

Mr J.F. Age 22

Presents with tiredness and fatigue that is severely affecting his ability to concentrate on his research, lectures, and both reading and writing at home. He is now considering quitting his studies as a result. Feeling very distressed, and irritable, and having frequent arguments with his partner. His appointment was made for 4.30pm.

History

John has always been fit and well. He cruised through school up to the sixth form when he began having trouble getting up for school. This became less of a problem when he began university because he arranged course lectures for later in the morning, or the afternoon. As a part time job, he worked the evening shift at McDonalds. He had increasing difficulty getting to sleep, usually not until 2 or 3am. If left, he could sleep through to midday or later. He has tried staying in on Friday and Saturday nights, but he still cannot sleep until 2 am.

He is a non-smoker, and now only drinks moderately at week-ends. Because of his irregular lifestyle, he tends to snack throughout the day. This is usually not particularly healthy food.

He was a keen sportsman, but now too tired to participate.

Past History

Nil of significance.

Specifically, no history of asthma, diabetes, recent viral illness, or psychiatric illness.

Family History

Parents both alive and well. Father is a night shift worker, and always described as an owl. No siblings

Examination

A tired, thin Caucasian, with no abnormal features.

BMI 21

BP 115/75

Cardiovascular, and Respiratory examination, all normal

Mr J.M. Age 56

John is a registered plumber who now owns his own company, and has 10 people working for him. He presents with increasing tiredness and headaches, especially in the morning, and not coping well at work.

History

He had been fit and well as a 20 to 30 year old. Played squash until 40. Since then he had attributed his tiredness to work stress with increased responsibility, and his teenage children!

He has difficulty with concentrating in meetings, especially in the afternoon. He is now concerned that he is frequently falling asleep in the evenings.

In the evening he will share a bottle of wine with his wife, although he does not drink after his meal.

He is a non-smoker.

His wife complains that he is increasingly irritable and argumentative, and they now sleep in separate rooms because he is so fidgety at night, and he snores.

On further questioning.

Sleeps well – very quickly, but still tired, often with headaches in the morning. Some Gastroesophageal reflux (GORD) at night. Occasionally wakes with a cough. Gets up to the toilet x 2 or 3 at night.

Past History

Nil of significance. Specifically, no history of hypertension, asthma, diabetes, or psychiatric illness.

Family History

Father died of an MI at 62 and was an heroic snorer. Mother is alive and well. He has one brother who is rather obese and suffers from angina.

Examination

BP 150/90 Weight 101.6 Kg BMI 32

Cardiovascular and Respiratory system– normal

No lymphadenopathy or thyroid enlargement

Mrs CB Age 48

Cathy presents with exhaustion and insomnia “I can’t sleep and I’m getting exhausted and unable to function properly at work.”

History

Cathy slept well in her early 20’s, and used to need 8 hours sleep to function well. Normal chronotype

She had her first child at 25, second at 27 and third at 28 years old. All seemed to have difficulty sleeping, and her sleep was constantly broken. This lasted until the youngest was 2 years old. i.e. 5 years in total. Since that time sleep has never been the same. All the children have now left home, but her sleep is still broken.

Sleep now interrupted with hot flushes during the night.

She has becoming irritable, with poor motivation, indecisive, not coping well at work and “can’t be bothered.” She has zero libido.

Examination (if thought necessary)

BP 120/85 Weight 50kg BMI 20

Cardiovascular and Respiratory – normal

No lymphadenopathy or thyroid enlargement

ESS 1

Past History

Diagnosis of Post Natal Depression with the first child. Treated with antidepressants for 6 months.

Family History

Both parents alive and well, though mother in her 80’s has been on sleeping tablets for years. Cathy does not want to get into that habit.

Alice S Age 4 years

Alice was brought in by mother because of her disruptive behaviour at preschool, and her teacher thought she might be deaf. Mother commented that her behaviour is not much better at home with tantrums and tiredness.

History

Alice was delivered by a normal vaginal delivery at term.

Her development was normal.

From about 2 years old her behaviour began to deteriorate. This was attributed to the birth of her brother.

She was often snuffly.

Alice was always a fussy eater, but increasingly she began to gain weight. NB Mother is obese.

Alice is a poor sleeper. There are always bedtime tantrums, she wakes at night, and constantly disturbs her exhausted parents.

In the morning she wake irritable, and struggles to get up. All day she seems tired, rubbing her eyes, pulling at her ears, and yawning.

During the day her behaviour deteriorates.

She hasn't had an afternoon nap for the past 2 years.

Sleep Pattern

She is always a noisy breather

Occasionally stops and starts breathing at night.

She has had episodes of waking screaming and sweating.

Her bed clothes are invariably off the bed in the morning, and she may be found sleeping with head over the side of the bed.

Examination

All normal apart from enlarged tonsils, and obesity. She is a mouth breather.

Miss J.N. Age 28

Jan presented with tiredness and fatigue that is severely affecting her ability to concentrate at work. She finally decided to come to the surgery because of a 'near miss' driving accident. Whilst driving to work, she was listening to the radio, began to laugh at a joke, and suddenly lost control of the car for a couple of seconds, nearly missing the oncoming traffic. She had been struggling with her work increasingly for the past two years.

History

Jan had always been fit and well. She was bright at school up to the sixth form when she began suffering bouts of extreme tiredness. She had been taken to the doctor when she was 18, who prescribed an iron supplement, and discussed the possibility of emerging depression. Her bouts of fatigue continued. Jan was managing her sleepiness with occasional naps in her lunch break, and at week-ends. She is a non-smoker, and now only drinks occasionally at week-ends.

Jan had become quite socially withdrawn because of her constant fatigue

Despite Jan's severe sleepiness, she sleeps poorly, waking several times in the night.

Past History

Nil of significance.

Specifically, no history of asthma, diabetes, recent viral illness, or psychiatric illness.

Family History

Parents both alive and well. Her grandmother had a similar history, and had always been looked upon as lazy. She had never been in paid employment.

Examination

Nil remarkable.

BMI 23

BP 115/75

Cardiovascular, and Respiratory examination, all normal

ESS 21

Mrs EB Age 52

Liz presented with increasing daytime sleepiness, and insomnia “I can’t settle and get to sleep, and I’m having to take time off work.”

History

She slept well in early 20’s, and used to need 7.5 hours of sleep to function well. As a child she remembers some difficulty with sleeping, and was diagnosed with ‘growing pains’. Mother would spend time massaging her legs when she was trying to go to sleep. During her first and only pregnancy, she experienced difficulty getting to sleep because of ‘fidgety legs’. However straight after the birth this resolved, and she thought no more of it. On a recent flight to Europe she had been unable to sleep because she was unable to sit comfortably, and spent much of the trip walking up and down the corridors.

Past History

A diagnosis of Depression had been made 2 years previously, and treated with Fluoxetine. Unfortunately this had not been very successful, and her sleep had become worse.

Family History

Father was alive and well, but mother had committed suicide in her 40’s.

Examination

BP 120/85 Weight 65 Kg BMI 27

Cardiovascular and Respiratory – normal

No lymphadenopathy or thyroid enlargement

Neurological examination was normal