**Meaning of P and Q values**

Prognosis = probability of good outcome - choose from these

P1: 0-20, P2: 20-40, P3: 40-60, P4: 60-80, P5 80-100

Probability of seizures: Qs use same scale

**Group 1**

Sid299 – 57m, hx cad/stent, tongue ca s/p chemo/xrt, p/w vf arrest/coma [P3, Q3]

Sid838 – 54M, h/o rectal ca s/p surgery, p/w R PICA SAH/IVH, GCS 13 [P4,Q3]

Sid 904 – 57M RF GBM, p/w gen wkness + L arm shaking + tumor progression + cerebral edema. [P4, Q5]

sid1358 -- 59M refractory epilepsy, admitted w/ gtcs multiple times / day. exam ~wnl. [P5, Q5]

Summary:

In favor of matching:

similar age range

similar mix of chronic disease

3 of 4 have history of (but not active) cancer

all but one have similar GCS scores (first has coma; others are GCS 13-15)

all are at fairly high risk of seizures / IIIC

Caveats:

Cardiac arrest + coma seems worse than the other cases

Broad range of APACHE-II scores (6-15)

Overall, matching seems reasonable w.r.t having similar prognoses based on admission data

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| sid1358 |

This is a 59 year old male with refractory epilepsy who was originally referred for Neuropace but ended in the ED at OSH due to seizures and was transferred to MGH for further management. It is not clear if all his event are epileptic and previous studies suggested multifocal epilepsy with non epileptic events.

**Plan:**

1- LTM to characterize events.

2- Lorazepam 1mg IV prn for seizures (prolonged >3mins, cluster, or convulsive)

3- Maintain current AED doses

4- We will decide on further adjustments to his AEDs based on the what we capture on LTM.

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| sid904 |

Pleasant 57 yo RHM with right frontal GBM with multifocal recurrence presenting with increasing generalized weakness, functional impairment, and multiple episodes of left arm shaking likely due to tumor progression and cerebral edema. Exam consistent with significant left-sided weakness, left pronator drift, apraxia in the left hand and poor delayed recall. Per Dr. Gerstner, given his c-MET amplification, he is in the Phase I c-MET inhibitor trial, however the side-effects have proven intolerable and he continues to decline clinically to the point that his wife is unable to care for him at home. Plan is to admit the patient to inpatient neurology for evaluation of his physical decline and initiation of dose dense temozolomide with bevacizumab.

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sid299

57yoM with HTN, HLD, stage IV squamous cell at left tongue base s/p chemo/XRT (in remission), CAD s/p stent, on whom neurology is consulted for cooling after VF arrest. Unfortunately there are no records of his exam prior to intubation, and he has since been sedated with at least 8mg of Versed, 2mg of Ativan, and several propofol, fentanyl and Demerol boluses. Thus, his current exam is likely significantly clouded by medication. However, given history of unresponsiveness and lack of absolute contraindications, recommend therapeutic hypothermia.

Recommend hypothermia: [x] yes [ ] no

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| sid838 |

54 y.o. R handed M with history of rectal cancer s/p low anterior resection and ileostomy reversal 5/2010, subacute subdurals 5/2010 s/p right minicraniotomy and evacuation presenting today after being found down at work at MIT with vomit at scene. No sign of head trauma, GCS 13 at scene.

Brought to ED by EMS with SBPs in 110s. Upon arrival, had NCHCT which showed blood in ventricles, subsequent CTA with prelim finding of 3mm right vertebral aneurysm just superior to the take off of the PICA. Per wife, patient has reported 3 days of headaches and took asa 325 this AM for his symptoms. **Neuro:** MENTAL STATUS: somnolent, arousable to loud voice. Following commands. Oriented to person and year, not place. Speech fluent but falls asleep.

revealing subarachnoid and intraventricular hemorrhage with associated mild to moderate hydrocephalus and an associated right verterbal artery V4 segment 3 mm dissecting aneurysm just distal to the origin of the PICA status post EVD placement.

