REASON FOR VISIT: ,The patient is a 76-year-old man referred for neurological consultation by Dr. X. The patient is companied to clinic today by his wife and daughter. He provides a small portion of his history; however, his family provides virtually all of it.,HISTORY OF PRESENT ILLNESS: , He has trouble with walking and balance, with bladder control, and with thinking and memory. When I asked him to provide me detail, he could not tell me much more than the fact that he has trouble with his walking and that he has trouble with his bladder. He is vaguely aware that he has trouble with his memory.,According to his family, he has had difficulty with his gait for at least three or four years. At first, they thought it was weakness and because of he was on the ground (for example, gardening) he was not able to get up by himself. They did try stopping the statin that he was taking at that time, but because there was no improvement over two weeks, they resumed the statin. As time progressed, he developed more and more difficulty. He started to shuffle. He started using a cane about two and a half years ago and has used a walker with wheels in the front since July of 2006. At this point, he frequently if not always has trouble getting in or out of the seat. He frequently tends to lean backwards or sideways when sitting. He frequently if not always has trouble getting in or out a car, always shuffles or scuffs his feet, always has trouble turning or changing direction, always has trouble with uneven surfaces or curbs, and always has to hold on to someone or something when walking. He has not fallen in the last month. He did fall earlier, but there seemed to be fewer

opportunities for him to fall. His family has recently purchased a lightweight wheelchair to use if he is traveling long distances. He has no stairs in his home, however, his family indicates that he would not be able to take stairs. His handwriting has become smaller and shakier.,In regard to the bladder, he states, ""I wet the bed."" In talking with his family, it seems as if he has no warning that he needs to empty his bladder. He was diagnosed with a small bladder tumor in 2005. This was treated by Dr. Y. Dr. X does not think that the bladder tumor has anything to do with the patient's urinary incontinence. The patient has worn a pad or undergarment for at least one to one and a half years. His wife states that they go through two or three of them per day. He has been placed on medications; however, they have not helped.,He has no headaches or sensation of head fullness.,In regard to the thinking and memory, at first he seemed forgetful and had trouble with dates. Now he seems less spontaneous and his family states he seems to have trouble expressing himself. His wife took over his medications about two years ago. She stopped his driving about three years ago. She discovered that his license had been expired for about a year and she was concerned enough at that time that she told him he could drive no more. Apparently, he did not object. At this point, he frequently has trouble with memory, orientation, and everyday problems solving at home. He needs coaching for his daily activities such as reminders to brush his teeth, put on his clothes, and so forth. He is a retired office machine repairman. He is currently up and active about 12 hours a day and

sleeping or lying down about 12 hours per day.,He has not had PT or OT and has not been treated with medications for Parkinson's disease or Alzheimer's disease. He has been treated for the bladder. He has not had lumbar puncture.,Past medical history and review of all 14 systems from the form they completed for this visit that I reviewed with them is negative with the exception that he has had hypertension since 1985, hypercholesterolemia since 1997, and diabetes since 1998. The bladder tumor was discovered in 2005 and was treated noninvasively. He has lost weight from about 200 pounds to 180 pounds over the last two or three years. He had a period of depression in 1999 and was on Prozac for a while, but this was then stopped. He used to drink a significant amount of alcohol. This was problematic enough that his wife was concerned. She states he stopped when she retired and she was at home all day.,SOCIAL HISTORY: ,He quit smoking in 1968. His current weight is 183 pounds. His tallest height is 5 feet 10 inches.,FAMILY HISTORY: ,His grandfather had arthritis. His father had Parkinson's disease. His mother had heart disease and a sister has diabetes.,He does not have a Living Will and indicates he would wish his wife to make decisions for him if he could not make them for himself.,REVIEW OF HYDROCEPHALUS RISK FACTORS: , None.,ALLERGIES: , None.,MEDICATIONS: , Metformin 500 mg three times a day, Lipitor 10 mg per day, lisinopril 20 mg per day, metoprolol 50 mg per day, Uroxatral 10 mg per day, Detrol LA 4 mg per day, and aspirin 81 mg per day.,PHYSICAL EXAM: , On examination today, this is a

pleasant 76-year-old man who is guided back from the clinic waiting area walking with his walker. He is well developed, well nourished, and kempt.,Vital Signs: His weight is 180 pounds.,Head: The head is normocephalic and atraumatic. The head circumference is 59 cm, which is the ,75-90th percentile for an adult man whose height is 178 cm.,Spine: The spine is straight and not tender. I can easily palpate the spinous processes. There is no scoliosis.,Skin: No neurocutaneous stigmata.,Cardiovascular Examination: No carotid or vertebral bruits.,Mental Status: Assessed for orientation, recent and remote memory, attention span, concentration, language, and fund of knowledge. The Mini-Mental State Exam score was 17/30. He did not know the year, season, or day of the week nor did he know the building or specialty or the floor. There was a tendency for perseveration during the evaluation. He could not copy the diagram of intersecting pentagons.,Cranial Nerve Exam: No evidence of papilledema. The pupillary light reflex is intact as are extraocular movements without nystagmus, facial expression and sensation, hearing, head turning, tongue, and palate movement.,Motor Exam: Normal bulk and strength, but the tone is marked by significant paratonia. There is no atrophy, fasciculations, or drift. There is tremulousness of the outstretched hands.,Sensory Exam: Is difficult to interpret. Either he does not understand the test or he is mostly guessing.,Cerebellar Exam: Is intact for finger-to-nose, heel-to-knee, and rapid alternating movement tests. There is no dysarthria.,Reflexes: Trace in the arms, 2+ at the knees,

and 0 at the ankles. It is not certain whether there is a Babinski sign or simply withdrawal.,Gait: Assessed using the Tinetti assessment tool that shows a balance score of 7-10/16 and a gait score of 2-5/12 for a total score of 9-15/28, which is significantly impaired.,REVIEW OF X-RAYS: , I personally reviewed the MRI scan of the brain from December 11, 2007 at Advanced Radiology. It shows the ventricles are enlarged with a frontal horn span of 5.0 cm. The 3rd ventricle contour is flat. The span is enlarged at 12 mm. The sylvian aqueduct is patent. There is a pulsation artifact. The corpus callosum is effaced. There are extensive T2 signal abnormalities that are confluent in the corona radiata. There are also scattered T2 abnormalities in the basal ganglia. There is a suggestion of hippocampal atrophy. There is also a suggestion of vermian atrophy.,ASSESSMENT: , The patient has a clinical syndrome that raises the question of idiopathic normal pressure hydrocephalus. His examination today is notable for moderate-to-severe dementia and moderate-to-severe gait impairment. His MRI scan raises the question of hydrocephalus, however, is also consistent with cerebral small vessel disease.,PROBLEMS/DIAGNOSES:,1. Possible idiopathic normal pressure hydrocephalus (331.5).,2. Probable cerebral small-vessel disease (290.40 & 438).,3. Gait impairment (781.2).,4. Urinary urgency and incontinence (788.33).,5. Dementia.,6. Hypertension.,7. Hypercholesterolemia.