CHAPTER 1

# Diseases and Disorders of the Nervous System

## BASIC HEALTH RECORD

Reason for Visit
right frontal perietal bleed

## Allergies

**Allergies:** NKA

## Discharge Summaries

**Discharge Summary Notes**

All notes

| Author | Service | Author Type | Filed | Note Time |
|---|---|---|---|---|
| | (none) | Physician | | |

Related Notes
Original Note :

**HOSPITAL DISCHARGE SUMMARY**

Age: 64 y.o.

Admission Date: 5/26/2008
Discharge Date: 5/29/08

He will be discharged from Hospital to home.

**PRINCIPAL DIAGNOSIS CAUSING ADMISSION**: Hemorrhagic transformation of an old stroke in the right middle cerebral artery distribution while on aspirin 325 milligrams a day

Patient Active Hospital Problem List:
*INTRACEREBRAL HEMORRHAGE (5/29/2008)
Hemorrhagic transformation of an old stroke (one month prior to hemorrage) in the right middle cerebral
artery distribution while on aspirin 325 milligrams a day (pt not on plavix at time of hemorrage)
OCCLUSION CEREBRAL ARTERY W INFARCT (4/20/2008)
TEE 5/27/08 admission showed severe nonmobile plaque in aorta, therefore suspect prior stroke embolic from this site. Also suspect brainstem infarct not appreciated on MRI accounting for significant dysphagia.
TOBACCO USE DISORDER (4/20/2008)
HYPERTENSION (4/20/2008)
HEAD INJURY ()

Discharge Summaries continued

CONCUSSION W LOC (4/20/2008)
LACERATION OF HEAD (4/20/2008)
HYPERLIPIDEMIA (4/22/2008)
ALCOHOL ABUSE (5/29/2008)

**DISCHARGE MEDICATIONS**

Medications prior to admission that will be resumed at discharge:

| Medication | Sig |
|---|---|
| • CLONIDINE 0.1 MG/24 HR WEEKLY TRANSDERM PATCH | 1 Patch Topical ONCE PER WEEK- last applied 4/24/2008 |
| • FLEXERIL 5 MG TAB | take 1 tablet (5 mg) by G TUBE route 3 times per day AS NEEDED |
| • LIDOCAINE 5 % (700 MG/PATCH) ADHESIVE PATCH | 1-3 Patch Transdermal EVERY MORNING |
| • LIDOCAINE PATCH OFF | 1-3 Patch Topical EVERY EVENING |
| • LISINOPRIL 20 MG TAB | take 1 tablet (20 mg) by G TUBE route once daily |
| • NICOTINE 21 MG/24 HR DAILY PATCH | 1 Patch Topical EVERY DAY |
| • ROXICET 5 MG-325 MG TAB | take 1 tablet by G TUBE route every 4 hours as needed |
| • SIMVASTATIN 10 MG TAB | take 1 tablet (10 mg) by G TUBE route once daily in the evening |

These are new, changed, or refilled medications at discharge:

| Medication | Sig |
|---|---|
| • ACETAMINOPHEN 500 MG TAB | take 2 tablets (1,000 mg) down feeding tube every 6 hours as needed for pain |
| • SERTRALINE 50 MG TAB | 100 mg Per G Tube EVERY MORNING |

Patient not dicharged with roxicet
**FOLLOW-UP**: He should see . (primary md) next week
Home Pt/OT/Speech follow up
Patient's primary physician to arrange close follow up with Neurology group in south metro area and outpt counseling and psychiatry follow up.

Special instructions: No aspirin, plavix or ibuprofen until seen by neurology in 3 weeks.
Continue tube feeds as prior to admission
No alcohol

**BRIEF HOSPITAL COURSE**:

This 64 y.o. patient's neurological history dates to 04/20/2006, when he presented to

Medical Center with an acute stroke. He had been found on a cement floor at home by his family. He was confused and had a left hemiparesis. The patient was sleepy and could not remember the events leading up to his fall. However, he was able to answer some yes-no questions and whisper longer phrases.

At : Medical Center, the patient underwent a cranial CT scan which showed a subtle area of diminished attenuation in the right frontotemporal area, felt to represent an acute stroke. In addition he had an small older stroke in the right posterior temporoparietal region. Stroke workup included a CT angiogram of the cervical and cranial vessels. There was near-occlusion of the distal M1 portion of the right middle cerebral artery, felt to most likely represent an embolic occlusion. There were atherosclerotic changes in the proximal internal carotid arteries bilaterally, not associated with significant stenoses. The patient had had prior facial surgery requiring placement of metal pieces around the left orbit, precluding MRI. The patient also underwent a transthoracic echocardiogram with bubble contrast study which did not reveal a source of stroke. His dysphagia precluded obtaining a TEE at that time.

Other laboratory studies included a fasting lipid panel which showed a total cholesterol of 190, triglycerides 115, HDL cholesterol of 45, LDL of 122, and normal glucose levels. Electrolytes, BUN, creatinine, and magnesium were within normal limits. Troponins were negative.

The patient continued to improve in terms of his left hemiparesis. However, he continued to have profound difficulty with phonation and swallowing. The patient had a percutaneous gastrostomy tube placed, and after of couple weeks of rehabilitation went home. The patient was discharged on:

1. Lipitor.

Discharge Summaries continued

2. Aspirin 325 milligrams daily

3. **Not discharged on plavix**

4. Clonidine 0.1 mg per 24 hours, changed weekly.

5. Lidocaine skin patch.

6. Nicotine skin patch.

7. Lisinopril 20 mg a day.

8. Flexeril 5 mg, 3 times a day as needed.

9. Percocet 1 tablet every 4 hours as needed.

10. Zoloft 50 mg a day.

The patient was at home with his wife on 05/26 when he suddenly developed weakness in his left leg and started to fall. His wife prevented him from falling. He was brought once again to Medical Center, where this time cranial CT scan showed hemorrhage into the area of his previous right frontotemporal stroke. He denies prior falls and alcohol use since last admission. No syncope,dizziness, palpitations.

With the finding of new intracranial hemorrhage, the patient was loaded with fosphenytoin and transferred to Hospital, where there is neurosurgical backup.

Pt noted to be hemodynamically stable. Admitted to ICU where he proved stable. Routine follow up head ct on hospital day #2 showed no progression of hemorrage. Neurologically, his pupils were slightly asymmetric L ~1.5mm greater than left, he had slight left facial droop and slight weakness in LUE. Peg tube in place. Asa stopped. Pt seen by neurosurgery service and no surgical intervention required. Neurology was consulted. Not entirly clear why pt had complicating hemorrage one month out from stroke. Pt's degree of dysphagia seemed out of proportion to pt's prior right sided infarct. Brain stem infarct suspected. Pt had TEE with results below. Suspect cva one month ago embolic from this site. Recommendation would be for anticoagulation with coumadin, however, current hemorrage precludes this at this time. Pt not to be discharged on aspirin. Pt informed not to take asa, plavix or ibuprofen. Diagnoses and plan discussed with pt's primary md who will arrange for close neurology follow up to decide on appropriate therapy at that time for embolic cva and subsequent hemorrage. Pt was stable from neurologic standpoint. Seen by ot/pt/speech. Per speech, pt still npo with continuation of tube feeds. He will need repeat video swallow eval in ~ 4-5 weeks. He will need outpt pt/ot/speech. Home care to be continued. Pt instructed to stop all alcohol. Unclear if alcohol use contributed to current bleed. Pt cleared by pt/ot and treatment team for discharge home

Pt also noted to be depressed and quit tearful at times. Pt's sertraline was increase to

100mg daily. Will take several weeks to take effect. Pt seen by psychiatry service. Outpt psychiatry/psychology follow up per primary md.

