

The Presbyterian Hospital
in the City of New York
Columbia - Presbyterian Medical Center
New York, NY 10032 - 3784

MRN

NAME

D.O.B.

Speken SETH

SPEKEN

SEX

0719970

M

6407105

EMERGENCY SERVICES TRIAGE

DATE: 8/21/93 TIME: 4:40 PM CATEGORY: ☒ E ☐ U ☐ N
CHIEF COMPLAINT: "passed out" DISPOSITION: ☐ A ☐ B ☐ REU ☐ PACU ☐ PSYCH ☐ ALLEN
CLINIC () TRIAGE SIGNATURE: [Signature] RN

DATE: 8/21/93 TIME: 4:40 PM ☐ AM ☒ PM ☐ MALE ☒ FEMALE AGE: 23
MODE OF ARRIVAL: ☐ AMBULANCE ☐ WALK ☐ W/C ☐ POLICE BADGE NO.:
ACCOMPANIED BY: ☐ SELF ☐ PARENTS ☐ OTHER: LAST ER VISIT:

PRIMARY MD: "Father is treating pt" IMMUNIZATIONS UP TO DATE: ☐ YES ☐ NO ☐ SEE BELOW

INITIAL VITAL SIGNS: T 98 P 120 R 20 B/P 100/70 WEIGHT:

ALLERGIES: "I'm allergic to" *Chronic Disease

CURRENT MEDICATIONS: Amitriptyline 40mg PMH @ Psych @ "Mild HTN - diet controlled @ DM - 40mg @

ASSESSMENT: presents AOX3 @ nausea @ vomited in staff

Ambulance - full R.D.M. - dimes abd pains present but cl
"heartburn" before arrival @ dizziness + headache.
presents @ 4 hr begun by EMS (600cc infused in field)
states "I feel much better now" D. Peluso RN

* Multiple abrasions noted to face, nose, cheek + temporal area. - D. Peluso RN

pt is a 23yo WM brought in by EMS following a syncope
episode. Pt has h/c Cohn's Disease (remission) + depression. Pt was
recently placed on Elavil by outside Psychiatrist to begin @ 10g QD @ to 1
QOD by 10g -> Pt had just graduated to 60g QD and last pm
developed lightheadedness when Sandy - father gave pt 1 dose of 25g of
Bethanecol - Today pt felt "jittery" + walked over to window @ his
sister when pt became pale lightheaded + fell to ground on

PAST MEDICAL/SURGICAL HISTORY: his face sustaining abrasions - pt was "shaking
like a fish (off) out of water" according to sister for about a 1
minute then was unconscious x 10min more pt awoke
confused + disoriented EMS called + transported pt to EL -
Pt remembers none of these events -> sister was witness
Pt denies CB, SOB - "just jittery" denies taking medication, denies
suicidal or homicidal ideation

ASSESSMENT CATEGORY ☐ E ☐ U ☐ N DISPOSITION: ☐ A ☐ B ☐ REU ☐ PACU ☐ PSYCH ☐ ALLEN

CLINIC () SIGNATURE: (cont'd) RN



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DR GOODMAN, ROBER

3697414

8/21/93 Attending FR (Cont'd)

PT took only meds prescribed as told except for the Bethenachol that father gave him (father is MD-psychiatrist for possible construction = 2bail) @N/V @stom on arrival - none thereafter @HA @abrasions on face @med pain @double or blurry vision NKA (told to avoid Imodium) @SOB @paresthesias or motor weakness

PE: NAD abrasions to nose cheeks & chin NC/Ayes RRRRA, EOMI fundi sharp Cap @ hemodynamic No abrasions on bridge NT @defecity - abrasions on cheeks & chin bil no point tenderness tongue midline moist mucosa. Neck supple NT RRRM

Chest clear to AP

CO RRR S/S

Abd soft NT @BS

EXT no C/C/E

Neck A/O 3

CNI - 80 intact

Motor S/S bil

Sensory @pinprick

RRR 3+ bil

Plantar ↓↓

EKG #1: SR 98/53/PR 0.156/QRS - 0.112/no ST-TD's

#2 (post-NaHCO₃): ST 111/71/PR 0.158/QRS 0.104/no ST-T

8/21/93 MAR-

Admit to telemetry SIP seizure on Elavil.

Interp Berkowitz 7089.

Resident Sohn

Att Goodman, Ward

MEDICAL RECORD DEPT



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DR GOODMAN, ROBER

8121193 MAR MSR STAT

23 y.o. W with h/o Crohn's dz (age 16-19) currently in remission, also with h/o panic attacks x 2 yrs with signs of depression. Recently started on Elavil 2wks ago with incremental doses (now on 60 qd). Pt has noted some sx's of orthostatic hypotension x last 2d with ↓ appetite, but has been otherwise well. Today was noted to have witnessed LOC while standing with observed tonic/clonic mov'ts with LOC persisting ~ 10 mins post event. No mention of fecal, urinary incontinence, but pt with multiple abrasions over face. Denies suicide attempt or excess med elavil 60 qd ingestion.

PIE BP 160/180 P110 R16 Tachy orthost
HEENT PERLA EOMI neck supple oroph clear
nodes multiple facial abrasions.

CNS S.S.Z

by CTR

abd BSC 50 ft NT ND 0 Hz M extr ocular 21 pulse
CNS WNL ATOX3 pleasant 07 non focal or meningeal signs

labs - 17.7 / 4.3 / 89 / 4.1 / 21 / 84 / 1.2 / 12.9 / 11.7 / 26 / 29.
Ca, Mg (P)

EKG - ST 100 0.11 / 0.11 / 0.36 (max) S.
acute ST T's flat T II
head CT (prelim) (N)
CXR -

Impression - likely SE in setting of new elavil loading. Doubt excessive ingestion.
No serious trauma.
Slight widening of QRS but no other arrhythmia.
Will admit to telemetry. Pt given 1003 + diamorphine. Amitriptyline level sent.



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ADRE 0719970 M 6407105
4125 MRN 3697917 DMAN, ROBER
STA NAME Spiker,
D.O.B. SEX

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8/21/93

MIA Note

Intermittent Patient

CC - IRII

HPI - This is the 1st CPME admission for this 23 yo recent college graduate
w/ the significant for panic attacks & the suggestion of recent depression started
on Elavil 2 wks ago.

The patient whose care is managed by his father began to take anti-
psychotic 2 wks ago. The patient was in his USGCH until 2 days prior when he
noticed symptoms of orthostatic hypotension. He never lost balance or consciousness. On
the morning of admission, he arose early (3 AM) and was not feeling himself. He
also experienced a small panic attack while alone w/ his 10 yo sister this
morning. The patient fell from a standing position and began to writhe like a
fish out of water according to the girl. The LOC lasted 10 and was not associated
w/ fecal or urinary incontinence. The patient was confused by the time EMS arrived,
but A+Ox3 upon arrival in the ER.

The patient denies drug abuse, OD attempt, suicidal or homicidal ideation.
He had a normal EEG 1-2 yrs ago.

PMHx Chronic Disease - now in remission, blood tests from 16-19 w/ (+) colonoscopy.

PSHx

All ? Immunization

PE 160/80, P110, R16 a ; 170/90, P110 9

Well developed, WY young man looking his stated age, lying nervously
in his stretcher in the ER, he had hypotension but talked clearly.

