Clinical Case Study

56 Year Old Black Male with Alcohol Induced Alzheimer’s Disease, Alcoholism and Substance Abuse

**Chief Complaint:**“I’m here because she is trying to get me in trouble and put me away!”

**HISTORY OF PRESENT ILLNESS (HPI)**

Mr. W. is a 56 year old black male with ongoing symptoms of alcohol induced Alzheimer’s disease with recent exacerbation from a 3 week long drinking binge of beer and vodka. Mr. W. is accompanied today by his wife who is his caregiver. Mr. W. states that he did not drink any alcohol and his wife is lying to get him into trouble and take his money. Mr. W. states “All she has ever wanted was my money and she is trying to have me put away so she can get rid of me”. Wife states he has no memory of his drinking and has been very” belligerent” to her and the family and it is getting worse. At times she states he becomes violent and she is scared for her safety. She also states there is now a 2 year old grandchild in the home and she does not know how much longer she can put up with his drinking.

Mr. W. has a long history (37 years) of domestic violence and verbal abuse with his wife and children. Wife states that Mr. W. has become increasingly easily agitated and is sneaking out of the house and driving the car to get alcohol. His driver’s license has been suspended due to numerous DUI”s. She states she tries to disable the car and hide the keys but he manages to find the keys and fix the car. She says he also calls his brother or friends to come and get him or bring him alcohol. She has taken away his cell phone but then he goes to the neighbor’s house and uses their phone.

Most recent episodes include Mr. W. climbing out a 2 story window of his home and sitting on the roof and yelling at neighbors and family members. Mrs. W. also states that he is urinating out the window and exposing himself to people. She states he recently went into her closet and took a bunch of her clothes and stabbed them with a knife and defecated on them. She also states he is now yelling at the toddler and throwing things at the wall. He recently took $3000 out of the checking account and cannot account for the money. He has lost 12 pounds since his last visit one month ago and is not sleeping at night. He does nap for short periods of time during the day. She feels he is noncompliant with his medications and refuses to let her help him. Mrs. W. does also mention that he is starting to drop things and stumble when he walks, she was not sure if this relates to his alcohol consumption or if there is an underlying problem.

**PAST PSYCHIATRIC HISTORY**

Mr. W. has a long history of domestic violence and being verbally abusive to his family. He has been hospitalized 4 times in the past at Camden Clark Memorial Hospital on the behavioral health unit for up to 30 days at a time. Most recent hospital admission was 1 year ago. Mr. W. states he is unaware of any hospitalizations in the past. He also states he has never been “mean” to his family. Mrs. W. states that she feels he has suffered from depression and anxiety most of their marriage but was never diagnosed or treated. She states he has also spent time in jail due to domestic violence and assault on a police officer. She also states that he has said in the past that he has heard voices telling him to drink alcohol and gamble. He states he was told by the voices that he would win the lottery. He states he thinks he did win the lottery years ago but his wife spent the money. She denies he won the lottery.

**SUBSTANCE USE HISTORY**

Alcohol use started when he was 12 years old and he states he has consumed alcohol ever since then but does not see a problem with that. He drank a case of beer every 2 days. Sometimes (2 times a week) he would drink a couple of shots of vodka. He also has a history of cocaine use and Percocet abuse. Mrs. W. states he smoked pot as a teenager into adulthood and would still do it if he could get it. Last usage of pot was 1year ago that she knows of. She also states he has smoked cigarettes since he was 13. He currently smokes a pack of cigarettes a day. Mr. W. states he does not currently smoke or drink. Mrs. W. states she thinks he currently drinks about 1-2 6 packs a day.

P**AST MEDICAL/SURGICAL HISTORY**

Mr. W. has a history of hypertension and hyperlipidemia and BPH. He has had no surgeries in the past. He has had several broken bones in his hands from hitting walls and people. He was in a MVA in 1978 where he sustained a broken right femur. He also sustained a head injury in 2000 from being thrown from a horse. He was on life support for 2 weeks. On occasion, he also suffers from Gout in his left great toe which he feels he is having a flare up of it now. He is scheduled for a hearing test and an eye exam in one week. Wife stated he always has the television turned up loud. She also states that he says people are talking too loud in conversations and he often puts his hands over his ears. She states she is worried he is hearing voices but won’t admit it.