Pt also noted to be bradycardic at times during hospital stay. HR ranged typically in 50-60s. Did go into 40s at times. Pt on telemetry. No pauses, heart block etc.. Pt remained in NSR and appeared to be asymptomatic from this.

RPR, antinuclear antibody, CRP, antineutrophilic cytoplasmic

antibodies, lupus anticoagulant, anticardiolipin antibody, antithrombin III,

homocysteine, Lyme titer, serum protein electrophoresis and immunofixation,

and urine protein electrophoresis and immunofixation were obtained and were all negative except crp minimally elevated at 1.2.

**PENDING TESTS:** SPEP AND UPEP
**IMAGING STUDIES**

HEAD CT ON ADMISSION: FINDINGS

There is acute appearing intraparenchymal hemorrhage within the right temporal and parietal lobes. The adjacent brain appears to be very malacic consistent with a previous infarct that was not present at the time of the prior exam. There is no midline shift or transtentorial herniation. The brain is mildly atrophied.

There is a metal plate along the left lamina papyracea. The visualized paranasal sinuses appear to be normally aerated.

CONCLUSION

Acute appearing intraparenchymal hemorrhage within the right temporal and parietal lobes. The adjacent brain appears to be very malacic consistent with a previous infarct. The findings have all developed since 04/20/08.

FOLLOW UP HEAD CT DURING ADMSSION:

1. Stable hemorrhage within a chronic infarct of the right MCA territory.

2. Stable mild supratentorial white matter changes are nonspecific, but likely representing chronic small vessel ischemic change.

3. Stable hardware along the medial aspect of the left orbit abutting the left medial rectus muscle.

**PAST MEDICAL HISTORY**

Notable for hypertension, chronic low back and left leg pain and numbness,

multiple facial injuries and subsequent surgeries several years ago,

depression, alcohol abuse, and tobacco smoking. He quit tobacco smoking at

the time of his stroke on 04/20/2008. No history of cardiac, pulmonary,

thyroid, serious infectious disease, diabetes, or bleeding or clotting diathesis. The patient had a kidney infection as a teenager.

**PROCEDURES PERFORMED DURING HOSPITALIZATION**: TEE:

1. Severe immobile atherosclerosis of the descending thoracic aorta and arch - up to 0.7 cm
2. Intact atrial septum
3. No LA appendage thrombus
4. Nl LV and RV size and function
5. Moderate MR (2+)
6. Prob mild TR

**COMPLICATIONS IN HOSPITAL**: None

**CONDITION AT DISCHARGE:** Improving

Total time spent for discharge on date of discharge: 50 minutes

Physician(s) in addition to primary physician who should receive a copy:

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DATE OF SERVICE: 05/27/2008

REASON FOR CONSULTATION
I was asked by Dr. to evaluate this 64-year-old right-handed man who presented with new cerebral hemorrhage.

HISTORY
The patient's neurological history dates to 04/20/2006, when he presented to , Medical Center with an acute stroke. He had been found on a cement floor at home by his family. He was confused and had a left hemiparesis. The patient was sleepy and could not remember the events leading up to his fall. However, he was able to answer some yes-no questions and whisper longer phrases.

At Medical Center, the patient underwent a cranial CT scan which showed a subtle area of diminished attenuation in the right frontotemporal area, felt to represent an acute stroke. In addition he had an small older stroke in the right posterior temporoparietal region. Stroke workup included a CT angiogram of the cervical and cranial vessels. There was near-occlusion of the distal M1 portion of the right middle cerebral artery, felt to most likely represent an embolic occlusion. There were atherosclerotic changes in the proximal internal carotid arteries bilaterally, not associated with significant stenoses. The patient had had prior facial surgery requiring placement of metal pieces around the left orbit, precluding MRI. The patient also underwent a transthoracic echocardiogram with bubble contrast study which did not reveal a source of stroke. Other laboratory studies included a fasting lipid panel which showed a total cholesterol of 190, triglycerides 115, HDL cholesterol of 45, LDL of 122, and normal glucose levels. Electrolytes, BUN, creatinine, and magnesium were within normal limits. Troponins were negative.

The patient continued to improve in terms of his left hemiparesis. However, he continued to have profound difficulty with phonation and swallowing. The patient had a percutaneous gastrostomy tube placed, and after of couple weeks of rehabilitation went home. The patient was discharged on:
1. Lipitor.
2. Aspirin 325 milligrams daily
3. Plavix (error-patient recived Plavix in hospital but was not discharged on it)
4. Clonidine 0.1 mg per 24 hours, changed weekly.

5. Lidocaine skin patch.
6. Nicotine skin patch.
7. Lisinopril 20 mg a day.
8. Flexeril 5 mg, 3 times a day as needed.
9. Percocet 1 tablet every 4 hours as needed.
10. Zoloft 50 mg a day.
11. Simvastatin 10 mg daily.

The patient was at home with his wife on 05/26 when he suddenly developed weakness in his left leg and started to fall. His wife prevented him from falling. He was brought once again to . Medical Center, where this time cranial CT scan showed hemorrhage into the area of his previous right frontotemporal stroke.
With the finding of new intracranial hemorrhage, the patient was loaded with fosphenytoin and transferred to . Hospital, where there is neurosurgical backup.

PAST MEDICAL HISTORY
Notable for hypertension, chronic low back and left leg pain and numbness, multiple facial injuries and subsequent surgeries several years ago, depression, alcohol abuse, and tobacco smoking. He quit tobacco smoking at the time of his stroke on 04/20/2008. No history of cardiac, pulmonary, thyroid, serious infectious disease, diabetes, or bleeding or clotting diathesis. The patient had a kidney infection as a teenager.

MEDICATIONS ON THIS ADMISSION
1. Aspirin 325 mg every day.
2. Clonidine 0.1-mg patches.
3. Lidocaine skin patch.
4. Morphine 2 mg/ml down feeding tube every 4 hours as needed.
5. Nicotine skin patch.
6. Simvastatin 10 mg a day.
7. Zoloft 50 mg a day.
8. Methocarbamol 750 mg every 6 hours.
9. Lisinopril 20 mg a day.

ALLERGIES
THE PATIENT HAS NO MEDICATION ALLERGIES.

FAMILY HISTORY
The patient's father had heart disease. The patient does not believe there is any history of stroke in the family.

SOCIAL HISTORY
The patient is retired and lives with his wife They have 3 grown children, who live independently, and a number of grandchildren, whom the patient's enjoys. He spends much of his time in his workshop making furniture and other household goods. Although he quit tobacco smoking a month ago.

