021
PSYCHIATRY
MINI-OSCE

عن العباس بن عبد المطلب رضي الله عنه قال: قلت: يا رسول الله، علمني شيئًا أسأله الله. قال: "سَلِ اللهَ العَافِيَةَ". فمكثتُ أيامًا، ثم جئت فقلت: يا رسول الله، علمني شيئًا أسأله الله. فقال لي: "يا عباسُ، يا عمَّ رسولِ اللهِ، سَلِ اللهَ العَافِيَةَ في الدنيا والآخرةِ"

SPECIAL THANKS 😊

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صدقة جارية عن المغفور له بإذن الله، عمر عطية من دفعة 2023 – كلية الطب، الجامعة الأردنية

اللهم ارحمه واغفر له، وأنزلْه منزلًا مباركًا، ووسِّع مدخله. إنا لله وإنا إليه راجعون. لا تنسوه من دعائكم

1st Rotation

Q1: A 24 years old medical student was found wandering the streets at night saying someone is trying to kill him, he was brought to the ER by the police, he was confused, agitated and irritable.

1. Mention three possible deferential diagnoses (other than substance use induced psychosis).

Schizophrenia, Acute mania (bipolar disorder), brief psychotic disorder, delirium (due to an acute medical condition)

2. Mention three parts from history that help determine if the condition is drug induced or not.

The patient is a medical student: good premorbid functioning, and lots of anxiety with possible access to elicit drugs Agitation, confusion, irritability

Another possible answer (depending on what the doctor means by the question):

History of illicit drug abuse ---- Onset and duration of symptoms ---- History of previous episodes and past psychiatric history

3. Mention 3 agents common to cause hallucinations.

LSD, PCP, Amphetamines, mushrooms, cocaine, cannabis, ketamine, MDMA

4. Mention two drugs you could give in the ER to calm the patient down.

Lorazepam (benzo), haloperidol

5. What tests would you order?

Urine tox screen, CBC, electrolytes, LFT, KFT

Brain Imaging if trauma is suspected

6. Why would you admit the patient forcefully?

If he is a danger to himself and others or if his diagnosis requires inpatient psychiatric care

Q2: A 13-year-old girl, her teachers say lately her attention span has decreased and she gets lower marks in school, her IQ is very high, and she spends hours watching her favorite shows on YouTube.

1. What is the most likely diagnosis?

ADHD

2. If her symptoms were only in school but not at home would the diagnosis still be the same?

No

3. What is the difference between males and females in clinical presentation?

Males tend to be more hyperactive, females tend to present with more inattentive symptoms

4. Mention three drugs used for treatment.

Methylphenidate, dextroamphetamine, atomoxetine

5. What important parameter should be monitored in children using these drugs?

Child growth (height)

Q3: A young woman suffers from recurrent non triggered episodes of chest pain, shortness of breath, palpitations, flushing and sweating and she feels like she might die, she visited the doctor multiple times, and all tests came back normal, she is now afraid to leave the house because she feels something might happen to her.

1. What is the most likely diagnosis?

Panic disorder

2. What other medical conditions should be ruled out?

Acute coronary syndrome, hypoglycemia, hyperthyroidism, pheochromocytoma

3. How to differentiate between this and other psychiatric conditions?

Attacks are not triggered

Physical symptoms (palpitations, chest pain...) peak in minutes in an episodic pattern

There's characteristic "fear of fear "

4. What drugs are used for the treatment?

SSRI's

5. Mention three side effects of these drugs.

Insomnia, Anxiety, sexual dysfunction, GI disturbances

6. What other non-pharmacological measures can help?

Regular exercise, breathing exercises, avoidance of caffeine and alcohol

Q4: A young woman complains of excessive daytime sleepiness, and she says she is tired throughout the day; she goes to bed every night at 12 am but stays awake until 3 am, she gets less than 8 hours sleep a night.

1. What is the most likely diagnosis?

Insomnia

2. What noninvasive subjective method could be used to confirm the diagnosis?

Sleep log or sleep diary

3. Mention two short term drugs used in the treatment of the condition.

Benzodiazepines, zolpedim

4. Mention three reasons why can't we use these drugs for a long duration.

Dependence and addiction

Rebound insomnia after discontinuation

Cognitive side effects

5. If the patient sleeps more than 8 hours and is still tired and sleepy throughout the day what would be the diagnosis be?

Hypersomnia

6. What lifestyle changes could help?

Reducing caffeine intake especially at night --- Fixed sleep schedule --- Avoid screens before bedtime

Q5: A 60-year-old man suffers from depression, initially he refused pharmacological treatment and preferred psychotherapy, he now comes to you after failure of psychotherapy and would like to initiate pharmacological treatment.