**CURRENT MEDICATIONS**

* Abilify 5 mg by mouth daily in the morning.
* HCTZ 25mg by mouth daily in the morning
* Aricept 5mg by mouth daily in the morning
* Pravastatin 40mg by mouth daily at bedtime
* Trazadone 50mg by mouth at bedtime

**ALLERGIES**

* Sulfa, cats.

**FAMILY PSYCHIATRIC HISTORY**

Mr. W. was adopted at age 5. He was in foster care from birth. He does know who his birth mother is. Mrs. W. states that his adopted mother suffered from depression, adopted father had no history of psychiatric illness. Mrs. W. states birth mother had mental health issues, she thinks she was bipolar. She also states that birth mother was an alcoholic and drank while pregnant and had no prenatal care. Birth father is unknown. Grandparents are not known. No known biological siblings but one adopted brother who has no psychiatric problems or substance abuse and is a successful business owner.

**SOCIAL HISTORY**

Mrs. W. does not recall hearing anyone mention about any complications at birth. She also states she has not heard anything about his childhood before the age of 5 due to him being in foster care. He was born in Marietta Ohio and taken by the state at age 3 weeks. To her knowledge he has no biological siblings. Birth mother died at age 26 from suicide. His highest level of education is 10th grade he does have a GED. Mr. W. states he struggled in school and did not get along well with others and was often suspended. He states he had a few friends and was considered the class clown. He is presently unemployed. He was fired from his job 1 year ago for coming to work drunk and embezzlement. He lives with his wife and 2 year old grandson. His children live at the home on and off. He is not social with friends and only goes to the store to get beer, gamble or to a doctor appointment. He lives in a single dwelling 2 story home on .5 acres in the city. He has several industrial plants near his neighborhood. He has no pets. He does admit to having an abusive relationship with his wife and he states it was mostly because of her greed for money. He has had past legal problems as a young man for battery against a policeman. He states his financial situation is bad due to his wife stealing all of his money. Mrs. W. States there is no military history. Mr. W. denies any sexual abuse.

**Review of Systems**

**General:** Reports a 3 pound weight gain over the past 2 week and thinks it’s from his drinking along with the increased abdominal girth. Wife is fearful it is his liver failing.

**Neurological:** Denies any LOC alterations, positive for problems with cognition, motor and sensory abnormalities. He states that people are talking too loud and often covers his ears during a conversation. He does admit to hearing voices in the past. Gait is unsteady and he is dropping items. He does experience problems with concentration and memory on a daily basis.

**HEENT:** Denies headaches. Describes vision as poor, needs new glasses. Denies pain, blurred vision and visual problems other than when trying to read. Denies obvious hearing loss, vertigo, earaches, infection or discharge.Last dental exam is unknown

**Neck and Lymphatics:** Denies lumps, swollen glands, goiter, or other thyroid enlargement or pain.

**Chest and Lungs:** Denies dyspnea, cough, sputum, hemoptysis, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, or pleurisy.

**Cardiac:** Denies known heart disease, cardiac murmurs and is positive for hypertension. Denies history of rheumatic fever, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, edema, chest pain, or palpitations.

**Peripheral Vascular:** Denies peripheral numbness, paresthesia’s, and coldness of extremities. Denies intermittent swelling, claudicating, cramps, varicose veins, or thrombophlebitis.

**Hematologic:** Denies bruising or bleeding. No history of blood transfusions.

**Gastrointestinal (GI)/Abdominal:**  Occasional heartburn, denies any difficulty swallowing, or food intolerance. No complaints of abdominal discomfort but positive for increased abdominal girth for the past month of about 1 inch. Denies liver and gall bladder disease, jaundice, or hepatitis.

**Urinary**: Positive for polyuria and Nocturia. Denies any dysuria, hematuria, urgency, hesitancy, incontinence, infections, or stones.