He had erythematous confluent covered w/ Varicella diffusely across his face.

HEENT - Pupils ERRLA, neck supple, no nodes, no JVD

Lungs - CTA

CV - RR 11 S1S2

Abd (+) BS, (+) HSM SNTND

Ext (+) pulses Equal

Neuro A+Ox3

Normal exam

CXR

ECG ST 100-110, PR 16/110 QRS widening

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8/21/93
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CONTROLS CORPORATION

BUFFALO, NEW YORK

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STACH



530 ortho states: 0 → 130/80 P-96neg @ 150/90 P-106
Pt. received amox- full R.Om - undressed food
noted on clothing + emesis basin - R. lead EKG
done STACH Hx 106, M.D. aware - See above morph
Strip - Presents to R/L #1 w/o finished - now #2 R/L
KVO - pulse of 96 (RA) side rails up - Sp. passing
out - can't recall incident → EMS called by sister who
witnessed incident, denies chest pain, ⊕ pulses pending
M.D. evaluation. D. Peluso RN
Tp Seen by Dr. Hewitt, CBC, Chem?, Pt. Pt. SMA 20 +
STAT flavil level sent to lab → transported to CT scan
house M.D. on port. cardiac monitor Hx 120-B/P
150/90 R-20, denies any pain or discomfort. - P. Peluso
730 Back p. XR - had head CT done - returned to wall CM - NSR in the acute
distress. Labs as follows:

137 / 101 / 14
4.11 21 10.2

17.7 / 15.1 / 253
4.98 44.3

17.7 / 15.1 / 14.3

Ct of head (pre) - negative

755 - EKG to be done #2 - explaining RV
8P - EKG done + read by Dr. Hewitt - explaining RV
925 BP - 140/90 A-102 R-20 17AR in + evaluated pt. for (A)
10P - Dilantin, K⁺ / AS 100 cc to run over 30 mins via IVAC pump
Pt. continuously on cardiac monitor for monitoring
945 - Pt for (A) - explain
955 - to go to OR - explain - awaiting transport - explain to

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Lab's ASA 12.9
Ca 9.4 26.2 17.7 / 44 / 253 137 / 101 / 14 / 84
Mg 2.0 89 41 / 21 / 12

Imp Elavil toxicity in a 23 yo M on elavil for ~2 wks
Neuro - characteristic seizure activity, hard on description following elavil
vsc. hanks, prodig. Th. prolongation of the QRS is consistent
w/ amantadine toxicity
+ AMP HCO₃ to protect heart
Tox - Denies suicide attempt but ASA, Tylenol ✓ (w/ML)
Vine for toxicity, sent
WBC - 17.7 could be dx or infection
CV - Wide QRS treated w/ HCO₃
Follow on telemetry

8/22/93 Attending
23 y.o. M with hx of Anxiety Depression, started on
Amitriptyline ~2 weeks ago, SLE Generalized Seizure yesterday,
sitting catatonic to floor, ECG otherwise unremarkable. EKG shows QRS > 100
ms CT Negative.
Now most Seizure ? due to Amitriptyline vs New onset seizure disorder
(vs head trauma, less likely). Pt to be monitored x 24 hrs,
Neurology to see.

8/22/93

IPN

R. Brown

Patient doing well

PC/O, drowsy, cl. palpitations, dizziness, N/V
Hb 100-110 Bk. yss at 4h
CV - unremarkable

MEDICAL RECORD DEPT

The Allen Pavilion • Dana W. Atchley Pavilion • Babies Hospital • The Edward S. Harkness Eye Institute • Milstein Hospital Building
Harkness Pavilion • Neurological Institute • New York Orthopaedic Hospital • Shoen Hospital • Senior Hospital Clinic • Vanderbilt Clinic



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Lungs CTA

Abd. PDS SNTD

Neuro A/C x 3

Non focal

ASA 0

Imp s/p seizure & Elavil toxicity

Neuro. awaiting neuro consult

CV - On Atorvastatin 20mg last night

Tox - As AG, other toxicology pending

WBC - probably post ictal EKG study

Myers

6/22/93

John Addl

(H) 718-601-7208

(Office) 212-988-4800

Myers

8/22/93 Neurology

23 y.o. recent college graduate in remission from Crohn's disease (had onset of anxiety - panic attacks several yrs. ago - when Crohn's became quiescent). Uses Ativan / Valium intermittently - he says "none since May" - father says "still in use." Long hx tremor (like his father).

Started on amitriptyline 2 wks ago - as doc. was raised to 60 mg q. hr he had symptomatic orthostasis yesterday, while standing from sitting position, he had a GM seizure with facial abrasions as result.

Father says he is sl. Confused or "slower" this P.M. than he was this morning.

Exam:

1) Diffident, hesitant speech - facial abrasions - tongue unbiten

2) Fund - negative

3) action tremor

4) significant H-K tremulousness

5) BP 160/80 supine

130/80 standing

Imp:

1) Drug-induced orthostatic hypotension

2) Convulsive syncope

3) Benign Familial Essential Tremor

4) Modified (benzodiazepine withdrawal state

Rec:

1) EEG

2) supplementary diazepam now (for protection)

3) psych. consult

4) MRI head if subsequent exams suggest cognitive decline



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DATE:
UNIT NO.:
NAME:
DATE OF BIRTH/SEX:
LOCATION CODE:

3697414
Spoken, Seth

PHYSICIAN CONSULTATION

REQUEST FOR: Psychiatry TO DR.: COLLINS DATE: 8/23/93

REASON FOR CONSULTATION AND BRIEF HISTORY/PERTINENT LAB DATA: Asked to evaluate this

23yo single, Jewish WOD c h/o panic disorder / ? depression, living c his
parents and 10yo sister, admitted c gen. t-c. seizure and ? Elavil toxicity for
suicidalty, ? depression, panic disorder. The pt has had panic disorder

c daily panic attacks c sx's T sweating, anxiety, fear of death, CP, L.E.S.
since last December ('92), treated by his father (a psychiatrist) c Xanax up
to 4mg daily until last May ('93), when he was tapered. He was seen by a
Dr. Avon (? spelling) a 2 wks ago and prescribed Elavil which was T'd to 60mg/d

PRINT ATTENDING NAME & PROVIDER NO. as of 8/21/93 -> when he developed orthostatic symptoms, fell, hit his head and
PRINT RESIDENT PHYSICIAN NAME, IF APPLICABLE had tonic-clonic seizures (? had seizure a hitting his head). Pt admits to sl. & mood

RECOMMENDATION ONLY ☐ RECOMMENDATION & TREATMENT ☐

CONCLUSION: over the last 6-8 months, c early morning awakening, c appetite,
10 # wt loss, Orthostasis - pt denies suicidalty - father states pt only wants to live
sl. of his 10yo sister. There are other discrepancies in stories offered by father and pt -
pt states that father committed suicide, father denies this; pt denies Xanax since
May - father states pt has been taking Xanax in past week - 2 wks. Father built bottle
of Xanax (rezipine) which pt had forged c father's signature. Father reports pt drank a
bottle of gin last wk - pt denies Elavil / Drugs.

