## **Chart 1**

**History of Present Illness:**65-year-old woman presents after her PCP noted a right-sided carotid bruit on a routine exam. She has experienced intermittent lightheadedness over the past two weeks, especially when standing up quickly or turning her head, but no syncope or focal neurologic deficits. She denies chest pain, headaches, or vision changes. She is mostly adherent to her antihypertensives but admits to missing doses several times per week.

**Past Medical History:**

* Hypertension
* Hyperlipidemia
* Hypothyroidism
* Osteoarthritis

**Medications:**

* Lisinopril 20 mg daily
* Atorvastatin 40 mg nightly
* Levothyroxine 88 mcg daily
* Ibuprofen 400 mg PRN

**Social History:**

* Retired teacher, lives with spouse
* Walks daily for exercise
* Former smoker (quit 10 years ago)
* Drinks one glass of wine nightly

**Review of Systems:**

* Positive: Lightheadedness
* Negative: Syncope, weakness, chest pain, headache, vision changes

**Physical Examination:**

* BP 152/88 mmHg, HR 68, SpO₂ 99%
* Right carotid bruit audible
* No focal neurologic deficits
* No lower extremity edema

**Assessment & Plan:**Findings concerning for carotid artery stenosis in a patient with uncontrolled hypertension and hyperlipidemia. Will order bilateral carotid duplex ultrasound to quantify stenosis and guide further management. Will counsel patient on strict medication adherence, low-sodium diet, and daily BP monitoring. Continue atorvastatin; will consider intensification if imaging shows >50% stenosis. Reinforce fall precautions and hydration. Follow-up in 2–3 weeks after imaging to discuss possible vascular surgery referral if stenosis is hemodynamically significant.

## 

## **Chart 2**

**History of Present Illness:**72-year-old man presents for follow-up after TIA last month characterized by left arm weakness and slurred speech, which resolved within 30 minutes. He has been taking his medications regularly since the event and has cut back on salt intake. He denies any recurrent neurologic symptoms.

**Past Medical History:**

* TIA (1 month ago)
* Type 2 diabetes mellitus
* Hypertension
* CAD (s/p stent)

**Medications:**

* Aspirin 81 mg daily
* Clopidogrel 75 mg daily
* Metformin 1000 mg BID
* Metoprolol succinate 50 mg daily
* Rosuvastatin 20 mg nightly

**Social History:**

* Retired construction worker
* Smokes occasional cigars (trying to quit)
* Enjoys fishing

**Review of Systems:**

* Negative: Weakness, speech difficulty, visual loss, headache

**Physical Examination:**

* BP 128/74 mmHg, HR 64
* Normal neuro exam, no bruits

**Assessment & Plan:**Post-TIA patient with well-controlled BP and LDL on dual antiplatelet therapy. Remains at elevated vascular risk given diabetes and CAD history. Will repeat carotid duplex ultrasound to monitor right ICA stenosis previously reported at 40%. Continue DAPT for total of 3 months, then transition to aspirin monotherapy per neurology. Encourage ongoing lifestyle changes including smoking cessation — offer referral to cessation program. Schedule diabetes educator visit for improved glycemic control (A1c goal <7%). Provide reassurance to patient and spouse regarding low recurrence risk with adherence to therapy.

## **Chart 3**

**History of Present Illness:**48-year-old man presents with exertional left-sided neck pain radiating to the jaw that developed after a long run yesterday. Pain is reproducible with head rotation and improves with rest. Denies chest pain, vision changes, neurologic deficits, or trauma.