**Genital:** Denies infections or discomfort.

**Musculoskeletal**: Positive for bil knee and ankle joint pain and stiffness. Denies any arthritis, muscle pain or cramps in upper extremities or hips. No complaints of back pain. He complains of pain and swelling in his left great toe

**Skin, Hair, Nails:** Positive for red itchy rash on back, denies any lumps, dryness, color changes, or changes in hair. Nails are brittle and break easily.

**Hematological:** Denies any abnormal bleeding.

**Endocrine:** Denies known thyroid problems, neck swelling or discomfort, temperature intolerance, excessive sweating, diabetes, excessive thirst, hunger, and palpitations.

**Physical Examination**

**General**: Mr. W. is 6 feet 0 inches 174 pounds BMI 23.6.

**Vital signs**: Blood pressure 146/70, heart rate 80, and respiratory rate 20.

**MENTAL STATUS AND ASSESSMENT**

Mr. W. is a 56 y/o confused black man that looks older than stated age. He is oriented to place and season only. MMS score 17 and PHQ-9 score 3 (See attached). He is appropriately dressed for the season and appears clean and no smell of body odor noted, hair is short and neatly combed. ETOH odor present. His gait into the room was unstable and wife was holding him by the arm. His eye contact during the exam was minimal and he looked at the floor most of the interview only looking up to argue with wife. He carries a beverage with him and he dropped it several times. He is argumentive but stays seated and listens to the conversation. His affect was constricted and tense and he often fidgeted in his seat, facial expressions through most of the interview were strained and he often “rolled his eyes” while his wife was speaking. Most of the emotion demonstrated during the interview was anger at what his wife was saying about his drinking and behavior. He disagrees with almost everything his wife states that he is doing and repeatedly states she is trying to get him in trouble. His mood today is “pissed off” per Mr. W. and answers are loud and with a sharp tone. Mrs. W. states that his mood is unpredictable and often explosive when confronted. He denies any thoughts of self-harm or harm to others…he states he “just wants to be left alone” in his “man cave”. His speech is clear but broken up at times when he feels unsure of an answer. His thinking is irrational and clouded. He states he was never mean to his family and denies throwing things against the wall. His thought content and judgement is abnormal, he feels it is still ok to drink, urinate out of the window, expose himself to neighbors and defecate on his wife’s clothes and stab them with a knife. He also feels that he has won the lottery in the past but his wife spent the money. Mrs. W. states he “sits and dwells” on how she is stealing his money and is keeping him a prisoner in his home by not letting him use the phone. He often asks her the same question repeatedly. He seems to be worse at night. He does state he has heard voices telling him to drink and gamble and that his wife is out to steal his money. He denies visual hallucinations. He also states he feels he can manage the bills but has no idea what bill he has to pay. His insight is poor, he feels he can take care of his self and pay bills, but has no recollection of what bills he owes and cannot account for $3000.00 missing from his bank account.

*Given the neurotoxic effects of alcohol and the inexorable increase in per capita consumption, future generations may see a disproportionate increase in alcohol-related dementia. This could be compounded by the effects of increasing use of recreational drugs such as ecstasy, whose long-term effects on cognition are still uncertain. Detection of these cases could be improved by the use of screening tests like the Michigan Alcohol Screening Test combined with tools such as the Lifetime Drinking History interview. There is a need to develop tools for assessment of alcohol-related cognitive impairment. It is always difficult to motivate change in public behavior when there is a delay between the risk-taking behavior and the onset of complications. Need reference here.*

**Laboratory Data**

He has not had any recent lab work done. Last lab work done was 2 years ago. Pt is due for an appointment with PCP in 1 week and will have results forwarded to me. Pt states that he is very fearful of needles and usually passes out. Lab work that I would order is a CBC, CMP, TSH, FLP, Hemoglobin AIC, PSA, Uric Acid level, UA w/micro, vitamin B12, folate and Thiamine, urine drug screen. The reason I would order these tests are to check liver function due to alcohol consumption, Also to check electrolytes, Also look for gout, due to complaints of big toe hurting at times. I would do a TSH to check thyroid function to rule out and thyroid disease. He also has a family history of diabetes. He would have a PSA done due to his age. Also since the patient is over 50, I would have him get an EKG and chest x-ray due to tobacco use.