ASSE: S.C. Orient, servly young WOD, making eye contact, c al speech, c sl. tremors,
an episode of disorientation - he wondered if he were still in his room or another boy room,
c circumstantial/hypothetical thought, sl. depressed mood, occasionally bizarre affect, denies A/H
(hallucinations), denies suicidalty, denies homicidality - there is some evidence of paranoia -
that his father would lie about his symptoms, w/ paranoid delusions (x that his fa's b. & 2
to suicide). Oriented to Mon. 8/22/93, Allen Avon (124th) St / B'way, S.I.C., recalls
3130 51, with WORLD 100 93 (85) (72) (unab), knows how to fix a house,
sm's - and 10mg c fruit, c a hair cream - c a hair cream

Impression: Complicated clinical picture - c discrepancies in hx from SD and father
who was treating pt -> 1) Panic d/o 2) agoraphobia 3) R/O major depression 4) R/O Xanax
dependence - c Xanax withdrawal 5) R/O post-traumatic stress syndrome 6) R/O chronic psychosis -
7) R/O mixed mania/d/o. I think his suicide risk is low and does not merit a 1:1
attendant.

Recommend: Hold pt while some of these issues are clarified -> please to know what treatment
I will explore possibility of admission relatively. (Call in BP)
Hold Avon to now.

DATE: 8/23/93 PHYSICIAN SIGNATURE: E. Collins M.D.



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CONTINUATION SHEET

8/23/93 Adolendas
1:30 PM Pt found wandering hallways - on 2 FW - looking
in other pt's rooms. When I saw him - I accidentally ran
into him - he told me little children were tormenting him -
he was looking for them. Then, when I returned him to his
room, he began searching in bathroom, behind door, saying
that they were in his room or another next door - as soon
as he looks - they will know a secret passage between the
rooms. He believes one of them is hiding behind a
non smoking sign in the room. He said the children were
giving him dolls whose appendages would come off.
Eup Paranoia - i visual hallucination.

Suspect Lennox-Gastaut's wld. (as post concussive syndrome)
will start Ativan Long & Clon.
1:1 attendant x 24 hrs.
Will advise G. & Adamina.

Stallins M.D.
Cocaine 8/25/93
my

8/23/93 Nutrition: 2:15 PM

Current Diet Regular (QAD)

Chart screened to identify if patient is at nutritional
risk. Patient interviewed. Food preferences taken.
Deferred obtaining diet hx. Patient will be provided
a routine nutrition case. Will F/U as necessary.

PTU/DT
#4033

8/23/93

IN

Consulte agreed

Patient day will go for dinner hygiene, N/V

PE unid

Temp Under but complicated & hx



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D.O.B. SEX

CONTINUATION SHEET

8/23/93 Med Intern Transfer Note

See MIA note 8/21/93

Briefly, this is a 23 yo ♂ w/ panic attacks for 2 yrs who has been Rx'd by his father a psychiatrist with several medications most recently Xanax and amitriptyline. The patient noted symptoms of orthostatic hypotension 2 days PDA and experienced a witnessed syncopal episode w/ tonic clonic movements resulting in abrasions on face. He was unconscious for several minutes but reached the ER A+O x3. On the ER he was found to be jittery w/ a mild tremor, tachycardia to 120 and BP 160/80 mm orthostatic. He was a fibrile. He was Rx'd presumptively for Ethical toxicity w/ 1 amp of HCO₃ as his QRS was J2. He received 1 gm of Phentol and was transferred in stable condition w/ psychotic features to Telemetry.

Yesterday, the patient was noted to have the acute onset of visual hallucinations. He was put on 160 PDA and given Ativan 2mg q 4^h. Additionally, conversations with Dr. Spiken revealed that his son may have been taking Xanax in the past 2 wks - a fact not disclosed on admission. Over the past 18 hrs the patient has experienced a waxing & waning delirium w/ visual & possibly auditory hallucinations. This morning he became more disoriented his HR rose slightly to 120 and his BP has been 160/120. He became fibrile to 100⁵ and the decision was made to transfer him to the ICU for closer monitoring and IV benzodiazepine Rx until Vitals are stable.

N. B. Lewitz 7/8/93

to possible recent suicidal gestures but not recently suicidal.
Patient's being withdrawn

1) 4 P/K + possible transfer to P2

2) Ativan 10 mg

3) No response W/K @ this time
M/7089

8/23/93

Just noticed the above 4 addendum
Recommend 24 hr IOT
Ativan 26 as recommended

M/7089

24 Aug 93

MSR

CTSP for bizarre behavior
BN / 1:1 unable to control

PT delusional

Psychotic

D/W C & coverage

Rec: Haldol 5mg IM
Cogentin 1mg PO

[Signature]



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8/24/93 Pyrexia

9:30 AM Pt continues to demonstrate evidence of delirium - he believes something on several different interviews that he is in the Grand Canyon. In the latter part of a research project, in French class. He was oriented to 8/24 - 8/24 - 8/24/93. He continues to describe "malnourished, small 10yo girls" who were hiding in bed springs. They were tormenting him - and only he could see them.

Last night - he reportedly tried to break the window in his room (? suicide attempt?). He was restrained and given Haldol 5mg / Cogentin 1mg.

Dr. Charles has approved his admission to P - his probable withdrawal delirium clears. Pt's mother reportedly observed at taking mult. OTC. Improbable. Probable benzodiazepine withdrawal.

Continue Afrin 2mg q 4hrs.

would have low threshold for physical restraints.

Follow VS closely (q 2hrs) - observe for evidence of autonomic instability (HR 150/100, 100/100, T 98.8)

May need ICU admit if delirium worsens, as he may need more intensive nursing care.

Consider IV hydration - if not taking po's.

Consider telemetry to monitor HR (if not necessary).

Dr. Benigni will be following tomorrow - she will make arrangements for transfer as appropriate.

Dismissed to Dr. Sebonitz, Mr. Kaufman

Collins #1252

8/24/93 - Neurology -

Patient's subsequent course: increasing agitation, hallucinations, bizarre ideation, i.e. delirium, all support dx of an abstinence encephalopathy (benzodiazepines in this patient). Even though he is afebrile, I would perform a lumbar



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SAR ICU

8/24

23 y/o male by prior disorder R'd by father of
c xanax high dose. Apparently was on xanax taper
or Dk. It had seizure 8/21 & admitted. Head CT (-)
felt to be syncopal sz. It exhibited bizarre behavior
& was convulsed. It became psychotic & fully delirious
further by revealed xanax use & withdrawal
suspected. Transferred to ICU for benzodiazepine
sedation & monitor = withdrawal H+T, tachy, dysphoric.
On exam it sedated & delirious, incoherent
BP 150/80 HR 120-130 RR 14 lungs CTA
Furrowed abdomen (3 hours during sz) lungs CTA
arr. S, C & Rhythm tachy abt being

Alg-

Encephalopathy likely 20 withdrawal
- sedate to benzos keep TPR & HR
rather over sedate & intubate than under sedate
& sz.
- R/o other cause re metabolic (✓ labs)
or infectious (do LP).

C. Bonds



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SEX

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ICU INTERN ACCEPT NOTE

chart reviewed, transfer note read and appreciated.