**Past Medical History:**

* Hyperlipidemia
* Mild asthma

**Medications:**

* Simvastatin 10 mg nightly
* Albuterol PRN

**Social History:**

* Works as software engineer
* Trains for half-marathons
* Vegetarian diet
* No tobacco, alcohol, or drug use

**Review of Systems:**

* Positive: Neck pain with exertion
* Negative: Weakness, headache, speech changes

**Physical Examination:**

* BP 126/78 mmHg, HR 72
* Mild left SCM tenderness, no bruit
* Neuro exam intact

**Assessment & Plan:**Neck pain likely musculoskeletal strain from exertion, but carotid dissection must be ruled out given location and exertional onset. Order carotid duplex ultrasound; if abnormal, proceed to CTA neck. Recommend rest and NSAIDs PRN for pain. Temporarily restrict vigorous exercise until imaging results available. Educate patient on warning signs of TIA/stroke and instruct to seek emergent care if symptoms develop. Follow-up within one week or sooner if symptoms worsen.

## 

## **Chart 4**

**History of Present Illness:**82-year-old woman presents after her daughter noted a transient left facial droop lasting 20 minutes earlier this week. No ER visit was made at the time. She has no residual weakness, dysarthria, or visual symptoms today.

**Past Medical History:**

* Atrial fibrillation (on apixaban)
* Hypertension
* CKD Stage 3
* Osteoporosis

**Medications:**

* Apixaban 5 mg BID
* Lisinopril 10 mg daily
* Calcium/Vitamin D supplement
* Alendronate weekly

**Social History:**

* Widowed, lives with daughter
* Walks with cane
* No tobacco, alcohol, or drugs

**Review of Systems:**

* Negative: Current neuro deficits, headache, chest pain

**Physical Examination:**

* BP 134/70 mmHg, HR 72 irregularly irregular
* Neuro exam normal
* No carotid bruits

**Assessment & Plan:**Likely TIA in high-risk patient on anticoagulation, raising concern for subtherapeutic dosing or cardioembolic source. Order bilateral carotid duplex to assess for stenosis. Refer to cardiology to review anticoagulation strategy and evaluate for rhythm or rate control options. Monitor renal function to ensure appropriate dosing of apixaban in CKD. Counsel on fall prevention and close neurologic monitoring. Arrange neurology follow-up within 2 weeks for further stroke workup.

## **Chart 5**

**History of Present Illness:**78-year-old man presents for annual physical and evaluation of known right carotid stenosis. He reports doing well overall but notes occasional dizziness when gardening in the heat. No syncope, no transient weakness, speech difficulty, or vision loss. He proudly states he “finally learned how to use the air fryer,” and jokes that his French fries now taste better than his cardiologist’s advice. No recent chest pain, palpitations, or claudication.

**Past Medical History:**

* CAD s/p CABG (2014)
* Carotid stenosis, right 50–69% (last US 1 year ago)
* Peripheral vascular disease
* AAA (stable)
* Hypertension
* Hyperlipidemia
* Type 2 diabetes

**Medications:**

* Aspirin 81 mg
* Clopidogrel 75 mg
* Metoprolol 50 mg BID
* Losartan 50 mg
* Rosuvastatin 40 mg nightly
* Metformin 1000 mg BID

**Social History:**

* Former smoker (quit 12 years ago)
* Lives with spouse
* Walks 30 minutes daily, enjoys gardening

**Review of Systems:**

* Positive: Occasional lightheadedness with exertion
* Negative: Focal neuro symptoms, chest pain, dyspnea

**Physical Examination:**

* BP 132/76 mmHg, HR 64, BMI 28
* Right carotid bruit present
* No neuro deficits, no edema

**Assessment & Plan:**78-year-old man with known right carotid stenosis (50–69%) and multiple cardiovascular comorbidities. Findings stable compared to prior visit, though he reports intermittent lightheadedness. Will order repeat bilateral carotid duplex ultrasound to assess progression. Continue dual antiplatelet therapy and high-intensity statin. Counsel on hydration and heat avoidance during gardening. Encourage continued exercise and adherence to medications. Follow-up after imaging to discuss any change in stenosis severity.

