BP BP <scleroplex@gmail.com>

Possible stroke patient

Nardin, Rachel <rnardin@challiance.org> **Fri, May 21, 2010 at 4:01 PM**
To: "Schorin, Melvin" <MSchorin@challiance.org>
Cc: scleroplex@gmail.com

Hi Mel,
I wanted to give you some f/u on [redacted]. Repeat brain MRI still not showing acute infarct. CTA without vessel cutoff, dissection or stenosis. His deficits have persisted. They are working him up for both stroke and giving him Solumedrol for possible MS flare. I think it's still possible that he had a small anterior choroidal artery infarct. Anyway, I think you did a great job caring for him and it was a pleasure to work with you!

Best,
Rachel

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[redacted]

Author: Bharti, Naila, M.D. Note Status: Preliminary
Date: 05/21/10

* * * THIS IS A TEXT VERSION OF THE ORIGINAL LMR NOTE. FOREIGN LANGUAGE CHARACTERS AND OTHER SPECIAL SYMBOLS MAY NOT APPEAR AS THEY DO IN THE ORIGINAL NOTE. * * *

Neurology Resident Admit Note

Patient Name: [redacted]
MRN [redacted]
Date/Time/Place of Exam/Initial Assessment: 5/21/10, MGH
Admit Chief Complaint/Dx and Admit Date: Rt sided weakness

HPI: The patient is a 47yo RHM with PMH of MS (presented 3/09 w L sided symptoms, ataxia; on beta-seron), HLP (on statin), smoker who developed R numbness at 3.30pm today and presented to Cambridge hospital; symptoms progressed and started to involve R face/arm/leg with weakness, and dysarthria. NIHSS 10 for 3-2, 4-2, 5-2, 6-3, 8-1, 10-1 per Dr. Nadin (OSH neurology). CT head unremarkable. MRI with negative DWI and FLAIR without plaque in L hemisphere per report. tPA given at 7pm (3.5 hrs, extended window), total dose 65mg, bolus 7mg.

Past Medical History:

Multiple sclerosis
Panic attacks

Medications at home:
Simvastatin 20 mg daily
Sertraline 100 mg daily
Ativan 0.5 mg BID
Verapamil 80 mg daily
Betaseron 0.3mg every other day
Adderall 5 mg TID
Viagra

Allergies: NKDA

Social History : Smoker

Physical Examination:
Vitals: BP 140-180/70-80, HR 70-80, RR 16-18, O2 sat 99% on RA
General:
Appearance: WDWN, NAD
Chest: CTAB with good flow.
CVS: RRR, Nl S1/S2. No M/G/R. No JVD.
Abd: Soft, NT, ND. Pos BS
Ext: No CCE. DP 2+.

MS:
Gen: Alert, appropriately interactive, normal affect.
Orientation: Full. Also able to tell his age.
Speech/Lang: Dysarthric; Follows simple and complex commands without L/R confusion.

CN:
I: Not tested.
II: Rt inferior quadrantanopsia. PERRL 4 mm ? 2 mm.
III,IV,VI EOMI w/o nystagmus (or diplopia). No ptosis.
V: Sensation decreased on the right side.
VII: Right facial weakness (functional component)
VIII: Hears finger rub equally and bilaterally.
IX,X: Dysarthric voice
XI: SCM and trapezii full.
XII: Tongue protrudes midline.

Motor: Full strength in LUE and LLE. RUE - 3/5, RLE - 4/5

Reflex:

BiTriBraPatAnkToes
C6C7C6L4S1
R22222up
L22222down

Sens:
LT intact. No evidence of extinction.