Briefly, this is a 23 yo white man with a history of Crohn's disease (age 16, recurrence age 19), panic disorder and possible recent depression, admitted 8/21 after "syncope" episode and seizure (tonic-clonic seizure witnessed by 10 yr. old sister) initially thought to be Elavil toxicity, now being transferred to the ICU for management of acute benzodiazepine withdrawal. Pt has had panic attack for a number of years and was treated with Xanax by his father, a psychiatrist, until recently. Pt then began seeing Dr. Owen Gp who prescribed Elavil beginning 2 wks ago. Pt began an increasing dosing scale of Elavil and was taking 60 mg PO QHS on the day of admission. ^{Pt denied benzo use, claimed last dose was May, 1993.} Two days prior to admission pt began experiencing dizziness upon standing, ~~and~~ not quite feeling like himself. He was given 25 mg Valium when the orthostatic hypotension persisted for a second day. The day of admission pt felt "jittery" and while standing, became pale & lightheaded, fell to the ground and had a grand mal seizure witnessed by his sister ("he was ^{shaking} ~~moving~~ like a fish out of water"). He was disoriented and confused for 10 minutes ~~7~~ the seizure and was then brought by EMS to the ER. on presentation to the ER pt was orthostatic (160/80 → 130/80), mildly tachycardic and afebrile. He had a prolonged QRS complex (0.11), ~~and~~ and was admitted to telemetry for probable Elavil toxicity. Pt had ⊕ Head CT. while on telemetry pt became disoriented and confused, anxious and began hallucinating. Pt was hypertensive and tachycardic and diagnosis of benzodiazepine withdrawal despite pt's initial denial of benzo ingestion. (Father states pt did take benzos recently). Because of hallucinations and paranoia pt was placed on 1:1 observation on telemetry by psychiatry, and Ativan 2mg q4 was begun. Pt became increasingly agitated and confused with frank delirium. He apparently tried to put his hand through a window 8/23 at night despite 1:1. Pt is now being transferred to the ICU for more intense observation and monitoring.

PMH Crohn's, as above. on no meds. currently in remission.
AC ?immodium

MEDS Elavil 60mg QHS at home
Xanax ?

FH ⊕ FH of panic disorder in paternal grandfather.

SH Pt is a recent college graduate who lives at home w/ parents and sister. Father is a practicing psychiatrist.

PE PT is a young male with obvious abrasions on his face, ~~and~~ restrained in bed, babbling about a production, with his eyes intermittently closing.

VITALS: P 103 BP 150/70 R 20 T 99.5 (RR)

HEENT abrasions on nose, cheeks, edges of mouth. PERICL: Unable to normally test EOM, but PT appears to move his eyes in all directions. Mouth: throat non-injected no ulcers. no evidence of tongue biting.

LUNGS clear

HEART S₁S₂ NL. #vi SM @ apex → axilla no clicks. no opening snap. @qlr.

ABD Soft, non-tender, non-distended. no guarding no rebound. no HSM. (+) BS.

EXT no clcfe. when awake → tremors of both hands.

NEURO oriented to name only. waxing and waning consciousness. speech fluent but nonsensical, tangential. acute hallucinations. responsive to some commands.

CN II-XII grossly intact as observed. PT not able to cooperate w/ exam.

MOTOR appears full strength.

LABS: ADMISSION	17.7	15.1 4.3	253	137 4.1	101 21	14 1.2	84	10.1	224 224	16.1	31
								2.7	80	93	199
								12.2	5.4	25	26

BZ	137	101	8	101
BZ	90	13.8 40.3	218	

U/A ⊖

HEAD CT ⊖. EKG:

CXR

imp/ 23 yo. w/ E h/o Crohn's disease, panic attacks and recent ~~depression~~ (current) depression admitted slip grand mal seizure and feeling jittery, now known to be benzodiazepine withdrawal.

① BZ withdrawal treatment is replacement benzodiazepines and supportive care. Because Xanax is only PO, will cover initial period with Ativan which can be given IV and IVS entry into circulation is ensured. PT's delirium puts him at aspiration risk which also makes PO Xanax a suboptimal choice.

- Ativan q2 2mg to treat ↑BP, ↑HR, agitation

Will do LP emergently to rule out other etiology of change in mental status, also to do blood 2° subdural hematoma 2° head injury from fall (seizure).

② TB seizure no evidence of seizure activity. Seizure 2° to withdrawal. Ativan should prevent further seizures. NPO and seizure precautions have

③ to psych when stable

Final Mar



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STAT

MRN
NAME
D.O.B.

SPEKEN, SETH
0719970
DR GOODMAN, ROBER

3697414

SEX

6407105

CONTINUATION SHEET

8/24/93

2300 - Benzodiazepine withdrawal. Seizures,
tachycardia, but no autonomic. Continue
treating. MRS reviewed, agreed

[Signature]

8/25/93

7A

IPN

PT resting comfortably. Easily arousable this morning. Remains delirious.

"I'm in the CBS studio in Burbank"

VITALS 160/60 (overnight 120-130/60) P 110 R 20 T 99 Ta 98 I/O 1600/1020

LUNGS clear

HEART S1S2 nl 1/VI SM @ APEX → axilla

ABD benign @ BS

EXT @ diaphoresis but greatly improved.

MENTAL STATUS Oriented to person.

continues working and wandering.

appears less physically agitated

LABS CSF: culture (P)

#1 2WBC, 2RBC

#4 0WBC, 1RBC

protein 27

glucose 91

IMP 23 up in acute benzodiazepine withdrawal.

① WITHDRAWAL overnight vitals were stable and improved from daytime

PT received 2mg Ativan at 7, 4mg at 8, 2mg at 9pm, 6pm at 10:30 which held
him until 6am today. PT then received 4mg and is currently undisturbed above.

BP slightly ↑ this am. Will consider ↑ ativan to 6mg q4 if BP/P remain elevated
or and PT becomes tingly agitated.

LP results ⊖ for blood (bacterial meningitis) or infection.

Continue seizure precautions.

Tolerating Ativan. No need to switch to Klonopin yet.

Will follow CPE and hydrate to prevent rhalsdo.

[Signature]

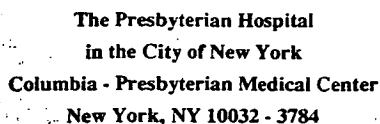
03 AM Psychiatry Flu (coverage for Dr Collins)

Chart reviewed. Pt interviewed. Mr Stephen is a 23yo SWJ college ^{senior} ~~graduate~~ living with his parents who has h/o panic b/o suicidal in past by his fxa a psychiatrist & Xanax & most recently by another psychiatrist & Elavil who presented 8/21 p Gen'd tonic clonic sz. Feet initially to be 2" Elavil toxicity. Later pt became agitated, disoriented & psychotic c/w delirium which was felt to be due to Benzo w/d. On 8/24 he was tx to ICU for supportive treatment & monitoring as he manifested Benzo w/d sx.

Current MSE - Pleasant young & lying calmly in bed & hand restraints. Speech fluent, probable somewhat rapid but not pressured. Mood dysphoric. Affect - very labile. Tearful. Denies suicidal/homicidal ideation.

Thought content - Denies auditory/visual hallucinations - somewhat paranoid - Feels the doctors have lied to him here (He thinks he was to be transferred to MA's Ochsner but no overt delusion. Alert & oriented to name, birthday, date (8/25/93) but not place (thinks he's in Massachusetts). He was reoriented & remembers having had come to Allen Pavilion.

