**. **6 months ago**, your beloved wife Cheryl died unexpectedly in a motor vehicle accident. Your daughter, Janine begged you to come into the GP today as she has been worried about **your recent memory loss and poor self-care**. During your interview with the GP registrar, you have a **closed posture with a sad affect and intermittent eye contact**. You occasionally become **teary** when asked or speaking about your wife and **quite distressed** when speaking about your cognitive symptoms. You speak softly and your responses are slightly slow.

Unless stated, assume Gerald does not know the answer to the question.	
Opening statement	*"My daughter Janine begged me to come in today - she has been worried that I haven't been myself and that I am losing my memory because I keep misplacing my keys and locking myself out of the house."*
If asked trigger/ belief for current presentation	"Well, **6 months ago Cheryl died** and everything seems to be going downhill since, and now I'm losing my memory too - I **must be getting Alzheimer's like my father**."
Current presentation	<u>*Memory:*</u> • *Duration:* Over the **last few weeks** you, and those around you have noticed some memory loss. • *Fluctuation:* You have **not noticed** that any of your symptoms are worse later in the day. • *Type of memory:* You are mostly struggling with **short term memory** *(misplacing belongings, remembering what is on your shopping list).* Your long-term memory (family members names, important dates) is intact. • *Pre-morbid*: Always had a reasonably good memory. <u>Relevant neurocognitive positives:</u> • **Difficulty concentrating** and paying attention to things (i.e. your mind wanders off while watching tv). • Difficulties **recalling** certain words – (i.e- the other morning you just couldn't think of the word for toaster). • You are **oriented to self/person, time and place**. • You do not know if your behaviour has changed but you suppose you have been **less inclined to be "social**." <u>Relevant neurocognitive negatives:</u> • NOT struggling with **familiar procedural tasks** (i.e- making a cup of tea or ironing a shirt). • NOT getting lost in familiar environments, NO wandering. <u>DEPRESSION SCREEN:</u> • *Mood*: Your mood has been **"a bit blue"** for the last few months, but lower than usual these last few weeks. • *Anhedonia:* You have **lost enjoyment** in your usual hobbies and activities - reading the morning paper and doing the crosswords, going out for walks or playing bridge with your friends. • *Sleep*: You have been going to bed at your usual time but toss and turn through the night. You often find you have been **waking up early** in the mornings and **unable to get back to bed**.

	• *Energy*: You have been feeling quite **low on energy** and fatigued all the time. • *Appetite*: You have **decreased appetite**. Your daughter has noticed that you are eating about ½ your previous portion size. • *Guilt/ Worthlessness:* You have been feeling **quite guilty** about being **"selfish"** and for being a bad father to Janine as she has had to support you a lot recently and "it should be the other way around." You also feel worthless as you feel you have been doing a poor job of your work. You **ruminate** about such things quite often. • *Suicidal Ideation:* You have had **fleeting thoughts** about ending your own life recently but you have **no active plans** and you know this would be a "silly idea" as your daughter Janine would be very hurt. *Exploration of grief:* • You miss your wife Cheryl a lot and think about her often. The grief still feels very fresh at times but you have slowly come to accept her death. You do **feel very lonely** without her. Often you think about what she would say if she were alive and how disappointed she would be if she were to see you as you are now.
Functional Impact	• WORK: Not enjoying work anymore and losing gardening clients over the reduced quality of your work. • ADL: You have forgotten to shower for a few days and you haven't done the laundry in three weeks.
Further Screening Questions	• *Anxiety:* You **have been worried** that you are getting dementia. • Nil restlessness, irritability or muscle tension. • *Psychosis:* **Nil hallucinations**. Nil odd thoughts or bizarre delusions. • *Mania:* **Nil elevated moods**, energy or other symptoms of mania. • *Organic Sx:* Nil recent trauma or falls, disturbances noted to gait, nil weakness or abnormalities of movement, nil fevers or infective symptoms.
Family History	• As per stem: Father - Alzheimer's dementia, diagnosed at age 75
Social History	• You were born in England. You had a normal and happy upbringing. You migrated here, met Cheryl and fell in love, and married her at age 22. • Janine is your only daughter and is very supportive. She comes around a few times a week to assist you with your domestic duties. You are otherwise independent. • Your daughter has been making you nutritious meals since Cheryl passed away. • You used to be more active and loved to take daily walks with Cheryl. You now force yourself to go for a walk once a week when Janine is visiting. • You are a spiritual, but not necessarily religious person.
Substance Use	• As per stem: Ex-smoker with a 20 pack year history. Drinks one to two glasses of wine on weekend nights, however recently this has increased to half a bottle a night. • Nil recreational substance use.

