SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY

SKOOL VIR GENEESKUNDE
DEPARTEMENT PSIGIATRIE

MBChB 5
GNK 581

Psychiatry and Social Dysfunction
Psigiatrie en Sosiale Disfunksie

Block 15 Test
Blok 15 Toets

Date: 25 January / Januarie 2013

Time/*Tyd*: 1 hour/*uur*

Internal examiner(s) :

Prof J L Roos and personnel

External examiner:

Prof C Szabo

TOTAL / *TOTAAL*: 80 marks

GENERAL INSTRUCTIONS / ALGEMENE INSTRUKSIES

• **No cell phones, books or study material may be brought into the examination venue.**	• **Geen selfone, boeke of studiemateriaal mag die eksamenlokaal binnegebring word nie.**

SPECIAL INSTRUCTIONS / SPESIALE INSTRUKSIES

• Answer all the questions on the test paper	• Beantwoord al die vrae op die vraestel

Question / *Vraag 1* (20)

Tabulate the clinical symptom domains of schizophrenia in different clusters. [20]
Tabuleer die kliniese simptome van skisofrenie in verskillende trosse (groepe). *[20]*

Positive symptoms: Delusions [1]; hallucinations [1]; disorganized speech [1];

Neuromotor (catatonia) [1]

Negative symptoms: Affect blunting [1]; Alogia [1]; Avolition [1]; anhedonia [1]; social

Withdrawal [1]

Cognitive deficits: Attention [1]; Memory [1]; executive function (e.g. abstraction) [1]

Mood symptoms: depression [1]; Hopelessness [1]; Suicidality [1]; Anxiety [1]; Agitation [1];

Hostility [1]

Comorbid symptoms: There is substance abuse [2]

Question 2 / *Vraag 2 (5)*

When will you refer a patient diagnosed with schizophrenia to a tertiary level of care? [5]
Wanneer sal u 'n pasiënt wat met skisofrenie gediagnoseer is na 'n tersiêre vlak van sorg verwys? *[5]*

Frequent relapses [1]

Resistance to treatment [1]

Comorbid conditions (NB: Substance abuse [1] and mood disorders [1])

Lack of sufficient support/resources at the primary level [1]

Serious suicidal [1] or homicidal tendencies [1]

Question 3 / *Vraag 3 (15)*

Ms MM is 42 years old, presenting at your office for consultation, after her husband requested that she should come and see you because she has been isolating herself in her room lately, and she has been crying a lot. She stopped going to her art classes the last 4 weeks (that used to be the highlight of her week). She says that her legs are feeling as if they are casted in cement. She is not taking care of her two teenage sons the way she used to and the house chores have been neglected with her husband having taken over the cooking, because she is too tired. At work where she is employed as an office assistant, she struggles to concentrate and misplaces documents. Her husband states that she is sleeping almost permanently when not at work, and has gained 5 kg the last month due to her carbohydrate cravings. She cries the moment someone only looks strangely at her, and needs constant reassurance from her husband. Her libido has decreased significantly. She does still laugh when the children share their jokes with her.

There is no substance abuse, underlying medical conditions, previous mania or hypomania present.

Her current physical examination is normal.

On mental status examination the following is found: Ms JC answers all questions appropriately, her speech is slow and she has psychomotor retardation. Her affect is depressed. There are no perceptual disturbances. There are thoughts of excessive guilt and ruminations about her inadequacies. She does not feel life is worthwhile anymore, but she has no suicide plan.