REVIEW OF SYSTEMS

The patient denies any trouble with vision, hearing, headache, or abdominal pain. He does have pain in the low back radiating down his left leg. He is aware of his difficulty swallowing and managing his oral secretions. He feels it is difficult to speak loudly, but he can express himself otherwise with ease. He denies any focal numbness at this time. He feels the strength in his left arm and leg are not back to normal, as they were before this event on 05/26/2008. The patient states he is usually continent. No dyspnea or chest pain. The patient admits to feeling very depressed. His wife relates that he has not tolerated four times daily tube feedings, so the frequency was reduced to three times daily. He didn't tolerate this schedule very well and she is concerned about malnutrition.

PHYSICAL EXAMINATION
GENERAL: On physical examination the patient appeared to be an alert, attentive man who looked older than his stated age.
VITAL SIGNS: Blood pressure was 98/62, heart rate in the 50s and regular, respiratory rate 14, with oxygen saturation 100% on 2 liters of nasal cannula.
HEAD AND NECK: General physical exam revealed no evidence of recent trauma to the head. There was several well-healed incisions on the forehead and nose. The patient had rhinophymia. His dentition was in only fair condition. Neck was supple, without bruits.
LUNGS: Clear to auscultation, with the exception of the upper airway noises.
SKIN: There were mild chronic venous stasis changes in the lower calves.
NEUROLOGIC: Mental status testing was not performed in detail. However, the patient was able to give me a fairly consistent history of the present illness from one time to the next. He had no difficulty following two-step commands. No left-right confusion. No evidence of visual-spatial neglect. Cranial nerve testing showed asymmetric pupils, larger on the left than the right by 1 to 1.5 mm. The left eye tended to drift in, but the patient was not aware of any diplopia when I asked him. Facial sensation was intact to touch and pin. There was very mild left lower facial weakness. Palate and uvula rose more prominently on the left than the right side of the mouth. Tongue protruded in the midline. Rapid alternating movements of the tongue only slightly slow. Voice was reduced in amplitude but well articulated. The patient had obvious difficulty with managing thick oral secretions and used a Yonkers suction device in order to assists him so. Motor testing revealed normal tone in all limbs. Strength was full. There was very slight ataxia on finger-to-nose and heel-to-shin on the left. Stretch reflexes were minimally brisker in the left biceps and patella relative to the right. Left toe was upgoing. There was no reduction to touch or proprioceptive sensation.

IMPRESSION AND PLAN
Hemorrhagic transformation of an old stroke in the right middle cerebral artery distribution while on aspirin 325 milligrams a day. Aspirin in conjunction with poor nutrition and perhaps
undisclosed continued alcohol use are factors which might have contributed to hemorrhage. In addition, the patient may have some other condition predisposing him to hemorrhage, such vasculitis.

I will check RPR, antinuclear antibody, CRP, antineutrophilic cytoplasmic

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antibodies, lupus anticoagulant, anticardiolipin antibody, antithrombin III, homocysteine, Lyme titer, serum protein electrophoresis and immunofixation, and urine protein electrophoresis and immunofixation. The patient will have a liver function panel done. I will consider additional imaging studies of the heart after discussing the patient with the stroke service.

Physical, occupational, and speech pathology consults. Increase activity as tolerated. Consider increasing sertraline dose for depression .

Consults continued

**CONSULTATION NOTE**

I was asked to see this patient by Dr. for evaluation of right post frontal/temporal ICH.

**HPI:** 64 year old male admit to 5/26/08 upon transfer from Medical Center. Pt reports CVA April 20, 2008. Was treated at Medical Center. Had gastrostomy placed due to dysphagia. Was discharged from for further rehabilitation. Was discharged home with home care on 5/21/08. On 5/26/08 he was at home on way to the BR. Felt sudden leg weakness and left leg gave out on him causing him to fall. He denies LOC. Was brought to where head CT revealed approximately 2 cm area of acute hemorrhage into previous infarct. Was therefore transferred to for further evaluation. Given load of fosphenytoin in ER.

Pt denies visual changes, no loss of vision, denies new paresthesia. Tube feedings at home, NPO status.
History of left foot numbness since laminectomy few years ago. Wants to go home. Foley in place.

**REVIEW OF SYSTEMS:** A comprehensive review of systems was negative except for items noted in HPI/Subjective.

**Patient Active Problem List**

| Diagnoses | Date Noted |
|---|---|
| • HYPERLIPIDEMIA [272.4] | 04/22/2008 |
| • OCCLUSION CEREBRAL ARTERY W INFARCT [434.91] | 04/20/2008 |
| • TOBACCO USE DISORDER [305.1] | 04/20/2008 |
| • HYPERTENSION [401.9] | 04/20/2008 |
| • CONCUSSION W LOC [850.5] | 04/20/2008 |
| • LACERATION OF HEAD [873.8] | 04/20/2008 |
| • HEAD INJURY [959.01] | |
| *assaulted* | |

**Past Medical History**

| Diagnosis | Date |
|---|---|
| • HYPERTENSION | |
| • INFECTION OF KIDNEY | |
| *in high school* | |
| • BACK DISORDER OTHER UNSPECIFIED | |
| *Back Disorder with left foot numbness* | |
| • DEPRESSION | |
| • HEAD INJURY | 2001 |
| *assaulted* | |

Consults continued

**Past Surgical History**

| Procedure | Date |
|---|---|
| • Hx appendectomy<br>*Appendectomy* | |
| • Hx tonsillectomy | |
| • Hx cranio/maxillofacial surgery<br>*after assaulted, reconstruction, with metal plate in face* | 2001 |
| • Hx back surgery | |

**Family History**

| Problem | Relation |
|---|---|
| • Heart Disease | Father |

**History**

Social History Narrative

*married, retired; lives with wife ; has 3 grown children; enjoys woodworking*

**History**

Social History Main Topics

- Tobacco Use: Yes -- 1.5 packs/day
- Alcohol Use: 0 oz/week
  *drinks 4-6 cans of beer daily, denies any today*
- Drug Use: Not on file
- Sexually Active: Not on file

Reports no further tobacco or ETOH use since 4/20 CVA.

**Current hospital medications**

| Medication | Dose | Route | Frequency | Provider | Last Rate |
|---|---|---|---|---|---|
| • aspirin 325 mg = 1 tablet | 325 mg | Per G Tube | DAILY WITH MEAL | | |
| • cyclobenzaprine 5 mg as half of a 10 mg tablet (FLEXERIL) | 5 mg | Oral | TID | | |
| • famotidine 20 mg = 2 mL x 10 mg/mL injection (PEPCID) | 20 mg | Intravenous | Q 12H | | |
| • magnesium replacement protocol | | Protocol | PROTOC | | |

Consults continued

| | | | |
|---|---|---|---|
| | | | OL |
| • NaCl 0.9% 75 mL/hr | 75 mL/hr | Intravenous | CONTINUOUS |
| • naloxone 0.08-0.4 mg injection (NARCAN) | 0.08-0.4 mg | Intravenous | Q 3MIN PRN |
| • potassium replacement protocol | | Protocol | PROTOCOL |
| • sertraline 50 mg = 1 tablet (ZOLOFT) | 50 mg | Per G Tube | Q AM |
| • simvastatin 10 mg = 1 tablet (ZOCOR) | 10 mg | Per G Tube | BEDTIME |

**ALLERGIES/SENSITIVITIES:** Allergies

| Allergen | Reactions |
|---|---|
| • Nka (No Known Allergies) | |

**Recent Labs**

| Basename | 5/26/08 1610 |
|---|---|
| • WBC | 8.8 |
| • RBC | 5.16 |
| • HGB | 15.9 |
| • HCT | 46.0 |
| • MCV | 89 |
| • MCH | 30.8 |
| • MCHC | 34.6 |
| • PLT | 203 |
| • MPV | 10.7 |

INR 1.1

**Recent Labs**

| Basename | 5/26/08 1610 |
|---|---|
| • SODIUM | 135 |
| • POTASSIUM | 4.6 |
| • CHLORIDE | 102 |
| • CO2TOTAL | 23 |

Consults continued

| | |
|---|---|
| • BUN | 29H |
| • CREATININE | 0.67 |
| • GLUCOSE | 95 |
| • CALCIUM | 9.2 |

No results found for this basename:
ALKPHOSPH:2,PROTEIN:2ALBUMIN:2,BILITOTAL:2,AST:2,ALT:2 in the last 720 hours

**PHYSICAL EXAM:**

General Appearance: Alert, NAD, seen while in bed on Unit 20.