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**Group 2**

Comments:

In favor of matching:

similar ages – except one young patient

similar APACHE II scores

similar mix of chronic disease

3 of 4 have history of (but not active) cancer

similar GCS scores

similar risk for seizures / IIIC during admission based on baseline information

Caveats: one patient is much younger, but has multiple health problems so probably at similar risk for poor outcome as the older patients in this group

Overall, matching seems reasonable w.r.t having similar prognoses based on admission data

Sid250 - 62F, h/o RF meningioma + gtcs / epilepsy, p/w recurrent gtc [P5,Q5]

Sid517 – 28F w/ recurrent PNA, R MT AVM + CPS, p/w R eye pain, hemorrhage in eye [P5, Q4]

Sid838 – 54M, h/o rectal ca s/p surgery, p/w R PICA SAH/IVH, GCS 13 [P4,Q3]

Sid933 - 64M distant h/o sz; p/w GTC, found to have large large frontal mass + edema; GCS 14 [P5, Q4]

sid1358 -- 59M refractory epilepsy, admitted w/ gtcs multiple times / day. exam ~wnl. [P5, Q5]

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| sid517 | 5158557 | 2017-01-06 00:00:00 | 2017-01-15 00:00:00 |

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| right eye redness/hemorrhage |

HPI

 28 F with h/o R sided temporal AVM, pectus excavatum s/p reconstructive surgery, likely CCAM with recurrent R-sided PNAs, migraines who presents from Emerson hospital due to red eye for 5 days and concern for ocular hemorrhage. The patient says she woke from sleep on New Year's Day and noticed R eye redness and irritation. She says her vision has been blurry on the R side but otherwise she has preserved EOMI, no pain with eye movements. She says she was seen by a community opthalmologist who was immediately concerned based on his exam and sent her to Emerson hospital where she was evaluated by opthalmology there. There they were concerned that her ocular complaints relate to her AVM and sent her to MGH for urgent evaluation.

She denies fevers/chills, dyspnea, chest pain, abdominal pain, nausea/vomiting, constipation/diarrhea.

**HPI:** 32RHF w hx anxiety, migraines, weekly blurry vision in R eye, monthly brief staring spells during which her eyes are open and she is unresponsive with no subsequent recollection of these events, and R medial temporal AVM dx 2015 after transient R eye visual loss, seen at that time at BWH by Dr. Du and s/p angio by Dr. Frierichs, per patient was recommended neurology evaluation and surgery but was lost to followup due to anxiety, now presenting with several day hx of R eye pain, blurry vision, and light and dark spots in R eye and is found on MRA and CTA to have right medial temporal AVM grossly similar to prior.  Neurosurgery is consulted regarding the patient's symptoms i/s/o R medial temporal AVM.

Pt reports she developed the aforementioned symptoms on 1/1/17, was subsequently seen by an ophthalmologist, knowing pt's hx of AVM her eye doctor advised her to go to the ED. Pt went to Emerson ED and was subsequently transferred to MGH for further evaluation.

Currently reports HA similar to baseline, nausea, numbness and tingling in hands and feet similar to baseline.  Denies vomiting, focal weakness.

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| sid250 |

62F, h/o RF meningioma + gtcs / epilepsy, p/w recurrent gtc

This is a 62 year-old, right-handed psychiatrist with a prior right frontotemporal meningioma complicated by GTCs (last in 2013) on Keppra 750mg BID, subsequently reduced to 500mg BID 6 months ago due to dowsiness. Two nights ago she had an episode of motionless staring and confusion lasting 30 min and then returned to her baseline. Approximately 2-hours later, while sleeping her husband heard a "thumping" noise and found that she fell out of her bed followed by shaking of the left foot then entirety of the left lower extremity and some involuntary "contorsions"of the left arm lasting 2-hours. On administration of versed her movments stopped. EEG here showed right-hemispheric PLEDs. Keppra was increased to 1G Keppra BID and she was monitoried with cvEEG

62 yo woman with a history of R Fronto-temporal meningioma s/p resection and complicated by

seizures on Keppra, who presents with acute onset “strange behavior” and L leg and arm shaking with preserved consciousness, with an exam notable for a profound L homonymous hemianopsia and dense L sided neglect + acalculia.

DDX includes sortical spreading affecting the post-central gyrus and causing a post-ictal neglect vs. new stroke/ bleed. Concern for possible posterior circulation truama from fall.

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| sid838 |

54 y.o. R handed M with history of rectal cancer s/p low anterior resection and ileostomy reversal in 5/2010, subacute subdurals in 5/2010 s/p right minicraniotomy and evacuation presenting today after being found down at work at MIT with vomit at scene. No sign of head trauma, GCS 13 at scene.

