Background for NavNeuro Fact-Finding Case 2

Note: Do not look at this document or the accompanying datasheet if you want to practice the fact find. Either have a partner be the examiner (in which case they will use this document to answer questions you ask) or listen to the episode prior to looking at this document.

IDENTIFYING INFORMATION

Age: 76
Sex: Female
Handedness: R
Education: 12
Race/ethnicity: Mexican-American

REASON FOR REFERRAL

Mrs. X was referred for a baseline neuropsychological evaluation due to concerns about cognitive impairment and diagnostic uncertainty. The purpose of this evaluation was to assess current neurocognitive functioning, assist with differential diagnosis, and provide recommendations to aid her healthcare team with treatment planning.

REVIEW OF MEDICAL RECORDS

Note: You [the examiner] should withhold this information until later in the case, after presenting the cognitive data and getting the examinee's impressions.

Per 9/10/19 brain MRI w/wo contrast impression:
-"Mild amount of probable chronic white matter infarction and gliosis, this may be related to vascular disease."
-"Mild cerebral atrophy at the temporal parietal lobes."

HISTORY OF PRESENTING ILLNESS

Patient/collateral (husband and daughter) report:
Mrs. X reported noticing speech and memory difficulties after she started "taking some pills." Her family said that she had been prescribed Ritalin for ~10 years but started to experience fatigued so the prescription was changed to Adderall in May, 2019. She only took Adderall for a couple days because she "felt off." Her husband began noticing word-finding difficulty ~1 week later, and then general memory difficulties soon after that (family was uncertain regarding the specific timeline). Upon further reflection, her husband acknowledged that there were probably memory changes up to one year prior, but he was uncertain. The difficulties continue to slowly worsen, particularly regarding word finding (her family has to fill in words for her). They said she is always able to describe the word/object (i.e., she knows the semantic category). Other symptoms include problem-solving difficulty, slowed thinking, trouble planning, trouble with math and writing/drawing, being distractible, losing her train of thought,

being confused, and forgetfulness for names (e.g., grandchildren), recent events, appointments, where she leaves items, etc.

FUNCTIONAL STATUS

Mrs. X said she is independent in managing basic activities of daily living (ADLs). In terms of instrumental ADLs, her husband has been managing the finances/bills since May because she "forgot how to complete checks." This is a drastic decline for her, since prior to the onset of cognitive difficulties she had been handling accounting for numerous rental properties. She does not cook or shop anymore due to forgetfulness/confusion; she can make coffee but sometimes makes mistakes. She has difficulty with even basic technology. She stopped driving ~1 year ago because she was getting lost. She cares for her dogs, does yard work, manages her medication, and handles household chores. Her family said that routine tasks are still mostly intact.

RELEVANT MEDICAL HISTORY (not referenced above)

- She was diagnosed with narcolepsy ~10 years ago
- She had her appendix removed in 1970s and her gallbladder removed in early 2000s
- She reported experiencing a concussion when she was young but denied any resulting neurocognitive issues
- She denied any history of stroke, cardiac issues, pain, unprovoked falls, frank incontinence, dysphagia, or seizures

MEDICATION

Per her husband: Ritalin [10+ years, reportedly for narcolepsy] 20mg tid.

PSYCHIATRIC HISTORY/STATUS

Mrs. X denied any history of formal psychiatric diagnosis or treatment.

Current status:

Mood: She said her mood is positive, and her family agreed. Suicidal/Homicidal Ideation: She denied SI and HI. Auditory/Visual Hallucinations: Denied. Personality: Her family said that she is not as outgoing due to word-finding issues; they denied noticing any uncharacteristic behavior.

SLEEP

- She gets 7-8 hours of sleep per night and said that she generally feels rested.
- She denied any history of sleep apnea or REM behavior symptoms
- As noted above, she was diagnosed with narcolepsy ~10 years ago, which is why the Ritalin was prescribed

DEVELOPMENTAL/EDUCATIONAL/OCCUPATIONAL HISTORY

- Normal developmental history
- Born in Midwest but raised on the West Coast

- She is a monolingual English speaker
- She completed high school
- She said she was an average student and denied any history of learning disability or attention deficit
- Occupation: She was primarily a homemaker, although she had several brief admin jobs over the years (not recently)

SOCIAL HISTORY/SUBSTANCE USE

- Married ~50 years (2nd marriage); lives with her husband; has two adult children
- Legal: She and her family denied any law suits or ongoing legal issues
- Substance use: She has not recently consumed alcohol and denied any history of problematic use. She denied current or past use of illicit substances. She quit tobacco products in her 30s.

FAMILY HISTORY

- Mother died of blood clots in her early 60s
- Father died in his mid 80s
- She denied any neurocognitive issues in her parents or siblings (she has five siblings)

BEHAVIORAL OBSERVATIONS

Arrival: Mrs. X arrived early and was accompanied by her husband and daughter. Appearance: She was appropriately dressed, well-groomed, and in no acute distress. Demeanor: I found her to be honest, open, and friendly. She was a poor historian and had difficulty expressing her thoughts, relying on her family to provide many biographical details. Attention: Alert and attentive in conversation. Motor: She ambulated independently but took short strides and seemed unbalanced. No involuntary movements were observed or reported. Language/Speech: Speech was notable for significant word-finding difficulty in conversation, even for relatively high-frequency words (e.g., "computer;" said "that" and pointed to the clock). She would often stammer as she searched for a word, and described the word that she wanted to say (circumlocution). She commented that the words "won't come out of my brain." Speech was otherwise relatively fluent. She also occasionally made phonemic paraphasic errors (e.g., said "sell" instead of "save"). However, there were no grammatical problems. She was often tangential. Receptive abilities were normal in conversation. Sensory: Hearing and vision (corrected with glasses) appeared adequate for testing. Thought Process/Content: There was no evidence of disordered thinking. Affect: Positive, although she was a bit frustrated by word-finding difficulty. Testing Observations: Mrs. X grasped simple task demands but needed further explanation and repetition as tasks became more complex; a few tests were not attempted because she could not grasp the instructions. She demonstrated good mental stamina and did not require breaks during testing. See the test results table for further test-specific observations. Performance Validity: Within normal limits.