AP Resolving Delirium 2° Benzo w/d
continue standing Ativan to treat w/d sx - I would not A back to Xanax as an antidepressant would be a better choice for treatment of this pris panic &



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mod symptoms.

- once pt no longer delirious &
- medically stable will reassess need for psychiatric admission -
- will continue to follow up you.

Bengali no.

$$8 \mid 25 \mid 93$$

I am Attending

Mr. Speken is a 23 y.o. ♂ c w/o Crohn's dz & Panic attacks. He had been rx'd c benzodiazepines but was recently rx'd c Elavil for possible depression. He was admitted S/p witness: generalized SE. He has been rx'd for presumed benzodiazepine withdrawal & is now transferred to the ICU for sedation & Close monitoring.

Neuro & Psych are following.

CT & LP negative. &

Pt now is sedated & stable VS. Plan is to cont. Sedation as per psych & monitoring of VS, oxygenation & mental status.

4 cm

8/25/93 - Neurology -

Best yet - speech clearer - knows this is a hospital - knows "August '93" - denies hallucinations. Back ache & prolonged immobilization.

Rec: start use of bedlike chair in
restraint of

11/11/00

11/11/00

8/28/00 ICW coronary

8/28/00

23yo ♂ s/p 12 / bradycardia in bradycardia
now is 120 = 300 in over 12 hours

? dig vs rheumatology

ph - 1000 lts, week

first challenge

W. J.

7/6/03 PROCEEDING NOTE from 8/24

An emergent LP was performed. It was able to give consent

It was prepped and draped in sterile fashion.

Udlocaine was used as anesthetic

A 20g spinal needle was inserted in L4-L5 space

Clear CSF was obtained

Specimens sent for cell count, protein, glucose and culture.

No complications. It was a successful procedure

Laurel May



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CONTINUATION SHEET

26/03 IPN / Intern Transfer Note

S. Speken is a 23yo W O⁺ c hx of Clostridium dx as an adolescent + panic disorder with recent bouts of depression who was admitted 8/21 for tonic-clonic seizures witnessed by 10 year old sister. I thought to be secondary to clonal toxicity since pt was on clonal for tx of depression. He denied BDZ use originally but tox screen revealed both BDZ + clonal + he was transferred to ICU for management of acute BDZ withdrawal. The pt was being treated by psychiatrist father + Xanax for panic disorder. He then began to see see Dr. Quan for psychiatric condition + was given clonal 60mg po QHS. 2 days PTA began feeling lightheaded + dizzy + was given Dilthiazol by father. He fainted + had seizure with 10 minute postictal period 2 days after feeling lightheaded. In ER pt was orthostatic, tachycardic + afib + prolonged QTc complex. Admitted to floor + clonal tox.

W/U head CT (-)

Pt became disoriented, confused, anxious + began hallucinating was HTN + tachycardic + dx of BDZ withdrawal made. Pt was on 1:1 + Alivan 2mg q4 + still became agitated + delirium. then transferred to ICU

PuTx - as above

Allergies - Immune

Meds clonal 60mg QHS at home

Xanax - amount

FH of panic dx in paternal grandfather

SH - recent college grad, lives at home

PE on admission - signs for facial abrasions after seizure
neuro - Oriented to name, varying + varying consciousness
speech nonsensical, tangential, (+) Hallucinations
Men focal

Lab reqn for WBC - 17.7, nl C₇, SMAc (C.P.K 26),
OUA,

During course of hospitalization pt put on Ativan & required
doses up to 14 mg over a 12 hour period. An LP was
performed which was negative. Eventually Ativan
4 mg q 4 hrs was all that was needed for light
sedation. The A/R pt is calm. No hallucinations or
agitation. Answering questions appropriately. FNAB.
He had some decreased urine output which was felt
to be secondary to dehydration. Subdo thought
Ch only ~2400. He was hydrated vigorously &
response of kidneys is being followed.

V/S I/O 5700/811

PE - pt lying in bed @ 4 pt restraints, easily arousable
Pt very appropriate

HEENT - multiple excoriations on face by mouth &
fore head. hearing nl. PERRLA, EOMs intact

Q - BBR, S.Sa, DM/g/r
lung - CTA (B)

abd - @BS, NT, MD, @ masses

extrem - @edema, C/C

neuro - a x O x 3, speech fluent & appropriate, @ hallucinations
@ agitation, non focal

clmp 23 yo E pms dx being treated for BDZ withdrawal
clonazepam

Plan - transfer to Psychiatry to work on issue
surrounding BDZ use

C/U - follow U/O & fluid status as well as Ch
hydrate as needed. If no UO or inadequate
investigate possible causes of LVO.



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CONTINUATION SHEET

8/26/93 1PM Psychiatric Flu / Transfer Note

Mr. Speken is a 23yo son of living to his parents, recently graduated from college & who has a bipolar disorder since Jan 94 until recently treated by his father, a psychiatrist to Xanax up to 4mg qid & more recently to Elavil up to 60mg qid which was started by another psychiatrist, Dr. Quen, following a 2 week taper of Xanax by the pt's fa. The pt reports a few months of intermittent mood, a anhedonia, psychomotor slowing, & sleep. T appetite, & concentration feelings of hopelessness but no suicidal ideation or plan.

The pt was brought to the ER 8/24 by his family after an observed generalized tonic-clonic seizure. The initial impression was Elavil toxicity, a level was sent but the qty was not sufficient. A tox was @ 0800. He was evaluated by both neurology & psychiatry on 8/25. The latter found him of amphetamine & S/H. There was some evidence of paranoia but no overt delusions. No AHTV. Alert & oriented x3 & cognitively intact.

A few hours later the pt was seen by Dr. Collins of Psychiatry to be wandering on the ward alone than his own. At that time he was delusional stating little girls, whom were unseen his bedspreads were "tormenting" him. He was somewhat agitated & disoriented.

The impression was delirium ? 20 benzo wld & he was given Ativan 4mg IV. The pt was TX to MICU for treatment (see medical summary for ↑ info)

Feb on 8/25 he was evaluated by me & found oriented to person & time, ment alert & less agitated. His affect was labile & intermittent tears.

Current MGE - 61. obese young ♂ & facial ecchymoses sitting up in bed, speech fluent, purposeful. mood - at. dysphoric. affect - full in amplitude & range. Denies suicidal / homicidal ideation. thoughts goal directed. thought content - no delusions. No auditory / visual hallucinations. A & O x 3.

ATP sip Belimumab likely 2nd Bezto. Also
stable now on Ativan 2mg q 4^h
but a persistent depressive
sy. & suicidal ideation on
psychosis.

- to be transferred to Eye 6 in AM on 8/27

- in preparation for transfer. Please ~~send~~ this note & medical transfer note & add to voluntary (in front of chart). Derby Psychiatry Consult
- it does not require 1:1 PDA.

~~XXXXXXXXXX~~
 Bongioni no
 1256



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MRN SPEKEN, SETH
NAME 071997J M 6407105
DR GOODMAN, ROBER
SEX

CONTINUATION SHEET

8/26/93 ~~Admission~~ ICU Attending
Mr. Speken is sleepy but easily
arousable.

