CC: ,Left hand numbness on presentation; then developed lethargy later that day.,HX: ,On the day of presentation, this 72 y/o RHM suddenly developed generalized weakness and lightheadedness, and could not rise from a chair. Four hours later he experienced sudden left hand numbness lasting two hours. There were no other associated symptoms except for the generalized weakness and lightheadedness. He denied vertigo.,He had been experiencing falling spells without associated LOC up to several times a month for the past year.,MEDS:, procardia SR, Lasix, Ecotrin, KCL, Digoxin, Colace, Coumadin.,PMH: ,1)8/92 evaluation for presyncope (Echocardiogram showed: AV fibrosis/calcification, AV stenosis/insufficiency, MV stenosis with annular calcification and regurgitation, moderate TR, Decreased LV systolic function, severe LAE. MRI brain: focal areas of increased T2 signal in the left cerebellum and in the brainstem probably representing microvascular ischemic disease. IVG (MUGA scan)revealed: global hypokinesis of the LV and biventricular dysfunction, RV ejection Fx 45% and LV ejection Fx 39%. He was subsequently placed on coumadin severe valvular heart disease), 2)HTN, 3)Rheumatic fever and heart disease, 4)COPD, 5)ETOH abuse, 6)colonic polyps, 7)CAD, 8)CHF, 9)Appendectomy, 10)Junctional tachycardia.,FHX:, stroke, bone cancer, dementia.,SHX: ,2ppd smoker since his teens; quit 2 years ago. 6-pack beer plus 2 drinks per day for many years: now claims he has been dry for 2 years. Denies illicit drug use.,EXAM: ,36.8C, 90BPM, BP138/56.,MS: Alert and oriented to person, place, but not date. Hypophonic and

dysarthric speech. 2/3 recall. Followed commands.,CN: Left homonymous hemianopia and left CN7 nerve palsy (old).,MOTOR: full strength throughout.,SENSORY: unremarkable.,COORDINATION: dysmetric FNF and HKS movements (left worse than right).,STATION: RUE pronator drift and Romberg sign present.,GAIT: shuffling and bradykinetic.,REFLEXES: 1+/1+ to 2+/2+ and symmetric throughout. Plantar responses were flexor bilaterally.,HEENT: Neck supple and no carotid bruits.,CV: RRR with 3/6 SEM and diastolic murmurs throughout the precordium.,Lungs: bibasilar crackles.,LABS:, PT 19 (elevated) and PTT 46 (elevated).,COURSE:, Coumadin was discontinued on admission as he was felt to have suffered a right hemispheric stroke. The initial HCT revealed a subtle low density area in the right occipital lobe and no evidence of hemorrhage. He was scheduled to undergo an MRI Brain scan the same day, and shortly before the procedure became lethargic. By the time the scan was complete he was stuporous. MRI Scan then revealed a hypointense area of T1 signal in the right temporal lobe with a small foci of hyperintensity within it. The hyperintense area seen on T1 weighted images appeared hypointense on T2 weighted images. There was edema surrounding the lesion The findings were consistent with a hematoma. A CT scan performed 4 hours later confirmed a large hematoma with surrounding edema involving the right temporal/parietal/occipital lobes. The patient subsequently died.