1. What drugs would you give him?

SSRIs

2. How much time would these drugs need to start its effect?

4-6 weeks

3. For how long should it be continued?

6-12 months

4. What are the risks TCA's hold especially in his age group?

Antiadrenergic properties: ECG changes (risk of arrhythmias), increases risk of orthostatic hypotension, dizziness

5. Mention 2 antidepressants prescribed in smoking cessation.

Bupropion, Varenicline

6. Mention 2 major side effects of MAOI's.

Serotonin syndrome ----- Hypertensive crisis

2nd Rotation

Q1: A patient presents with a longstanding history of feeling persistently sad, lacking motivation, and having low self-confidence. He reports poor concentration and increased appetite (hyperphagia), but no sleep disturbances. He has no history of psychosis or mania, and he does not have suicidal thoughts or plans.

1. What is the most likely diagnosis?

Persistent Depressive Disorder (Dysthymia)

2. Are there more severe subtypes than this condition?

Yes, Major Depressive Disorder (MDD) is more severe.

3. What are 2 pharmacological and 2 psychotherapy treatment options?

- Pharmacological: SSRIs, SNRIs
- Psychotherapy: Cognitive Behavioral Therapy (CBT), Interpersonal Therapy

4. Which one has a worse prognosis: Persistent Depressive Disorder (PDD) or Major Depressive Disorder (MDD)?

Dysthymia (PDD)

5. Is hospital admission required?

No

6. What laboratory investigations should be done?

TSH, CBC, Vitamins

Q2: A patient is brought to the emergency department with pinpoint pupils (miosis), respiratory depression/failure, and altered mental status.

1. What is the diagnosis?

Heroin intoxication (opioid intoxication)

2. What should you give him immediately?

Naloxone

3. What substances can worsen the case?

Benzodiazepines, Alcohol

4. What household medication could give the same symptoms?

Cough syrup

5. What symptoms cannot be tolerated?

Constipation and Miosis

6. What medication used for Deintoxication?

Methadone

Q3: A patient presents with persistent intrusive thoughts related to religion. He reports experiencing repetitive blasphemous thoughts (about leaving his faith), followed by urges of repentance and asking for forgiveness. He describes these thoughts as unwanted, excessive, and distressing, and he tries to resist them but cannot. He has no psychosis or mania.

1. What is the diagnosis?

Obsessive-Compulsive Disorder (OCD)

2. Is there a high chance that this patient may commit suicide?

Yes

3. What other disorders can be associated with this diagnosis?

Tics, ADHD

4. What psychotherapy solutions can be used?

Cognitive Behavioral Therapy (CBT), Behavioral therapy

5. What is the difference between OCD and OCPD (Obsessive-Compulsive Personality Disorder)?

OCD is ego-dystonic, while OCPD is ego-syntonic

6. What are other types/subtypes of this disorder?

Contamination, Harm, Hoarding

Q4: A female patient thinks that everything around her is not real, including her own body and even her family. She feels detached from her surroundings and herself.

1. What is the diagnosis?

Dissociative disorder (Depersonalization/Derealization disorder)

2. Do you need to give this patient medications?

No

3. What other disorders are commonly associated with this condition?

Depression, Anxiety

4. What is the mainstay treatment?

Cognitive Behavioral Therapy (CBT)

5. What other diagnoses should be considered?

PTSD, Panic Attacks

6. What is the main difference between this disorder and Schizophrenia?

In depersonalization/derealization disorder, reality testing is preserved, while in schizophrenia, reality testing is impaired (psychosis).

Q5: A female patient, under 20 years old, presents with a BMI of 13. After eating, she does excessive exercise. She believes she is overweight, even though she is severely underweight. On examination, she has bradycardia, hypotension, hypothermia, lanugo hair, dry skin, and brittle nails.

1. What is the diagnosis?

Anorexia Nervosa

2. Is there an indication for admission?

Yes (because her weight is > 25% below optimal and her BMI is severely low)

3. What is the treatment?

SSRIs, CBT, and nutritional rehabilitation (food is most important)

4. What are the causes of death?

Suicide, Arrhythmias

5. What is a serious complication of treatment?

Refeeding syndrome

6. What is the appetite status?

Normal

3rd Rotation

Q1: A 29-year-old female is brought to the emergency department by her family, yet is full of energy during the day. She talks very rapidly, jumps from one topic to another, and becomes irritable when interrupted. She also approached strangers, claiming she had a "special mission from God."

