Student’s Name: Edwin Rono

Adm no: H31/2193/2010

**ANXIETY DISORDER CASE**

**BIODATA**

Name Paul Kamau

Age 40 years old

Gender Male

Marital status Married

Occupation subsistence Farmer

Religion Christian

Residence Murang’a

**MODE OF REFERRAL**

The patient voluntarily admitted himself to the patient support centre in Kenyatta National Hospital.

**CHIEF COMPLAINT**

Mr. Kamau said that he has had sleep disturbance and insomnia. Sometimes he could sweat a lot and would hear his own heart beat. He also added that he was tense for no reason especially where there is an unfamiliar crowd. He also had headaches and tremors.

**HISTORY OF PRESENTING COMPLAINT**

The patient was well until around the 31st January 2013 when he started experiencing the above mentioned symptoms.

**PAST PSYCHIATRIC HISTORY**

Mr. Kamau said that he started experiencing these symptoms in 1999. He used to work at a construction site and normally sometimes there was no job. He says he got stressed one day out of frustration and that’s when the symptoms started. He said he checked into a hotel and he was unable to take the tea he had ordered due to fear of the people that were looking at him. Since then he has been treated several times in various hospital with episode of relapses. He was admitted for 4 days at Mathari mental hospital in 2006

**PAST MEDICAL HISTORY**

In 1999, the patient contracted syphilis after having unprotected sex. He was then treated at a local dispensary the same condition relapsed after two weeks and since then there has been instances of relapse. The latest relapse was early this year, though he a\has not sought medical attention on the same. He was also been diagnosed with meningitis in 2005 and 2006 where He was admitted at KNH and Mbagathi District hospital respectively.

**FAMILY HISTORY**

The patient was the fifth born in a family of six children;

1) John Gitau-51yrs-works at Kenya power, educated up to form four

2) Mary Waithera-born 1967 died 2010 due to breast cancer.

3) Patrick Irungu -DOB unspecified, deceased in 2005, unspecified illness

4) David Njoroge, age 41, a nurse at Kenyatta national Hospital

5) Duncan Gathetu –age 38yrs-Businessman, reached form four

**PERSONAL HISTORY**

**a) Prenatal, perinatal and early childhood**

His birth was through normal delivery, He has normal childhood

**b) Education**

Mr. Kamau stated nursery at 7 years in Gathera Nursery school. He then joined Gathera Primary school where he scored 299/700 marks. He had many friends in school. He joined Gathera Sec school in 1991where was expelled in form 2 after leading students strike. He then joined Maragua Sec School for form three and four. He has never gone to checked His results..

**d) Social habits and hobbies**

The patient used to drink alcohol but he has since stopped. He is not very clear about his hobbies

**e) Psychosexual history**

The patient had his first sexual experience in 1991.since then, he has had multiple sexual partners.

**Marriage and family**

He is married with two children, one about 6yrs and the other 1 yr. 4months old.

**f) Forensic history**

The patient has been arrested twice before, for being drunk and disorderly.

**g) Drug and alcohol use**

The patient said that he was a social drinker in the past but could not say the exact number of bottles. He has since stopped drinking. He has no History of smoking.

**h) Pre-morbid personality**

The patient said that he had a positive outlook in life, was more outgoing and interactive with other people before he became sick. He also handled his work more efficiently.

**i) Vegetative history**

The patient has good appetite. He also has no problems with his bowel movement and his urinary habits were normal. He sleeps well.

**MENTAL STATUS EXAMINATION**

**General appearance**- the patient’s appearance was good. He looked well- groomed and well- kempt. He has a good, relaxed posture and a normal gait. His motor activity is normal and could maintain eye contact. The patient is able to establish a rapport easily with.

**Speech**- the patient had neither poverty of speech nor pressured speech. The speech had a normal rate, volume and pitch.No neologism, or echolalia was noted.

**Mood**- the patient had a euthymic mood.

**Affect**- mood and effect is congruent. The depth of affect was normal.

**Thought process**-the patient had no thought block, no word salad, and no flight of ideas or tangentiality . It was generally normal.

**Thought content**- the patient has had suicidal thoughts, though he has never acted on them. He has had no delusions

**Perception disturbances,**

-No hallucinations or illusions.

**COGNITIVE FUNCTION**

**Orientation**- the patient was well oriented in time, place and person.

**Concentration and attention**- the patient’s concentration was normal at the time of examination. He was able to list the days of the week backwards.

**Memory**- the patient’s immediate and long term memory was intact. He could remember events that had happened in the past with ease.

**Judgment**- good; the patient was asked to describe what he would do if he found a child was inside a burning house and he responded as expected of a reasonable person.

**Abstract thinking**- good; the patient was asked to interpret a common saying. Insight- the patient was aware that he was unwell and he believes that the medication that he was being provided with was helping him

**FORMULATION**

Paul Kamau a 40 year old male from Murang’a ,married with two children aged six and one, HIV positive from collaborative history presents to the psychiatric out-patient clinic complaining of headache, palpitation, intense fear for unfamiliar crowd accompanied by tremors and lack of sleep. He has had history of meningitis nine years ago and was diagnosed with syphilis 15yrs ago where relapse has been noted. He has been treated for depression before.

He has ever smoked bhang and cigarettes.

He used to smoke cigarettes but he has since stopped.

The cognitive functions were normal.

**MULTI AXIAL DIAGNOSIS**

**Axis I (Principal diagnosis)**

**Anxiety disorder**- the patient’s main complaint is fear of crowded places. He had palpitations and hyperhidrosis

**Other Differential diagnosis**

**a) Panic disorder**

The patient reported that he was tense persistently. He had some of the classic symptoms of panic disorder; palpitations and hyperhidrosis.

**Axis II (Personality disorder**)-none

**Axis III (General Medical Condition)-** The patient has been diagnosed with HIV, recurrent Syphilis and Meningitis

**Axis IV (Psychosocial/Environmental stressors)**

1) Lack of employment-The patient has no job to sustain his family and he is very frustrated about it

2) Lack of money-he has no money due to lack of any source of income

3) He is concerned that his age is advancing and his friends are rich while he is not

**Axis V (Global Assessment of function)-**71-80

Though the patient is unable to get employment, He is still able to live a basic normal life. He checked into the outpatient by himself and is able to live in the community well.

**MANAGEMENT PLAN**

**Investigation**

This should be done to rule out organic causes of the disease

-HIV CD4 count to ensure his immunity is maintained.

-Laboratory tests to confirm if there is any relapse of syphilis

**Treatment**

**Psychotherapy**

The patient should be advised to accept his condition and ensure he stays in an environment familiar to him.

**Cognitive behavioral therapy**

A Behavioral program of graded exposure and cognitive appraisal of the situation should be instituted. Its main aim is to reduce anxiety.

**Pharmacotherapy**

Anxiolytics such as benzodiazepines and tricyclic antidepressants like doxepin and buspirone

**PROGNOSIS**

The prognosis is generally good with adequate counseling of the patient.