Jonze Slayk 2014.07.28 05:02:09 -04'00'

Dr. Baker 311 4/26 6:00PM
311 Depressive disorder, NOS

Dr. Murray 780.09 4/27 8:00AM
780.09 Semicoma, stupor (ICD-9)
Alteration of consciousness, other 780.09 (Medicare CPT code)

Dr. Kardon 401.9 4/29 Hypertension
401 Essential hypertension
401.0 Malignant essential hypertension
401.1 Benign essential hypertension
401.9 Unspecified essential hypertension

Breiman 465.9 4/30, 5/03
465 Acute upper respiratory infections of multiple or unspecified sites
Excludes: upper respiratory infection due to:
influenza (487.1)
Streptococcus (034.0)
465.9 Unspecified site
Acute URI NOS
Upper respiratory infection (acute)

Herpes HSV-1/2 infection possible? Cracking of left edge of lips... ?
remedy: acyclovir (Zovirax)

Rx for viral infection:
Eat well, drink plenty of liquids, and rest:
NOT IN THE BEHAVIORAL SERVICES UNIT!

Prior to admission:

Pinkeye/conjunctivitis from 3/1 ???

Herpes (?) on lip join, 4/20 ?

First awakening from sleep crying out: "I've been poisoned!",
nerves were "on fire", shaking, was on Wednesday morning 4/24 at about 4AM.

Night sweats

I went to the hospital because I felt physically ill, believing I was
suffering from poisoning (with many suspicions of possible causes:
contaminated marijuana, environmental contamination in my house/well, ?).

ER 4/26 4:00 PM
discharged after blood sample, which was solely for drug tests!
The doctor and I agreed that I should come in if I lost another
night's sleep

ER 4/27 6:00 AM Dr. Murray ("Maybury, get it may bury, ha ha!")
Having lost another night's sleep, I had Alice drive me down.

My recall is poor (in part due to being dosed later)
Dr. Murray did not seem concerned with my physical state,
instead focussing on presenting me with the results of the
"blood tests" (25 ng/ml of THCOOH, zippo otherwise).

I lost my patience with being interrogated by Dr. Murray when he
asked me "Do you read a lot of science fiction?", and called
for Alice... Alice came in, I noted the defects in the form to her;
very soon a number of health aides appeared.

I was presented with the 9.39 form, and I immediately noted "This isn't even filled out correctly!": The doctor's signature did not agree with the label, the signature was illegible, and the date was incorrect. At that time, in my state of fever and exhaustion, I did not adequately note that this was a 9.39 form stating the claim that I had been found "dangerous" to myself or others.

(Alice was apparently not called, instead she snuck in! According to
Alice, they were prepared to dose me IMMEDIATELY with
"anti-psychotic" drugs at that time!)

I agreed to accompany the health aides into the BSU, which temporarily postponed the dosing procedure. Alice accompanied me, asking "Do you feel safe here?" I responded, "Yes, of course... why shouldn't I feel safe?" Alice soon left.

Once in the BSU, I was seated at a table by a window. After a bit, Dr. Roemmelt came in, presenting me with the BASIS-32 Symptom Checklist. I asked Dr. Roemmelt whether the form was not ridiculous... "Who makes these things up? How would Winston Churchill respond to this, say, during the Battle of Britain? Do you know the purpose of such forms? To cut down tall trees!" He seemed to agree that the questionnaire was not greatly useful.

... I discussed the events 5 years earlier, the metabolic logjam on P450IID6, my exposure to Prozac + Vistaril + Trazodone -> mCPP, a panic-inducing hallucinogen.

After awhile I began to feel uncomfortable and needed to urinate... when I asked where the bathroom was, I was told that "you should go to the bathroom in your room." At that point I responded that "I don't want a room! What for? Who's going to pay for a room, anyway? Not me!" I asked again whether there was not a publically accessible bathroom, and was told there was no such facility available.

- the shower was dirty; I cleaned it before taking a shower. There was water and towels all over the floor, evidently left by my "room mate", "Will". The water on the floor left my pants wet, so I needed clothing; I was given two items, a hospital gown which I couldn't figure out, pajama bottoms with no snap to conceal my privates. (This "clothing" BTW violated the Unit's rules requiring street clothes be worn during the day. I was not given the pants that I had brought along in a carry-bag, under the assumption that I would be admitted to the hospital and would need clean clothes when leaving.)

Over the course of the shower, I was becoming increasingly delusional, believing that various thumps and noises coming through the wall were intended as signals to me. Evidently the nurses' station bathroom or other facilities were directly adjacent to the shower; it is also possible that construction was underway, even though it was Saturday.

(Construction activities proceeding during the day were extremely loud, including banging and grinding, which produced deep rumbles throughout the facility: the walls would in fact shake at times; apparently the work involved grinding concrete.)

I went out into the unit, confused and weary, and dismayed by the fact that I had to hold the pajamas together to conceal my genitals. At that point I lost my patience with this involuntary confinement, took off my clothes, and announced that we should all leave! I was escorted back to my room, where a pair of nurses patiently explained that "some people are upset by nudity".
At that point I was left alone in my room.

