Nneka Okoye
Soap Note Critique #4

On my honor as a student, I have neither given nor received aid on this assignment.

Vital Signs

T: 97.7° F
P: 68
RR: 16
BP: 126/80

CC: Patient is a 65 – year old Caucasian female who presents with the chief complaint of increased anxiety.

S: This is a 50 – year old, married, Caucasian female with a history of depression seen in the clinic for complaints of increased anxiety. Anxiety has been a long-standing problem for this patient. The anxiety has been steadily increasing for 1 week and is associated with insomnia, shakiness, body tension and a “wound up” feeling upon awakening. “I’m feeling like I did before I started my Celexa.” “I just feel so depressed and blah.” Patient wants to discuss increasing her Celexa dosage. The patient’s symptoms are severe enough to interfere with instrumental activities of daily living. She has complied with medication therapy, yet the symptoms have worsened with the current therapy (Celexa 40mg). She has had many recent life stressors. Patient has had a recent brain subdural hematoma with subsequent hospitalization. In the hospital, she was put on Keppra because, per patient, a neurologist thought she had a seizure. She titrated herself off of Keppra and has been off of this drug for about a week. Patient believes her subdural hematoma was because her blood pressure was too high. Her aunt, for whom the patient is the primary caregiver, is close to death. The patient’s mother recently passed away in March 2011 is still grieving. The patient was very tearful as she recounted her sources of stress. She states she has a lot of support from her husband, but the life stressors are overwhelming her. Has seen a psychiatrist in the past for her anxiety/depression. Denies SOB, GI upset,
palpitations and fatigue. Patient is positive for muscle aches/tension, insomnia and restlessness. Negative for night sweats, fever, chills, appetite change or weight change, visual disturbances, epistaxis, sinus congestion/pain, sore throat, post nasal drip, chronic cough, increasing SOB, pleuritic chest pain, orthopnea, ischemic chest pain, palpitations, syncope, dysphagia, reflux or heartburn, abdominal pain, changes in bowel habits or blood/mucous in stool, urinary symptoms and unusual headaches. Never drinks alcohol nor does she smoke.

Deletions/Revisions

- I did not ask how long she was on Celexa nor when she was diagnosed with depression and anxiety. I should have put ‘patient was diagnosed with anxiety and depression in 1999 and was started on Celexa in 2004’.
  - As part of the comprehensive assessment, consider a history of mental health disorders, past experience of, and response to, treatments (National Collaborating Center for Mental Health, 2011).
- I did not ask if her life stressors have caused her to have any suicidal tendencies. I should have done a suicide screening and assessed for suicide ideation.
  - Late in life, suicide may be one consequence of anxiety triggered by trauma (including crime), illness in the spouse, and bereavement (Allgulander, 2009).
  - Patients may ruminate about death, feel that life is not worth living, have suicidal thoughts, make plans or attempt to kill themselves (Rothberg & Schneck, 2011).
- I should have asked if the patient had a family history of anxiety
  - Genes can influence health and behavior and it is important to consider family members with similar symptoms (Walker - Schmucker, 2008).
  - Genetic factors appear to play a modest role in the etiology of GAD and recent research suggests that there is a shared genetic vulnerability to GAD, major depression, and the personality trait of neuroticism. The tendency of GAD to run in families has also been described as largely due to genetic features shared with relatives rather than effects of family environment (Ciechanowski & Katon, 2011).
GENERAL: Well-developed Caucasian female, afebrile, alert and in no acute distress


NECK: Neck reveals no carotid bruits, no JVD, and no lymphadenopathy. There is no evidence of thyromegaly.

CHEST/LUNG: Chest expansion is symmetrical. Lungs are clear to auscultation and percussion bilaterally.

HEART: Heart has a regular rate and rhythm. Normal S1 and S2.

Abdomen: Abdomen is soft, benign, non-tender. Bowel sounds are normoactive. No CVA tenderness

Deletions/Revision:
  ▪ I should have addressed that I did not observe any ophthalmopathy (addresses possible hyperthyroid).

Diagnostics:
  ▪ No labs were obtained at time of clinic visit. “Diagnostic tests should be guided by the history and physical examination” (Walker - Schmucker, 2008).

