Exam samples

Case 1:

A 22-year-old male college student failed six weeks ago in two subjects. This is his first semester in the College of Education. He was in the College of Sciences last year. He has been complaining for the past four weeks, of excessive worries about his future, poor sleep and crying bouts.

Q – 1 What is your differential diagnosis؟

Q – 2 What is the most likely diagnosis؟

Q – 3 What would be the most effective treatment for this patient؟

Case 2:

A 30-year-old married man presented with five years history of low self-esteem, diminished interest and low spirit.

Q – 1 What is the most likely diagnosis and why؟

Q – 2 What is the other psychiatric disorder that you should exclude؟

Q – 3 Would you admit this patient into a psychiatric unit؟

Case 3:

A 48-year old man known to have psychiatric illness for more than 15years with relapses and remissions, brought to Emergency Department at 2 a.m. by his concerned son who found him awake ، weeping and asking his wife to forgive him and to take care of the children.

Q – 1 What is the most likely diagnosis؟

Q – 2 Can this patient be psychotic؟

Q – 3 Would you recommend giving him amitriptyline and seeing him after two weeks at the out-patient psychiatric clinic؟

Case 4:

A 50-year-old man referred to out-patient psychiatry clinic by a gastroentorologist consultant who has investigated him thoroughly and found no organic pathology behind his non - specific abdominal pain and distention. The patient was not convinced about the referral and was overconcerned with a hidden physical disease that has not been discovered yet.

Q – 1 What is the psychiatric diagnosis؟

Q – 2 What are the possible concomittent psychiatric disorders this patient may have ؟

Q – 3 How would you manage this patient?

Case 5:

A 29-year-old housewife referred to psychiatry from primary care clinic with one-year history of medically unexplained continuous multiple symptoms including headache, chest pain, abdominal discomfort, dizziness and paraesthesia over the upper limbs ، dysphagia and heartburn. Her baseline investigations were normal. She was not preoccupied with a serious disease.

Q – 1 What is the most likely psychiatric diagnosis and why؟

Q – 2 what is the next likely diagnosis and why؟

Q – 3 Would you recommend pain killers in her case؟

Case 6:

A 40-year-old female teacher mother of 8 children referred to outpatient psychiatric clinic with one year history of excessive worries about her children and home duties, dizziness, tinnitus, disturbed sleep, facial numbness, headache, poor concentration, reduced appetite, excessive sweating. Symptoms fluctuate in severity but never disappeared.

Q – 1 What is the most likely diagnosis, and why؟

Q – 2 Mention 3 medical diseases that can present with such a presentation.

Q – 3 What are the possible psychological aetiological factors؟

Case 7:

A 27-year-old man referred to the psychiatry clinic from a cardiology clinic with 7 months' history of increasing episodes of sudden palpitation, tremor, headache, shortness of breath and extreme fear. His investigations showed no abnormality.

Q – 1 What is the diagnosis؟

Q – 2 What physical conditions that can result in such symptoms.؟

Q – 3 How can cognitive therapy help this patient؟

Case 8:

A 21-year-old male college student presented with feeling tense in the presence of others. His academic achievement has been adversely affected by his condition, his attendance was poor so as his participation in seminars.

Q – 1 What is the most likely diagnosis

Q – 2 What is the most common personality disorder associated with this psychiatric problem?Q – 3 Would you consider the possibility of substance abuse in this case؟

Case 9:

A 32-year-old housewife brought to the psychiatry clinic by her husband with two years history of being anxious when she is away from home, unable to go shopping alone.

Q – 1 What is the most likely diagnosis؟

Q – 2 What is the other psychiatric problem commonly found in such a patient؟

Q – 3 How would you treat her؟

Case 10:

A 68-year-old lady admitted in the medical ward because of complications of her uncontrolled hypertension and diabetes mellitus. She was noticed by the nursing staff to be uncooperative ، irritable, aggressive, shouting and drowsy at times.

Q – 1 What is the most likely diagnosis?

Q – 2 What are the possible causes?

Q – 3 Would you consider dementia in this case?

Case 11:

A 75-year-old man brought to psychiatric clinic by his grandson who thinks his grandfather developed schizophrenia as he started to be agitated, verbally aggressive, suspicious and uncooperative with relatives.

He has poor sleep and appetite.

He talks a lot about his childhood.

Q – 1 Was schizophrenia the correct diagnosis?

Q – 2 What is the most likely diagnosis?

Q – 3 What is the functional (non organic) psychiatric disorder that can present with such a picture?