## 

## **Chart 6**

**History of Present Illness:**70-year-old woman presents with a single episode of transient left arm numbness and mild lip droop lasting about 15 minutes, resolved spontaneously. No headache, no trauma, no prior similar events. She reports she was “in the middle of a heated Scrabble match with her granddaughter” when it happened and jokes that it was probably stress from trying to play a 50-point word.

**Past Medical History:**

* Hypertension
* Type 2 diabetes
* CKD stage 2
* Hyperlipidemia
* Osteoarthritis

**Medications:**

* Lisinopril 20 mg daily
* Amlodipine 5 mg daily
* Atorvastatin 40 mg nightly
* Metformin 1000 mg BID
* Acetaminophen PRN

**Social History:**

* Widowed, lives independently
* Non-smoker
* Walks dog twice daily

**Review of Systems:**

* Positive: Single brief neuro episode
* Negative: Weakness currently, vision loss, dysarthria

**Physical Examination:**

* BP 138/80 mmHg, HR 72
* No carotid bruits
* Normal neuro exam

**Assessment & Plan:**70-year-old woman with probable TIA and multiple vascular risk factors. Will obtain urgent carotid duplex ultrasound and brain MRI/MRA to rule out significant stenosis or acute infarct. Begin aspirin 81 mg daily pending imaging results. Reinforce medication adherence, optimize glycemic control, and advise on stroke warning symptoms. Close follow-up in 1–2 weeks for results and secondary prevention plan.

## 

## **Chart 7**

**History of Present Illness:**83-year-old man presents for evaluation of chronic bilateral carotid stenosis. He denies new neuro symptoms but complains his hearing aids “pick up more gossip than news,” which his wife confirms. Walks a quarter mile daily with mild calf cramping at baseline. Denies chest pain or dyspnea.

**Past Medical History:**

* Bilateral carotid stenosis (L 50–69%, R <50%)
* CAD with prior stent
* Hypertension
* Hyperlipidemia
* PVD
* GERD

**Medications:**

* Aspirin 81 mg
* Clopidogrel 75 mg
* Metoprolol succinate 100 mg daily
* Lisinopril 20 mg
* Atorvastatin 80 mg
* Pantoprazole 40 mg daily

**Social History:**

* Former smoker (quit 20 yrs ago)
* Enjoys crossword puzzles
* Lives with spouse

**Review of Systems:**

* Positive: Chronic mild claudication
* Negative: Neuro deficits, chest pain

**Physical Examination:**

* BP 140/82 mmHg, HR 68
* Bilateral carotid bruits
* Diminished distal pulses, no edema

**Assessment & Plan:**83-year-old man with bilateral carotid stenosis (L 50–69%, R <50%) and stable claudication. Will repeat carotid duplex ultrasound to monitor progression. Continue dual antiplatelet therapy and high-intensity statin. Encourage supervised walking program to improve symptoms and overall cardiovascular conditioning. Maintain BP <130/80 mmHg and reinforce adherence to risk factor management. Recheck in 6 months or earlier if new symptoms develop.

## 

## **Chart 8**

**History of Present Illness:**62-year-old woman presents after transient right eye vision loss lasting 10 minutes last week, now resolved. No pain, no headache. She humorously mentions she “thought her cat had turned off the lights” until she realized it was just her eye.

**Past Medical History:**

* Hyperlipidemia
* Hypertension
* Obstructive sleep apnea
* Hypothyroidism

**Medications:**

* Levothyroxine 75 mcg
* Atorvastatin 40 mg
* Lisinopril 10 mg
* CPAP nightly

**Social History:**

* Never smoker
* Works part-time as librarian
* No alcohol use

**Review of Systems:**

* Positive: Amaurosis fugax
* Negative: Weakness, headache, dysarthria

**Physical Examination:**

* BP 126/78 mmHg, HR 70
* Left carotid bruit present
* Normal neuro exam

**Assessment & Plan:**62-year-old woman with amaurosis fugax, likely embolic in origin. Will order bilateral carotid duplex ultrasound and consider CTA head/neck if >50% stenosis is detected. Optimize secondary prevention with statin (target LDL <70 mg/dL) and antihypertensive therapy. Reinforce nightly CPAP use for OSA, as untreated OSA increases stroke risk. Provide stroke education and follow up in 2 weeks for results and next steps.

