Name: Smeeta Antony | DOB: 3/27/1972 | MRN: 0007392385 | PCP: Mark A. Wolters, MD

Appointment Details

Notes

Progress Notes

Progress Notes by Sophia Vinogradov, MD at 5/26/2022 12:00 PM

Psychiatry Discharge Note

ID: This is a follow-up visit for this 49 year old divorced South Asian female. She had a history of atypical hx of psychiatric and neurologic sx in the past. She is now doing extremely well over the past 3+ years and her symptoms have essentially resolved as she has attained a high and stable level of functioning.

Pt has been taking her meds consistently.

We met via telemedicine telephone visit to terminate her work in our clinic and to prepare for her follow-up with her primary care provider.

Start Time: 1:30 End Time: 2:00 pm

ASSESSMENT/ PLAN

1) Coprolalia, working diagnosis is atypical Tourette's syndrome.

Overall dramatically improved. Has reduced gabapentin 1600 mg at bedtime as recommended by her neurologist (to help reduce weight gain and GI sx). Has also stopped fluoxetine on her own.

Pt has developed many excellent coping strategies. Has observed that when she is talking or busy at work, there is no urge for vocalizations. New office job requires frequent talking and interaction, which has been very helpful. At most, has 1-2 brief Tourette's-like episodes after her shower in the morning or when doing housework at home and not otherwise engaged.

Willl continue gabapentin, lorazepam, clonidine, as these appear to be supporting excellent functioning, a full night's sleep, and contributing to sustained sense of well-being.

Meds: gabapentin 1600mg at bedtime, clonidine 0.1 mg at bedtime, lorazepam 1 mg at bedtime.

2) Somatic sx (such as feelings of electric shocks in arms and legs, chronic neck pain, back pain, knee pain), and also persistent genital arousal

These are now attenuated; possibly due to increasing exercise and improved sleep. Though never confirmed, a fibromyalgia picture is possible.

PGA has greatly improved with PTNS by uro-gyn. Prozac may also have been helpful here, and even though she has discontinued this over the past month but is much improved.

3) Revision of previous psychiatric diagnoses--

Previous diagnoses of Schizophrenia and other Psychosis related diagnosis,and of Major Depression, are no longer applicable given all of the many strong functional features noted below, and the impressive restructuring of her life and capabiliites that pt has undertaken.

My current working diagnoses are therefore as listed above (atypical Tourette's syndrome and PGAD), and I acknowledge that her presentation and course have not been typical of any DSM-V psychiatric diagnosis. Patient herself wonders if she may have been prone to episodes of "transient altered awareness" which may have been the source of her prior presentations.

TELEPHONE VISIT
Smeeta Antony is a 49 year old pt. who is being evaluated via a billable telephone visit.

The patient has been notified of the following:
“We have found that certain health care needs can be provided without the need for a physical exam. This service lets us provide the care you need with a short phone conversation. If a prescription is necessary we can send it directly to your pharmacy. If lab work is needed we can place an order for that and you can then stop by our lab to have the test done at a later time. Insurers are generally covering virtual visits as they would in-office visits so billing should not be different than normal. If for some reason you do get billed incorrectly, you should contact the billing office to correct it and that number is in the AVS”.

Patient has given verbal consent for a telephone visit?: Y
How would the pt like to obtain the AVS?: No AVS required.
AVS SmartPhrase [PsychAVS] has been placed in 'Patient Instructions': NA

As the provider I attest to compliance with applicable laws and regulations related to telemedicine.

Chief Complaint

"I had a good visit with the neurologist and she says I have done a great job managing my atypical Tourette's syndrome."

Interim History/ History of Present Illness

Currently taking **gabapentin 1600mg at bedtime, clonidine 0.1 mg a day, lorazepam 1 mg at bedtime (down from 2 mg previously).**

Recently saw a new neurologist for management of her Atypuial Tourette's syndrome, and was commended by the neurologist for how well she has managed. Neurologist also lowered her Gabapentin dose form 2400 mg at bedtime to 1600 mg at bedtime. Pt stopped Prozac on her own over the past mont and has been doing well.

Mental Health Symptoms:
Had requested a court order to seal all of her court records and medical records, which was only partially granted.

Has been pursuing ablity to have unsupervised visits with her daughters. I have written letters describing her psychiatric stability.

From a psychiatric pov, pt remains essentially asymptomatic. Is working in a new position as an office support person for a disability van company, and is enjoying this role a great deal. Finds her coprolalia symptoms are abated by keeping busy.

Is also maintaining a very busy schedule of after-work exercise and activities which have been very helpful. Physical exercise especially is helping with physical pain and stiffness symptoms.

Constipation:
Now resolved through dietary changes..

Persistent Genital Arousal :
Is now back on schedule receiving percutaneous tibial nerve stimulation at uro-gyn for "urge incontinence" and for PGA, finding that symptoms are almost resolved.

PSYCHIATRIC REVIEW OF SYMPTOMS:

Patient's self-reported symptoms have been as follows:

1. Episodes (uncontrollable) of vocalizations, usually profane, occurring mainly while preoccupied with quiet work (reading, working on her laptop; usually happening while she is alone. Currently essentially resolved.

2. Ability to function well in structured environments where she has external stimuli to focus on (dance classes, swimming, court appearances, doctor's visits, work)-- now that she is working full-time, functioning is greatly improved.

3. Persistent genital arousal and orgasmic sensations, occurring during the same periods of internally focused attention as described above. These symptoms led her to seek a total hysterectomy 4 years ago.