BP 127/70 | Pulse 49 | Temp 97.6 °F (36.4 °C) | Resp 28 | Ht 1.753 m (5' 9") | Wt 79.1 kg (174 lb 6.1 oz) | SpO2 100%
Body mass index is 25.75 kg/(m^2).

NECK: Normal
RESPIRATORY: Normal
CARDIOVASCULAR: Normal
ABDOMEN: Normal. G Tube in place. Dressed. Non tender
NEUROLOGIC:
Alert, appropriate
O x 4
PERRL, full EOM, no diplopia
VFF gross confrontation
Sl left facial asymmetry
Dysarthria, mild
Hypophonic
Palate elevates symmetrically
Tongue midline
Shrug intact
Strength full

**ADDITIONAL COMMENTS:** Non contrast Head Ct completed yesterday at 1700:
CONCLUSION
Acute appearing intraparenchymal hemorrhage within the right temporal and parietal lobes. The adjacent brain appears to be very malacic consistent with a previous infarct. The findings have all developed since 04/20/08.

**CONSULTATION ASSESSMENT AND PLAN:**
**ICH into previously noted infarct**
**Clinically stable**
**No need for neurosurgical intervention at this time. Will repeat Head CT and discuss with neurosurgical staff.**
**Hold on further anticonvulsant**

Consults continued

**Consult with Neurology pending**

Critical Care Service

Accepted in transfer from for further evaluation of right sided stroke.

Patient presented to today for new onset weakness in the left leg. Changes began this a.m. with numbness and tingling, and proceeded to weakness and inability to walk. Of note, patient had suffered a stroke 20 April 2008 with left sided effects, but the left hemiparesis fully resolved. Residual symptom of difficulty with swallowing was treated with a feeding tube.

Per ED notes, patient (and family) denied visual changes, HA, or changes in speech/behavior. No N / V was noted.

Patient was evaluated in the ED. Head CT was done, and revealed new bleeding into the stroke area of April 2008. No mass effect or shift was noted. Foshenytoin was administered at 15 mg/kg.

Patient was transferred to for further care.

Allergy:
NKDA

Medications prior to this admission: (doses found in Excellian)
ASA
Clonidine transderm
flexeril 5 mg TID
lidocaine transderm
lisinopril 20 mg daily
methocarbamol 750 mg q 6 hours
nicotine patch
roxicet
sertraline 50 mg daily
simvastatin 10 mg daily

PMH/PSH:
stroke April 2008
HTN
chronic low back pain
appy

Consults continued

hx head injury, cranio/maxillofacial surgery following assult 2001
hx back surgery
hx depression

FH/SH:
married, 3 children, retired
1.5 packs per day since age 15, until recent hospitalization and none since
EtOH 4-6 cans of beer daily, until recent hospitalization and none since
+heart disease--father
+cancer, both maternal and paternal families

ROS:
as above
comprehensive review else negative
specifically denies CP or SOB

PE:
96/54-52-14 100% on 2 liter NC
awake and interactive, oriented to person and place
CN grossly intact, mild slurring of speech not new
UE's motor intact, sl decrease strength LLE, RLE intact
neck supple
lungs equal, clear
RRR no murmur noted
abd soft, NT, +feeding tube, site without sig erythema
no foley
ext without edema
skin warm/dry

labs at at 1610:
Na 135, K 4.6, Cl 102, bicarb 23, Ca 9.2, Cr 0.6
WBC 8.8, Hgb 15.9, platelets 203

EKG at
NSR, no acute ST changes

1. CNS dx bleeding into right stroke bed. No mass effect. Serial neuro exams, repeat HCT if needed. Discussed with --will formally consult in a.m., available on emergent basis if needed.

2. Pulm dx resp insuff--mild. Supplemental O2 to keep SaO2 greater than 93%.

3. GI dx s/p feeding tube. Resume feeds in a.m.

4. CV dx HTN. Resume lisinopril in a.m., clonidine patch on. PRN BP control tonight if needed--sys goal 120-130's tonight.

5. Heme dx ?abnormal coag parameters. INR pending, treat as appropriate.

**Procedure Notes**



All notes

| Author | Service | Author Type | Filed | Note Time |
|---|---|---|---|---|
| | (none) | Physician | | |

Procedure Orders:
1. ECHOCARDIOGRAM TEE WITH BUBBLE STUDY WO CONTRAST [138345935] ordered by

TEE - 5 mg Versed, 150 mcg Fentanyl

1. Severe immobile atherosclerosis of the descending thoracic aorta and arch - up to 0.7 cm
2. Intact atrial septum
3. No LA appendage thrombus
4. Nl LV and RV size and function
5. Moderate MR (2+)
6. Prob mild TR

All Progress Notes continued

Mrs. , also expressed her desire to have patient home as soon as possible for his mental health.

| Author | | Service | Author Type | Filed | Note Time |
|---|---|---|---|---|---|
| | MD | (none) | Physician | 05/28/2008 1727 | 05/28/2008 1109 |

Related Notes
Original Note :

**Hospitalist Service**

64 y.o. male transferred from Medical Center on 5/26/2008 w/ new head bleed.He had a CVA April 20, 2008 and was treated Medical Center (left sided weakness/deficits had completely resolved). A gastrostomy was placed due to dysphagia and he was discharged from to for further rehabilitation. He was discharged to home with home care on 5/21/08. On 5/26/08 he was at home on way to the bathroom when he felt a sudden leg weakness and his L leg gave out on him causing him to fall. He denies LOC. He was brought to where head CT revealed approximately 2 cm area of acute hemorrhage into previous infarct. He was then transferred to for further evaluation.

**SUBJECTIVE:** Stable overnight with exceptio of tearfulness/crying this am. States he wants to go home. Feels hopeless and depressed. No other complaints. No cough, sob, HA.
**OBJECTIVE:**
**General Appearance:** Alert, oriented times three, overweight caucasian male lying in bed in NAD.