**Chart 9**

**History of Present Illness:**74-year-old man with CAD (s/p stent), T2DM, HTN, HLD, and bilateral carotid stenosis here for routine follow-up; he says he’s “been pretty good, you know, good-ish,” and then launches into a running monologue about mornings starting with oatmeal “unless there’s leftover pizza,” how he walks a mile with his neighbor unless it rains (in which case they “mall-walk and critique shoes”), and how he joined pickleball—“I bought the paddle, I talk a big game, but somehow I’m always on sub duty which is great for my heart rate.” No chest pain, no dyspnea, no palpitations, no presyncope; he gets a fleeting head-rush when he stands after kneeling to tie his shoes in the foyer but “it goes away by the time I remember what I was doing.” No focal weakness, no face droop, no slurred speech, no vision loss. Diet “mostly decent” except for weekend barbecues; sugars “okay” at home per fingerstick. No recent hospitalizations. Medication adherence “90%—unless the pillbox hides from me.” Side story: he sheepishly admits he once showed up at pickleball with a **tennis** racquet and “played a heroic three minutes before the paddle police intervened,” which he swears is unrelated to any neurologic issue.

**Past Medical History:**

* CAD, s/p PCI
* Bilateral carotid stenosis (L 50–69%, R <50%)
* Type 2 diabetes mellitus
* Hypertension
* Hyperlipidemia
* GERD
* Former smoker (>15 yrs since quit)

**Medications:**

* Aspirin 81 mg qd
* Rosuvastatin 40 mg qhs
* Lisinopril 20 mg qd
* Metoprolol succinate 50 mg qd
* Metformin 1000 mg BID
* Omeprazole 20 mg qd

**Allergies:** NKDA

**Social History:** Retired accountant; occasional wine; walks daily; no illicit drugs; former smoker.

**Family History:** Father MI in 60s; no family stroke.

**Review of Systems:** Negative for chest pain, orthopnea, PND, palpitations, syncope, focal neurologic deficits, amaurosis.

**Physical Examination:**

* Vitals: BP 130/76 mmHg, HR 66, RR 14, SpO₂ 98% RA, BMI 29
* General: Well-appearing, talkative, no distress
* HEENT/Neck: Left carotid bruit; no JVD; no cervical masses
* CV: Regular rhythm, normal S1/S2, no S3/S4, no new murmurs
* Lungs: CTAB
* Abd: Soft, NT/ND, +BS
* Ext: No edema; distal pulses diminished but symmetric
* Neuro: AOx3, CN II–XII intact, motor/sensory intact, normal gait

**Studies:**

* Prior carotid duplex (10/2024): L 50–69%, R <50% (surveillance)
* Last LDL 68; A1c 7.1 (clinic records)

**Assessment & Plan:  
74-year-old man with bilateral carotid stenosis (L 50–69%, R <50%)** on optimal medical therapy, asymptomatic.

* **Imaging:** Repeat **bilateral carotid duplex** to assess progression; include velocities and plaque morphology.
* **Medical therapy:** Continue **aspirin** and **high-intensity statin**; maintain BP <130/80; reinforce diabetes control (goal A1c ~<7% if safe).
* **Lifestyle:** Encourage *actual* pickleball play (aerobic minutes), hydration, slow position changes for orthostatic lightheadedness.
* **Labs:** Fasting lipid panel, A1c, BMP.
* **Follow-up:** Return in **6 months** or sooner for new neuro symptoms.