Labs/Studies:
05/20/2010 NA 137, K 3.8, CL 103, CO2 25.2, BUN 13, CRE 0.79, EGFR >60 [1], GLU 116 (H)
05/20/2010 CA 9.6, PHOS 3.7, MG 1.9, TBILI 0.4, DBILI 0.1, TP 7.1, ALB 4.3, GLOB 2.8
05/20/2010 ALT/SGPT 26, AST/SGOT 28, ALKP 104, TBILI 0.4, DBILI 0.1
05/20/2010 CK-MB Negative, TROP-I Negative
05/20/2010 WBC 13.6 (H), RBC 4.63, HGB 14.7, HCT 42.1, MCV 91, MCH 31.7, MCHC 34.8, PLT 281
05/20/2010 METHOD Auto, %NEUT 62, %LYMPH 31, %MONO 6, %EOS 1, %BASO 0
05/20/2010 ANEUT 8.46 (H), ALYMP 4.13, AMONS 0.74, AEOSN 0.18, ABASOP 0.06
05/20/2010 ANISO None, HYPO None, MACRO None, MICRO None
05/20/2010 PT 11.8 [1], PT-INR 1.0, PTT 20.6 (L) [2]
05/20/2010 UA-COLOR Yellow, UA-APP Clear, UA-GLUC Negative, UA-BILI Negative, UA-KET Negative, UR-SPGR 1.015 [1], UA-BLD Negative, UA-PH 6.5
05/20/2010 UA-PROT Negative, UA-UROBI Negative, UA-NIT Negative, UA-WBC Negative
05/20/2010 UR-ACETOM Negative, UAMPH Negative, UBARB Negative, UBENZ Positive [1], UCOCA Negative, UMAMPH Negative, UMETHD Negative, UOPI Negative
05/20/2010 URPCP Negative, UTHC Negative, TRC-UG Negative [1]

MRI (5/20/10):
No evidence of acute infarction or hemorrhage.

Scattered T2/FLAIR periventricular and subcortical hyperintensities, with pronounced involvement of the callososeptal interface. These findings are compatible with demyelinating plaques in the setting of reported multiple sclerosis. No definite enhancement is identified to suggest active demyelination.

EKG (Today): Normal sinus rhythm

A/P: 47yo M with MS p/w R face/arm/leg numbness and weakness, with negative imaging. His exam is elaborated. His deficits could be because of the demyelinating plaque but there is no enhancement. Unlikely to be a stroke/TIA.

Plan:
Neuro:
- MS flare versus small stroke, eg brainstem or capsule
- s/p tPA, tPA precautions
- Hold ASA, arterial sticks, and foley placement
- Imaging: repeat CT scan 24 hours post-tPA and immediately if neurological exam changes

- start ASA once 24 hr CT head stable
- TTE, holter
- Labs: fasting lipid panel,HbA1c, TSH, ESR, CRP, RPR
- treat also as if MS flare with solumedrol 250mg iv Q 6 hrs x 3-5 days
- PT/OT
- smoking cessation
- continue beta-seron

CV:
- telemetry, TTE as above, 24-hr holter monitor
- Allow for BP autoregulation with SBP goal <180 and DBP <105 as per IVtPA protocol
- serial cardiac enzymes q8 x3

Heme:
- Hold prophylactic lovenox and use teds/boots for first 24 hours s/p IVtPA
- Start antiplatelet therapy and prophylactic lovenox after 24-hr head CT if no hemorrhagic conversion of stroke

Endo:
- Strict Glycemic control: RISS with FSBG checks per ICU protol with FSBG goal 80-120

Pulm:
- Supplemental O2 for SpO2 goal > 95%

Renal:
- Goal eunatremia

GI/FEN:
- NPO for now
- Dysphagia screen before initiating PO intake
- SLP consult to further assess for swallowing dysfunction if pt fails dysphagia screen

Secondary prevention:
- Smoking cessation consult and/or nicotine replacement therapy prior to discharge (if any smoking in the past 12 months)

PPX
DVT: teds/boots for now, lovenox 40mg sc qday after 24 hrs post-tPA
GI: ranitidine
Bowel: colace/senna
Code Status: Full Code

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Neurology Resident (PGY2)