BP 127/67 | Pulse 55 | Temp 98.4 °F (36.9 °C) | Resp 16 | Ht 1.753 m (5' 9") | Wt 79.1 kg (174 lb 6.1 oz) | SpO2 99%
Temp (24hrs), Avg:97.9 °F (36.6 °C), Min:97.6 °F (36.4 °C), Max:98.4 °F (36.9 °C)

**admission weight:** 79.2 kg

Patient Wt. in the past 120 hrs:

| | Wt. |
|---|---|
| 05/27/08 0000 | 79.1 kg (174 lb 6.1 oz) |
| 05/26/08 1830 | 79.2 kg (174 lb 9.7 oz) |

EYES: R pupil and L pupil both react briskly. EOM's intact.
HENT: normocephalic, atraumatic. oropharynx clear.
NECK: supple.
RESP: CTA, good resp effort.
CV: S1 S2-no m/g/r.
ABD: soft, nontender, BS present. L gastrostomy tube in place-site looks good.
GU: foley catheter in place, draining clear yellow urine.
EXT: pulses present, no edema, no clubbing.
SKIN: warm, dry. no visible rashes or lesions.
NEURO: mild L facial droop, 4/5 left grip strength, LUE abduction and flexion 4/5

All Progress Notes continued

PSYCH: alert, oriented x 3. mood, affect normal.

**ADDITIONAL COMMENTS:**

I reviewed the patient's recent lab results.
I have reviewed the patient's current inpatient medications.

Recent Labs

| Basename | 5/26/08 1610 |
|---|---|
| • WBC | 8.8 |
| • RBC | 5.16 |
| • HGB | 15.9 |
| • HCT | 46.0 |
| • MCV | 89 |
| • MCH | 30.8 |
| • MCHC | 34.6 |
| • PLT | 203 |
| • MPV | 10.7 |

Recent Labs

| Basename | 5/26/08 2120 |
|---|---|
| • INR | 1.1 |
| • PTT | -- |
| • HEPARIN | -- |
| • ACT | -- |
| • DDIMER | -- |
| • FIBRINOGEN | -- |

Recent Labs

| Basename | 5/26/08 2120 | 5/26/08 1610 |
|---|---|---|
| • SODIUM | -- | 135 |
| • POTASSIUM | -- | 4.6 |
| • MAGNESIUM | 2.2 | -- |
| • CHLORIDE | -- | 102 |
| • CO2TOTAL | -- | 23 |

Recent Labs

| Basename | 5/26/08 1610 |
|---|---|
| • BUN | 29H |
| • CREATININE | 0.67 |
| • GLUCOSE | 95 |
| • CALCIUM | 9.2 |
| • PHOSPHORUS | -- |
| • ALBUMIN | -- |

**Head CT 5/26/08:** Acute appearing intraparenchymal hemorrhage within the right temporal and parietal lobes. The adjacent brain appears to be very malacic consistent with a previous infarct. The findings have all developed since 04/20/08.

All Progress Notes continued

**ASSESSMENT AND PLAN**

**1. Neuro: R Post-Frontal / Temporal ICH:** head CT at OSH revealed ~ 2 cm area of acute hemorrhage into previous infarct. Got phosphenytoin load in ED. Seen by Neurosurgery today and no need for neurosurgical intervention at this time. Recommend holding further anticonvulsant. Neurology was consulted and has seen patient. Routine f/u head ct to f/u bleed today. Restart asa once have opportunity to talk with neurology. Had dose today.

**2. CV: a) Hyperlipidemia:** continue home zocor. **b) HTN:** currently normotensive. Hold clonidine patch. Resume lisinopril tomorrow.

**3. Pulm: Tobacco Use Disorder:** nicotine patch ordered, was using at home. Slight cough, but clear lung exam. Monitor for signs of infections. Has stopped smoking.

**4. Renal:** replete electrolytes as indicated.

**5. Heme:** INR 1.1. On asa.

**6. ID:** no active issues.

**7. Psych: Depression:** home zoloft.

**8. Nutrition:** enteral nutrition via perc feeding tube due to dysphagia. Will have SLP re-eval his swallow. Was on bolus feedings at home. Enteral nutrition per Dietician's recommendations, appreciate.

**9. Prophylaxis:** scds. Prevacid.

**10. Dispo:** will transfer to H8000.
**11. Etoh abuse**: States he drank~8 drinks per day. No recent withdrawal. No prior CD treatment. Last drink was prior to stroke. Monitor for withdrawal. Rediscuss.
12. Sinus bradycardia: ? Asymptomatic SSS. Nl tele. ? Related to clonidine. Monitor off clonidine. No syncope. Remote tele on floor.
**12. GU**: discontinue foley.
**13. Endo:** Continue accuchecks for now.

**Critical Care Progress Note - Intensivist Service**

64 y.o. male transferred from [redacted] Medical Center on 5/26/2008 w/ new head bleed.He had a CVA April 20, 2008 and was treated at [redacted] Medical Center. A gastrostomy was placed due to dysphagia and he was discharged from [redacted] to

All Progress Notes continued

for further rehabilitation. He was discharged to home with home care on 5/21/08. On 5/26/08 he was at home on way to the bathroom when he felt a sudden leg weakness and his L leg gave out on him causing him to fall. He denies LOC. He was brought to where head CT revealed approximately 2 cm area of acute hemorrhage into previous infarct. He was then transferred to for further evaluation.

**SUBJECTIVE:** Wants to go home, otherwise no complaints. Denies HA, chest pain, dyspnea, nausea, numbness/tingling in extremities, visual disturbances. All else negative.

**OBJECTIVE:**
**General Appearance:** Alert, oriented, overweight caucasian male lying in bed in NAD.

BP 127/70 | Pulse 49 | Temp 97.6 °F (36.4 °C) | Resp 28 | Ht 1.753 m (5' 9") | Wt 79.1 kg (174 lb 6.1 oz) | SpO2 100%
Temp (24hrs), Avg:97.7 °F (36.5 °C), Min:97.2 °F (36.2 °C), Max:98 °F (36.7 °C)

**I/O 24 Hrs:** -125 ml

**admission weight:** 79.2 kg

Patient Wt. in the past 120 hrs:

| | **Wt.** |
|---|---|
| **05/27/08 0000** | 79.1 kg (174 lb 6.1 oz) |
| **05/26/08 1830** | 79.2 kg (174 lb 9.7 oz) |

EYES: R pupil 3 mm, L pupil 3.5 mm, both react briskly. EOM's intact.
HENT: normocephalic, atraumatic. oropharynx clear.
NECK: supple.
RESP: CTA, good resp effort.
CV: S1 S2-no m/g/r.
ABD: soft, nontender, BS present. L gastrostomy tube in place-site looks good.
GU: foley catheter in place, draining clear yellow urine.
EXT: pulses present, no edema, no clubbing.
SKIN: warm, dry. no visible rashes or lesions.
NEURO: ?mild L facial droop and very mild dyscoordination finger to nose, esp on L. Otherwise, CN's II - XII intact. full, symmetrical strength all ext.
PSYCH: alert, oriented x 3. mood, affect normal.

**ADDITIONAL COMMENTS:**

I reviewed the patient's recent lab results.
I discussed the patient's treatment plan
I have reviewed the patient's current inpatient medications.