1. What is the diagnosis (episodic and disorder)?

- **Episodic diagnosis:** Manic Episode
- **Overall disorder:** Bipolar I Disorder

2. What are the differential diagnoses?

1. Schizoaffective disorder
2. Schizophrenia
3. Substance-induced mania: due to stimulants (cocaine, amphetamines).
4. Cyclothymic disorder

3. What are the common causes of relapses in this patient?

1. Non-adherence to medication
2. Substance abuse
3. Sleep deprivation
4. Psychosocial stressors
5. Physical illness or medical conditions
6. Improper use of antidepressants

4. Is it associated with violence?

yes

5. What happens to the patient's:

- **Impulse control:** decreased
- **Speech:** increased (very talkative)
- **Need for sleep:** decreased

6. Does this disorder affect the patient's productivity and educational performance?

Yes

Q2: Regarding the previous question:

1. Give Two atypical antipsychotics that can cause hyperprolactinemia.

Risperidone, palipredone

2. Give Two drugs that can cause Stevens–Johnson Syndrome (SJS).

lamotrigine, carbamazepine

3. How do we know that the patient is compliant with his medications?

1. Improved mood and behavior
2. Regular follow-up visits with the psychiatrist and attending appointments on time.
3. No signs of relapse such as decreased sleep or increased activity.
4. Therapeutic blood levels of medication (especially for lithium or valproate).
5. Family confirmation that the patient is taking the medication consistently.

4. Give the therapeutics dose for lithium and valproic acid.

- **Lithium:** 0.8-1.2 mEq/L
- **Valproic acid:** 80-120 mcg/mL

5. Is a coarse tremor in a patient taking lithium a side effect or a sign of toxicity?

Sign of Toxicity

6. List 3 organs that require follow-up or monitoring in patients on long-term lithium therapy.

Kidneys, thyroid, heart.

Q3: A 35-year-old man presents to the psychiatric clinic after surviving a serious car accident in which his friend was severely injured. He required surgery for leg fractures and spent several months in the hospital. Since the accident, he reports sometimes wakes up sweating and panicked. He avoids talking about the event and tells his friends: Don't remind me of it

1. What is the most likely diagnosis?

Post traumatic stress disorder (PTSD)

2. What type of psychotherapy is used in the treatment?

Specialized form of CBT (CBT with exposure, cognitive processing therapy) (supportive/psychodynamic/couple/family can be used)

3. What are the main symptoms in this case?

1.Re-experiencing (Intrusion symptoms):

- Flashbacks or nightmares of the trauma
- Psychological distress when reminded (e.g., loud sounds trigger panic)
- Physical reactions (palpitations, sweating)

2.Avoidance:

- Avoids places, people, or conversations related to the event
- Refuses to discuss the trauma ("Don't remind me of it")

3.Negative alterations in mood or thinking:

- Guilt, detachment, emotional numbness
- Loss of interest in activities
- Persistent negative beliefs about self or world

4.Hyperarousal (Increased reactivity):

- Irritability, anger outbursts
- Hypervigilance
- Exaggerated startle response
- Sleep disturbance and poor concentration

4. When the patient hears loud noises, what happens to his symptoms? (Improved, Unchanged Exacerbated)?

Exacerbated

5. If this patient had not experienced a traumatic accident, what is the most likely diagnosis?

Adjustment Disorder (The doctor mentioned that 'Acute Stress Disorder' will also be accepted as a correct answer).

6. Do all people develop this disorder?

No.

Q4: A 75-year-old woman is brought to the geriatric psychiatry clinic by her daughter. Over the past year, her daughter has noticed that her mother has increasing difficulty concentrating and trouble managing daily tasks. She has also developed a stiff, some days she is alert and responsive, but on other days she seems drowsy and confused. The daughter reports that her mother has seen small animals in the house that are not there and sometimes talks to them.

1. What is the most likely diagnosis?

Lewy Body Dementia (LBD), (The doctor mentioned that 'Neurocognitive Disorder' and 'Parkinson's Disease with Dementia' will also be accepted as correct answers.)

2. What drugs are commonly used to manage symptoms?

1. Cognitive impairment: Cholinesterase inhibitors (donepezil, rivastigmine)
2. Parkinsonism: Levodopa (use cautiously; may worsen hallucinations)
3. Behavioral/psychotic symptoms: Atypical antipsychotics (quetiapine, clozapine at low dose)

3. What are the core symptoms in this case?

1. Cognitive impairment: attention, concentration, executive function
2. Fluctuating cognition: alert one day, drowsy/confused another day
3. Visual hallucinations: detailed, recurrent
4. Parkinsonism: rigidity, tremor, bradykinesia
5. Sleep disturbances: REM sleep behavior disorder

4. Why should dopamine agonists not be given?

Dopamine agonists can exacerbate hallucinations, delusions, and cognitive impairment in Lewy Body Dementia, so they are usually avoided

5. Which atypical antipsychotics are considered safer in this case?

Quetiapine, Clozapine

6. What drugs should be avoided?

1. Typical antipsychotics: haloperidol, chlorpromazine → risk of severe parkinsonism
2. Anticholinergics: benztropine, diphenhydramine → worsen cognition
3. Long-acting benzodiazepines: increase confusion and fall risk

"The doctor mentioned that any answer regarding delirium will also be accepted as correct."