After awhile, I began to feel that the air was poisoned... as indeed it was, by the construction activities, which produced particles of wallboard and concrete... these permeated the air at all times due to inadequate filtration. (Later there was an apology given to the patients by--I believe-- Dr. Roemmelt, for the state of the unit, the cramped area, the noise, and other construction activities which were making the area so unpleasant.)

"My room," as it happened, overlooked a gigantic container labelled "Messer" resembling the base of a rocket: a huge storage tank for Liquid Oxygen, the oxidizer of choice for liquid-fueled rockets, and potentially extremely dangerous component if abused to create an explosive mixture (with, say, the contents of a propane truck). Believing -- correctly! -- that the atmosphere was toxic, I sought to break open the window to admit fresh air by seizing a bag, placing it over the center of the window, and pounding on it with my fist.

(Does this response indicate dangerousness? I felt the entire admission procedure was ridiculous, given the clearly defective 9.39 form I had been given. The environment was in truth dangerous to my health; in my weakened condition, I was placing in what appeared to be a threatening environment; I was receiving no treatment for a serious physical malady with serious psychiatric side effects, and my condition was steadily worsening as a result. I was in a much better state of mind when I first arose, took some 30 minutes in my confused state to gather my things, and then arrived at the hospital. I believe I had received no food since the time of my arrival, when a nurse brought a tray of food which I devoured.)

At this point a large group of aides and the security guard came in, I was told I was to receive an injection -- I cooperated while this group of people held me down.

According to what I was told, this intramuscular injection was comprised of:

Haldol + Cogentin + Ativan

I was also given that evening a tablet of the "anti-psychotic" Zyprexa. When I rejected the tablet the next eventing, after asking for and being given a copy of the PDR to check for its purpose and side-effects, I was later told I had accepted the tablet. This indicates how severely the injection had affected my ability to make competent decisions.

Symptoms AFTER admission/dosage:

Fogged mind-clouded thinking/very unpleasant "clamped" sensation in forebrain
Falling down briefly at some point after injection, legs and arms shaking
Desire to cough, suppressed because of dry throat

Dry nose, blood appearing when using tissues on nose

Urination/drinking/urination cycle continuing all night
Constipation

My temperatures as I recall were constant at about 100.6° F (-1°),
about 1.6°F higher than my baseline temperature of 98°F,
dismissed as "normal" by nurses although I repeatedly drew attention
to this as a "higher than normal" temperature
My blood pressure was consistently much higher than normal after the dose.

4/29 Dr. Kardon diagnosed 401.9 Unspecified essential hypertension
4/30 Dr. Breiman

Inability to sleep properly:
About 7 days total without sleep (probably slept intermittently)
2 nights of "sleeplessness" was a major presenting problem!
Interrupted every 15-30 minutes for "observation"
By Wednesday I had made a reasonably good recovery from my illness,
although I was beat from lack of sleep. I requested several times
that the nurses not disrupt my sleep by
Not allowed to rest during the day

Food only provided normally at meals: 8 AM, 12 Noon, 5 PM
I needed to eat continually in order to combat the fever, once I realized
this the nurses were cooperative in helping me obtain food.

Rhinitis aggravated due to bad air:
The BSU was adjacent to a construction site with no air filtration provided

DRUGS INVOLUNTARILY ADMINISTERED:

Haloperidol (Haldol)
Ativan (Lorazepam)
Benztropine Mesylate (Cogentin) Anticholinergic antihistamine P450IID6 ?
Olanzapine (Zyprexa) Atypical antipsychotic Anticholinergic P450 1A2 2D6
("minor")
INDICATIONS
Olanzapine is indicated for the management of
the manifestations of psychotic disorders.
The antipsychotic efficacy of olanzapine was
established in short-term (6-week) controlled
trials of schizophrenic inpatients (see CLINICAL STUDIES).

<http://www.mmhc.com/cg/articles/CG9908/Catterson.html>

The addition of haloperidol leads to extrapyramidal side effects necessitating the use
of benztropine.
...
The L-dopa probably accounts for the advent of psychotic symptoms in the case example.9
This L-dopa was unnecessarily prescribed for pseudoparkinsonism from the metoclopramide.
The prescription for haloperidol is a knee-jerk response to treating psychotic symptoms

with an antipsychotic without regard to underlying physiology and pharmacology. It would have been better to consider a decrease in the dose of L-dopa and carbidopa than adding the haloperidol. It could be said that the haloperidol in this case resulted in "pseudo-pseudo" parkinsonism. When benztropine, a muscarinic cholinergic antagonist,10 was added to treat the pseudo-pseudo parkinsonian side effects, the result was another pharmacodynamic drug-drug interaction that mitigated donepezil's enhancement of cholinergic neurotransmission via inhibitory effects on acetylcholinesterase.11

<http://www.mmhc.com/cg/articles/CG9908/Catterson.html>

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<http://www.uic.edu/classes/phar/phar403/ld4.htm>

PHAR 403

Alzheimer's Dementia

CASE STUDY:
...
Physician's order: Psychopharmacy Consultation to assess the patient's increase in agitation and behavioral/psychiatric symptoms.

