Performance Overview for Martin Mutesasira on case Sarah O'Neil

The following table summarizes your performance on each section of the case, whether you completed that section or not.

Time spent: 5hr 8min 2sec
Status: Submitted

Case Section	Status	Your Score	Time spent	Performance Details
Total Score		47%		
History	Done	55%	1hr 46min 42sec	110 questions asked, 26 correct, 22 missed relative to the case's list
Physical exams	Done	50%	43min 28sec	57 exams performed, 4 correct, 0 partially correct, 4 missed relative to the case's list
Key findings organization	Done		4min 33sec	10 findings listed; 9 listed by the case
Problem Statement	Done		6min 8sec	105 words long; the case's was 238 words
Differentials	Done	14%	10min 12sec	5 items in the DDx, 1 correct, 6 missed relative to the case's list
Differentials ranking	Done	71% (lead/alt score) 86% (must not miss score)	2min 20sec	
Tests	Done	0%	9min 8sec	3 tests ordered, 0 correct, 2 missed relative to the case's list
Diagnosis	Done	100%	50sec	
Management Plan	Done		18min 46sec	152 words long; the case's was 1594 words
Exercises	Done	48% (of scored items only)	14min 6sec	3 of 11 correct (of scored items only) 4 partially correct

History Notecard by Martin Mutesasira on case Sarah O'Neil

Use this worksheet to organize your thoughts before developing a differential diagnosis list.

1. Indicate key symptoms (**Sx**) you have identified from the history. Start with the patient's reason(s) for the encounter and add additional symptoms obtained from further questioning.
2. Characterize the attributes of each symptom using **"OLDCARTS"**. Capture the details in the appropriate column and row.
3. Review your findings and consider possible diagnoses that may correlate with these symptoms. (Remember to consider the patient's age and risk factors.) Use your ideas to help guide your physical examination in the next section of the case.

HPI	Sx =	Sx =	Sx =	Sx =	Sx =	Sx =
Onset						
Location						
Duration						
Characteristics						
Aggravating						
Relieving						
Timing / Treatments						
Severity						

Problem Statement by Martin Mutesasira on case Sarah O'Neil

Sarah is a 25 y/o female presenting for assessment of her depression. She reports intermittent suicidal ideation, difficulty with sleep (hypersomnia), and feels fatigued most of the time. She reports paranoid thoughts feeling that her workers are judging her and making a list to get her fired. She reports a history of a hypomanic episode where she went for days without sleeping and started writing a novel. She has gained about 10 pounds in the past months. The symptoms have impaired her work and interpersonal relationships. She has a history obesity. Sarah reports a recent episode of binge drinking where she ended up blacking out.

Attempt: 3079435

Report generated on 3/24/2024, 12:35:22 AM Africa/Nairobi

Management Plan by Martin Mutesasira on case Sarah O'Neil

Prescribe olanzapine 25 mg PO to be taken daily to address mania, with consideration of the low effects on mood changes.
Prescribe fluoxetine 20 mg PO daily. Combining fluoxetine and olanzapine has been shown effective in treating depression associated with bipolar disorder.
The patient should continue with multivitamin supplementation because of the positive effects on depressive symptoms
Cognitive behavioral therapy with weekly sessions are initiated.
Benefits and risks of medication non-adherence and the possible side effects of the prescribed medications are discussed.
The patient is advised about the possibility of an increase in suicidal thoughts after the initiation of fluoxetine
The patient is encouraged to start a daily exercise routine to address her weight gain and buffer from additional weight gain associated with the prescription of second-generation antipsychotics (olanzapine).
Patient is given an emergency contact to report any new symptoms, increase in suicidal ideation, or other crises
Follow-up scheduled in four weeks

Electronic Health Record by Martin Mutesasira on case Sarah O'Neil

History of Present Illness

Category	Data entered by Martin Mutesasira
Reason for Encounter	"I've been so sad almost every day for the past month"
History of present illness	Sara is a 25 y/o married presenting after a referral by her primary physician for assessment of her depression after the physical examination in the ED revealed no organic explanations. She visited her PCP after her manager encouraged her to be checked because of constant episodes of crying at work and impaired performance. She reports being sad every day for the past month and "every minute of the day" for the previous two weeks. She endorses suicidal thoughts but does not report a plan of acting on them. She is paranoid and thinks that her coworkers are conspiring to get her fired. She claims that she went for days without sleeping six weeks ago, attempted to write a novel, and acted in a way out of her normal character. She went to a pub by herself, considered having an extramarital affair, almost left with a male stranger, and passed out after the drinking episode. Her sadness has affected her work performance and relationship with her husband. She recalls a previous depressive period in high school during which she engaged in self-harming behavior. Family history is positive for schizophrenia, suicide, and alcohol-related problems.