## 

## **Chart 10**

**History of Present Illness:**79-year-old woman with TIA 6 months ago, CAD s/p CABG, AFib, CKD3, HTN, HLD here for carotid surveillance; she starts by telling me she now wears her medical alert bracelet “even to bingo and yes it clashes with my lucky sweater but that’s the price of safety,” and she narrates her day: morning pills with applesauce, short walk to the mailbox (“downhill is fun, uphill is character-building”), elevates legs in the evening because her ankles “puff like little dinner rolls” if she’s on her feet too long. No recurrent neuro symptoms—no unilateral weakness, no facial droop, no speech change, no monocular vision loss; one mild “head rush” last week when standing quickly from the couch. Diet “almost low-sodium,” except “kettle chips on bingo night are non-negotiable.” Denies chest pain, orthopnea, PND. She sleeps well, wears slippers with good tread after “a stern talking-to from my daughter” post-TIA. Side story: a bingo caller misread “B-12” as “Be-twelve” and she laughed so hard she set off her step counter.

**Past Medical History:**

* TIA (6 mo prior)
* CAD, s/p CABG
* Atrial fibrillation
* Hypertension; Hyperlipidemia
* CKD stage 3
* Osteoarthritis

**Medications:**

* **Apixaban 5 mg BID**
* **Clopidogrel 75 mg qd** (per cardiology post-CABG strategy)
* Atorvastatin 80 mg qhs
* Metoprolol tartrate 50 mg BID
* Lisinopril 10 mg qd

**Allergies:** Penicillin—rash

**Social History:** Widowed; lives with daughter; non-smoker; no alcohol; senior-center activities.

**Family History:** Noncontributory for stroke.

**Review of Systems:** Mild evening ankle edema; otherwise negative for chest pain, DOE, palpitations beyond baseline AF, neuro deficits.

**Physical Examination:**

* Vitals: BP 138/78 mmHg, HR 70 (irreg), SpO₂ 98% RA, BMI 30
* Neck: No carotid bruits today
* CV: Irregularly irregular, no murmurs/rubs/gallops
* Lungs: CTAB
* Abd: Benign
* Ext: 1+ pitting edema at ankles bilaterally
* Neuro: Nonfocal exam

**Studies:**

* Prior carotid duplex (11/2024): R <50%, L 50–69%
* Prior MRI/MRA (post-TIA): No infarct; no critical intracranial stenosis

**Assessment & Plan:  
79-year-old woman with history of TIA and bilateral carotid disease (L 50–69%, R <50%)** on anticoagulation for AFib.

* **Imaging:** **Repeat carotid duplex** now to evaluate progression; pursue CTA head/neck if duplex suggests ≥70% stenosis.
* **Antithrombotic therapy:** Continue **apixaban**; defer DAPT changes to cardiology given CABG history—reconcile long-term need for clopidogrel at next visit.
* **Risk factor control:** Maintain BP <130/80; continue high-intensity statin (LDL target <70). Sodium restriction for edema; leg elevation; consider compression stockings if tolerated.
* **Safety & education:** Stroke/TIA symptom review; footwear/fall-prevention reinforced.
* **Labs:** BMP for renal dosing; lipid panel; A1c.
* **Follow-up:** **3–4 months** or sooner with recurrent symptoms.

## 

## **Chart 11**

**History of Present Illness:**67-year-old man with HTN, HLD, T2DM, OSA (CPAP), and GERD presents after a transient episode last week: right arm felt “asleep and clumsy” for ~20 minutes while unloading groceries; he says he told his teenage son “look, medical excuse, grab the cat litter,” and by the time the cat food was in the pantry the arm felt normal. No trauma, no headache, no speech change, no facial droop, no vision loss; back to baseline since. He describes his days as “a series of lists”—morning pills, quick CPAP cleaning, work calls, then a brisk walk “unless it’s humid because then I become a houseplant.” Diet is “pretty decent” except for weekend pizza; he quit smoking years ago. He’s been taking meds consistently, uses a phone alarm, and jokes that when the alarm chimes his dog thinks it means treat time, so “everyone’s adherent.”

