

CC:, Found down.,HX:, 54y/o RHF went to bed at 10 PM at her boyfriend's home on 1/16/96. She was found lethargic by her son the next morning. Three other individuals in the house were lethargic and complained of HA that same morning. Her last memory was talking to her granddaughter at 5:00PM on 1/16/96. She next remembered riding in the ambulance from a Hospital. Initial Carboxyhemoglobin level was 24% (normal < 1.5%) and ABG 7.41/30/370 with O2Sat 75% on 100%FiO2.,MEDS:, unknown anxiolytic, estrogen.,PMH:, PUD, ?stroke and memory difficulty in the past 1-2 years.,FHx:, unknown.,SHx:, divorced. unknown history of tobacco/ETOH/illicit drug use.,EXAM: ,BP126/91, HR86, RR 30, 37.1C.,MS:, Oriented to name only. Speech without dysarthria. 2/3 recall at 5minutes.,CN:, unremarkable.,MOTOR: ,full strength throughout with normal muscle tone and bulk.,SENSORY: ,unremarkable.,COORD/STATION:, unremarkable.,GAIT:, not tested on admission.,GEN EXAM:, notable for erythema of the face and chest.,COURSE:, She underwent a total of four dives under Hyperbaric Oxygen (2 dives on 1/17 and 2 dives on 1/18). Neuropsychologic assessment on 1/18/96 revealed marked cognitive impairments with defects in anterograde memory, praxis, associative fluency, attention, and speed of information processing. She was discharged home on 1/19/96 and returned on 2/11/96 after neurologic deterioration. She progressively developed more illogical behavior, anhedonia, anorexia and changes in sleep pattern. She became completely dependent and could not undergo repeat

neuropsychologic assessment in 2/96. She was later transferred to another care facility against medical advice. The etiology for these changes became complicated by a newly discovered history of possible ETOH abuse and usual "anxiety" disorder.,MRI brain, 2/14/96, revealed increased T2 signal within the periventricular white matter, bilaterally. EEG showed diffuse slowing without epileptiform activity.