**Affiliated Hospital of Yan'an University**

**Discharge Records**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: Patient3 | Gender: Male | Age: 51 | Department: Neurology Ward 2 | | Bed No.: 22 | Medical Record No.: 0002444695 |
| Name: Patient3 | | | | Gender: Male | | |
| Age: 51 | | | | Hospitalization No.: 0002444695 | | |
| ID No.: 36210119720519103X | | | | Ward Name: Neurology Ward II | | |
| Date of Admission: 2023-11-20 11:46 | | | | Date of Discharge: 2023-11-27 09:00 | | |
| Admission Condition: 1 day ago, the patient had no obvious reasons and incentives for speech disadvantage, numbness of the left upper limb, feeling tongue, unclear articulation, feeling weakness of the left limb, no limb pain, no obvious dizziness, headache and discomfort, no nausea, Vomiting, no palpitation, chest tightness and shortness of breath discomfort, no transient black punch in both eyes, ignoring object rotation, ignoring object blurring, no tinnitus and hearing loss, unconsciousness and orientation disorder, no drinking water, coughing and dysphagia, no limb convulsions and inappropriate breathing, self-control of urine and defecation. In the emergency department of our hospital, the brain DWI showed: small patches of DWI high signal shadow, ADC signal decreased, acute cerebral infarction in the pontine. Now for further diagnosis and treatment, he came to our hospital, and the outpatient department was admitted to the hospital with "acute cerebral infarction". Since the onset of the disease, the patient has no chest tightness, chest pain, chills, or fever. The general condition is acceptable, the intake is acceptable, the night rest is acceptable, and the urination and defecation are as usual.  Admission Diagnosis: 1. Acute brainstem infarction; 2. Bilateral internal carotid atherosclerosis; 3. Hypertriglyceridemia; 4. Emphysema with bullae in both lungs; 5. Fatty liver; 6. Chronic viral hepatitis B.  Positive Auxiliary Examination Results: fecal routine: occult blood positive; Complete set of blood lipids detection: serum triglyceride determination: 2.91 mmol/L ↑, low-density lipoprotein cholesterol determination: 3.02 mmol/1 ↑, apolipoprotein AI: 0.92 g/L ↓, serum total bile acid determination: 11.9 umol/L ↑, serum γ-glutamyltransferase determination: 89 U/L ↑, blood seeding four items: hepatitis B surface antigen volume: 19.33 (positive reaction) IU/ml: cranial MRA (3.0 T): A1 segment of right anterior cerebral artery is absent. MRA of the remaining brain showed no significant abnormalities. Chest CT plain scan: 1. Emphysema in both lungs with bullae formation. 2. Fatty liver. Color Doppler ultrasound of cervical vessels: plaque formation at the bifurcation of bilateral internal and external carotid arteries. Craniocerebral DWI: cerebral infarction in the acute phase of the pontine.  Examination and Treatment after Admission: Improve the relevant examination after admission, and give left limb electronic biofeedback therapy, nutrition of brain cells, improvement of cerebral circulation and other treatments.  Discharge Diagnosis: 1. Acute brainstem infarction; 2. Bilateral internal carotid atherosclerosis; 3. Hypertriglyceridemia; 4. Emphysema with bullae in both lungs; 5. Fatty liver; 6. Chronic viral hepatitis B  Symptoms and signs at the time of discharge: the patient's speech is unfavorable, the numbness of the left upper limb has improved significantly compared with that at the time of admission, no other special discomfort has been complained of, no headache, no tinnitus, earache, no nausea, vomiting, no rotation of objects, double vision, no tinnitus, Nystagmus, clear speech, good physical movement, good spirit, eating, rest at night, normal defecation and urination. There was no obvious change in physical examination. Nervous system physical examination: clear consciousness, question-and-answer, clear speech, physical examination cooperation, sensitive response. Rough tests of memory, | | | | | | |

**Affiliated Hospital of Yan'an University**

**Discharge Records**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: Patient3 | Gender: Male | Age: 51 | Department: Neurology Ward 2 | Bed No.: 22 | Medical Record No.: 0002444695 |
| calculation, comprehension, judgment, and orientation were normal, and there were no apraxia, agnosia, and aphasia. Negative cranial nerves; the muscle volume of the limbs was normal, the muscle tone of the limbs was moderate, the muscle strength of the left limb was 4 grades, and the muscle strength of the remaining limbs was grade 5s. Bilateral finger-nose test and heel-knee-shin test were stable and accurate. Extremities pain temperature sense, tactile sense bilateral symmetrical existence.  Discharge Condition: improving  Discharge Doctor's Order: After discharge: 1. Low-salt and low-fat diet, dynamic monitoring of blood pressure levels. 2. Pay attention to rest, avoid fatigue and colds, keep a happy mood, and exercise properly. 3. Regular oral drugs outside the hospital: aspirin enteric-coated tablets, each dose: 0.1 g, orally, qd, clopidogrel bisulfate tablets, each dose: 75mg, orally, qd, (a total of 21 days after oral administration), atorvastatin calcium tablets J, each dose: 20mg, orally, qd, 4. Follow-up guidance: review of liver function, blood lipids, and cervical blood vessels after 3 months Color Doppler ultrasound: annual review of chest CT, Respiratory medicine follow-up. Regular monitoring of liver function, outpatient follow-up for infectious diseases; visit to the hospital on discomfort. | | | | | |