*Routine laboratory studies are necessary for the purposes of screening for concurrent*

*disease states, ruling out organicity, and establishing baseline values of functioning.*

*Thyroid disease and other endocrine abnormalities can present as a mood disorder and*

*Cancer and infectious diseases can present as depression (Kaplan & Sadock, 2007).*

*According to WEBMD, there is a severs chance someone with a history of gout will have flare ups while on HCTZ*

*According to DiPiro, (pg. 820) vitamin B12, folate and thiamine should be checked for*

*Alzheimer’s and alcohol use.*

**Psychiatric Summary**

Mr. W. is a black 56 y/o male that is educated on a 9th grade level but has obtained his GED. He is suffering severe mood swings and aggression towards his family and the neighbors, He has been recently exposing himself to people and sneaking out of the house to purchase beer. If he cannot leave the house he calls a friend or relative to go get him beer and bring in to him at his home. He has been forgetting things more often and loosing common items such as a cup and his “Cheese it “box where he stores things he does not want other people to see. He has also become increasingly paranoid about being in trouble and going to jail. He is also experiencing more paranoia towards his wife and feels she is trying to steal all of his money. Wife and family are becoming more concerned about the fact that his memory is getting worse, his drinking is becoming more on a daily basis and now he is exposing himself to people from the window of his home. And, the fact that he is taking a knife and shredding and defecating on his wife’s clothes is disturbing to them. Mr. W. Denies doing this act and also denies hearing any auditory hallucinations. Mr. W. dies not recall much of his childhood due to his present condition. But his wife states his life was chaotic and he was in foster care and drank a lot as a teenager. She denies hearing him talk about sexual or physical abuse. Mr. W. does not feel he has any problems and that his drinking is in control and everyone is making up these stories to hurt him and get him in trouble. He feels his mood is always “pissed off” due to people “getting in his business”. He states he would like a divorce so he can live his life how he wants to. During the interview Mr. W. is easily distracted by any movement outside of the windows and puts his head down and pretends he does not hear the questions being asked and then becomes agitated when asked the same question several times.

**Diagnosis According to:** DSM V

ICD-9 Code: 291.2 Alcohol induced persisting dementia

ICD-9 Code: 305.00 Alcohol Use Disorder, severe

ICD-9 Code: 303.9 Alcohol Dependence

History of broken right femur 1978.

History of head injury in 2000.

History and current episodes of Gout

Tobacco use

*The DSM-5 (formerly DSM-IV TR) is produced by the American Psychiatric Association and*

*is utilized as a diagnostic tool for psychiatry.*

**Plan:**

***Safety***

At this time he is a risk for harm to himself and others, he is unable to make rational decisions. I spoke with the wife about documenting his outbursts and keep a cell phone near to call police and record the episode. We discussed about Mr. W. not being left alone in the home and making the window in his bedroom very hard to open. Also possibly keeping a urinal in that room for him would maybe decrease his need to urinate out the window. We also discussed about keeping the grandchild away from him. We also discussed the need to keep the car disabled or putting the keys in a very remote area and switch locations often

*According to the National Institute on Aging….think prevention, adapt the environment, and minimize danger. Some example to help the wife: install smoke alarms and carbon monoxide detectors in or near the kitchen and all sleeping areas. Check their functioning and batteries frequently. Avoid the use of flammable and volatile compounds near gas appliances. Do not store these materials in an area where a gas pilot light is used. Install secure locks on all outside doors and windows. Hide a spare house key outside in case the person with Alzheimer's disease locks you out of the house.*

***Alcohol/Substance Abuse***

We discussed the need for no alcohol in the home and limiting/eliminating ways for patient to get it. Talk to local stores and explain the situation and ask them not to sell it to him. Limit his cell phone usage. Talk to neighbors, friends and family about the health risks the patient is experiencing. I also recommended that the wife seek help through AA, NA and

