CC: ,Falling to left.,HX:, 26y/oRHF fell and struck her head on the ice 3.5 weeks prior to presentation. There was no associated loss of consciousness. She noted a dull headache and severe sharp pain behind her left ear 8 days ago. The pain lasted 1-2 minutes in duration. The next morning she experienced difficulty walking and consistently fell to the left. In addition the left side of her face had become numb and she began choking on food. Family noted her pupils had become unequal in size. She was seen locally and felt to be depressed and admitted to a psychiatric facility. She was subsequently transferred to UIHC following evaluation by a local ophthalmologist.,MEDS:, Prozac and Ativan (both recently started at the psychiatric facility).,PMH: ,1) Right esotropia and hyperopia since age 1year. 2) Recurrent UTI.,FHX:, Unremarkable.,SHX:, Divorced. Lives with children. No spontaneous abortions. Denied ETOH/Tobacco/Illicit Drug use.,EXAM:, BP 138/110. HR 85. RR 16. Temp 37.2C.,MS: A&O; to person, place, time. Speech fluent and without dysarthria. Intact naming, comprehension, repetition.,CN: Pupils 4/2 decreasing to 3/1 on exposure to light. Optic Disks flat. VFFTC. Esotropia OD, otherwise EOM full. Horizontal nystagmus on leftward gaze. Decreased corneal reflex, OS. Decreased PP/TEMP sensation on left side of face. Light touch testing normal. Decreased gag response on left. Uvula deviates to right. The rest of the CN exam was unremarkable.,Motor: 5/5 strength throughout with normal muscle bulk and tone.,Sensory: Decreased PP and TEMP on right side of body. PROP/VIB intact.,Coord: Difficulty with

FNF/HKS/RAM on left. Normal on right side.,Station: No pronator drift. Romberg test not noted.,Gait: unsteady with tendency to fall to left.,Reflexes: 3/3 throughout BUE and Patellae. 2+/2+ Achilles. Plantar responses were flexor, bilaterally.,Gen Exam: Obese. In no acute distress. Otherwise unremarkable.,HEENT: No carotid/vertebral/cranial bruits.,COURSE:, PT/PTT, GS, CBC, TSH, FT4 and Cholesterol screen were all within normal limits. HCT on admission was negative. MRI Brain (done locally 2/2/93) was reviewed and a left lateral medullary stroke was appreciated. The patient underwent a cerebral angiogram on 2/3/93 which revealed significant narrowing of the left vertebral artery beginning at C2 and extending to and involving the basilar artery. There is severe, irregular narrowing of the horizontal portion above the posterior arch of C1. The findings were felt consistent with a left vertebral artery dissection. Neuro-opthalmology confirmed a left Horner's pupil by clinical exam and history. Cookie swallow study was unremarkable. The Patient was placed on Heparin then converted to Coumadin. The PT on discharge was 17.,She remained on Coumadin for 3 months and then was switched to ASA for 1 year. An Otolaryngologic evaluation on 10/96 noted true left vocal cord paralysis with full glottic closure. A prosthesis was made and no surgical invention was done.