Me. MM is 42 jaar oud en presenteer by u spreekkamer vir konsultasie na haar man versoek het dat sy u moet kom sien omdat sy die laaste ruk haarself in haar kamer isoleer en baie huil .Sy het die laaste vier weke opgehou om haar kunsklasse by te woon (dit was altyd die hoogtepunt van haar week). Sy sê dat dit voel of haar bene in sement vasgevang is. Sy versorg nie meer haar twee tienerseuns soos wat sy altyd gedoen het nie en haar huiswerk word afgeskeep sodat haar man die kosmakery moes oorneem omdat sy te moeg is. By die werk waar sy in diens is as `n kantoor-assistent sukkel sy om te konsentreer en verloor dokumente. Haar man sê dat sy omtrent permanent slaap as sy nie by die werk is nie en sy het 5kg opgetel as gevolg van haar koolhidraat hunkering. Sy huil as iemand net skeef na haar kyk en het konstante versekering van haar man af nodig, en tog is haar libido baie verminderd. Sy lag nog as die kinders vir haar grappies vertel.

Daar is geen substansmisbruik, onderliggende mediese toestand, vorige manie of hipomanie teenwoordig nie.

Haar huidige fisiese ondersoek is normaal.

Met geestestoestandevaluering word die volgende gevind: Me. MM antwoord alle vrae toepaslik, haar spraak is stadig en sy het psigomotorvertraging. Haar affek is depressief. Daar is geen perseptuele

versteurings nie. Daar is gedagtes van oordrewe skuldgevoelens en ruminerings oor haar tekortkominge. Sy voel nie die lewe is meer die moeite werd nie, maar het geen selfmoordplan nie.

a) What will be the most likely diagnosis on Axis 1? (2)
a) Wat is die mees waarskynlike diagnose op As 1? (2)

Major depressive disorder

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b) What specific specifier applies? Motivate your answer with examples from the case study. (7)
b) Watter spesifieke spesifiseerder is van toepassing? Motiveer u antwoord met voorbeelde uit die gevallestudie (7)

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1. **Atypical features (√√)**

   - **Hypersomnia [1] "sleeping almost permanently"**
   - **Psychomotor retardation [1] "mental status examination psychomotor retardation"**
   - **Weight gain / increased appetite [2] "gained 5 kg the last month due to her carbohydrate cravings"**
   - **Rejection sensitivity [1] "She cries the moment someone only looks strange at her, and needs constant reassurance from her husband"**
   - **Reactive mood / affect [1] "She does still laugh when the children share their jokes with her."**
   - **Leaden paralysis [1]**

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c) Discuss the prognosis of the disorder briefly by writing cryptic notes. (6)
c) Besreek die prognose van die versteuring kortliks deur kort notas te skryf (6)

(Any 6 of the following 9, 1 marks each)

- **If left untreated, self-limiting – last 6-13 months**
- **If treated: last 3 months**
- **Generally episodes occur more frequently as disorder progresses.**
- **Risk for subsequent episode 50% within 2 years**
- **Lifetime risk after single episode: 50-85%**
- **Lifetime risk after second episode: 80-90%**
- **15 % commit suicide**
- **50-60% respond to antidepressants**
- **Combined treatment of both antidepressant and psychotherapy produce a significantly ↑ response rate**

Question 4 / *Vraag 4 (15)*

As a medical officer in the casualty department at a designated secondary hospital you need to start involuntary admission procedures according to the Mental Health Care Act No 17, 2002 on a possible Mental Health Care User. Name the necessary admission procedures. (15)

In 'n pos as mediese offisier in 'n ongevalle afdeling van 'n toegewysde sekondêre hospital moet u onwillekeurige opname prosedures volgens die Geestesgesondheidsorgwet Nr 17, 2002 op 'n moontlike Geestesgesondheidsorggebruiker begin. Noem die nodige opname stappe. (15)

Application: Support to Applicant, Next of kin priority, alternative MHC Provider, Form 4 or application form **[4]**
Examination 2xMPC Practitioners One must be Practitioner able physical examination Report on Examination form 5 Request involuntary admission **[4]**
For HHE to access if congruent, human rights management; OK the request; Initiate transfer to designated HE, Forms to MHCR **[3]**
Liaise with MHC practitioner at designated HE, supply necessary clinical information, collateral information and special investigations (if any) **[4]**