*According to The National Institute of Health: Autopsy evaluations suggest that up to 78% of individuals with diagnosed alcoholism demonstrate some degree of brain pathology. Neuroimaging and neuropathological evidence show prominent white matter loss (most notable in the prefrontal cortex, corpus callosum, and cerebellum) and neuronal loss in the superior frontal association cortex, hypothalamus, and cerebellum. The frontal lobes of individuals with diagnosed alcoholism appear particularly susceptible to damage, with evidence of markedly decreased neuron density, volume shrinkage, and altered glucose metabolism and perfusion”. Also, another hypothesis is that thiamine (vitamin B1) deficiency is primarily responsible for the development of ARD. Individuals with alcohol use disorders are at particularly high risk of thiamine deficiency, not only from poor dietary nutrition but because alcohol directly compromises thiamine metabolism. (NIH)*

*According to DiPiro (pg. 1003), Alcohol-Attributable deaths report 80,374 U.S. citizens with medium and high average daily alcohol consumption die each year because of alcohol related causes, including collisions and cirrhosis of the liver*

***Medications***.

I reviewed his medications with his wife and agree with the above; however I would increase the Aricept to 10 mg a day to see if the dementia symptoms stabilize. I would stop the HCTZ due to the risk of causing more gout episodes, and allergy to sulfa. And start Lisinopril because it is kidney friendly and he has a family history of diabetes and he has not had blood work done in a while. Also, I would stop the Pravachol until his blood work results are in due to his use of alcohol, I would want to see what liver functions are.

*According to Stahl, the dose of Aricept can be increased to 10 mg and there is the possibility to increase to 23mg if needed and the patient tolerates it well. I would only change one medication at time so I can assess the efficacy or side effects of that change. Due to his symptoms, I would look into increasing the trazadone and Abilify later. I would stop the HCTZ due to his episodes of gout. Also Stahl mentions to closely monitor glucose levels as Abilify can increase the risk of diabetes, Diabetic Ketoacidosis and weight gain.*

***Diagnostic Studies***

I would order the above lab work and suggest that an EKG be performed for being on Abilify and due to the patient’s age and not having a good family history medical background. I would also recommend a screening colonoscopy and lung CT due to his history, race, age and current usage of tobacco.

*According to Stahl (2014), Abilify can cause hypotension, dizziness and dry mouth. There is also a chance of tachycardia from Abilify according to Rxlist.com*

*The American College of Gastroenterology recommends that African Americans have colorectal screening starting at age 45.*

*The recommendations are based on a careful review of several studies that looked at low-dose CT screening. The most significant was the National Lung Screening Trial (NLST). This study included more than 50,000 people aged 55 to 74 who were current or former smokers with at least a 30 pack-year history of smoking (equal to smoking a pack a day for 30 years, or 2 packs a day for 15 years). The NLST found that people who got low-dose CT had a 20% lower chance of dying from lung cancer than those who got chest x-rays. However, other trials found no benefit from screening.(The American Cancer society)*

***Education***

We talked about the importance of sleep for Mr. W. and for his wife. I advised the wife to visit the website “National Sleep foundation” which gives great tips for Alzheimer patients and the “sun downing “ episodes and how to reduce them. Keep a regular schedule, keep him exposed to as much light as possible during the day and at night keep the room as dark as possible, avoid caffeine. We discussed the importance of following through on safety plans and making sure the car is only drivable when she can drive it. We talked about her getting more information on this disease and keeping in close contact with his PCP. We also discussed the signs and symptoms of alcohol cirrhosis and the dangers of him continuing to drink.

*According to National Institute of health (NIH) Epidemiological studies suggest that individuals with Alcohol related dementia (ARD) typically have a younger age of onset than those with other forms of dementia, are more likely to be male, and often are socially isolated.*

***Support System***

We also talked about talking with the local police department and local stores that sell beer about his situation to keep everyone informed so they can assist her if needed. We discussed about her starting church. Keeping in touch with family members and allowing time for her by having someone come into sit with him a few times a week. She also has agreed to join an AA group and take her husband.