**Past Medical History:**

* Hypertension; Hyperlipidemia
* Type 2 diabetes mellitus
* Obstructive sleep apnea (CPAP nightly)
* GERD

**Medications:**

* Amlodipine 10 mg qd
* Atorvastatin 40 mg qhs
* Metformin 1000 mg BID
* Pantoprazole 40 mg qam
* CPAP: adherent nightly

**Allergies:** NKDA

**Social History:** Former smoker; electrician; occasional beer on weekends; no drugs.

**Family History:** Father with MI; no early strokes.

**Review of Systems:** Positive for single brief unilateral arm numbness; negative for persistent weakness, dysarthria, diplopia, chest pain, palpitations.

**Physical Examination:**

* Vitals: BP 136/82 mmHg, HR 72, SpO₂ 99% RA, BMI 31
* Neck: **Left carotid bruit**
* CV: Regular rhythm, no murmurs
* Lungs: CTAB
* Ext: No edema
* Neuro: Nonfocal; strength and sensation normal

**Studies:**

* None new today (first evaluation for this event)

**Assessment & Plan:  
67-year-old man with probable TIA** (transient unilateral arm sensory-motor symptoms) and **left carotid bruit** with vascular risk factors.

* **Urgent imaging:** **Bilateral carotid duplex** today; obtain **brain MRI/MRA** to exclude acute ischemia and evaluate intracranial circulation.
* **Antithrombotic therapy:** Start **aspirin 81 mg daily** (if no contraindication); consider short-course DAPT if imaging supports high-risk TIA—coordinate with neurology.
* **Risk factor optimization:** Tighten BP control (<130/80), reinforce CPAP adherence (OSA increases stroke risk), continue statin aiming LDL <70; diabetes control with A1c goal <7% if appropriate.
* **Education:** Stroke warning signs; ED precautions.
* **Follow-up:** **1–2 weeks** for results and to determine vascular referral if ≥70% stenosis is present.

## 

## **Chart 12**

**History of Present Illness:**80-year-old man with AAA (stable), CAD, PVD, HTN, HLD here for annual follow-up; he begins with “first of all I finally beat my grandson at chess and yes I gloated, respectfully,” then explains he’s been walking every morning “two laps around the block unless my neighbor’s dog insists on sniffing every mailbox,” no chest pain, no dyspnea beyond baseline on stairs, no claudication on flat ground, and no neuro symptoms. Appetite good; salt shaker “exiled to the back of the cabinet”; weight steady. He checks BP at home, readings mostly 120s–130s systolic. He denies vision loss, slurred speech, focal weakness. He does note a faint “whoosh” sound in his ear when he lies on his right side at night “but that could be the old radiator,” not positional during the day. Medication adherence is excellent thanks to a color-coded pillbox that his spouse “runs like mission control.” Side story: he ordered groceries online and accidentally bought **twenty**bananas again—family smoothies for a week, “potassium levels of a tropical bird.”

**Past Medical History:**

* Abdominal aortic aneurysm (stable surveillance)
* Coronary artery disease
* Peripheral vascular disease
* Hypertension; Hyperlipidemia
* CKD stage 2

**Medications:**

* Aspirin 81 mg qd
* Rosuvastatin 40 mg qhs
* Losartan 50 mg qd
* Metoprolol succinate 50 mg qd
* Hydrochlorothiazide 25 mg qam

**Allergies:** NKDA

**Social History:** Retired; lives with spouse; former smoker (>20 yrs); no alcohol.

**Family History:** Father MI; brother with AAA.

**Review of Systems:** Negative for chest pain, rest pain, TIAs, amaurosis, or new edema.

**Physical Examination:**

* Vitals: BP 128/74 mmHg, HR 64, SpO₂ 98% RA, BMI 28
* Neck: **Right carotid bruit**
* CV: Regular rhythm, no new murmurs
* Lungs: CTAB
* Abd: Soft; **pulsatile abdominal mass** consistent with known AAA; nontender
* Ext: No edema; distal pulses diminished
* Neuro: Nonfocal exam

**Studies:**

* Prior AAA U/S (03/2025): Stable diameter vs 2024
* Last lipid panel: LDL 64; A1c 6.8

**Assessment & Plan:  
80-year-old man with right carotid bruit and extensive atherosclerotic disease (AAA, CAD, PVD)**, currently asymptomatic.