BP 160/86 P98
lungs: clear to P & A
Card: reg S/S
Ext: 5 C/C or E

Doing well. Scheduled for transfer to Psych in
A.M. Cont Ativan regimen as per Psych
recommendation.

Gordon

8/26 ICU coverage att.

23 yo ♂ w/ hx of benzo abuse, presented w/ sz's,
now stable on ativan taper. Plan discussed
w/ team.

+ Gordon MD



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CONTINUATION SHEET

S PT 5 complaints.

VITALS 160/110 2800/2850 90 20

HEENT PERRL, EOMI

MRD benign CBS

UNAS clear

EXT NO C/C/E.

HEENT SID, SL DIM/LR

LABS

ANA @	90	158	71.3	39
ESR 20	3.7	6.5	80	216
	4.4	3.9	59	1011

PT 12.7/11.8

PT 29.6/29.7

143/110/4
3.7/2.5/.9

8.5/12.7
97.2/188

7:30/40/89 97%.

creatinine 328

U_{Na} 207

U_{osm} 929

U_K 54

U_{Cl} 275

imp/ 23 yo with panic disorder admitted & benzodiazepine withdrawal.

Now stable -

① WITHDRAWAL PT Rly melted - on 2mg PO ativan q4. DOING well. NO seizures, delirium or agitation. Transfer to psych.

② CPK ting continue PO hydration -

Medically cleared

Stable for transfer.

laurel may

8/27

ICU Attending

Mr. Speken is alert, oriented & conversant.

BP & HR mildly ↑'d likely 2' anxiety & ?

2' with dexam. Cont Ativan. Transfer to

Psych today.



The Presbyterian Hospital

DATE: 8/27/93

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CONTINUATION SHEET

PHYSICIAN ADMISSION ASSESSMENT

LOCATION CODE:

NAME: SETH

SPEKEN, SETH

DATE OF BIRTH/SEX: 0719970 M

640710

PAGE 1

DR GOODMAN, ROBE

DATE: 8/27/93

IDENTIFYING DATA: 23 y/o son of who lives home w parents and young sister, w 1/2 Crohn's dz, panic d/o, & major depression. Transferred from Allen ICU p 1 wk for 5 1/2 x 1.

LEGAL STATUS: voluntary

CHIEF COMPLAINT: "I have panic disorder"

HISTORY OF PRESENT ILLNESS:

23 y/o w/o, 1st & admit 9/0 ~ 24 w/o panic attacks, consisting of PRR, feeling of suffocation, & sweating, often brought on in situations where he feels a task is demanded of him. The first time one occurred, pt felt as if he were having an MI, & was tied in an ER & told to see a psychiatrist. Pt saw a YMO x 4, was prescribed Klonopin 6mg/d to some relief, but stopped p his father (a YMO) said it was too much medicine.

Pt's father began tying him to Xanax 4mg qd & severity of attacks. Pt reports having the attacks qd, though was able to do well in college, drive, go to movies, & vacation. He reports taking Xanax 4mg only on weekdays, not weekends or vacations, & taking some 1-2 month drug holidays during which he did not have panic attacks (on withdrawal 5/5, since he knew how to taper).

6 mos PRA, in setting of painful rejection from grad school, pt. noted to be dysphoric, anhedonic, hypersomnolent, & appetite, & feelings of hopelessness, but never SI. Over ensuing 2 mos, pt had ting guilt over Xanax use - "felt like a drug addict," "felt out of control over my life." These feelings were reinforced by his father, who told him he was taking too much, but continued to prescribe. Pt denies ever getting meds on his own & father's prescription pad (X Flexeril, yrs ago when father away).

4 mos PRA, father tapered him off Xanax & started Zolof. Pt took 1 x 1 month & improvement in mood, & severe agitation. Then restarted Xanax 4mg/d and



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CONTINUATION SHEET

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PAGE 2

H.P.I. CONT: experienced worsening guilt/loss of control

2° to BDZ use → decided to totally d/c Xanax when school finished in 2 mos. Also felt the need to "commit myself" & to get a psychiatrist. Xanax tapered 1 month PTA, totally d/c by 15d PTA (pt is adamant that he took no BDZ until admit; father, by report thinks he did).

2 wks PTA, pt seen by Dr Quen (who) who prescribed Elavil 10mg, $\uparrow$ to 60mg by 8/20. Given Benhexol 10 for dizziness

1d prior to Allen admit, pt felt dizzy upon rising to a standing position, though did not lose balance or consciousness.

The am of Allen admit, he awoke @ 3 am, did not feel like himself, & had some panic. Later that am, while alone & his sister he fell from a standing position & was noted by his sister to (conv?)

PSYCHIATRIC HISTORY (INCLUDE INPATIENT & OUTPATIENT TX & PSYCHOTROPIC MEDS):

Per HPI. At 17 y/o, father gave him Prozac for "depression" (pt describes some $\uparrow$ TI, but no dysphoria/anhedonia). It became very agitated, & d/cd, in med.

ALCOHOL AND DRUG HISTORY: Denies EXOT — never until 2 wks PTA, then 1/2 bottle cum. within 2 wks (2° to "panic")
Never tobacco, MJ, Coc, IV D

FAMILY PSYCHIATRIC AND ALCOHOL AND DRUG HISTORY: F (+) panic d/c x 520y, untreated; Father's sister MR; Mother sister "dysthymic"

Fam Med: M (+) Graves, cystic breast F (+) kidney stones

LIVING ARRANGEMENTS/PRESENCE OF MINOR CHILDREN/ABILITY TO PARENT:

Lives w/ parents, 10 y/o sister. Has car travels about, has job (research assistant @ Albert Einstein). Lives in Riverdale.



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SEX

CONTINUATION SHEET

7/27/73 HPI (cont)

be "writhing like a fish." LOC lasted 10 min, 5 writhes
incont. He was brought to the Allen ER confused &
disoriented, 2 multiple facial abrasions. He denied
h/a, neck pain, visual d/s, paresthesias/motor weakness, SOB,
but did h/o some N/V. Noted to have widened QRS (Tx'd
w/ HCO_3^-), WBC 17.7, CT WNL, CSF exam WNL, & admitted
for presumed Elavil toxicity (level not done). Tox screen $\rightarrow$
+ BZ, possibly Valium load during 52 Hx. Seen by
neuro & psych, thought to have convulsive syncope,
h/o BZ withdrawal, & not thought to be suicidal.

2 d p admit, found by Y consult to be wandering in
hallways, 2 delusion/hallucination of 2 children tormenting
him, under his bed, 2 agitation, disorientation. Dx'd
2 delirium 2° to BZ withdrawal, Tx'd 2 Ativan 2mg
q2h prn (required $\rightarrow$ 16 mg), & transferred to MICU for obs.
Tx'd 2 Haldol 5 that pm p he put his hand through a
window. Delirium resolved p 1d in MICU, 2 T BZ Hx.
Noted by Y consult 8/5 to be oriented, non suicidal,
& 5 Yatic YP, though somewhat labile. Pt was
cleared medically, & transferred to E16 for Keral & Hx.

