The case of PNP

Name:	P N P
Age:	61 years old
Gender:	Female
Race:	Chinese
Religion:	Taoism
Occupation:	Housewife
Marital status:	Widow
Informant:	The entire history was elicited from patient's daughters because she was unable to give any history due to her illness.

CHIEF COMPLAINT:

1) Progressive memory loss for more than 2 years;
2) Disturbing behaviour over past 4 months.

HISTORY OF PRESENTING ILLNESS:

Madam PNP was previously a healthy and active lady but she started to show some sign of forgetfulness for more than 2 years.
It happened very gradually and only become noticeable by her family members towards the end of 1999.

Initially she would forget about the things she wanted to say, the things she wanted to do and misplacing her belongings.
Her daughters who lived with her regarded these as 'normal' process of aging.
They became more concern when patient's forgetfulness deteriorated.
Patient frequently forgot where she had put her money and clothes. She would be searching the whole house for her belongings.
Sometimes it frustrated her so much that she started to cry.
She would also accuse someone of trying to steal her things.

There were occasions when patient wandered out of house purportedly to visit her neighbours but failed to find her way about.
She would wandered around her neighbourhood looking lost.
Fortunately she was always found by her daughters or neighbours who would bring her back home.
Therefore, the gate was locked fearing she would wander off again.

She failed to remember the important events and dates.
In the past, she always made early preparation for festivals but had not been doing so since last year.
She could not remember who were her relatives and lately failed to remember her daughters' names.

There had been a gradual impairment in her functioning level.
She was unable to perform house chores like cooking and washing dishes.
She could not do simple tasks like feeding herself and wearing her shoes.
She had deteriorated to the extent that she neglected her personal care and hygiene.
She could not brush her teeth, comb her hair, bathe herself nor wash herself after ablution.
She would pass urine and faeces in her clothes unless brought to the toilet regularly.
In other words, she depended on her daughters to care for her.

About 4 months prior to consultation, her condition took a turn for the worse when she started to behave like a child.
She frequently threw temper tantrums when her daughters were slow in helping her.
They had troubles understanding what patient wanted, in addition, she would cry for no apparent reason.
Lately she started to talk to her image in the mirror.
She also appeared to be conversing with the characters in movie played on the television.
Her daughters complained about patient walking about the house in the middle of the night talking to herself.
In a few occasions, she claimed someone was trying to come into the house to catch her, hence she wanted to run out of the house.
She was difficult to control at home due to her disturbing behaviour, thus, she was sent to the hospital for admission.

PAST PSYCHIATRIC HISTORY:

Patient had no past psychiatric illness prior to this.

PAST MEDICAL/ SURGICAL HISTORY:

She was treated for diabetes mellitus with oral hypoglycemic drug which was advised by the doctor to stop 8 years ago, instead she was to continue her diabetic diet.
She had no hypertension, cerebrovascular accident or trauma to the head.

FAMILY HISTORY:

Not much was known about patient's family background from her daughters, except that she was probably the 6th child among her 12 siblings.
Her parents passed away before her daughters were born.
Her daughters were unaware of any similar illness among her 1st degree and 2nd degree relatives.

PERSONAL HISTORY:

Birth and Developmental history:

Patient was born at home, assisted by the village midwife.
There was no perinatal complication.
She had normal developmental milestone and no significant childhood illness.

Academic and Occupational history:

She studied in a Chinese school up to Primary 6.
She had average result but stopped schooling because her parents believed a girl should learn the skills to be a good housewife, rather than becoming an intellectual.
She was sent to learn tailoring.
She became a seamstress and continued her trade from home even after her marriage.

Relationship history:

Patient met her husband in her early 20s.
They got married soon after and it was a love marriage.
Her husband was 3 years older than her and worked as a businessman selling clothes.
Patient's daughters described him as a loving and caring man.
Their marriage was a happy one with no serious quarrels or fights.
Her husband passed away 10 years ago at the age of 54 due to stroke.
Although she was sad, she did not exhibit pathological grief or symptoms amounting to a depressive disorder.
She had 3 daughters from her marriage.
They are now aged 37, 35 and 25 years-old.
The eldest daughter had married, patient is currently living with her other 2 daughters.
They had good relationship among each other.

Other relevant personal history:

Patient attained menopause around 54 years old.
She was a non-smoker.
She did not abuse any illicit substance.

PREMORBID PERSONALITY:

Daughters described patient as a loving, caring and responsible mother. She was strict but fair to all her children.
She never complained about her housework, on the contrary, she sewed clothes for her neighbours as an additional income.
She was an extrovert who liked talking and socializing with neighbours.
She could easily make friends and be kind to them.
On the other hand, she was particular about cleanliness and tidiness but not to an excessive extent.

MENTAL STATE EXAMINATION (7.6.2001):

General appearance and behaviour:

Patient was an elderly Chinese lady.
She looked thin and frail and stooping at her shoulder.
Although she appeared neat in hospital attire, her hair was not combed properly and looked ruffled.
She was sitting on her bed starring at the doctor with hardly any body movement.
She had a sad look, at times frowning her forehead appearing perplexed.