Q5: A 25-year-old man is brought to a psychiatric clinic by the police after being arrested for stealing from a store. He has a long history of lying, stealing, and getting into fights since his teenage years.His friends describe him as manipulative, impulsive, and aggressive, and he has had multiple encounters with the lawsince he was a teenager.

1. What is the most likely diagnosis?

Antisocial Personality Disorder (ASPD)

2. What other diagnosis must he have had to develop this psychiatric disorder?

Conduct Disorder

3. What psychiatric disorder is he most likely to develop?

Substance Use Disorders

4. At what age must other psychiatric disorders (e.g., conduct disorder) develop to support ASPD diagnosis?

By age 15 "The doctor said that any number under 18 years old will also be considered correct."

5. Is he punishable by law?

Yes

6. Is there remorse?

No

4th Rotation

Q1: A 24-year-old woman presented to your office with painful menstrual cycles associated with heavy bleeding. Prior to menses, she complains of loss of appetite, fatigue, poor concentration and inability to enjoy social activities. These symptoms occur monthly before her painful menses. Answer the following:

1. What is the most likely diagnosis?

Premenstrual dysphoric disorder

2. How can you prove the diagnosis?

Daily ratings for at least 2 menstrual cycles

3. What is the treatment?

SSRI

4. Do symptoms improve or worsen in the perimenstrual period?

worsen

5. If the patient doesn't want to take the medication all days of the month, what alternative can you consider?

luteal phase only treatment

6. What treatment can be considered in severe refractory cases?

Bilateral oophorectomy with hysterectomy

Q2: A 30-year-old man is brought to the clinic with his wife. His wife insists that you examin him. He says " I don't see anything wrong with me". After talking to the wife, she states that " my husband is always accusing me of cheating on him, he insists on this idea and he said that you've made long eye contact with the man on the reception, I'm sure you're cheating on me." upon interviewing the patient, he insists on the idea of his wife cheating on him but has no proof of his claim at all.

1. What is the most likely diagnosis and what is the subtype?

Delusional disorder, delusions of jealousy

2. Mention other subtypes of the diagnosis?

Persecutory and grandiose

3. Is the patient expected to have auditory hallucinations?

NO

4. Compared to schizophrenia, does this disease have a better or worse prognosis?

Better

5. What is the treatment?

Antipsychotics

6. Is the wife at significant increased risk of harm by her husband?

yes

Q3: A 19- year- old patient is admitted to the ICU. She takes medications for a mental disorder. The patient is now sedated and you're speaking to the family. Upon admission, the patient was agitated and had hallucinations. Blood pressure is 180/90 and temperature is 40C. There is diffuse rigidity of the body.

1. What is the most likely diagnosis?

Neuroepileptic malignant syndrome

2. Mention 2 risk factors for developing this condition?

First generation or second antipsychotics with Genetic predisposition , initating treatment at higher doses IV/IM

3. Mention 2 treatments?

Dantrolene and Bromocriptine

4. Mention 3 elevated blood markers

creatinine kinase , myoglobin, leukocytosis

5. Should the patient be prescribed medication for her original illness?

YES

6. What are 2 differences between this condition and a similar condition?

Serotonin syndrome myoclonus and hyperreflexia

Q4: A patient is examined in your office. Before initiating treatment for mania, she has some questions regarding psychoanalysis.

1. What is Freud's 3 components of the theory of mind?

ID , EGO , SUPEREGO

2. Mention two principles of psychoanalysis

Transference and cotransference

3. What are the two types of conditioning in psychoanalysis?

Classical and operant

4. Is psychoanalysis indicated during the episode of mania?

NO

5. Mention 2 behavioral therapies.

Systematic deconditioning and aversion therapy

6. Mention 2 cognitive treatments in depression

Negative thoughts and cognitive distortions

Q5: A 5-year-old girl is brought to the clinic by her mother. The mother is concerned because the daughter rarely engages in social activities, makes poor eye contact and flaps her hands together. She has a favorite object that she doesn't let go off. Her height and growth parameters are measured and they're within normal range.

1. What is the most likely diagnosis?

Autism spectrum disorder

2. Is this condition more common in males or females?

Males

3. What are the 2 predictive indicators of prognosis in adults

Intellectual functioning and language

4. What medical test should be ordered before treatment?

Auditory hearing tests

5. What is the most common single genetic mutation associated with the disease?

Fragile x syndrome

6. What treatment is considered cure for this disorder.

Psychotherapy with behavioral but no cure

5th Rotation

Q1: A 24-year-old male who no longer enjoys activities he previously liked, presenting with low mood, psychomotor slowing (feeling heavy and difficulty moving his legs), weight gain, and hypersomnia (sleeps most of the day). He has a history of prior elevated mood and used to talk excessively.