As above, pt notes ~ 6 mo h/o dysphoria, anhedonia,
appetite, ↓ self-esteem, ↑ guilt, ↑ hopelessness. Notes some
motor slowing, Y1. Denies ever h/o ↑ energy, ↓ need for
sleep, racing thoughts. Denies ever 5/4/1. Denies A/V/H,
or O/H, or ~~abnormal~~ incontinence, last time. Chronic
anxiety, related to panic but separate.



CONTINUATION SHEET

NAME:

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BIRTH/SEX:

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PAGE 3

PSYCHOSOCIAL HISTORY: NL L+D, all milestones. Father 8mo, mother
homemaker, 21 y/o sister, 10 y/o sister.

EDUCATION/VOCATIONAL HISTORY: Grad. from Lehman Col. 2 mos ago,
works as research asst. @ Alb. Einstein. Upset over
bad rec. from teachers → not accepted to grad
program.

ECONOMIC SITUATION (i.e., Self supporting, disability, public assistance):

supports self

MEDICAL HISTORY:

a) MEDICAL HISTORY (INCLUDE NEUROLOGICAL HX, i.e., head injury, seizures):

Cholera dx dxed @ 16 y/o, good control - has been on
Amlyfidine Pipentium yrs ago Denies heading, sz
NKDA No allergy → berries, dairy

b) ACTIVE MEDICAL PROBLEMS/REVIEW OF SYSTEMS: Denies h/a, N/V, GI upset,
urinary Preg/incont

R/o BDZ dependence/withdrawal

c) CURRENT MEDICATIONS: Ativan 2mg po q 4°

d) PHYSICAL EXAM (PERFORMED BY WHOM)



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CONTINUATION SHEET

DATE:

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DATE OF
BIRTH/SEX:

LOCATION CODE:

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e) AIMS COMPLETED: YES NO

RESULTS:

IF NO, STATE REASON:

MENTAL STATUS: WDNW W/O, unshaven, in hosp garb, smiling

APPEARANCE: good eye contact, pleasant & hyperactive

MOTOR BEHAVIOR: motor rest, calm bearing

MOOD AND AFFECT: dysphoric, anxious at times affect full range to brightening, not labile

SPEECH AND THOUGHT: All tone/rate/prosody goal directed & COA/FOI/pressure @ PI/VI/TB/VTU/IOE Remembers delusions of 4 d ago, laughs at that - states that it was not real. Denies Audio/Visual/Olfact Halluc

SUICIDAL: a) IDEATION none, denies ever

b) POTENTIAL none apparent

HOMICIDAL: a) IDEATION none

b) POTENTIAL none apparent

SOMATIC FUNCTIONING AND CONCERN: Denies concern

SENSORIUM / ORIENTATION: Alert, O -> CPMC, 8/27/93 Registers 3/3, 3/3p 5m

@ serial 7's, spells world =, digit span 6 -> 5 abstract al to split milk

INTELLIGENCE: Above average

JUDGMENT/IMPULSE CONTROL: intact to mail letter

glass house @ similar to

ATTITUDE TOWARDS ILLNESS: agrees to admission but may be guarding history

DIAGNOSIS

CODE

NAME

AXIS I

AXIS II

AXIS III

AXIS IV: PSYCHOSOCIAL STRESSORS 1 2 3 4 5

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (1 - 90)



The Presbyterian Hospital

DATE:

UNIT NO:

3697414

NAME:

DATE OF BIRTH:

SEX:

SPEKEN, SETH

07/19/970

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6407105

LOCATION CODE:

DR GOODMAN, ROBE

PATIENT ASSETS AND LIABILITIES:

PATIENT'S FAMILY/OTHER PARTICIPATION IN TREATMENT PLAN:

INITIAL TREATMENT PLAN (INCLUDE PSYCHIATRIC, PHYSICAL, SOCIAL/FAMILY, ECONOMIC AND SUBSTANCE ABUSE PROBLEMS):

PROBLEM

INTERVENTION

ADMITTING PHYSICIAN:

SIGNATURE:

ATTENDING COUNTERSIGNATURE:

SEIDMAN

Ann Salen 1/27/93



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Speken, Seth

CONTINUATION SHEET

8/27/93 R2 note
7pm

CTSP during my Y wfu, a final dx assessment or PE (per Dr Kotz). Events of afternoon as follows:

~ 1pm Pt arrived on Et6. I reviewed chart, and cosigned orders. VSS.

~ 1:00-1:20 Pt seen by Beth, RN. History taken.

~ 1:15-3:15 I sat @ pt in his room for initial examination. Pt was alert & oriented, pleasant & cooperative, and 3 any complaints. Please see Y wfu.

~ 3:15 I left pt's room @ pt. He went to phone to call his father, and then had vitals taken. VSS.

~ 3:40 I returned to pt's room. I called to him in the bathroom, and asked for his father's office phone #. Pt answered that he did not know the number. I asked why not, and he stated that he just did not know it. His voice was calm.

As I was writing my note, it came to my attention that pt had been coded & found in the bathroom unresponsive. I provided relevant info to code team.

My initial diagnostic impression was that this 23 y/o was a male with almost daily panic attacks x 2y, and s/s depressive dx x 6mos, & chronic BDZ use x 2y (until at least 12 hrs PTA) who was admitted 6 d ago following a SE, & x 6 d for presumed BDZ withdrawal, and transferred for Y. Pt denied recent BDZ or other drug use. Initial plan was to complete medical assessment, continue tx for BDZ withdrawal, and begin wfu for s/s panic, & depression, including further hx, organic wfu.



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MRN

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D.O.B.

SPEKEN

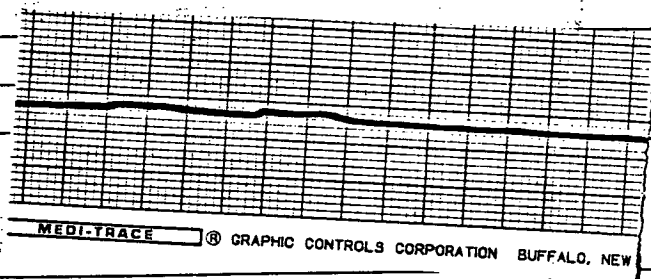
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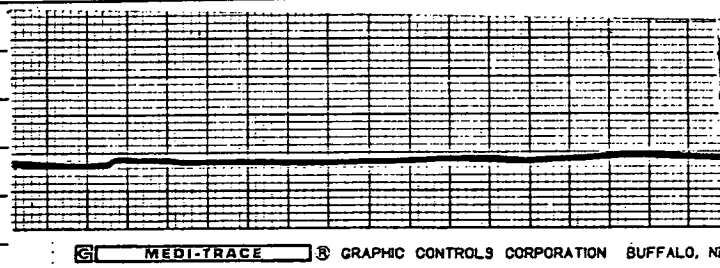
CONTINUATION SHEET

8/27/93 - MIR Arrest Note

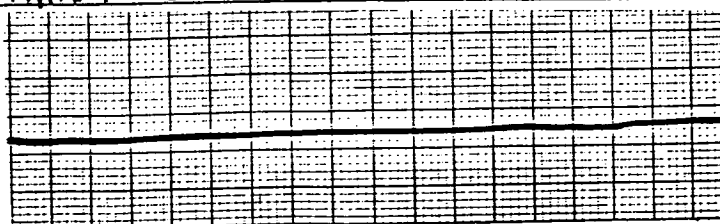
Patient was found by nursing staff unresponsive in bathroom
no pulse. Arrest called. Patient was pulseless + apneic when
I arrived. CPR being instituted. A "quick look" @ paddles
showed asystole. Central venous access was obtained +
patient was given epinephrine / atropine x 2. CPR was
continued. Patient was intubated + bilateral breath sounds
auscultated. EKG leads applied...