Question / *Vraag 5 (10)*

Name two extrapyramidal side-effects that can be life-threatening and discuss the management. (10)

Noem twee ekstrapiramidale newe-effekte wat lewens-bedreigend kan wees en bespreek die hantering daarvan. (10)

Acute dystonia (laryngeospasm)
Rx: Biperidine 5mg IMI/IVI

Neurolept malignant syndrome
Mx: Emergency – admit to highcare / ICU
Stop all anti-psychotics
Cool pt off
Aggressive hydration
Monitor vitals
Prevent aspiration (nasogastric tube)
Diazepam or lorazepam
DVT prophylaxis
Beware renal failure (↑CK / myoglobin)
Dantrolene 3-5mg/kg IV in divided dose
Bromocriptine 5mg qid (? L dopa)
If no response: ECT

Question / *Vraag 6 (10)*

Mrs C is a 71 year old married woman who was first evaluated 4 years ago when her husband noticed changes in her memory and behaviour. She frequently forgot her keys or would go into a room and would then forget what she wanted. She also became very quiet and withdrawn where she was previously an outgoing person. She was in general good health and was not on any medication. There was no significant family, psychiatric or substance use history. Her husband now contacted Dr. X because he was worried about her condition deteriorating. On examination she was fully awake and conscious with no prominent psychomotor abnormalities. She had no focal neurological abnormalities but she had difficulty sustaining attention. Mrs C was disorientated to place and date. There was no evidence of any mood or sleep disturbances. She also had impairment in her memory, judgment and planning abilities. After extensive investigation a diagnosis of dementia of Alzheimer's type was made.

Mev C is a 71 jarige getroude dame wat 4 jaar gelede die eerste keer geëvalueer is, nadat haar man veranderinge in haar geheue en gedrag opgemerk het. Sy het gereeld haar sleutels vergeet en sal in 'n vertrek inloop en vergeet wat sy daar wou doen. Sy het baie stil en teruggetrokke geword, waar sy tevore 'n baie ekstroverte persoon was. Haar algemene gesondheid was goed en sy was nie op enige medikasie nie. Daar is geen familie geskiedenis, vorige psigiatriese of middel-misbruik probleme teenwoordig nie. Haar man het nou vir Dr X gekontak omdat hy bekommerd is dat haar toestand agteruit gaan. Op ondersoek is sy helder wakker en het geen psigomotor abnormaliteite nie. Sy het geen fokale neurologiese abnormaliteite nie, maar sy het gesukkel om haar aandag te fokus. Mev C was ook gedisoriënteerd tov tyd en plek. Daar is geen aanduidings van enige gemoeds- of slaapversteurings nie. Haar geheue, oordeel en beplanningsvermoë is ingekort. Na 'n volledige ondersoek word 'n diagnose van Alzheimer's demensie gemaak.

a) List 5 features in Mrs C's clinical presentation that would help to differentiate dementia from delirium. (10)

a) Noem 5 kenmerke in Mev C se kliniese beeld wat sal help om tussen 'n delirium en 'n demensie te onderskei. (10)

Gradual onset [2]

Progression over a period of a few years [2]

No fluctuation in consciousness [2]

No disruption in sleep-wake cycle [2]

Absence of psychomotor abnormalities [2]

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b) Briefly discuss some of the environmental interventions that can be implemented for the behavioural and psychological symptoms in dementia. (5)

b) Bespreek kortiliks die omgewingsingrepe wat geïmplementeer kan word om die gedrags- en sielkundige simptome in demensie aan te spreek. (5)

Familiar personnel [1]

Provide clues to environment (signs etc.) [1]

Calm and quiet environment [1]

Avoid physical restraints [1]

Regular physical activity and get patient up [1]

Structured activities and planned pleasurable activities [1]

Social contact [1] – pets, one to one, family [1]

Medical [1] - light therapy, hearing aids, pain management [1]

½ mark for each answer

GRAND TOTAL / *GROOT TOTAAL* = 80