D. How long has she been treated with haloperidol and benztropine? Answer: The patient was started on haloperidol and benztropine shortly after admission on the psychiatric unit and has been on the haloperidol/benztropine for approximately 2 weeks. She is compliant with treatment.

...

2. Problems (8 points)

A. The anticholinergic effects of Benztropine and Imipramine can negatively affect her memory and cognitive function leading to an increased level of agitation.

B. The antipsychotic haloperidol has not demonstrated any mild or moderate improvement (over 3 weeks) in the patient's delusional thinking or agitated behavior and may be possibly worsening agitated symptoms.

...

4. Treatment (8 points)

A. Discontinue haloperidol, benztropine, and imipramine. Reason: to minimize the anticholinergic properties and lack of efficacy.

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<http://www.ascp.com/public/pubs/tcp/1997/dec/research1.html>

Table 4. Possible Antiparkinsonian Medication Adverse Effects

Benztropine 1/3 (33) Constipation, confusion, disorientation

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"Anticholinergic adverse effects were most common with benztropine..."

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<http://www.prn.usm.my/bulletin/1999/prn22.html>

Anticholinergics

Treatment is primarily supportive and includes monitoring for the development of seizures, hypertension, rhabdomyolysis, and arrhythmias. Prevention of absorption may be accomplished by gastric lavage followed by activated charcoal/cathartic.

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<http://www.emedicine.com/EMERG/topic157.htm>

Toxicity, Medication-Induced Dystonic Reactions
Authored by Geofrey Nochimson, MD, Consulting Staff, Department of Emergency Medicine, Sentara Hampton General Hospital

Drug Category: Anticholinergic agents -- Intravenous anticholinergic agents are the treatment of choice. IV is the route of choice, with signs and symptoms often resolving within 10 minutes. The medication can be delivered IM if an IV line cannot be established, but medications will take 30 min to be absorbed. More than 1 dose may be necessary for complete resolution of dystonia.

Drug Name Benztropine (Cogentin) -- By blocking striatal cholinergic receptors, may help in balancing cholinergic and dopaminergic activity.
Adult Dose 1-2 mg PO/IV/IM qd or bid; IV has most rapid onset
Pediatric Dose >3 years: 0.02-0.05 mg/kg PO/IV/IM; not to exceed 2 mg/d
Contraindications Documented hypersensitivity; angle-closure glaucoma; stenosing peptic ulcers; prostatic hypertrophy or bladder neck obstructions; myasthenia gravis; pyloric or duodenal obstruction; achalasia (megaesophagus); megacolon
Interactions  Decreases effects of levodopa; increases effects of narcotic analgesics, phenothiazines, quinidine, tricyclic antidepressants, and anticholinergics
Pregnancy C - Safety for use during pregnancy has not been established.
Precautions May exacerbate hypertension, tachycardia, cardiac arrhythmias, liver or kidney disorders, hypotension, prostatic hypertrophy, urinary retention, and obstructive disease of GI/GU tracts; may cause toxic psychosis in psychiatric patients with extrapyramidal reactions resulting from phenothiazine

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<http://www.hawaii.edu/medicine/pediatrics/pemxray/v7c09.html>

...

HSV is the most common cause of sporadic viral encephalitis in the United States, accounting for approximately 10 to 20 percent of all cases. It is estimated that about 2 persons per million per year will suffer from HSV encephalitis. HSV-1 is acquired more frequently and earlier in life than HSV-2. By the fifth decade of life, more than 90 percent of adults will be HSV-1 seropositive. It has been also estimated that about 22 percent of the adults in the United States are HSV-2 seropositive. HSV-1 accounts for more than 95 percent of all cases of HSV encephalitis (3). Unlike other sources of viral encephalitis, HSV encephalitis has no seasonal pattern. HSV encephalitis is most prevalent in the neonatal, 5 to 30, and over 50 age groups.

...

In the case of HSV encephalitis, the patient will generally present with an altered state of consciousness, an abnormal mental state, and focal neurologic signs and symptoms, in addition to the acute febrile illness characteristic of viral meningitis. The level of consciousness may vary from mild lethargy to a comatose state. The patient is not mentally alert and is often confused, delirious, or disoriented. The patient may also suffer hallucinations and exhibit personality and/or behavioral changes, sometimes escalating into frank psychosis. Focal neurologic changes depend upon the site of infection within the brain. Common neurologic abnormalities include: aphasia, ataxia, cranial nerve deficits, hemiparesis, hyperactive tendon reflexes, and involuntary movements, such as myoclonic jerks (1). Prolonged seizures, or status epilepticus, which are refractory to anticonvulsants are also common in the presentation of encephalitis.

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