Recent Labs
Basename 5/26/08 1610

All Progress Notes continued

| | |
|---|---|
| • WBC | 8.8 |
| • RBC | 5.16 |
| • HGB | 15.9 |
| • HCT | 46.0 |
| • MCV | 89 |
| • MCH | 30.8 |
| • MCHC | 34.6 |
| • PLT | 203 |
| • MPV | 10.7 |

Recent Labs

| Basename | 5/26/08 2120 |
|---|---|
| • INR | 1.1 |
| • PTT | -- |
| • HEPARIN | -- |
| • ACT | -- |
| • DDIMER | -- |
| • FIBRINOGEN | -- |

Recent Labs

| Basename | 5/26/08 2120 | 5/26/08 1610 |
|---|---|---|
| • SODIUM | -- | 135 |
| • POTASSIUM | -- | 4.6 |
| • MAGNESIUM | 2.2 | -- |
| • CHLORIDE | -- | 102 |
| • CO2TOTAL | -- | 23 |

Recent Labs

| Basename | 5/26/08 1610 |
|---|---|
| • BUN | 29H |
| • CREATININE | 0.67 |
| • GLUCOSE | 95 |
| • CALCIUM | 9.2 |
| • PHOSPHORUS | -- |
| • ALBUMIN | -- |

**Head CT 5/26/08:** Acute appearing intraparenchymal hemorrhage within the right temporal and parietal lobes. The adjacent brain appears to be very malacic consistent with a previous infarct. The findings have all developed since 04/20/08.

**ASSESSMENT AND PLAN**

**1. Neuro: R Post-Frontal / Temporal ICH:** head CT at revealed ~ 2 cm area of acute hemorrhage into previous infarct. Got phosphenytoin load in ED. Seen by Neurosurgery today and no need for neurosurgical intervention at this time. Recommend holding further anticonvulsant. Neurology was consulted and are seeing patient at present.

All Progress Notes continued

**2. CV: a) Hyperlipidemia:** continue home zocor. **b) HTN:** currently normotensive. on clonidine patch and lisinopril at home. Resume home meds as indicated--doesn't need them restarted now.

**3. Pulm: Tobacco Use Disorder:** nicotine patch ordered, was using at home.

**4. Renal:** replete electrolytes as indicated.

**5. Heme:** INR 1.1. On asa.

**6. ID:** no active issues.

**7. Psych: Depression:** home zoloft.

**8. Nutrition:** enteral nutrition via perc feeding tube due to dysphagia. Will have SLP re-eval his swallow. Was on bolus feedings at home. Enteral nutrition per Dietician's recommendations, appreciate.

**9. Prophylaxis:** scds. Prevacid.

**10. Dispo:** will transfer to and have Hospitalist Service see today. Intensivist Service will sign off.

**Problem: A PLAN CVA F NUTRITION**
**Goal:** PATIENT'S RISK FOR ASPIRATION IS DETERMINED.

**Clinical Nutrition / Initial Assessment**

**Reason for Referral:**
Screened at nutritional risk due to: Difficulty chewing or swallowing.**No RD consult sent.**

**Problem:**
Nutrition Diagnosis Oral or Nutrition Support Intake Inadequate oral food / beverage intake
As Related to R sided stroke.
As Evidenced by Prolonged NPO status (NPO since stroke in 2008), PEG.
Ht: 5'9" CBW: 79.1 kg BMI: 25.75 Wt previous admission (4/26): 84 kg

All Progress Notes continued

Diet Rx: NPO, pt admitted he has been on TF since the last stroke. I attempted to call pt's wife, but she was not home. I spoke with pt's daughter and she reported pt was on Two Cal HN, but pt nor pt's daughter know how many cans he was receiving. Per last admission note, pt was receiving Isosource 1.5 @ 60 ml/hr.
Meds: Reviewed.
Recent Labs

| Basename | 5/26/08 2120 | 5/26/08 1610 | |
|---|---|---|---|
| • ALBUMIN | | -- | -- |
| • PREALBUMIN | | -- | -- |
| • SODIUM | | -- | 135 |
| • BUN | | -- | 29H |
| • CREATININE | | -- | 0.67 |
| • POTASSIUM | | -- | 4.6 |
| • PHOSPHORUS | | -- | -- |
| • MAGNESIUM | | 2.2 | -- |

**Goal:** TF to meet pts nutritional needs adequately and safely.
Estimated Nutritional Needs:
1888-2203 kcal (Mifflin 1.2-1.4/CBW)
87-103 g protein (1.1-1.3 g/kg/CBW)
2370 ml fluid (30 ml/kg/CBW)

**Intervention:**
1. Once TF is to be restarted, recommend bolus Two Cal HN 1 can 4.5 times per day to provide pt with 2138 kcal, 90 g protein, 234 g CHO and 747 ml fluid.
2. Pt will need 50 ml free water flush before and after each bolus and an additional 1100 ml free water per day (180 ml free water flush six times per day).
3. Recommend repeating the swallow eval per speech as medically appropriate.
4. Will monitor plan of care and will make further recommendations as appropriate.
RD following per high nutritional risk protocol.

Nutrition Education: Nutrition education will be provided as appropriate.

Addendum: Called pts wife x 2 and she was not home-spoke with pts daughter. Asked that pts wife call back to give me the exact number of bolus feeds per day. RN aware that we are waiting for a return call.

Addendum: Spoke with pt's wife and pt was receiving Two Cal HN 1 can four times per day, but since he has a "rolling stomach" he cut it down to 3 cans per day (1425 kcal and 60 g protein). She also reported pt was taking 1 packet beneprotein with each bolus (25 kcal and 5 g protein each). I told her I did not feel three were enough and I recommended 4.5 cans. Recommend initiating reglan when the bolus TF are initiated. RD following.

All Progress Notes continued

**Hospitalist Service**

64 y.o. male transferred from ; Medical Center on 5/26/2008 w/ new head bleed.He had a CVA April 20, 2008 and was treated at ; Medical Center (left sided weakness/deficits had completely resolved). A gastrostomy was placed due to dysphagia and he was discharged from for further rehabilitation. He was discharged to home with home care on 5/21/08. On 5/26/08 he was at home on way to the bathroom when he felt a sudden leg weakness and his L leg gave out on him causing him to fall. He denies LOC. He was brought to where head CT revealed approximately 2 cm area of acute hemorrhage into previous infarct. He was then transferred to for further evaluation.

**SUBJECTIVE:** Stable, transfering out of icu. Seen by neurosurgery, no ha, cp, sob. Occasional cough productive of whitish sputum. No syncope
**OBJECTIVE:**
**General Appearance:** Alert, oriented times three, overweight caucasian male lying in bed in NAD.

BP 127/70 | Pulse 49 | Temp 97.6 °F (36.4 °C) | Resp 28 | Ht 1.753 m (5' 9") | Wt 79.1 kg (174 lb 6.1 oz) | SpO2 100%
Temp (24hrs), Avg:97.7 °F (36.5 °C), Min:97.2 °F (36.2 °C), Max:98 °F (36.7 °C)

**I/O 24 Hrs:** -125 ml

**admission weight:** 79.2 kg

Patient Wt. in the past 120 hrs:

| | Wt. |
|---|---|
| 05/27/08 0000 | 79.1 kg (174 lb 6.1 oz) |
| 05/26/08 1830 | 79.2 kg (174 lb 9.7 oz) |

EYES: R pupil and L pupil both react briskly. EOM's intact.
HENT: normocephalic, atraumatic. oropharynx clear.
NECK: supple.
RESP: CTA, good resp effort.
CV: S1 S2-no m/g/r.
ABD: soft, nontender, BS present. L gastrostomy tube in place-site looks good.
GU: foley catheter in place, draining clear yellow urine.
EXT: pulses present, no edema, no clubbing.
SKIN: warm, dry. no visible rashes or lesions.
NEURO: mild L facial droop, 4/5 left grip strength, LUE abduction and flexion, LLE 4/5 strength with flesion. Otherwise, CN's II - XII intact, full, symmetrical strength all ext.