Case 12:

A 45-year-old businessman admitted into the surgical ward for hernia operation. Two days later, before the operation he developed disorientation, illusions, hallucinations, sweating, tremor and unstable blood pressure but no fever. His liver functions were grossly impaired.

Q – 1 What is the most likely diagnosis?

Q – 2 Is this patient psychotic?

Q – 3 What is the treatment?

Case 13:

A 19-year-old male brought to Emergency Department by policemen who found him quarrelling with others, physically and verbally abusive and irritable. When his mother was contacted at home she reported that he left home two days ago, his sleep has been recently interrupted.

Q – 1 What is your differential diagnosis؟

Q – 2 How would you manage him؟

Q – 3 If there is no available bed in the psychiatric ward, how would you manage him؟

Case 14:

A 21-year-old male brought to out-patient psychiatric clinic by his parents with seven months history of poor self-care, isolation and deteriorating academic performance.

Q – 1 What is your differential diagnosis؟

Q – 2 In mental state examination, what should you be concerned about to clarify the diagnosis؟

Q – 3 How would you treat him؟

Case 15:

A 19-year-old girl brought to Emergency Department with tilted neck, rigid limbs and protruding tongue.

Q – 1 What are the most common two psychiatric problems that

can present with such a picture؟

Q – 2 How can you differentiate between the two؟

Q – 3 How would you manage her؟

Case 16:

An 18-year-old girl was found semi-conscious at home after a hot debate with her brother who found her talking over the telephone to a non-relative man about her love affair. The mother found an empty bottle of medicine in her daughter's room.

Q – 1 What is your diagnosis؟

Q – 2 What are the possible aetiological factors.

Q – 3 What is the expected outcome?

Case 17:

A 30-year-old jobless male admitted two days ago in the haematology unit with swollen tender left leg. Gradually he started to complain of severe muscular and joint pain ، vomiting and diarrhoea. He kept asking for pethidine. Haematologist consultant referred him for psychiatric assessment.

Q – 1 What is the most likely psychiatric diagnosis؟

Q – 2 What are the complications of this condition؟

Q – 3 How would you manage such a case؟

Case 18:

A 7-year-old boy brought by his parents with history of repeated bed wetting for the past four months. He achieved urine continence by the age of five years for more than a year.

Q – 1 What is the diagnosis?

Q – 2 Is this an organic or functional psychiatric problem?

Q – 3 What is the management?

Case 19:

A 9-year-old boy student in the first class referred by his teacher for assessment of his intelligence. Teachers reported excessive movement, inability to settle in one place, learning difficulties and disobedience.

Q – 1 What is your diagnosis?

Q – 2 Is he mentally retarded?

Q – 3 How would you treat him?

Case 20:

A 7-year-old girl student in the first class brought by her parents who reported vague abdominal pain associated with crying. Pain usually comes in the morning and disappears when she is taken to the Paediatrician.

In Paediatric clinic she was assessed thoroughly by a consultant who advised the parents to take her to a psychiatrist.

Q – 1 What is the most likely diagnosis?

Q – 2 What is the most common important cause of this disorder؟

Q – 3 What is the prognosis؟

Case 21:

A 6-year-old boy referred to psychiatric clinic by a speech therapist. The mother complained that her son is delayed in his speech (utters only few words), prefers to stay alone ، insists to engage in the same repetitive games.Q – 1 What is the diagnosis؟

Q – 2 The mother is concerned with an abnormal parenting as a cause of the problem. Would you agree with her؟

Q – 3 What is the treatment؟

ANSWERS

Case 1

A – 1 Differential diagnosis includes:

.1Adjustment disorder

.2Major depressive disorder

.3Normal adjustment reaction

A – 2 The most likely diagnosis is:

Adjustment disorder with mixed anxious and depressed mood.

A – 3 Though drugs can help in reducing his symptoms, this patient requires psychological treatment (especially crisis intervention and counselling) which is the most effective on the long - term.

Case 2

A – 1 Dysthymic disorder

Because:

·The nature of symptoms

·Chronic course

·Mild degree of depressive features

A – 2 Major depressive disorder which is characterized by:

·More severe depression.

·Presence of death wishes and suicidal ideation.

·Biological features :

-Early morning waking

-Poor appetite and

weight loss- Constipation

However, major depression can complicate dysthymic disorder leading to double depression.

A – 3 Admission is not required unless he is resistant to antidepressant or a hidden physical disease is suspected requiring an in – patient investigation.

Case 3

A – 1 Major depressive disorder (recurrent type.(

A – 2 Yes, he may have a delusion of guilt.

