CONSULT REQUEST FOR:, Medical management.,The patient has been in special procedures now for over 2 hours and I am unable to examine.,HISTORY OF PRESENT ILLNESS:, Obtained from Dr. A on an 81-year-old white female, who is right handed, who by history, had a large stroke to the right brain, causing left body findings, last night. She was unfortunately outside of the window for emergent treatment and had a negative CT scan of the head. Was started on protocol medication and that is similar to TPA, which is an investigational study.,During the evaluation she was found to be in atrial fibrillation on admission with hypertension that was treated with labetalol en route. Her heart rate was 130. She was brought down with Cardizem. She received the study drug in the night and about an hour later thought to have another large stroke effecting the opposite side of the brain, that the doctors and company think is probably cardioembolic and not related to the study drug, as TPA has no obvious known association with this.,At that time the patient became comatose and required emergent intubation and paralyzation. Her diastolic at that time rose up to 190, likely the result of the acute second stroke. She is currently in arteriogram and a clot has been extracted from the proximal left carotid, but there is still distal clot that they are working on. Dr. A has updated the family to her extremely guarded and critical prognosis.,At present, it is not known yet, we do not have the STAT echocardiogram, if she has a large clot in the heart or if she could have a patent foramen ovale clot in the legs that has been passed to the heart. Echo that is

pending, and cannot be done till the patient is out of arteriogram, which is her lifesaving procedure right now.,REVIEW OF SYSTEMS:, Complete review of systems is unobtainable at present. From what I can tell, is that she is scheduled for an upcoming bladder distension surgery and I do not know if this is why she is off Coumadin for chronic AFib or what, at this point. Tremor for 3-4 years, diagnosed as early Parkinson's.,PAST MEDICAL HISTORY:, GERD, hypertension times 20 years, arthritis, Parkinson's, TIA, chronic atrial fibrillation, on Coumadin three years.,PAST SURGICAL HISTORY:, Cholecystectomy, TAH 33, gallstones, back surgery 1998, thoracotomy for unknown reason at present.,ALLERGIES:, MORPHINE, SULFAS (RASH), PROZAC.,MEDICATIONS AT HOME: Lanoxin 0.25 daily; Inderal LA 80 daily; MOBIC 7.5 daily; Robaxin 750 q.8; aspirin 80 one daily; acyclovir dose unknown daily; potassium, dose unknown; oxazepam 15 mg daily; aspirin 80 one daily; ibuprofen PRN; Darvocet-N 100 PRN.,SOCIAL HISTORY:, She does not drink or smoke. Lives in Fayetteville, Tennessee.,FAMILY HISTORY:, Mother died of cancer, unknown type. Dad died of an MI.,VACCINATION STATUS: Unknown.,PHYSICAL EXAMINATION:,VITAL SIGNS: On arrival were temperature 97.1, blood pressure 174/100, heart rate 100, 97%, respirations 15.,GENERAL: She was apparently alert and able to give history on arrival. Currently do not have any available vital signs or physical exam, as I cannot get to the patient.,LABORATORY: ,Reviewed and are remarkable for white count of 13 with 76 neutrophils. BMP is

normal, except for a blood sugar of 157, hemoglobin A1c is pending. TSH 2.1, cholesterol 165, Digoxin 1.24, CPK 57. ABG 7.47/32/459 on 100%. Magnesium 1.5. ESR 9, coags normal.,EKG is pending my review.,Chest x-ray is read as mild cardiomegaly and atherosclerotic aorta.,Chest x-ray, shoulder films and CT scan of the head: I have reviewed. Chest x-ray has good ET tube placement. She has mild cardiomegaly. Some mild interstitial opacities consistent with OGD and minimal amount of atherosclerosis of the aorta.,CT scan of the head: I do not see any active bleeding.,X-rays of the shoulders appear intact to me and we are awaiting radiologies final approval on those.,ASSESSMENT/PLAN/PROBLEMS:,1. Large cardioembolic stroke initially to the right brain, with devastating effects, and now stroke into the left brain as well, with fluctuating mental status. Obviously she is in critical condition and stable with multiple strokes. One must also wonder if she could have a large clot burden below the heart and patent foramen ovale, etc. We need STAT records from her prior cardiologist and prior echocardiogram report to see exactly what are the details. I have ordered a STAT echo and to have the group that sees her read it, that if he has a large clot burdened in the heart or has distal clot with a PFO we may be able to better prognosticate at this point. Obviously, she cannot have any anticoagulants, except for the study drug, at present, which is her only chance and hopefully they will be able to retrieve most of the clot with emergency retrieval device as activated heroically, by Dr. A and

interventional radiology.,2. Hypertension/atrial fibrillation: This will be a difficult management and the fact that she has been on a beta-blocker for Parkinson's, she may have withdrawal to the beta-blockers as we remove this. Given her atrial fibrillation, I do agree the safest agent right now is to use a Cardizem drip as needed and would use it for systolic greater than 160 to 180, or diastolics greater than 90 to 100. Also, would use it to control the atrial fibrillation. We would, however, be very cautious not to put her in heart block with the Digoxin and the beta-blocker on board. Weighing all risks and benefits, I think that given the fact that she has a beta-blocker on board and Digoxin, we would like to avoid the beta-blocker for vasospasm protection and will favor using calcium channel blocker for now. If, however, we run into trouble with this, I would prefer to switch her to Brevibloc or an Esmolol drip and see how she does, as she may withdraw from the beta-blocker. I will be watching this closely and managing the hypertension as I see fit at the moment, based on all factors. Will also ask cardiology if she has one that sees her here, to help guide this. Her Digoxin level is appropriate, as well as a TSH. I do not feel that we need to work this up further, other than the STAT echo and ultrasound of the leg.,3. Respiratory failure requiring ventilator: I have discussed this with Dr. Devlin, we do not feel the need to hyperventilate her at present. We will keep her comfortable on the breathing machine and try to keep her pH in a normal range, around 7.4, and her CO2 in the 30 to 40 range. If she has brain swelling, we will need to hyperventilate her to a pCO2 of 30

and a pH of 7.5, to optimize the cardiac arrhythmia potential of alkalosis weighed with the control of brain swelling.,4. Optimize electrolytes as you can.,5. Deep vein thrombosis prophylaxis for now, with thigh-high TED hose, possibly SCDs, although I do not have experience with the vampire/venom to know if we need to worry about DIC which the SCDs may worsen. Will follow daily CBCs for that.,6. Nutrition: Will go ahead and start a low dose of tube feeds and hope that she does survive.,I will defer all updates to the family for the next 24 to 48 hours to Dr. Devlin's expertise, given her unknown and fluctuating neurologic prognosis.,Thank you so much for allowing us to participate in her care. We will be happy to do all medication treatment until the point that I feel that I would need any help from critical care. I believe that we will be able to manage her fully at this point, for simplicity sake.