Past Medical History

Category	Data entered by Martin Mutesasira
Past Medical History	Obesity Sexually active: Uses contraceptive; LMP 2wks ago, regular Usual childhood illness; asthma, acne as a teen
Hospitalizations / Surgeries	Appendectomy at age 13

Medications

Category	Data entered by Martin Mutesasira
Medications	Orthotricyclen (oral contraceptive) Daily multivitamin

Allergies

Category	Data entered by Martin Mutesasira
Allergies	No known drug or food allergies

Preventive Health

Category	Data entered by Martin Mutesasira
Preventive health	Vaccines up to date Last PAP 6 months ago Negative for STI/HIV prior to marriage Safety measures: Lives in an apartment with smoke alarms, wears a seat belt, does not own a gun, does not have access to stores of medications Environmental and occupational exposures: Exposure to routine illnesses, given work at a pediatrician's doctor's office Exercise: Previously enjoyed tennis a few times a week, but has not played recently due to feeling fatigued

Family History

Category	Data entered by Martin Mutesasira
Family History	Mother: died at 48; suicide, schizophrenia Father: alive, 58, hypertension, alcoholism Sister: alive, 27, depression, on fluoxetine

Social History

Category	Data entered by Martin Mutesasira
Social History	Occupation: Works at a pediatrician's office as a receptionist Education: Associate degree and working on a bachelor's degree in part-time night school Marital status: Married to her high school boyfriend who works as a firefighter. Her husband is supportive but the recent symptoms have strained the relationship. No reports of domestic violence Substance use: Reports recent episodes of drinking 6-8 drinks. Had a blackout during the recent drinking episode. No DUIs. Se reports using marijuana less than one time a month during high school years. She denies tobacco or caffeine use. Diet: Reports a recent 10lb weight gain. No recent changes in appetite reported. Reports lack of energy to prepare meals.

Review of Systems

Category	Data entered by Martin Mutesasira
General	Denies fever, chills, malaise, or sweats. Reports gaining 10lbs
Integumentary / Breast	Negative
HEENT / Neck	Negative
Cardiovascular	Negative
Respiratory	Negative
Gastrointestinal	Negative
Genitourinary	Negative
Musculoskeletal	Negative
Allergic / Immunologic	Negative
Endocrine	Negative
Hematologic / Lymphatic	Negative
Neurologic	Negative
Psychiatric	Reports sadness, fatigue, loss of interest, feelings of hopelessness and low self-worth, anxiety, and irritability

Physical Exams

Category	Data entered by Martin Mutesasira
General	Alert and oriented X3. No signs of acute distress.
Skin	No pallor, jaundice, or rash. Normal skin and hair texture. No trauma, self-injury, or drug injection
HEENT / Neck	PERRLA, conjunctivae pink with no discharge, sclera white, mouth and oropharynx normal, no lymphadenopathy, thyroid normal size and consistency, no masses noted
Cardiovascular	PMI quarter-sized brisk and tapping at the 5th intercostal space at the midclavicular line S1 and S2, normal upon auscultation
Chest / Respiratory	Chest symmetrical and AP normal; symmetric exertion, no distension scars, masses, or rashes; no tenderness, masses, heaves, thrills, or crepitus to palpation; lungs resonant bilaterally; normal lung sounds to auscultation
Abdomen	Flat, symmetric, with no scars, deformities, striae, or lesions; normoactive bowel sounds in all quadrants; no pain, tenderness, masses, guarding, or rebound tenderness; no hepatosplenomegaly; liver span normal; spleen not palpable
Genitourinary / Rectal	Normal external genitalia; no masses or tenderness; normal pelvic exam
Musculoskeletal / Osteopathic Structural Examination	Normal muscle bulk and tone
Neurologic	MMSE - 3/3 registration and recall. Attention intact. Names 2/2 objects accurately. Able to follow multi-step commands. Spatial and executive function intact on drawing task. Score: 30/20
Psychiatric	
Lymphatic	No adenopathy