All Progress Notes continued

strength with flesion. Otherwise, CN's II - XII intact. full, symmetrical strength all ext - no change in exam
PSYCH: alert, oriented x 3. Mood seems depressed, tearful, ? **labile,** alternates between tearfulness and nl conversation

**ADDITIONAL COMMENTS:**

I reviewed the patient's recent lab results.
I have reviewed the patient's current inpatient medications.

Recent Labs

| Basename | 5/28/08 0705 | 5/26/08 1610 |
|---|---|---|
| • WBC | 8.6 | 8.8 |
| • RBC | 4.64 | 5.16 |
| • HGB | 14.1 | 15.9 |
| • HCT | 41.0 | 46.0 |
| • MCV | 88 | 89 |
| • MCH | 30.4 | 30.8 |
| • MCHC | 34.4 | 34.6 |
| • PLT | 177 | 203 |
| • MPV | 10.7 | 10.7 |

Recent Labs

| Basename | 5/26/08 2120 |
|---|---|
| • INR | 1.1 |
| • PTT | -- |
| • HEPARIN | -- |
| • ACT | -- |
| • DDIMER | -- |
| • FIBRINOGEN | -- |

Recent Labs

| Basename | 5/28/08 0705 | 5/26/08 2120 | 5/26/08 1610 |
|---|---|---|---|
| • SODIUM | 136 | -- | 135 |
| • POTASSIUM | 4.2 | -- | 4.6 |
| • MAGNESIUM | 2.1 | 2.2 | -- |
| • CHLORIDE | 106 | -- | 102 |
| • CO2TOTAL | 24 | -- | 23 |

Recent Labs

| Basename | 5/28/08 0705 | 5/26/08 1610 |
|---|---|---|
| • BUN | 19 | 29H |
| • CREATININE | 0.67 | 0.67 |
| • GLUCOSE | 83 | 95 |
| • CALCIUM | 8.6 | 9.2 |
| • PHOSPHORUS | -- | -- |
| • ALBUMIN | 3.4L | -- |

**Head CT 5/26/08:** Acute appearing intraparenchymal hemorrhage within the right temporal and parietal lobes. The adjacent brain appears to be very malacic consistent with a

previous infarct. The findings have all developed since 04/20/08.

**ASSESSMENT AND PLAN**

**1. Neuro: R Post-Frontal / Temporal ICH:** head CT at revealed ~ 2 cm area of acute hemorrhage into previous infarct. Got phosphenytoin load in ED. Seen by Neurosurgery today and no need for neurosurgical intervention at this time. Recommend holding further anticonvulsant. Neurology was consulted and has seen patient. Asa discontinued yesterday. Discuss etiology of bleed with neuro. Stable night neurologically. No nsaids, asa, heparin products given bleed.

**2. CV: a) Hyperlipidemia:** continue home zocor. **b) HTN:** currently normotensive. Hold clonidine patch. May resume lisinopril if bp proves stable. Monitor.

**3. Pulm: Tobacco Use Disorder:** nicotine patch ordered, was using at home. Slight cough, but clear lung exam. Monitor for signs of infections. Has stopped smoking.

**4. Renal:** replete electrolytes as indicated.

**5. Heme:** INR 1.1. On asa.

**6. ID:** no active issues.

**7. Psych: Depression:** home zoloft.

**8. Nutrition:** enteral nutrition via perc feeding tube due to dysphagia. Will have SLP re-eval his swallow. Was on bolus feedings at home. Enteral nutrition per Dietician's recommendations, appreciate.

**9. Prophylaxis:** scds. Prevacid.

**10. Dispo:** per neuro and pt/ot.
**11. Etoh abuse**: States he drank~8 drinks per day. No recent withdrawal. No prior CD treatment. Last drink was prior to stroke. Monitor for withdrawal. **? If played role in pt's bleed - ? If fall involved while intoxicated.**
**12. Sinus bradycardia:** ? Asymptomatic SSS. NI tele. ? Related to clonidine. Monitor off clonidine. No syncope. Remote tele on floor. NI tele except hr in low 40s without pauses or hrt block overnight. Continue tele for now.
**12. GU**: discontinue foley.
**13. Endo:** Continue accuchecks for now.
**14. Depression:** Decompensation related to cva. ? Lability to mood (? Related to locatio of stroke). Continue outpt regemine. Psychiatry to see. Will need outpt counseling set up.

Discussed care plan with patient and RN, neuro.

ADDENDUM: TEE reviewed. ? Etiology to cva. Not candidate currently for anticoagulation given bleed. May be able to resume asa in one month if hemmorage improves. Etoh may be playing a role - ? If pt had fall on etoh (while on asa and plavix) which developed into intracranial hemmorage.

All Progress Notes continued

**Problem: A PLAN CVA F NUTRITION**
**Goal:** SAFE NUTRITIONAL PLAN IS ESTABLISHED/TOLERATED.
Clinical Nutrition Note:
Received consult to re-evaluate pt's current TF regimen. Pt currently receiving 4.5 cans per day of TwoCal HN as bolus feedings. Consult states that pt is not tolerating bolus feedings per gravity administration because of upset stomach and diarrhea with urgency. Spoke with pt's RN today and she said that pt has denied any GI complaints. Pt has been experiencing some loose stools (3 documented yesterday and 1 so far today) but his BM's are less frequent than the number of times he goes to the bathroom. RN stated that pt goes to the bathroom frequently but often does not do anything. MD note from yesterday states that pt's wife does not want a TF pump, therefore, other than bolus feedings there would be no other options. Current TF is the most calorically dense formula that is available, therefore, if we change the formula we would have to increase the number of boluses and this does not seem desirable. One option would be to continue with current regimen, but only provide 1/2 can at a time, wait a hour, then the administer the remainder of formula. Realize that this would equate to 8.5 feedings a day. First, recommend trying the use of Reglan before boluses feedings to help with reported nausea. However, met with pt this morning and he denied that the TF is giving him any difficulties. Pt denied nausea when asked. If pt's wife becomes open to the idea of a pump, nocturnal feedings could be a solution as well. Noted that is to see pt later this morning. RD following. Please page for further assistance.

Neurology Progress Note
5/28/08

S: Wants to go home. Has back pain with exertion.

O: Alert, voice amplitude low with reduced phonation but annunication clear. Coughs and clears throat intermittently as attempts to raise thick secretions. Uses Yonkers suction infrequently. Does not seem to be aspirating oral secretions.

All Progress Notes continued

Patient cried twice for brief periods during our discussion.