EXAMINER MARKING GUIDE

Criteria	Poor	Adequate	Excellent
Interactions with patient • Introduces self and confirms patient details. • Sets context for the interview including consent. • Uses open and closed questions appropriately. • Establishes good rapport.			
HISTORY TAKING: Task #1			
HOPC • Type of memory affected (Short term, long term, procedural, recall…) • Duration and onset • Evolution of symptoms • Events leading up to the presentation.			
SCREEN FOR DEPRESSION • Identifies core symptoms of depression (low mood and anhedonia) and ≥ 4 other pertinent symptoms (low energy, poor sleep, poor concentration, changes to appetite, suicidal thoughts, feelings of guilt and worthlessness). • Screen for unexplained somatic symptoms (dizziness, chronic aches and pains, constipation, insomnia) as these can be common presentations of depression in the elderly.			
SCREEN FOR NEUROCOGNITIVE DISEASE • Identifies memory loss and nature of memory loss (anterograde or retrograde, short-term or long-term/autobiographical), and >/2 neurocognitive domains (language, attention, perceptual-motor function, executive function, social cognition).			
SCREEN FOR GRIEF • Explores grief in the elderly patient and signs of complex grief (abnormal preoccupation and intense yearning for deceased, denial or disbelief regarding the death, sense of identity disruption, intense and persistent emotional pain regarding the death, emotional numbness, difficulty reintegrating into one's relationships and activities after the death, sense of intense loneliness etc.)			
SCREEN FOR OTHER PSYCHIATRIC DIFFERENTIALS • ORGANIC SCREEN: Asks questions pertinent to screening for major organic causes of cognitive decline (including but not limited to infection, stroke, other neurological disorders). • OTHER PSYCH SCREEN: Excludes of ≥ 3 causes: organic sx, manic sx, psychotic sx, anxiety sx.			
FUNCTIONAL IMPAIRMENT + SOCIAL HISTORY • Identifies relevant functional impact of sx upon patient across various domains. • Elicits relevant details of the patient's social history (level of function and functional decline, may ask about other domains which may be relevant for the management of the elderly patient i.e. nutrition, exercise or spirituality.)			

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PRESENT A MANAGEMENT PLAN: Task #2			
Utilises Bio-Psycho-Social model to approach management and considers immediate, ST and LT management.			
IMMEDIATE PLAN: • Investigates for possible organic causes, such as FBC, UEC, TSH, LFTs, CMP, Vitamin B12 and folate. • Considers gathering further collateral history from daughter. • Conducts depression and cognitive screening tests: GDS-15, MMSE etc. • Considers ongoing follow-up with GP and mental health care plan.			
SHORT TERM PLAN • Considers antidepressant medication and psychoeducation for patient and family. • Considers the use of appropriate first line agents in the elderly including citalopram, escitalopram, and sertraline, or alternatively mirtazapine in this patient (good for increasing appetite). • Understand that memory loss will usually improve with treatment of underlying depression, however if this does not improve, screening for further underlying organic or neurological causes.			
LONG TERM PLAN • Continued management of physical health issues by GP, monitoring for adverse effects and polypharmacy, and providing advice on SNAP-W and avenues for social or spiritual support where necessary. • Considers the role for continued risk assessment + continual administering of cognitive screening/questionnaires to track mood and cognitive function. • Considers the need for psychotherapy and grief counselling where grief or developing persistent complicated grief disorder may be a factor in the patient's depression.			
General feedback:			

USEFUL RESOURCES

Depression in the elderly	https://psysom.mumus.org/wp-content/uploads/2022/04/Depression-in-the-Elderly.pdf
Dementia summary table	https://psysom.mumus.org/wp-content/uploads/2022/04/Dementia-Comparison-Table.pdf
DSM-5 table for depressive disorders	https://psysom.mumus.org/wp-content/uploads/2022/04/Summary-Package-2.pdf
Psychiatry history taking	https://psysom.mumus.org/wp-content/uploads/2022/08/Summary-Package-1.pdf
Antidepressants	https://psysom.mumus.org/wp-content/uploads/2022/07/2-Antidepressant-Medications.pdf
Major depressive disorder	https://psysom.mumus.org/wp-content/uploads/2022/07/1-Major-Depressive-Disorder.pdf