A – 3 No, because the suicidal risk is very high he should be admitted into a secure psychiatric ward and treated with ECT.Tricyclic antidepressants are lethal in overdose and should not be given to a patient with high suicidal risk. Selective serotonin reuptake inhibitors are preferred in this case after treating him with ECT as in - patient.

Case 4

A – 1 Hypochondriasis

A – 2 Depressive disorder

Anxiety disorder

Irritable bowel syndrome

A – 3

·Reassurance and explanation.

·Searching for and treating any associated psychiatric disorder (e.g . depression.(

·Avoiding unnecessary investigations.

·Cognitive-behaviour therapy.

·Regular visits with predetermined
appointments.

Case 5

A – 1 Somatization disorder, because:

-Age

-Chronic continuous multiple physical
symptoms not explained medically.

-No obvious depressive or anxiety
psychopathological features.

A – 2 Generalized anxiety disorder

-She has several physical features of anxiety ،
which are non-episodic.

A – 3 No. Pains and aches in somatization disorder are less
likely to respond to painkillers.
Psychotropic drugs (e.g. moderate dose of a tricyclic
antidepressant such as amitriptyline) can help her.

Case 6

A – 1

-Generalized anxiety disorder.

-She has psychological and physical features
of anxiety which are not episodic and not related
to a specific situation.

A – 2 1. Hyperthyroidism

.2Diabetes mellitus

.3Hypoparathyroidism

A –3

-anxiety traits (worried, anxiety–
prone person.(
-being a teacher and having 8 children.
-possible conflicts at work.
-possible marital discord.
-ill parents.

Case 7

A – 1 Panic disorder

A – 2 1. Stimulant intoxication (e.g. amphetamine, cocaine(
.2Phaeochromocytoma
.3hyperthyroidism

A – 3 Patients with panic disorder have distorted believes that physical symptoms of anxiety (e.g. palpitation) are evidences of a serious physical disease. These beliefs increase the anxiety (vicious circle.(

The patient is informed about the nature of symptoms (normal response to stress) and the cognitive distortions and their role in increasing the anxiety. Positive thinking is encouraged.

Anticipatory anxiety is also reduced.

Case 8

A – 1 Social phobia

A – 2 Avoidant personality disorder

A – 3 Yes, because some persons with social phobia tend to resort to abusing stimulants or alcohol to overcome their social anxiety.

Case 9

A – 1 Agoraphobia

A – 2 Panic attack

A – 3

-Look for associated depression and treat it.

-Behaviour therapy

·Exposure

·Relaxation training

-Drugs:

·E.g. Imipramine· Anxiolytic (short

course(

Case 10

A – 1 Delirium (acute organic brain syndrome(

A – 2 ● Uncontrolled diabetes mellitus

·Medications

·Infections

·hypoxia

A – 3 Dementia might be present in this case but can't be diagnosed before delirium clears out, unless a clear - cut dementia features are reported by relatives who are acquainted with her before she develops delirium.

Case 11

A – 1 No, in fact, there is little in the presentation to suggest schizophrenia.

A – 2 Organic brain syndrome

·Dementia (chronic(

·Delirium (acute(

Absence of disturbed consciousness makes delirium less likely.

A – 3 Pseudodementia (major depression in the elderly

affecting the higher mental functions.(

Case 12

A – 1 Delirium tremens is the most likely diagnosis.

A – 2 Yes, this is a case of organic psychosis.

A – 3

-Close supportive medical supervision.- Benzodiazepines (e.g. diazepam 10 mg) in

divided doses to guard against withdrawal fit.

-Repeated reassurance and reorientation to

reduce anxiety and disorientation.

-Vitamin B-1 (thiamin) and dextrose.

-Monitor vital signs.

Case 13

A – 1 1. Intoxication with stimulants.

.2Manic episode

.3Brief psychosis

.4Schizophreniform disorder

A – 2

·Non – provocative approach.

·IM major tranquilizers (e.g. haloperidol, droperidol

or chlorpromazine.(

·Hospitalization in a locked psychiatric ward for

further assessment and management.

A – 3

·Contact another hospital where a

psychiatric secure ward is available.

·If there is no chance for admission in another hospital, medium acting major tranquilizer can be given (clopixol acuphase 100 – 50mg. IM), repeated after 2 – 3 days with frequent assessment until a bed is available.

Case 14

A – 1 1. Schizophrenia

.2Depressive disorder

.3Substance abuse

A – 2

·Psychotic features: delusions ، hallucinations, bizarre behaviour ، incoherent speech and lack of insight)these features indicate schizophrenia.(

·Depressed mood, guilt feeling ، hopelessness, helplessness, pessimistic thinking, loss of pleasure, death wishes and suicidal ideation (these features indicate a depressive disorder.(

A – 3

-He can be treated as an outpatient.

