For my first site evaluation, I presented a case of a 34 y/o M with GAD who came to clinic for recurrent “panic attacks” occurring about twice a week, lasting 15–20 minutes, and resolving on their own. During these episodes, he reported palpitations, sweating, chest tightness, shortness of breath, and severe headaches, followed by fatigue afterward. He had been on escitalopram for 6 weeks without much improvement and had stopped exercising because he was worried it would trigger symptoms. His blood pressure was elevated in clinic. I chose this case because it really showed how similar psychiatric and medical conditions can look at first glance. It would have been easy to settle on panic disorder, but the episodic symptoms and hypertension made me think more about other possibilities like pheochromocytoma. My evaluator said my presentation was organized and that my differential and plan were solid, especially the way I worked through endocrine and substance-related causes before focusing on a psychiatric diagnosis.

For my second site evaluation, I presented a case of a 40 y/o F with several chronic conditions who came in with 6 months of fatigue despite sleeping well. She also reported weight gain, feeling cold, constipation, dry skin, irritability, and trouble concentrating. On exam, she had dry skin and a diffusely enlarged thyroid without nodules. The overall picture fit most with hypothyroidism, though other considerations included anemia, obstructive sleep apnea, vitamin deficiencies, and depression. I chose this case because fatigue is such a common complaint, but this case showed how important it is to slow down and actually piece together the symptoms and exam findings instead of assuming it is just mood or lifestyle related. My evaluator noted that my assessment and plan were well organized and that I appropriately prioritized thyroid disease while still keeping other causes in mind.

For my journal article, I looked at the relationship between fatigue, peripheral serotonin, and L-carnitine in hypothyroidism and chronic fatigue syndrome. I chose it because I had a patient with hypothyroidism who continued to report fatigue even though she was taking her medication as prescribed. That made me start thinking about why some patients still feel unwell even when their thyroid labs are normal. The study looked at whether low peripheral serotonin might play a role in fatigue and whether L-carnitine could help improve symptoms. Patients with both hypothyroidism and chronic fatigue syndrome started with low serotonin levels, which increased after 7 weeks of supplementation along with improvement in fatigue scores. Higher serotonin levels were linked with lower fatigue. The study had limitations, including a small sample size, no control group, short follow-up, and limited generalizability. It made me think more about fatigue as something that is often multifactorial and not always fully explained by one diagnosis alone.