1. What is the episode and what is the most likely diagnosis?

Episode: Major Depressive Episode

Most likely diagnosis: Bipolar II Disorder with atypical features

2. What is the meaning of rapid cycling?

The occurrence of four or more mood episodes (major depressive, hypomanic, or manic) in 1 year

3. Mention two evidence-based medications.

1- Mood stabilizers: Lithium (gold standard), carbamazepine, valproic acid

2- Atypical antipsychotics: Risperidone, olanzapine, quetiapine, ziprasidone (effective as monotherapy or adjunct for acute mania)

4. 2 features of atypical depression:

hypersomnia, leaden paralysis, Hyperphagia

5. Why do we not use SSRI as monotherapy in this condition?

Antidepressants are discouraged as monotherapy due to risk of triggering mania or hypomania

6. Factors that promote relapses.

Non-adherence to mood stabilizers, Substance abuse, Stressful life events and lack of support

Q2: Question about Medications

1. Mention 2 side effects of mirtazapine?

• Sedation, weight gain, increased appetite, dizziness, dry mouth, constipation, and (rarely) agranulocytosis.

• (Also fewer sexual side effects and fewer drug interactions compared to SSRIs.)

2. What subtype of antipsychotics cause Anti-HAM side effects?

Low-potency first-generation antipsychotics.

3. Does zolpidem cause dependence?

Yes

4. Why do we use anti dementia drugs for dementia patients?

To slow cognitive decline, reduce clinical deterioration, and improve daily functioning.

5. Mention 2 uses for pregabalin and gabapentin?

Gabapentin: Neuropathic pain**,** Adjunct for partial seizures

Pregabalin: Generalized anxiety disorder (second-line)**,** Fibromyalgia

Q3: A 25-year-old patient comes to the clinic requesting Adderall and Ritalin. He has mydriasis, blood pressure 150/90, and heart rate 120. While the doctor is documenting, he starts shouting and reports formication (feeling of insects crawling on his skin). He has a history of similar reactions before.

1. What is the most likely diagnosis?

Stimulant (amphetamine) use disorder with acute intoxication

2. Mention 2 withdrawal symptoms for this substance.

1- Prolonged depression, malaise, fatigue

2- Increased appetite

3. Mention FDA-approved medication for preventing relapse?

No FDA-approved pharmacotherapy for amphetamine use disorder

4. Type of hallucinations associated with it?

Tactile

5. Mention 2 deadly complications?

1- Rhabdomyolysis

2- Acute kidney injury

6. What treatment to give if the patient has mild agitation and intoxication?

Benzodiazepines

Q4: Question about Personality Disorders:

1. Mention two features of Borderline personality?

Unstable image of self; unstable interpersonal relationships; uses splitting as defense mechanism

2. What is the defense mechanism associated with Histrionic Personality?

Regression

3. Difference between schizoid and avoidant?

Schizoid prefers to be alone; avoidant prefers to be in relationship but fears rejection.

4. Mention 2 predisposing conditions for developing dependent personality disorder?

Medical illness, separation anxiety disorder

5. Mention 2 features of schizotypal personality disorder?

Odd beliefs and magical thinking

6. Do narcissistic patients have high or fragile self-esteem?

Fragile

Q5: Question about Sleep-Wake Disorders

1. Mention 2 non-benzo drugs for treatment of acute insomnia?

Melatonin & zolpidem

2. Main treatment for chronic insomnia?

Cognitive Behavioral Therapy (CBT)

3. Which psychostimulant drug is used in treatment of narcolepsy but not ADHD?

Modafinil

4. Sleep terrors Tx?

- Reassurance that the condition is benign and self-limited
- Most cases do not need treatment as they are self-limiting
- Education, reassurance, addressing precipitating factors, ensuring a safe environment, and proper sleep hygiene
- Refractory cases may respond to low-dose benzodiazepines (e.g., clonazepam)

5. During sleepwalking, is the patient awake or confused?

Confused

6. Hallucinations that arise while going to sleep?

Hypnagogic hallucinations

6th Rotation

Q1: A young man is brought to the emergency department by his father due to decreased level of consciousness. On arrival, the patient is drowsy and not fully alert. There is a noticeable smell of alcohol on his breath. Based on the history provided by the father and the clinical findings, the most likely diagnosis is acute alcohol intoxication.

1. How many units of alcohol does the liver metabolize per hour?

Between 15 and 35 mg/Dl per hour

2. At what blood alcohol concentration (BAC) do most people develop alcohol intoxication?

Most adults will show some signs of intoxication with BAC >100 and obvious signs with BAC >150 mg/dL.

