REASON FOR CONSULTATION:, Regarding weakness and a history of polymyositis.,HISTORY OF PRESENT ILLNESS:, The patient is an 87-year-old white female who gives a history of polymyositis diagnosed in 1993. The patient did have biopsy of the quadriceps muscle performed at that time which, per her account, did show an abnormality. She was previously followed by Dr. C, neurology, over several years but was last followed up in the last three to four years. She is also seeing Dr. R at rheumatology in the past. Initially, she was treated with steroids but apparently was intolerant of that. She was given other therapy but she is unclear of the details of that. She has had persistent weakness of the bilateral lower extremities and has ambulated with the assistance of a walker for many years. She has also had a history of spine disease though the process there is not known to me at this time.,She presented on February 1, 2006 with productive cough, fevers and chills, left flank rash and pain there as well as profound weakness. Since admission, she has been diagnosed with a left lower lobe pneumonic process as well as shingles and is on therapy for both. She reports that strength in the proximal upper extremities has remained good. However, she has no grip strength. Apparently, this has been progressive over the last several years as well. She also presently has virtually no strength in the lower extremities and that is worse within the last few days. Prior to admission, she has had cough with mild shortness of breath. Phlegm has been dark in color. She has had reflux and occasional dysphagia. She has also had constipation but no other GI issues. She has no history of

seizure or stroke like symptoms. She occasionally has headaches. No vision changes. Other than the left flank skin changes, she has had no other skin issues. She does have a history of DVT but this was 30 to 40 years ago. No history of dry eyes or dry mouth. She denies chest pain at present.,PAST MEDICAL AND SURGICAL HISTORY:, Hysterectomy, cholecystectomy, congestive heart failure, hypertension, history of DVT, previous colonoscopy that was normal, renal artery stenosis.,MEDICATIONS:, Medications prior to admission: Os-Cal, Zyrtec, potassium, Plavix, Bumex, Diovan.,CURRENT MEDICATIONS:, Acyclovir, azithromycin, ceftriaxone, Diovan, albuterol, Robitussin, hydralazine, Atrovent.,ALLERGIES:, NO KNOWN DRUG ALLERGIES.,SOCIAL HISTORY:, She is a widow. She has 8 children that are healthy with the exception of one who has coronary artery disease and has had bypass. She also has a son with lumbar spine disease. No tobacco, alcohol or IV drug abuse.,FAMILY HISTORY:, No history of neurologic or rheumatologic issues.,REVIEW OF SYSTEMS:, As above.,PHYSICAL EXAMINATION:,VITAL SIGNS: She is afebrile. Current temperature 98. Respirations 16, heart rate 80 to 90. Blood pressure 114/55.,GENERAL APPEARANCE: She is alert and oriented and in no acute distress. She is pleasant. She is reclining in the bed.,HEENT: Pupils are reactive. Sclera are clear. Oropharynx is clear.,NECK: No thyromegaly. No lymphadenopathy.,CARDIOVASCULAR: Heart is regular rate and rhythm.,RESPIRATORY: Lungs have a few rales only.,ABDOMEN: Positive bowel sounds.

Soft, nontender, nondistended. No hepatosplenomegaly.,EXTREMITIES: No edema.,SKIN: Left flank dermatome with vesicular rash that is red and raised consistent with zoster.,JOINTS: No synovitis anywhere. Strength is 5/5 in the proximal upper extremities. Proximal lower extremities are 0 out of 5. She has no grip strength at present.,NEUROLOGICAL: Cranial nerves II through XII grossly intact. Reflexes 2/4 at the biceps, brachial radialis, triceps. Nil out of four at the patella and Achilles bilaterally. Sensation seems normal. Chest x-ray shows COPD, left basilar infiltrate, cardiomegaly, atherosclerotic changes.,LABORATORY DATA:, White blood cell count 6.1, hemoglobin 11.9, platelets 314,000. Sed rate 29 and 30. Electrolytes: Sodium 134, potassium 4.9, creatinine 1.2, normal liver enzymes. TSH is slightly elevated at 5.38. CPK 36, BNP 645. Troponin less than 0.04.,IMPRESSION:,1. The patient has a history of polymyositis, apparently biopsy proven with a long standing history of bilateral lower extremity weakness. She has experienced dramatic worsening in the last 24 hours of the lower extremity weakness. This in the setting of an acute illness, presumably a pneumonic process.,2. She also gives a history of spine disease though the details of that process are not available either.,The question raised at this time is of recurrence in inflammatory myopathy which would need to include not only polymyositis but also inclusion body myositis versus progressive spine disease versus weakness secondary to acute illness versus neuropathic process versus other.,3. Zoster of the left flank.,4.

Left lower lobe pneumonic process.,5. Elevation of the thyroid stimulating hormone.,RECOMMENDATIONS:,1. I have asked Dr. C to see the patient and he has done so tonight. He is planning for EMG nerve conduction study in the morning.,2. I would consider further spine evaluation pending review of the EMG nerve conduction study.,3. Agree with supportive care being administered thus far and will follow along with you.