Deletions/Revisions:
  ▪ I should have done an anxiety screening.
    ▪ “Screening for anxiety disorders is necessary because a large and growing percentage of anxious individuals are now treated in primary care setting” (Walker - Schmucker, 2008).
  ▪ Due to lack of knowledge about this screening tool, I did not utilize this. Utilizing the GAD – 7 screening tool would have helped me realize how severe her anxiety was. We could have also kept a record of it in the chart and have her screened again in 3 months to re-evaluate the effectiveness of treatment.
    ▪ The GAD – 7 tool has been validated to screen for generalized anxiety, as well as for other types of anxiety (panic disorder, social anxiety disorder, and posttraumatic stress disorder) A score of 10 or greater on the GAD-7 represents a reasonable cut point for identifying cases of GAD with a sensitivity of 89 % and specificity of 82 %. Cut points of 5, 10, and 15
have been established as representing mild, moderate, and severe levels of anxiety on the GAD – 7 (Ciechanowski & Katon, 2011).

- We should have done a formal suicide screening.
  - Suicide screening should include assessing current level of depression, severity of symptoms, feelings of hopelessness; current suicidal thoughts and behaviors (as well as past attempts), use of drugs or alcohol (which can increase levels of impulsivity and worsen dysphoria), current levels of anxiety and agitation, access to lethal means (especially firearms), presence of psychosis (command hallucinations, poor reality testing), recent acute stressors, and presence (or absence) of a psychosocial support system (Rothberg & Schneck, 2011).

- Based on clinical presentation, it is not imperative to have a TSH drawn.

A:
Most likely generalized anxiety disorder due to multiple life stressors

Deletions/Revisions:
- After performing a literature review, I believe this patient most likely has Adjustment Disorder with Anxious Mood.
  - Patient has been experiencing increased anxiety in response to multiple life stressors and it has not persisted for more than 6 months.
  - “Many patients have the full constellation of symptoms that meet the DSM-IV criteria, but have had symptoms for a shorter period than the required six months. These individuals often have symptoms of anxiety as a result of a specific stressor, or symptoms that occur within three months of the onset of a stressor; they fulfill the DSM-IV diagnostic criteria for "adjustment disorder with anxious mood" rather than GAD” (Ciechanowski & Katon, 2011).

- Major Depressive Disorder (confirmed)
  - “In elderly persons (>65 years) the prevalence of all anxiety disorders appears to decline, except for GAD, which is maintained
at 4% prevalence and may increase over time” (Rothberg & Schneck, 2011).

- Major depression and anxiety are often found together. Studies have consistently shown that anxiety disorders are the most frequently occurring co-morbid disorder with major depression, with 50% to 60% of major depressed patients with both illnesses (Rothberg & Schneck, 2011).
- The patient has verbalized feeling depressed and is presenting with depressive symptoms. Patient also has a history of depression and is on medication for this condition.
  - The essential feature of a major depressive episode is a period lasting at least 2 weeks during which the patient experiences depressed mood or loss of interest or pleasure in almost all activities, a distinct change in usual self, and clinically significant distress or changes in functioning. It is accompanied by a constellation of other symptoms, such as changes in sleep, eating, energy, motivation, and concentration; difficulty making decisions; and often feelings of hopelessness, worthlessness and guilt (Rothberg & Schneck, 2011).

- Generalized Anxiety Disorder (refuted)
  - GAD is characterized by excessive worry and anxiety that are difficult to control and that cause significant distress and impairment (Ciechanowski & Katon, 2011).
  - The patient has not been experiencing her symptoms more than 6 months. Although she does present with 3 out of 6 keys symptoms of GAD (restlessness/nervousness, muscle tension and sleep disturbance), she has to be experiencing these symptoms for at least 6 months.

- Acute Situational Anxiety (refuted)
- Situational worries are less likely to be accompanied by physical symptoms (American Psychiatric Association, 2000). Restlessness, fatigue and other physical symptoms are rarely present.
  - Medication – induced anxiety (refuted)
    - Almost all classes of antidepressants cause anxiety in some patients, particularly during the initiation of treatment
  - Hyperthyroidism (refuted)
    - We needed a TSH level, but did not get one. Patient has no previous history. Patient denies weight loss, warm moist skin, heat intolerance. No exopthalmos or goiter observed.