3. On average, when do alcohol withdrawal symptoms begin after cessation of alcohol intake?

The earliest symptoms of EtOH withdrawal begin between 6 and 24 hours after the patient's last drink and depend on the duration and quantity of EtOH consumption, liver size, and body mass

4. If this patient presented two hours after drinking alcohol, would gastric lavage be useful?

No. Gastrointestinal evacuation (e.g., gastric lavage, induction of emesis, and charcoal) is not indicated in the treatment of EtOH overdose unless a significant amount of EtOH was ingested within the preceding 30–60 minutes

5. Why is a brain CT scan commonly performed in patients with acute alcohol intoxication?

To rule out subdural hematoma or other brain injury (which may be missed due to altered mental status and because intoxicated patients are at high risk of trauma).

6. Which electrolyte disturbance can cause seizures in alcohol-intoxicated patients?

Hypomagnesemia is a common electrolyte disturbance in chronic alcohol users and can lead to seizures. Hypomagnesemia may predispose to seizures; thus, it should be corrected promptly

(Other contributing factors may include hypoglycemia and hyponatremia.)

Q2: A woman in her 30s presents complaining of persistent fear about her performance in social and professional settings, despite recently receiving a job promotion. she is constantly worried about how others perceive her and describes ongoing and excessive concern about her three children. She has a long-standing history of excessive anxiety and worry The patient also reports feeling anxious about multiple other aspects of her life.

1. What is the most likely diagnosis?

Generalized Anxiety Disorder (GAD).

2. What is the minimum duration of symptoms required to make this diagnosis?

Symptoms must be present for at least 6 months, with excessive anxiety and worry occurring more days than not.

3. Why do patients with this disorder often present first to primary health care services?

Patients with Generalized Anxiety Disorder often present first to primary care because they commonly experience somatic symptoms such as headache, fatigue, muscle tension, gastrointestinal discomfort, and sleep disturbances. These physical symptoms lead them to seek medical evaluation rather than psychiatric care.

4. Is full remission possible in this disorder?

rates of full remission are low (so it's possible)

5. Are patients able to control their worries?

No

6. Which lifestyle factors can worsen this disorder?

- Chronic stress and lack of adequate coping strategies
- Sleep deprivation or poor sleep quality
- Excessive caffeine intake (e.g., coffee, energy drinks)
- Nicotine use
- Lack of physical activity
- Poor work–life balance
- Irregular daily routine
- Alcohol or substance use, which may initially reduce anxiety but ultimately worsen symptoms

Q3: An elderly man presents to the clinic with his daughter. He was recently diagnosed with Alzheimer's disease. His daughter is concerned about his cognitive status and management.

1. What is the usual cut-off score in the Mini-Mental State?

A score of ≤24/30 is commonly used as the cut-off to suggest cognitive impairment consistent with dementia. (Scores should be interpreted considering age and education.)

2. What are the main genetic risk factors for Alzheimer's disease?

- APOE ε4 allele (major genetic risk factor for late-onset Alzheimer's)
- Rare mutations in APP, PSEN1, and PSEN2 genes (associated with early-onset familial Alzheimer's)
- Down syndrome

3. What is the definitive diagnostic tool for Alzheimer's disease?

Histopathological examination at autopsy (demonstrating amyloid plaques and neurofibrillary tangles) is the definitive diagnosis.

4. Name two reversible causes of dementia?

- Hypothyroidism
- Vitamin B12 deficiency
- Normal pressure hydrocephalus
- Chronic infections (e.g., HIV, syphilis)
- Medication-induced cognitive impairment
- Metabolic disturbances (electrolyte imbalance, hepatic or renal failure)

5. Why should atypical antipsychotics be used only short-term in this patient?

Elderly patients with dementia are at increased risk of cerebrovascular events and mortality when using atypical antipsychotics. Therefore, these medications should be limited to short-term use for severe agitation or psychosis only, with regular monitoring.

6. Which patient unrelated medical conditions should be monitored to optimize treatment outcomes?

Caregiver and social support

Q4: A patient with a history of psychosis was previously treated with haloperidol, which improved his hallucinations and other psychotic symptoms. Improvement of positive symptoms, he is no longer listening to the weird sounds. He now presents again complaining of severe restlessness and inability to sit still.

1. What is the likely diagnosis or name of this condition?

Acute Akathisia

2. Does this medication have a high or low risk for causing arrhythmias?

Low risk

3. What are the two main interventions to relieve this condition?

1. Dose reduction or switching to a lower-potency or atypical antipsychotic

2. Addition of medications to counteract akathisia, such as:

- Beta-blockers (e.g., propranolol)
- Benzodiazepines (e.g., lorazepam)
- Anticholinergics (less commonly)

4. Which symptoms can this drug worsen in the patient?

Negative symptoms

5. If the patient develops hyperprolactinemia from this drug, what treatment can reduce this effect (drug could be added to fix the situation?)?