CRANIAL NERVES II-XII: left pupil 4.5 mm and right pupil 3 mm in ambient light. Mild amblyopia with left eye deviating nasally intermittently (no diplopia with this). Facial sensation intact.. Mild left lower facial weakness. Palate rises more poorly on right than left. Motor testing shows normal tone all limbs. Trace weakness left deltoid and finger extension; mainly it takes patient longer to activate left arm in comparison to right. Left hip flexor minimally weaker than right. Reflexes slightly increased left biceps and patella. Plantar responses extensor on left and flexor on right. Intact sensation to touch and proprioception distally in limbs.

TRANSESOPHOGEAL ECHOCARDIOGRAPHY shows severe aortic atherosclerosis.

Prealb 18 (lower limit of ref range)
Albumin 3.4 (minimally low)
Magnesium 2.1
CRP 1.2
Homocysteine 8.3
Anticardiolipin ab normal
CBC and basic metabolic panel normal
ANCA, LYME, Vit K, ANA, lupus anticoag, AT III, RPR, Anti-nuclear antibody,and serum and urine electrophoresis still pending

Impression and plan: (1) Ischemic stroke(s) 4/20/08. Aorta is likely source of cerebral infarcts, given lack of significant stenoses in the cervical and intracranial vessels by CT ANGIOGRAM. This means that patient could have had a second, smaller embolus to the brainstem to explain his profound dysphagia, out of proportion to his left hemiparesis. Antiplatelet therapy is the optimal prophylactic agent in this setting in a patient who has a higher chance of cerebral hemorrhage on warfarin anticoagulation.

(2) Hemorrhage into right hemisphere infarct 4/26/08 likely related to having both aspirin and Plaivx on board. However, I suspect some other factors predisposing to hemorrhage, including excessive alcohol use and suboptimal nutrition. Recommend that antiplatelet agents be avoided for 1 month, then patient should go back on aspirin only at 325 milligrams a day. Continue statin. I have discussed with patient that he should not exceed 2 small servings of an alcoholic beverage a day.

(3) Disposition. Patient agreeable to working with physical therapist tomorrow. If passible with assistive device, it is reasonable to send patient home with home services- PT, OT and speech.

ADDENDUM: I called patient's wife to discuss the above with her, at the patient's request. She understood my concerns regarding nutritional status and alcohol. Her response to these concerns is that patient was not tolerating the bolus tube feedings at home. The home care nurse instructed wife to reduce the number of feedings from 4 times to 3 times a day, but patient still felt nauseated and it seemed as if feedings just sat in his stomach and didn't empty.
I spoke with patient's RN about getting a dietician to look at alternative feeding schedules. Patient's wife said specifically that she does not want to use a pump.

All Progress Notes continued

| Author | Service | Author Type | Filed | Note Time |
|---|---|---|---|---|
| | | SLP- Speech Language Pathologist | 05/29/2008 1021 | 05/29/2008 1019 |

brief f/u. Pt lying quietly in bed, appears slightly anxious. He hopes to go home today. He does not feel there has been a change in swallow. He continues to use suction for secretions. Pt was able to demonstrate pharyngeal strengthening exercises he had been given at previous facility. Recommend services to monitor status and determine appropriate timing of repeat VFSS (estimate another 3-5 weeks). Continue NPO status until repeat VFSS completed. Will follow while admitted.

| Author | Service | Author Type | Filed | Note Time |
|---|---|---|---|---|
| | (none) | NURS- Registered Nurse | 05/29/2008 1012 | 05/29/2008 1012 |

**Problem: A PLAN CVA A CARE PRIORITY**
**Goal:** ESTABLISH PATIENT/FAMILY CARE PRIORITY FOR THE DAY.
Date initiated:
Today's Date: 5/29/08
Today's Care Priority: Pain will be controlled and patient will remain safe.
I have reviewed the Plan of Care with the patient. We have determined that the care priority for today is as stated above. Tylenol given for back pain. Moist warm pack to back with some improvement. Patient uses call light appropriately.

| Author | Service | Author Type | Filed | Note Time |
|---|---|---|---|---|
| | (none) | SWS- Licensed Social Worker | 05/29/2008 0955 | 05/29/2008 0951 |

**Social Work Services Discharge Note**

**Patient Name:**
**Date**: 5/29/2008
**Anticipated Discharge Date:** May 29, 2008

**Discharge Disposition:** Home with Home Care:
MD orders to be faxed when complete.

**Additional Services Arranged:** SW received a consult to give pt resources on psychiatrists/therapists in pt's home town. Writer has a list and will give to pt and pt's spouse when she arrives.

**Patient / Family response to discharge plan:** Pt agrees with plan to d/c to home today with HHC.

TRANSESOPHAGEAL ECHOCARDIOGRAM REPORT

Final Impression:
1. Severe immobile atherosclerosis of the descending thoracic aorta and arch, measuring up to 0.7cm.
2. Intact atrial septum.
3. No left atrial appendage thrombus.
4. Normal left and right ventricular size and systolic function.
5. Moderate mitral regurgitation through multiple jets (2+).
6. Probable mild tricuspid regurgitation.

Interpretation:
PROCEDURE: Transesophageal echocardiogram, color and spectral Doppler, bubble contrast study.

PROCEDURAL ASPECTS: Indications, goals, risks, and alternatives of the procedure were discussed with the patient and informed consent was obtained. The patient received conscious sedation with 5mg of intravenous Versed and 150mcg of intravenous fentanyl, as well as topical Cetacaine spray to the oropharynx. The probe was advanced into the esophagus without difficulty. The patient tolerated the procedure well and there were no apparent complications.

FINDINGS: The left ventricle appears normal in size with overall normal systolic function. The right ventricle appears normal in size with overall normal systolic function. The left atrial appendage is free of thrombus. All four pulmonary veins are identified with normal connection to the left atrium. The atrial septum is intact by colorflow imaging and after agitated saline contrast injection, with and without Valsalva maneuver. There is severe immobile atherosclerosis of the descending thoracic aorta and arch, measuring up to 0.7cm in thickness. No mobile component is noted.

The aortic valve is trileaflet without significant stenosis or regurgitation. There is moderate mitral regurgitation through multiple jets (2+). There is probable mild tricuspid valve regurgitation. The pulmonary valve grossly appears normal.

There is no significant pericardial effusion.

**Result Information**

| Status | | Provider Status |
|---|---|---|
| Normal | Final result (5/28/2008 10:03 PM) | Reviewed |



**Result Narrative**

NONCONTRAST CT HEAD 05/27/08

CLINICAL HISTORY: Infarct.

Compared to prior study from 05/26/08.

FINDINGS: Stable large zone of encephalomalacic and gliotic change involving the right MCA territory compatible with a chronic appearing infarct. When accounting for differences in technique, stable acute blood within the chronic infarct again noted. No evidence of intraventricular extension of hemorrhage. No evidence of midline shift. Stable, mild scattered foci of decreased attenuation within the white matter of both cerebral hemispheres compatible with small vessel ischemic change. Calcification of the cavernous carotid compatible with advanced atherosclerotic disease. Stable metallic hardware along the medial aspect of the right orbit closely abutting the right medial rectus muscle and the globe.

**Result Impression**

1. Stable hemorrhage within a chronic infarct of the right MCA territory.

2. Stable mild supratentorial white matter changes are nonspecific, but likely representing chronic small vessel ischemic change.

3. Stable hardware along the medial aspect of the left orbit abutting the left medial rectus muscle.