-Treatment depends on the diagnosis

·Schizophrenia–

antipsychotics

·Depressive

disorder–

antidepressant.

-Admission is

indicated if he requires

ECT (e.g. suicidal), or

he does not respond to

enough doses of

psychotropic drugs or

an organic pathology is

suspected that requires

extensive

investigations.

Case 15

A –1 1. Acute dystonic reaction (a side effect of antipsychotic

drugs.(

.2Conversion disorder

A – 2 History:

·If she is known psychotic, and

recently received antipsychotic

drugs then acute dystonia is the

most likely diagnosis.

·If no history of antipsychotic

drugs and the features were

preceded by a psychological

problem then the most likely

diagnosis is conversion disorder.

A – 3 According to the diagnosis:

·If acute dystonia, give anticholinergic

drugs e. g. procyclidine (kemadrin) IM 5 mg to

counteract severe hypodopaminergic state ؛

symptoms usually disappear within half an

hour.

·If conversion disorder, abreaction with 10

mg IV slowly infused diazepam helps in

resolving symptoms.

Case 16

A – 1 Deliberate self – harm

Most likely she took a drug overdose to influence her family

and as a temporary escape from her problem.

A – 2

·Unstable personality (borderline / histrionic:(

-Unstable relationships

-Impulsive behaviour

·Psychiatric disorder (depression–

anxiety(…

·Stressful life problems

A – 3 There is a high risk of:

-Long-term

psychological problems.

-Repetition of deliberate

self-harm and suicidal
attempts.
-Interpersonal problems
with family, relatives and
spouse (if she gets
married).

Case 17

A – 1 Opioid withdrawal (most commonly heroin.(

A – 2

·Accidental overdose, often related to loss of
tolerance after a period of enforced abstinence. It
commonly leads to death because of respiratory
suppression.

·Complications of intravenous drug usage:

-HIV.

-Hepatitis B and C.

-Endocarditis.

-Necrosis at the injection site.

-Deep vein thrombosis and
pulmonary embolism.

A – 3 Although withdrawal symptoms are very unpleasant, they are not usually dangerous to an otherwise healthy person. Therefore, it is best not to offer pethidine.

Severe pain can be controlled by non-steroidal painkillers)e.g. voltaren). Methadone (longer acting drug) may be used in planned withdrawal of opioids. Benzodiazepine can

be used to control symptoms.

Psychological management is important.

Case 18

A – 1 Nocturnal enuresis – secondary type.

A – 2 Secondary nocturnal incontinence is usually psychological.

Possible precipitating factors:

→Entering school

→Birth of a sibling

→Anxiety, depression.

A – 3

·Proper assessment.· Identify and treat any psychiatric problem.

·Fluid restriction before bedtime.

·Advice to parents.

-Praise success

-Avoid disapproval

·Tricyclic antidepressant

)e.g. imipramine 25 mg at

bedtime.(

·Behaviour therapy.

-Star charts

-Pad and bell

Case 19

A – 1 Attention-Deficit Hyperactivity Disorder(ADHD

،Hyperkinetic Syndrome.(

A – 2 Many children with mental retardation are distractive ، overactive and impulsive. Hyperkinetic disorder occurs more commonly among children with mental retardation than among those of normal intelligence. However ، diagnosis of mental retardation in this boy is better deferred until his hyperkinetic disorder is treated, then IQ test can be done.

A – 3

-Stimulant drugs (e.g. methylphenidate) can reduce overactivity and improve the attention span.

-Explain the nature of the condition to the parents and teachers who should be supported in their efforts to contain and live with the condition.

-Remedial teaching is require if no improvement with the above measure

Case 20

A – 1 School phobia.

A – 2 Separation anxiety.

A – 3 Prognosis depends on presence or absence of good and bad prognostic factors. Most younger children eventually return to school unless the case is severe, and perpetuating factors keep maintaining the disorder (e.g. marital problems, failure in class, bullying by other children.(

Case 21

A - ! Autistic disorder (childhood autism.(

A – 2 No, abnormal parenting has not been shown to be a cause of autistic disorder. The cause is still unknown ، though some studies suggest an organic pathology.

A – 3 There is no specific treatment.

Management should include:

·Special schooling

)may be residential) to help the child to achieve his remaining potential development

·Control or modification of abnormal behaviour.

·Support for the family.

The above questions were taken thankfully from

Prof.Sughayir website.

http://faculty.ksu.edu.sa/sughayir/Pages/Questions-Answers.aspx