Switching to an antipsychotic with lower prolactin elevation, such as:

- Aripiprazole (partial dopamine agonist)
- Clozapine or quetiapine (lower risk)

6. If a patient presents with generalized rigidity altered mental status, and autonomic instability, what is the most likely diagnosis?

Neuroleptic Malignant Syndrome

Q5: A patient presents with recurrent intrusive thoughts and repetitive behaviors that are time-consuming and cause significant distress and impairment in daily functioning. The symptoms are consistent with Obsessive–Compulsive Disorder (OCD).

1. Which neurotransmitter is primarily targeted in the treatment of this disorder?

Serotonin (treated with SSRIs).

2. In patients with hair-pulling disorder (trichotillomania), what is a serious complication other than hair loss that may occur?

Formation of a trichobezoar, which can lead to intestinal obstruction or perforation (Rapunzel syndrome).

3. In patients with hoarding disorder, what factor other than suicidality contributes to increased morbidity and mortality?

Unsafe living conditions, including fire hazards, poor sanitation, infections, malnutrition, and falls.

4. What type of cognitive behavioral therapy is specifically used for patients with excoriation (skin-picking) disorder?

Habit Reversal Training (HRT).

5. What is the most common body dysmorphic concern in males?

Muscle dysmorphia (belief of being insufficiently muscular)

7th Rotation

Q1: A male in his twenties was brought by his parents to the emergency department, they say he talks with an elevated mood, he barely slept the past few days, and he says he doesn't need to sleep because he is very busy, he has important projects to complete that will change the world. On physical exam the patient showed agitation, excessive talking, hyperactivity, he kept on interrupting the physician, he kept on moving from one idea to another while speaking, and he was very restless, the parents said he has been like this for a week.

1. Diagnosis?

Bipolar I Disorder

2. What mood episode is required?

At least one manic episode.

3. Three features of this episode?

1- Decreased need for sleep

2- Pressured speech

3- Grandiosity/flight of ideas

4. Age of onset?

Late adolescence to early 20s.

5. Class of medication?

Mood stabilizers (Lithium first-line) ± atypical antipsychotics.

6. Why not SSRI?

Risk of precipitating mania if used as monotherapy.

Q2: A male in his twenties was brought by his parents because of social withdrawal , and fatigue for the past 8 months , they say his grades in college have dropped, and he didn't get out of his room a lot, during the last month he has been complaining of hearing voices speaking to him , on physical exam he shows flat affect. Answer the following questions: -

1. What is the most likely diagnosis?

Schizophrenia.

2. What is the minimum duration of symptoms required to make this diagnosis?

≥6 months total (with ≥1-month active symptoms).

3. One positive symptom?

Auditory hallucinations.

4. One negative symptom?

Flat affect. / Social withdrawal is also correct

5. Age of onset in males?

Early 20s. (20-25)

6. Treatment?

Second-generation antipsychotics (e.g., Risperidone).

Q3: A middle-aged woman came to the clinic because of constant stress, she says she can't sleep properly anymore because of constant worrying about her work, she is also very stressed about her children's grades in school, she reports suffering from muscle tension recently and restlessness, answer the following questions.

1. Diagnosis?

Generalized Anxiety Disorder (GAD).

2. Duration?

≥6 months.

3. Two physical symptoms?

- Muscle tension,
- Sleep disturbance
- Diarrhea
- Abdominal pain
- Palpitations

4. Best psych treatment?

Cognitive Behavioral Therapy (CBT).

5. One first-line medication?

SSRI (e.g., Sertraline) (SNRIs is also correct)

6. Chronic or episodic?

Chronic.

Q4: A young woman came to the clinic due to constant fighting with her husband that ended in a divorce, she said they always had fights all the time, and that occasionally after these fights she would cut her wrists, she reports she has frequent mood swings, during the same day she is angry then sad then happy then very angry . She says she feels empty inside. Answer the following:

1. What is the likely diagnosis or name of this condition?

Borderline Personality Disorder (BPD).

2. One behavior?

Recurrent self-harm.

3. One mood feature?

Affective instability.

4. One interpersonal feature?

Unstable relationships/fear of abandonment.

5. Best form of psych treatment?

Dialectical Behavior Therapy (DBT).

6. Role of medication?

Adjunct therapy for comorbidities (SSRIs for Comorbid MDD// Antipsychotics for psychotic episode/ etc..)

Q5: A middle-aged man came to the clinic because of constant alcohol drinking, he says the constant drinking caused him a lot of family and social issues, he drinks around 9 beers daily, he tried to stop for a day, but he developed anxiety and tremors, he says he drinks to cope with the work stress.

1. Diagnosis?

Alcohol Use Disorder (with physiological dependence).

2. One withdrawal symptom?

Tremor.

