Addendum Dictated By: GIPPS, VERONICA S MD
Addendum Dictated Date: 10/30/20 1611

<Electronically signed by VERONICA S GIPPS MD>
Electronic Signature Date: 10/30/20 1611

Ht – 182.88cm
Wt – 84.37 kg
BMI – 25.2 kg/m2.

M, S

PH Initials

63 y/o Male.

History of Present Illness

Encounter Date & Time
10/22/20
Service: Rehab Medicine
Primary Care Physician
Pcp,Patient Reports No Local
Attending Physician
Gipps,Veronica S (PM)
Accompanied By: No One, Spouse (Earlier)
Source: Patient, Old Medical Record, Spouse (Earlier)
Chief Complaint
General weakness
HPI
This is a 63-year-old male who was admitted to Holy Cross Hospital on 9/22/2020 to the service of Dr. Kristal Wolfe. He had presented with new onset right facial weakness and numbness that had started some hours earlier. A stroke alert was called and initial imaging was negative for an acute infarct or bleed. He was found to have new onset atrial fibrillation on EKG. He was evaluated by neurology, Dr. Azaret, and found to have a lateral medullary syndrome. Abnormalities were noted on MRI as well with an area of infarct in the right medulla. He was not a candidate for TPA given he was outside the window of intervention, with an NIH stroke scale of 1. He was found to have an elevated hemoglobin A1c of 6.5. Further work-up disclosed significant four-vessel coronary artery disease. On 10/2/2020 he underwent a Maze procedure and a four-vessel coronary artery bypass graft by Dr. Irving David. An ICD was placed on 10/7/2020. He had noted worsening of gait postoperatively. He underwent a CT of the brain on 10/11/2020 which disclosed a left cerebellar subacute infarct. He was started in therapies and appeared to be requiring moderate assist for mobility, with left-sided ataxia without focal weakness. Patient notably on the IRU developed rapid atrial fibrillation. This was accompanied by significant hypotension. He was being followed by Dr. Rishi Anand, cardiology. Recommendations were made for transfer back to a monitored bed for further evaluation. Was seen by Dr. Collado, cardiology. AV nodal ablation was recommended for management of tachybradycardia syndrome, to assure the biventricular pacing was greater than 90%. Procedure was successfully performed on 10/21/2020. Patient was cleared to return to the IRU today.

Review of Systems

Additional Comments
Patient denies any other symptoms regarding any organ system other than those already stated

Past Medical History

Medications

Active Meds Reviewed: Yes

Allergies

Coded Allergies:

No Known Allergies (Unverified , 9/22/20)

Medical History

Medical/Surgical History

Right hand surgery
ACL repair of the left lower extremity
Hypertension

Family history is positive for heart disease

Family History

Heart disease

FATHER, Onset:60 years & older
PATERNAL GRANDFATHER, Onset:50's - 60

Social History

Smoking Status: Never Smoker
Alcohol Use: Denies
Recreational Drug Use: Denies
Additional Comments

Patient reports to have been independent in all ADLs and ambulation priorly. He has a supportive spouse.

Physical Exam

Weight in Kg

Physical Exam

Older male, in no distress, no issues reported to me by nursing

HEENT: EOM intact, no pharyngeal erythema, no neck masses

Heart: Normal sinus rhythm, no gallop

Chest is essentially clear to auscultation.

Abdomen is soft, not tender, bowel sounds present

Extremities, with no calf pain, no significant edema, functional passive range of motion of bilateral upper as well as bilateral lower extremities, right upper and right lower extremity muscle strength 5/5, left upper and left lower extremity muscle strength grossly 5/5 as well

Neurologic examination: Cranial nerve function is noted for mild right facial weakness, notably improved, left upper extremity involuntary movements, myoclonus/ataxia, gait ataxia, sensation appears to be grossly intact

Results

Diagnostics Reviewed: Yes

Plan

Assessment

Problem List:

(1) Cerebellar stroke, acute
(2) Infarction of medulla oblongata
(3) Myoclonus
(4) S/P CABG x 4
(5) S/P Maze operation for atrial fibrillation
(6) S/P implantation of automatic cardioverter/defibrillator (AICD)
(7) Ischemic cardiomyopathy
(8) Acute HFrEF (heart failure with reduced ejection fraction)
(9) Status post ablation of atrial fibrillation
(10) New onset atrial fibrillation
(11) Tachy-brady syndrome
(12) Hypotension
(13) Diabetes mellitus, new onset

Management Plan

Plan

Patient's post admission physician evaluation is consistent with the pre-admission screening. Patient can safely participate in 3 hours of therapy per day 5 days/week. The patient requires IRU admission. The patient's care cannot be provided in a less intense setting. The patient requires an interdisciplinary team approach including physical and occupational therapy as well as skilled nursing, medical management and physiatry management. This patient is at risk for complications including falls ,decubitus, infections, and anemia requiring blood transfusions. Close medical management and monitoring will decrease the risk of complications.

Plan of care: This is a 63-year-old male has been admitted to the rehabilitation unit status post cerebellar stroke and medulla stroke. He notably has left-sided ataxia, impaired mobility. He is status post coronary artery bypass graft, four-vessel, status post maze procedure for atrial fibrillation as well as an ablation, and status post AICD placement. He has an underlying history of ischemic cardiomyopathy and recent new onset atrial fibrillation. Also notably he has evidence of new onset diabetes mellitus. He requires close continued medical management and care.

Physical therapy will work on bed mobility, transfers, balance and gait training with use of an assistive device. He will receive 2 hours of physical therapy daily. Patient will therapy will work on activities of daily living and strengthening of the upper extremities. Emphasis will be placed on coordination as well. He will receive 1 to 2 hours of the patient will therapy daily. Speech therapy will further evaluate for any cognitive issues. Receive 1 hour speech therapy daily.

Prognosis for improvement is good.

His estimated length of stay is 3 weeks depending on progress.

It is expected he will return home with home health services upon discharge. His case will be conferenced on a weekly basis and adjustments will be made to his plan of care as needed.

Additional Information

Condition: Fair

GIPPS,VERONICA S (PM) Oct 22, 2020 21:44

Report Dictated by: GIPPS, VERONICA S MD
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