RE: Debra Jones
DATE: 12/01/10
MR: 240804
DOB: 12/01/65

DIAGNOSES:

1. Cerebrovascular accident.

2. Schizophrenia.

3. Recurrent transient ischemic attacks.

PROCEDURES:

1. Echocardiogram.

2. Holter monitor.

HISTORY OF PRESENT ILLNESS:

This is a 59-year-old, right-handed woman with a history of hypertension, schizophrenia, and a fallopian ovarian tumor resection surgically and with radiotherapy treatment, who presented to the emergency room with a four-hour history of difficulty talking, and numbness and weakness on the right side. She was in her usual state of health until early the morning of admission when she woke up and noted numbness on her right side. Her numbness was associated with weakness as well as difficulty speaking, with no associated headache, chest pain, fever, chills, double vision difficulty swallowing, or palpitations. She reported having a similar incident about one month prior to admission when she was seen in the emergency room, but at that time, her symptoms resolve while in the emergency room. CT scan at that time showed bilateral basal ganglion infarcts. Carotid duplex then showed minimal plaque, rig ht greater than left, with no hemodynamic stenosis. At that time, she was sent home on aspirin 1 q.d. which she has been taking except for the day prior to admission when she missed her dose.

PHYSICAL EXAMINATIOS:

VITAL SIGNS: Temperature of 37.1, blood pressure of 164/100 in both arms.

HEENT: Clear.

NECK: Mild right bruit.

HEART: Regular rate and rhythm with no murmurs.

LUNGS: Clear.

ABDOMEN: Obese with a surgical scar. Bowel sounds were present.

EXTREMITIES: No clubbing, cyanosis or edema.

NEUROLOGIC: She is alert and oriented x 3. She had difficulty with speech, mostly lingual sounds. No aphasic symptoms. Normal flow, normal rate, and normal content. No breathlessness noted. Cranial nerves showed right fundi with sharp discs, pupils reactive 3 to 2 bilaterally, full extraocular movements and full visual fields. Corneal reflexes were present bilaterally. Decreased

V1 through V3 pinprick on the face. Masticatory muscles were normal. Face was symmetric. Eye closure, puffed cheeks and smile were symmetric. Uvula and tongue were midline. Her gag was present bilaterally, left greater than right. Motor examination showed increased tone in the left arm. Strength was 4/4 in the right upper and lower extremities and 5/5 in the left upper and lower extremities. Reflexes were 2+ throughout with downgoing toes. Sensory examination showed decreased pinprick on the right side. There was decreased vibration bilaterally in upper and lower extremities. Normal stereognosis and graphesthesia. Gait: She was able to bear weight on the left with some difficulty.

LABORATORY DATA: Unremarkable. Head CT scan at the time of admission showed bilateral lacunae of the anterior internal capsule with basal ganglion involvement; no change from prior CT scan. Electrocardiogram showed normal sinus rhythm at 81 with Q-waves in leads I and aVL, and small Q-waves in V1 and V6.

HOSPITAL COURSE: The patient was admitted to the neurology service with concern for an embolic versus ischemic event in the face of aspirin therapy. As an inpatient, she had an echocardiogram which was reported to show mild, concentric, left ventricular hypertrophy with normal left ventricular function, no segmental wall abnormalities, no mitral regurgitation, no aortic regurgitation and no tricuspid regurgitation. No evidence of coral thrombus. Carotids were not repeated, since she had a carotid study one month prior to admission that showed an occlusion of her carotids. RPR was nonreactive. Blood pressure remained under control during hospitalization. Her psychiatric symptoms were stable during this time. She was seen by physical therapy and occupational therapy who helped her with ambulation, and by discharge she was making good progress, ambulating and using her arms, although she remained with weakness on the right more marked than the left. She was discharged in good health.

DISCHARGE MEDICATIONS:

1. Nortriptyline 25 mg p.o. q.h.s.

2. Benadryl 50 mg p.o. q.h.s.

1. Navane 5 mg p.o. q.h.s

2. Aspirin two p.o. b.i.d.

DISCHARGE INSTRUCTIONS:

1. Diet: Low-cholesterol, low-fat diet.

2. Activity: As tolerated.

FOLLOW-UP CARE:

1. Follow up with physical therapy and occupational therapy.

2. Return to the neurology clinic about one month after discharge.