**P:**
Will increase Celexa to 60mg daily which patient states she has used in the past with good results.
Declines any meds for insomnia
Utilize relaxation techniques to help reduce stress
Keep appointment with osteopathic physician in about 3 weeks
Will arrange for counseling/evaluation by psychologist
Follow up with clinic in 2 months, sooner if needed for problems or questions

**Deletions/Revision:**
- It is dangerous to increase the Celexa to 60mg. Carol looked up a 2008 NPPR book and it said Celexa could be maxed out at 60mg. My Epocrates said 40mg/daily is the max.
  - Due to increased serum concentrations in patient’s ≥60 years and the risk of QT prolongation, the maximum recommended dose in elderly patients is 20 mg/day. Patients with hepatic impairment, >60 years of age, poor CYP2C19 metabolizers, or taking cimetidine should not receive citalopram doses >20 mg/day due to the potential for increased citalopram serum concentrations (Up To Date, 2011).
- Celexa is not indicated in generalized anxiety disorder nor does increasing the dose >40mg help with her depressive symptoms. UpToDate reports that it is used for the treatment of depression.
  - Dosages >40 mg/day have not been shown to be more effective in treating depression during clinical trials (UpToDate, 2011).
- I would have changed her medication to Lexapro 20mg PO QD since it is in the same class as Celexa and proven to be more efficacious for anxiety and depression.
  - A task force appointed by the World Federation of Societies of Biological Psychiatry recently updated the treatment recommendations for GAD and determined the most efficacious drugs were: escitalopram, paroxetine, sertraline, venlafaxine, duloxetine, pregabalin, and quetiapine (Allgulander, 2009).

**Teaching/Education:**

**Deletions/Revision:**
- We should have discussed with the patient that GAD associated with MDD is a chronic, non-remitting and relapsing disorder. That it is quite okay to be feeling the she’s feeling given her current situation. We should empower the patient and assured her that, with adequate support, she will get through this life hurdle.
  - A means of improving the care for primary care patients who have GAD or depression is to provide adjunct psycho-education for the patient and key relatives, compliance monitoring, and feedback (Allgulander, 2009).
- Worry management skills and mindfulness meditation encourage greater tolerance for uncertainty (Shearer, 2007).
  - Educate the patient and family members about treatment options as well as realistic treatment expectations and reassure them of the absence of medical causes (Blevins & Goddard, 2011).
- We should have discussed the importance of regularly attending counseling sessions to understand how to adequately cope with life stressors and deal with root of her anxiety/depression.
  - Treating underlying depressive and anxiety disorders not only improves the emotional well-being of patients, but also improves overall health outcomes and lowers health care costs (Rothberg & Schneck, 2011).
  - A combination of psychotherapy and medication management is recommended in all of the anxiety disorders. Cognitive-behavioral therapy (CBT) has the strongest empiric support of all the psychotherapies, but it requires commitment to treatment on the part of the patient (Blevins & Goddard, 2011).
- We should have warned her about using over – the – counter medications like SAM – E (increased risk of serotonin syndrome), aspirin (increased bleeding) and dextromethorphan (increased risk of serotonin syndrome).
  - Discuss the use of over-the-counter medications and preparations with people with GAD and explain the potential for interactions with other prescribed and over-the-counter medications (National Collaborating Center for Mental Health, 2011).
- Physical activity can be adjunctive treatment in GAD.
  - “Preliminary evidence suggests that exercise reduces anxiety sensitivity and may reduce generalized anxiety, yet clinical implications of this limited data is to be determined” (Bystritsky, 2011).

**Follow Up Plan**
- Follow up in clinic in 2 months, sooner if needed for problems or questions.

**CPT code**
- (99214) Office Output Estimated 25 minutes, Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these three components: A detailed history; A detailed examination; Medical
decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem (s) and the patient’s and/or family need (s). Usually, the presenting problem (s) are of moderate to high severity (Epocrates, 2009).

**ICD – 9 Code**

- Anxiety (272.4)