Speech:

She did not appear to understand the questions asked, but stared blankly at the doctor.
She would only answer irrelevantly when the questions were repeated many times.
It was hard to understand and follow he flow of speech.
No perseveration noted in her speech.
She only answered her name correctly.

Affect and Mood:

She had a perplexed look, at times appearing sad and worried.
She was not tearful for the duration of the interview.
She was noted to be crying at home for no apparent reason and had never told anyone that she was depressed.
She had not done anything to harm herself to suggest suicidality.

Thought and Perception:

It was difficult to elicit any history of hallucination because the only time she seemed to be talking to herself was when she looked at her mirror image, and ‘conversing’ with the characters played on television.
She was not noted to talk or mumble or gesture to an unseen person although there were times when she mumbled to herself at night.

On the other hand, she did have persecutory delusion. She was noted to run and hide herself at home, when questioned by her daughters, she claimed there were people outside the house wanting to catch her.

Orientation:

She mumbled irrelevantly when questioned, thus, unable to assess her orientation to time, place and person.
She kept saying, " I don't know, I don't know", when pointed out her daughters to her.

Memory, Attention, Concentration, Intelligence, Judgement and Insight:

These remaining mental state examination could not be assessed because patient was not able to answer the questions posed.

PHYSICAL EXAMINATION:

Patient was a medium built lady.
She walked with careful small steps.
There was no shuffling gait, tremors, bradykinesia or rigidity.
She did not have pallor, jaundice, clubbing, pedal edema or cervical lymphadenopathy.

Blood pressure: 130/90 mmHg.
Pulse rate: 88/ min, regular, normal volume and character.
Afebrile.

Central Nervous System:

Cranial nerves were intact.
She had normal fundoscopy.
The tone, power, reflexes and sensations were normal in both upper limbs and lower limbs.
Glabellar tap, rooting reflex and grasp reflex were normal, i.e., no frontal release sign.

Cardiovascular System:

1^{st} and 2^{nd} heart sounds were heard, there was no murmur.

Respiratory System:

Lung fields were clear, air entry equal bilaterally.

Abdomen:

Soft, non-tender.
No mass palpable.

Mini Mental State Examination (Folstein, 1975) was attempted but patient could not answer or follow the instructions.
Psychological Assessment:

Patient lacked response, oblivious to her surrounding, difficulty in following instructions. She had blunted mood, limited emotional expression, very restless, very disorientated.

1) *Clock drawing* was attempted but she only follow the circle, not writing the number on the clock face.
2) *Rey Auditory Verbal Learning (RAVLT)* was attempted but she did not give any response.
3) *Dementia Rating Scale* was attempted but she was not responsive.
4) *Activities of daily living;* requires assistance for basic personal care.
   Impression: she is now in the Moderate severity stage of dementia.

SUMMARY

PNP is a 61 year old Chinese widow who lives with her two daughters. She was noted to be progressively forgetful, especially for the past four years. She had often misplaced her things, forgotten important events and dates, and names of her relatives and close family members. she also had difficulty naming and recognizing things. In addition, she could not do the house chores and unable to take care of her own personal needs. This deterioration in her cognitive function warranted her daughters to care for her as it impaired all her areas of functioning. Her conditioned worsened and few months abck when she started to show signs of regression and experiencing persecutory delusion.

She did not have other psychiatric illness in the past. However, she was treated for diabetes mellitus before. Mental state examination showed an elderly, frail lady with perplexed look. She hardly answered to questions, and sometimes spoke irrelevantly. She looked puzzled, anxious and easily distracted. Other cognitive functions are unable to be assessed. Physical examination showed dullness of percussion over the upper part of left lung, with reduced air entry possibly a consolidation. Further tests are recommended.

PROVISIONAL DIAGNOSIS:

290.10 DEMENTIA OF THE ALZHEIMER'S TYPE, WITH EARLY ONSET.

After the write-up of her case, Mdm. PNP showed the following progress:

Investigations:

7.6.2001

Haemoglobin	12.6 g/dl
Total white count	7.5 x 10 9/L
Platelets	259 x 10 9/L
Fasting blood sugar	6.6 mmol/L
Sodium	138 mmol/L
Potassium	**3.2 mmol/L**
Urea	3.6 mmol/L
Liver Function Test	Normal
VDRL	Non-reactive
HbsAG	Negative
Anti HIV 1 and 2	Negative

Chest Xray:
Left upper lobe mass.

20.6.2001

CT-Brain:
No focal enhancing brain lesion. The ventricles and sulci are prominent consistent with atrophy.
No midline shift or mass effect.
No metastasis to the brain.

CT-Thorax:
Carcinoma of the lung (upper lobe of left lung).
Suggest FNA for definitive diagnosis.

5.7.2001
CT-guided biopsy of the lesion in upper lobe of left lung shows Adenocarcinoma of Lung stage 1.
Patient's family opted for radiotherapy and chemotherapy.