*According to DiPiro, (pg. 822 table 38-4) there is an abundance of resources for caregivers of persons with Alzheimer’s Dementia.*

***Therapy***

He is currently not in any therapy and is refusing to speak to a therapist. With his level of understanding and memory impairment, I’m not sure therapy would be beneficial, but is certainly an option. I recommended an adult day program that specializes in Alzheimer disease. I recommend Mrs. W. seek counselling to help deal with the alcoholism, past domestic violence and her depression. Also, an Alzheimer support group for caretakers. I will obtain a release of information from the patient to be able contact the PCP for continuity of care. I do feel he would benefit from art therapy and music. I also advised Mrs. W. to get some word puzzle books just to have him to try to concentrate on something and advised her to try and play checkers with him if possible.

*Health information privacy protections under HIPAA requires written authorization from individuals to release medical information (U.S. Department of Health and Human Services, 2003).*

*According to the National Institute on Aging, there are a number of support groups for caregivers across the nation.*

*According to everydayhealth.com, different non-pharmacologic therapies can help with stress or depression such as music, art, pet and religious therapy.*

***Monitoring***

BMI monthly for 3 months then quarterly, blood pressure at each visit, fasting glucose, Hemo A1C, fasting lipids within 3 months and then annually, CBC frequently during the first few months. Monitor weight. EKG baseline and annually. Perform a MMS exam as needed for change in mental status.

*Due to metabolic effect of atypical antipsychotics it is important to monitor BMI, lipids, glucose and blood pressure. It is important to check CBC due to possible drug induced leucopenia/neutropenia (Stahl, 2014)*

*According to the Journal of Psychiatric Research, a Mini Mental Status Exam is a practical method for grading the cognitive state of the patient for the clinician*

He will follow-up with this provider in 1 week to have blood work done and discuss further screening testing such as a prostate exam, colonoscopy and chest x-ray.

References:

American Cancer Society Retrieved from internet July 7, 2015

<http://www.cancer.org/cancer/news/new-lung-cancer-screening-guidelines-for-heavy-smokers>

American College of Gastroenterology retrieved from internet July 7, 2015

<http://gi.org/guideline/colorectal-cancer-screening/>

British Journal of Psychiatry retrieved from the internet July 8, 2015

<http://bjp.rcpsych.org/content/193/5/351.full>

DiPiro, J.T. (Ed). (2014). *Pharmacotherapy: a pathophysiologic approach* (9th ed.). New York, New York: McGraw-Hill/ Medical.

Everyday Health, Retrieved from internet June 10th 2015

<http://www.everydayhealth.com/alzheimers/non-medical-alzheimers-therapy.aspx>

Journal of Psychiatric Research retrieved from the internet July 8, 2015

<http://www.journalofpsychiatricresearch.com/article/0022-3956(75)90026-6/abstract>

National Institute on Aging Retrieved from internet on June 22, 2015

<https://www.nia.nih.gov/alzheimers/publication/home-safety-people-alzheimers-disease/what-alzheimers-disease>

National Institute of Health Retrieved from the internet June 22, 2015 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3580328/>

Rxlist.com retrieved from internet on July 7, 2015

<http://www.rxlist.com/abilify-drug/side-effects-interactions.htm>

Sadock, B.J. (2014). *Kaplan & Sadocks’s synopsis of psychiatry: behavioral sciences/clinical psychiatry* (Eleventh edition). Philadelphia: Wolters Kluwer.

Retrieved from the internet on June 25, 2015

<http://sleepfoundation.org/ask-the-expert/sleep-and-alzheimers-disease/page/0/1>

Stahl, S. M. (2014). *Stahl’s essential psychopharmacology: the prescriber’s guide*. 5th Edition, Cambridge, UK; New York: Cambridge University Press.

U.S. Department of Health and Human Services retrieved from internet July 8, 2015

<http://www.hhs.gov/ocr/privacy/hipaa/understanding>

WEBMD Retrieved from internet on July 8, 2015

<http://www.webmd.com/drugs/2/drug-5310/hydrochlorothiazide-oral/details/list-sideeffects>