Brought to ED by EMS with SBPs in 110s. Upon arrival, had NCHCT which showed blood in ventricles, subsequent CTA with prelim finding of 3mm right vertebral aneurysm just superior to the take off of the PICA. Per wife, patient has reported 3 days of headaches and took asa 325 this AM for his symptoms. **Neuro:** MENTAL STATUS: somnolent, arousable to loud voice. Following commands. Oriented to person and year, not place. Speech fluent but falls asleep.

revealing subarachnoid and intraventricular hemorrhage with associated mild to moderate hydrocephalus and an associated right verterbal artery V4 segment 3 mm dissecting aneurysm just distal to the origin of the PICA status post EVD placement.

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| sid933 |

64M distant h/o sz; p/w GTC, found to have lartge large frontal mass, extensive edema; GCS 14 [

frontal mass, newly diagnosed. He has midline shift due to ehe extensive surrounding edema

64 yo man with hx. of ? brain mass at age 2 years, seizure disorder on Carbamazepine who is coming as a transfer from OSH where he presented due to a seizure and was found to have a large frontal mass on NCHCT. Per OSH reports, he presented there midday today after a friend found him having a seizure and called 911. He underwent CT head which showed a large, heterogenous mass and marked surrounding vasogenic edema in the R frontal lobenear midline. There is significant effacement of the lateral ventricles and a 5 mm R to L midline shift. Also per OSH report, he was at the same hospital in March 2014 after a seizure and at that time his imaging did not show abnormalities. He now complains of a mild headache, but ROS is negative for: dysarthria, vertigo/lightheadiness; dysphagia, numbness/tingling, weakness, bowel or bladder incontinence, Also negative for fever/chills/night sweats, CP, SOB, palpitations, abd pain, N/V/D/C, URI sx, wt

changes, cough, UTI sx, back pain, neck pain.

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| sid1358 |

59M refractory epilepsy, admitted w/ daily szs

This is a 59 year old male with refractory epilepsy who was originally referred for Neuropace but ended in the ED at OSH due to seizures and was transferred to MGH for further management. It is not clear if all his event are epileptic and previous studies suggested multifocal epilepsy with non epileptic events.

**Plan:**

1- LTM to characterize events.

2- Lorazepam 1mg IV prn for seizures (prolonged >3mins, cluster, or convulsive)

3- Maintain current AED doses

4- We will decide on further adjustments to his AEDs based on the what we capture on LTM.

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**Group 3**

GCS of all is 15 on presentation

Apache II scores range 3-5

sid152 - 48M p/w headaches, RT lesion suspicious for brain tumor [P5, Q4]

sid208 - 61yo LHF with medication refractory epilepsy, p/w recurrent szs [P5, Q5]

sid603 - 49M w/ adult onset blindness, pn, vertigo, ceribellar ataxia, p/w spells of behavioral arrest [P5, Q4]

sid1380 - 55M, HCV, R Jugular foramen epidermoid, p/w disequilibrium and R SDH. Inoxicated. [P5, Q4]

sid1621- 55M, HTN, DL, recent lami, p/w fever, acute aphasia, imaging neg for stroke [P4, Q4]

sid1771- 42M w/ NSCLC mets> brain + epilepsy, p/w somnolence, CT = multiple small ICH from mets [P4, Q4]

sid1989 - 61M w/ NSCLC mets to liever, p/w confusion + a new brain mass [P4, Q4]

Comments:

In favor of matching:

similar APACHE II scores

similar mix of chronic disease

3 of 4 have history of (but not active) cancer

all same GCS scores

similar risk for seizures / IIIC during admission based on baseline information

Caveats: age range is a little bit broad

Overall, matching seems reasonable w.r.t having similar prognoses based on admission data

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| sid1989 |

61M w/ NSCLC mets to liever, p/w confusion + a new brain mass

Vincent A Palazzo is a 61 y.o. man with a history of metastatic NSCLC (known liver mets) on afatinib who presented with confusion and was found to have a new brain mass.

Per chart review, his wife noted confusion over the past 5 days. He also had inappropriate laughing and difficulty speaking. No one other than the patient was available at the time of the interview to provide collateral information.

The patient was unsure of why he is in the hospital. Reports he feels hot but does not feel like he has a fever. Reports having memory problems. Denies SOB, chest pain, abdominal pain, dysuria, or leg swelling.