3. One feature differentiating dependence from abuse?

Presence of tolerance or withdrawal.

4. One chronic complication (neurologic? not sure)?

Korsakoff syndrome /// if not neurologic cirrhosis

5. One medication to maintain abstinence?

Naltrexone / Acamprosate

6. What is the first step in management of Acute Alcohol toxicity?

Monitor and make sure ABC are good

8th Rotation

Q1: A young man is brought to the emergency department by his mother because he believes that aliens are going to attack him. He recently dropped out of college. His behavior has become socially withdrawn, and he spends most of his time alone. His father has previously been admitted to a psychiatric facility.

1. What is the most likely diagnosis?

Schizophrenia.

2. What is the minimum duration of symptoms required to make this diagnosis?

≥6 months total.

3. One positive symptom & One negative symptom?

Delusions & Social withdrawal.

4. Mention 2 Investigations to exclude other medical causes?

Urine tox screen, CBC

5. How would you interpret the information that his father had previously been admitted to a psychiatric facility in relation to this condition?

This suggests a family history, which supports a genetic predisposition to schizophrenia

6. What is the pharmacological class of medications used to treat this condition? Give one example.

Antipsychotics (e.g., Risperidone).

Q2: A woman sales clerk who arrives at your outpatient clinic complaining of sadness after her boyfriend of 6 months ended their relationship 1 month ago. She arrived late to work on several occasions because of oversleeping. She also has difficulty in getting out of bed stating, "It's difficult to walk; it's like my legs weigh a ton." She feels fatigued during the day despite spending over 12 hours in bed, working days, she has difficulty concentrating and has become tearful in front of clients, she feels tremendous guilt, she brightens up when talking about her newborn nephew

1. What is the likely diagnosis?

MDD with atypical features.

2. What is the Psychiatric term of "she brightens up when talking about her newborn nephew"?

Mood reactivity

3. What is the Psychiatric term of "it's like my legs weigh a ton"?

leaden paralysis

4. Three symptoms?

- Poor concentration
- Feelings of guilt
- Hypersomnia

5. Best psych treatment?

Cognitive Behavioral Therapy (CBT).

6. One first-line medication?

SSRI (e.g., Sertraline)

Q3: A woman is brought to the hospital by her husband because she is constantly anxious and worried. Her husband reports that she has been feeling tense and worried for several years about many aspects of her life, including her work, home responsibilities, and her children. She also complains of poor sleep, fatigue, muscle tension in her neck and back, and persistent nervousness.

1. Diagnosis?

Generalized Anxiety Disorder (GAD).

2. Duration?

≥6 months.

3. Three physical and/or psychological symptoms?

- Muscle tension,
- Sleep disturbance
- Fatigue

4. Best psych treatment?

Cognitive Behavioral Therapy (CBT).

5. One first-line medication?

SSRI (e.g., Sertraline)

6. Medical condition must be excluded?

Hypoglycemia (any medical condition from Table 5-3 is correct)

Q4: A 19-year-old woman is brought to the clinic by her roommate. About one month ago, she attended a party. Since returning from the party, she has become socially withdrawn and avoids people. She also reports recurrent nightmares related to the event, feels sad, and has significant distress.

1. What is the most likely diagnosis?

Post traumatic stress disorder (PTSD)

2. Mention one possible traumatic event that could have occurred at the party and triggered this condition.

Sexual assault

3. o which symptom cluster does: Nightmares & Doesn't leave her house belong?

Nightmares: Reexperiencing

Doesn't leave her house: Avoidance

4. What is the minimum duration required to establish this diagnosis?

1 month

5. Mention one first-line pharmacological treatment and one psychotherapy used for this disorder.

- Medication: SSRIs
- Psychotherapy: Cognitive Behavioral Therapy

6. If the symptoms lasted only three weeks, what would be the most likely diagnosis?

Acute Stress Disorder

Q5: A patient presents with 3–4 weeks of sleeping only about 3 hours per night. reports At work, he repeatedly tells his colleagues that he is the best and the greatest. He speaks very rapidly and excessively, and others find it difficult to interrupt him. This is the first time he has experienced such symptoms, and he has no previous psychiatric diagnosis.

1. Diagnosis?

Bipolar I Disorder

2. What is the minimum duration required for this episode to meet diagnostic criteria?

1 week

3. Three features of this episode?

1- Decreased need for sleep

2- Pressured speech

3- Grandiosity/flight of ideas

4. What is the most important safety concern that should be assessed in this patient?

Risk of harm to self or others, including Suicidality/ aggression.

5. Name the 1st line mood stabilizer used to treat this condition and state its therapeutic serum range.

Lithium; 0.8 – 1.2 mEq/L

6. Why can antidepressant medications be dangerous in this situation?

They can trigger or worsen mania, causing manic switching or rapid cycling.