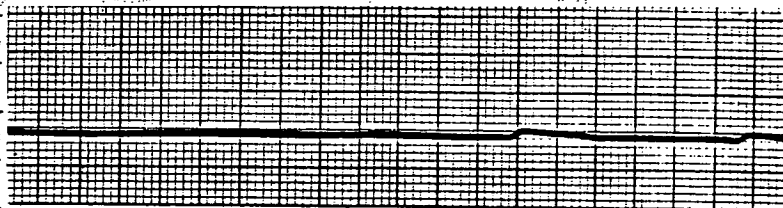
Rhythm asystole as above + verified in multiple leads.
CPR continued. Patient given Narcan + D50 T amp -
IV. Another epinephrine + atropine obtained given.



Rhythm as above - still asystole verified in multiple leads.
Epinephrine + atropine given. AEC obtained - looked
poorly oxygenating. Two amps of Naloxone given. CPR
continued. Rhythm as below



Patient still asystolic. Given epinephrine + atropine again.
CPR continued. Patient still pulseless + apneic.



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Rhythm as below. Arrest terminated 2° to cardiovascular
unresponsiveness @ 4:35 PM.

Mat Hawley



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SETH SPERKEN

NAME

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CONTINUATION SHEET

8/27/93 ASSISTANT UNIT DIRECTOR NOTE REVIEWING CASE / HOSP. COMB.

THIS 23 YO SWM WAS TRANSFERRED FROM ALLEN PAVILION TODAY WITH DIAGNOSIS OF PANIC DISORDER AND 70 BENZODIAZEPINE WITHDRAWAL, WAS ADMITTED AT 100 PM AND FOUND UNRESPONSIVE AT 410 AND PHONICALLY DEPT AT 425.

THE PATIENT IS A RECENT COLLEGE GRADUATE LIVING WITH HIS PARENTS. HE HAD AN APPROXIMATELY 2 YEAR HX OF PANIC SYMPTOMS AND WAS RECEIVING XANAX UP TO 4 MG QD FROM THIS PSYCHIATRIST FATHER DR. RALPH SPERKEN. THE PATIENT ALSO HAD A 6 MONTH HX OF SEVERE DEPRESSIVE SYMPTOMS. PT'S FATHER HAD ADVANCEMENT COMPLETED A MONTH THEN WITHIN A 2 WEEK PERIOD AND THE PATIENT THEN BEGAN SEEING A DR. QUN WHO STATED SLURRY, (TENSE OR DECALESSES BETWEEN THE PT'S HX - HIS DENIES RECENT XANAX USE, AND THE FATHER'S HX - HE NEGATED ANY SMOKY BOTTLES OF XANAX), UP TO 60 MG QD.

ON 8/24/93 THE PT LOSE CSC - WITNESSED BY 10 YR OLD SISTER - AND WAS ADMITTED TO ALLEN PAVILION TO 70 SLURRY TOXICITY AND SEIZURE. HE WAS EVALUATED ON 8/22 BY NEUROLOGY AND 8/23 BY PSYCHIATRY. HE WAS FOUND 2 PANIC AND VIT ON 8/23 WITH HE 70 XANAX DEP/WITHDRAWAL, NO RST CONVULSIVE SYMPTOMS, PUPILS 3, 10 MM. HIS W/O INCLUSION NEGATIVE CT SCAN OF HEAD, NEGATIVE LP ON 8/23 HE WAS TRANSFERRED TO THE ICU FOR MANAGEMENT OF PROBABLE XANAX WITHDRAWAL (THE FATHER ADVISED HIS SUSPICION OF XANAX USE/ABUSE). HE WAS MANAGED ON FENTON 2.94 IV THEN 2.94 PO STARTING 8/26. ON 8/26 HE WAS FELT TO BE MEDICALLY STABLE FOR TRANSFER TO EYE-6 INPATIENT PSYCH UNIT BY ICU ATTEND / ASSISTANT AND 137 PSYCHIATRY CONSULT. HE WAS TRANSFERRED BY AMBUANCE, ARRIVING 100 PM. HE WAS SEEN BY NP @ 100 - 120

(CONTINUED)

RESIDENT EVALUATION PT $\approx 15-35$, NEUTROPHILS $PT \approx 340$. PT WAS
FOUND UNRESPONSIVE BY AN AT 410, CODE CALLED,
PT ANCHORED DEAD 425 PM.

THE RESIDENT HAS COMPLETED EVALUATION (AFTERNOON MEDICAL
CONSULT) AND WAS UNABLE TO LOCATE PT INITIALLY.
HISTORIC MEDICAL W/O OF NO ACUTE DIS; NO MDD;
NO SUBSTANTIAL ABUSE / WITHDRAWAL; NO SUBSTANTIAL
WITHDRAWAL DISORDER, RESOLVED; NO COMPLICATIONS.
THE PATIENT WAS, ON THE UNIT, FULLY ORIENTED, CALM,
COOPERATIVE, WITHOUT AGITATION, WITHOUT THOUGHT DISORDER
OR HALLUCINATIONS AND DENIED SUICIDE. HE WAS
NOTED TO HAVE STABLE VS AT ≈ 315 . HE WAS
SCHEDULED TO BE SEEN BY MEDICAL CONSULT
TO COMPLETE EVALUATION. MEDICAL CONSULT WAS ON PICO
TO SEE PATIENT BEFORE PT CODED AS ABOVE.

PT'S PASTOR CALLED, AND AND CAROL DEPHILIPIS
CALLED. HIS DEATH AND SITUATION CALLED.

CHW JN MD

CHRISTOPHER JOHNSON MD



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3697414

PS MRN

SPEKEN, SETH

Site 3090

NAME

0719970 M 6407105

D.O.B.

DR GOODMAN, ROBER

SEX

CONTINUATION SHEET

8-27-93 Reg. Adm. Summary

Trans in from Allen - 23 yr old Psychology student.
Hx of panic attacks, fearful of crowds, able to
continue at school for the past 2 years only by
taking Xanax 5mg/day - Being treated by own father.
Had a "seizure" 2 wks ago at home. Patches of reddened
areas over nose & face from falling on face.
Seizure pt. attributes from rapid Xanax tapering.
Adm to Allen - last week became delirious
& out of control, needed restraints. Presently
alert/oriented x r. Fearful episodes & depressed
loner SE at present

Engelton, W

8/27/93 Attending

Patient arrived via ambulance from Allen Pavilion at 1pm
approximately. He was interviewed by nursing
until 1201pm then by Dr Sudman, PGYII, until
3301pm. At approximately 3401pm Dr Sudman
spoke to pt who at that time was in the bathroom
with the door closed. At approximately 4101pm
pt was discovered in his bathroom unresponsive.
Pt was nude, sitting on floor between
wall & toilet. (Toilet contained stool)
Cardiac arrest was immediately called, CPR
begun. Pt intubated. 4301pm pt was
pronounced dead.

Ann Geller MD