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| sid1771 |

42M w/ NSCLC mets to brain + epilepsy, p/w somnolence, CT = multifocal small ICH from mets

42 yo male with PMHx of NSCLC stage 4 s/p chemotherapy, known brain mets s/p WBXRT and stereotaxic radiationm, seizure d/o on keppra, recent

cerebellar CVA in 11/2012, who presents with 4 days of progressive weakness and R. sided peripheral vision loss. He feels these symptoms have

progressively gotten worse. He has had mild headaches since yesterday, which are bilateral frontal, 6/10 in severity, constant, and wakes up with them

being worse. His wife also states he has been more confused and has slept more over the past 2 days, although he is easy to arouse and is not falling

asleep during the day if he has interaction. He is also having issues with calculations. He denies any changes to vision, language, swallowing, or

breathing. He was discharged on Lovenox after an admission in Albany, NY, for stroke prevention in the setting of cancer. He has never had a DVT, PE, or abnormal heart rhythm in the past. On CT scan in the ED he was found to have a multiple areas of well circumscribed hemorrhage in R. temporal, R. occipital, L. frontalm with extension into L. lateral ventricle. MRI shows that these are likely bleeds from his metastatic disease.

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| sid152 |

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48M p/w headaches, RT lesion suspicious for tumor

48M p/w RT medial temporal lobe non-enhancing, ill-defined lesion found during the workup of headaches who returns in followup. PMH/PSH: DM type 2, hyperlipidemia, migraines, inguinal hernia repair. Exam normal. MRI 10/26/15: Ill-defined, mildly expansile, FLAIR hyperintense lesion involving the medial aspect of the right temporal lobe without associated enhancement. DDx: low-grade glioma versus focal cortical dysplasia. Admitted for elective resection.

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| sid208 |

61yo LHF with medication refractory epilepsy. She has a history of febrile seizures as an infant, epilepsy as a child, however was seizure free up until her 40s when she had a recurrence of seizures. Her current semiology is characterized by an aura of feeling flushed and hot, followed by a medicinal taste in her mouth. She then has confusion followed by generalized convulsions. She has seizures 2-3 times a month. P/w recurrent szs

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| sid603 |

49M w/ adult onset blindness, pn, vertigo, ceribellar ataxia, p/w spells of behavioral arrest

49 yo RH man w/ constellation of adult-onset blindness, peripheral neuropathy, vertigo, cerebellar

dysfunction, migraines (? mitochondrial vs. neurodegenerative disease) who presented to medicine service

with multiple spells of transient subjective feeling of tunnel vision and slow to respond. While admitted, he continued to have spells that typically occurred each morning ~ 7 am. Each spell lasted ~5 minutes and consisted of a subjective feeling of the world closing in

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| sid1380 |

55M, HCV, R Jugular foramen epidermoid, p/w disequilibrium and R SDH. Inoxicated.

55 y/o M, hx HCV and R jugular foramen epidermoid, s/p partial resection at Tufts in 2007 and total resection 11/2013 via

translabyrinthine/transcochlear approach (known to Dr. McKenna, ENT at MEEI). Since his surgery in November has had

multiple falls which he attributes to poor balance / dysequilibrium. His last fall was 3 days ago. Yesterday, presented to MEEI

for appointment and head CT was obtained. This demonstrated R SDH. He was transferred to MGH for further evaluation. Of

note, pt continues to drink and is intoxicated at the time of this interview. He has a hx of delirium tremens after last operation.

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| sid1621 |

Sid1621- 55M, HTN, DL, recent lami, p/w fever, acute aphasia, imaging neg for stroke

55 yo RHM, with h/o HTN, HLD, on no anticoagulation with recent laminectomy on June 5th, p/w left facial droop, and aphasia. LSW 9:30PM last night. C/o HA and fever yesterday evening, felt dizzy. This morning at 8AM, the wife was passing by and asked him if he was going to bed but she did not look at him at that time so unsure if was well then. Then the patient called his daughter at 9:40 AM, speaking few words, which were clear (not slurred) but could not understand. Daughter called mother and brought to OSH. He had NCHCT and 325 mg of ASA at OSH and was transferred to MGH for further management. He continues to have the same speech problems with no improvement but no worsening. Of note, he has been ambulating, walking up 3 miles a day for the past few days, last walked July 3