4. Multiple Somatic Symptoms-- generally of the type of highly sensitive sensory processing (electricity moving through her limbs and neck; extreme sensitivity to sounds, physical sensation of clothes;chronic pain in neck, back, hips, etc.). Greatly improved overall, possibly due to increased physical activity and/or to med regimen.

5. Mood Symptoms: Denies depression, anxiety, mania.

6. Psychosis sx: None. No hallucinations, no overt delusional material currently endorsed.

7. No suicidal ideation, no homicidal ideation.

Substance Use History

Denies.

Psychiatric History

--Hospitalized in 2012 (involuntary).
-- 24h ambulatory EEG by Dr. John Worley done in 2016, during which she had some of her typical spells (she played her personal video recording from that time and the spells appeared similar to the others reviewed.) EEG was reported as normal, including during those spells.
--Reports a 3 hour EEG done at Mayo Clinic in January 2017 - results of this are not available, but she reports the study was normal, however she had no episodes during it. MRI brain reportedly also done at that time was reportedly normal.
--Neuropsych testing completed June 2017 at Courage Kenny was consistent with Delusional Disorder and Dissociative disorder

-- Reports an abusive marriage, with physical and emotional abuse. Divorce occurred 3 years ago-- has been attempting to fight husband in court since then on various issues.

Pt experienced bed-wetting as a child, until about the age of 11.

Denies other earlier affective sx, neurologic sx, physical sx.

Psychiatric Medication Trials

"Bad reactions" to psychiatric medications in past.
Does not want to take medications per se, though has found gabapentin and lorazepam helpful, especially in assuring that she has a good night's sleep.
Unable to say if Prozac has been helpful-- is puzzled as to why an antidepressant might be useful when she does not feel depressed. Willing to continue it for the time being.

Social/ Family History

Currently employed 25 hours a week.

Had been having supervised visitation rights with her children for 4 hours every 2 weeks. They are now 15. And she would like to see them more spontaneously.

Reports she was trained as a software design engineer-- used to work in architectural project management.

No known family history of mental illness, per patient's report. Pt is the eldest of 2 girls, raised in a traditional patriarchal Indian fmaily in Mumbai. Father had an explosive and domineering temper-- often yelled at her or hit her. Pt says he would then withdraw and keep to himself. Father was a highly successful chemical engineer, with his own company.

Medical / Surgical History

Patient Active Problem List

Diagnosis

- Transient alteration of awareness
- Spell of altered consciousness
- PA (pernicious anemia)

Past Surgical History:

Procedure	Laterality	Date
• GYN SURGERY *hysterectomy*		
• HYSTERECTOMY		12/26/2017

Allergy

Escitalopram; Flexeril [cyclobenzaprine]; No clinical screening - see comments; Percocet [oxycodone-acetaminophen]; and Tylenol [acetaminophen]

Current Medications

Current Outpatient Medications

Medication

- cetirizine (ZYRTEC) 10 MG tablet
- cloNIDine (CATAPRES) 0.1 MG tablet
- docusate sodium (COLACE) 100 MG capsule
- FLUoxetine (PROZAC) 40 MG capsule

- gabapentin (NEURONTIN) 800 MG tablet
- linaclotide (LINZESS) 145 MCG capsule
- LORazepam (ATIVAN) 1 MG tablet
- plecanatide (TRULANCE) 3 MG tablet
- polyethylene glycol (MIRALAX) 17 GM/Dose powder

No current facility-administered medications for this visit.

Vitals	**3, 3**

not currently breastfeeding.

Mental Status Exam	**9, 14 cog gs**

Alertness: Alert.
Orientation: O x 4
Gait and Station: Not observed due to telehealth visit..
Appearance: Not observed
Behavior/Demeanor: Cooperative, very engaged with the conversation. Strongly expressive.
Speech: Clear, coherent, articulate. Flow of speech is very rapid and pressured,difficult to interrupt. No speech abnormalities.
Language: Language use WNL. Excellent vocabulary. Much more spontaneous in her communications.
Psychomotor: Not observed.
Mood: Mood is "good", seems slightly irritable.
Affect: Affect is full range.
Thought Process/Associations: Rapid.
Thought Content: Able to focus on her many accomplishments over past 24 months and her many improvements.
Perception: Denies hallucinations or illusions. Somatic hyper-sensitivities and joint/muscle pain as described above.
Insight: Good insight into her strengths, open to accepting positive feedback for all of the gains she has made.
Judgment: Understands she has a neurologic disorder, does not feel she has any psychiatric issues.
Cognition: Appears to be of good general intelligence, with cognition more connected to affective state than previously. Cognition not formally tested at this session.
Attention: Intact.
Concentration: Intact.
Recent Memory: Intact.
Remote Memory:good.
Fund of Knowledge: Good.

Assessment	**m2, h3**

Atypical Tourette's syndrome
Persistent Genital Arousal Disorder

This has been an unusual psychiatric picture in this 49 year old divorced South Asian woman with episodic coprolalia since 2010 (when she had a breast lumpectomy). Also has PGAD, and in the past had concerns about mind-control and electronic harassment/stalking (by ex-husband). These concerns are no longer present.

Over the past 2 1/2 years she has shown impressive symptomatic and functional improvement, which I attribute to a combination of her self determination, structured and productive activities, and adhering with her med regimen. Her engagement in work and recreational activities along with her now stable living situation have contributed to improve

her self-efficacy, which has increased her ability to handle the stresses of her remaining symptoms. Better sleep is also likely contributing to her improved overall function.