* **Imaging:** Order **bilateral carotid duplex** for bruit/risk profile; **repeat AAA ultrasound** per surveillance interval.
* **Medical therapy:** Continue aspirin and high-intensity statin; maintain BP <130/80 with ARB + beta-blocker/thiazide as tolerated; reinforce adherence.   
  **Lifestyle:** Continue daily walking; low-sodium diet; hydration; home BP log.
* **Labs:** Lipid panel, A1c, CBC/Chem 8.
* **Follow-up:** **6 months**; sooner for any neurologic symptoms.

## 

## **Chart 13**

**History of Present Illness:**82-year-old man with CAD s/p CABG, HTN, T2DM, CKD3, and remote smoking history presents for follow-up of carotid disease. Reports he feels “steady these days,” with no neuro symptoms—no weakness, speech change, vision loss, or syncope. Walks half a mile daily, stops for calf tightness after two blocks but improves with rest. Notes occasional mild dizziness if he stands too quickly but resolves quickly. Diet mostly low-salt, occasional restaurant meals. No chest pain, orthopnea, or edema.

**Past Medical History:**

* CAD, s/p CABG
* Hypertension
* Hyperlipidemia
* Type 2 diabetes
* CKD stage 3
* PVD
* Former smoker (quit 15 yrs ago)

**Medications:**

* Aspirin 81 mg
* Rosuvastatin 40 mg
* Metoprolol succinate 50 mg
* Lisinopril 20 mg
* Metformin 1000 mg BID

**Social History:** Retired; lives with spouse; no alcohol/illicit drugs.

**Review of Systems:** Negative for neuro complaints, chest pain, SOB.

**Physical Exam:**

* Vitals: BP 142/80, HR 68
* Neck: Left carotid bruit
* CV: Regular rhythm
* Ext: Trace ankle edema
* Neuro: No focal deficits

**Assessment & Plan:**82M with left carotid bruit, CAD, diabetes — repeat carotid U/S, continue ASA/statin, optimize BP <130/80, RTC 3 mo.

## 

## **Chart 14**

**History of Present Illness:**68-year-old woman with prior TIA, AFib, and hyperlipidemia presents for surveillance. No recurrence of neuro symptoms since starting anticoagulation. Reports good energy, mild fatigue on busy days. Sleeps well, good appetite. Has been more consistent with exercise—walks dog twice daily. Diet improved (“except on taco night,” she jokes). No falls, no bleeding.

**Past Medical History:**

* TIA (1 yr ago)
* AFib
* Hypertension
* Hyperlipidemia

**Medications:**

* Apixaban 5 mg BID
* Atorvastatin 80 mg
* Amlodipine 5 mg
* Metoprolol 25 mg

**Social History:** Lives with husband; former smoker; occasional wine.

**Review of Systems:** Negative for bleeding, weakness, palpitations beyond baseline.

**Physical Exam:**

* Vitals: BP 128/74, HR 76 irregular
* Neck: No bruit
* CV: Irregularly irregular rhythm
* Neuro: Intact

**Assessment & Plan:**68F with hx TIA, AFib — order carotid U/S, continue anticoagulation/statin, reinforce stroke precautions, RTC 6 mo.

## 

## **Chart 15**

**History of Present Illness:**76-year-old man with AAA, CAD, HLD, HTN, PVD presents for annual check. Reports doing “fine” overall. Walks with cane but independent. Denies neuro symptoms, chest pain, or dyspnea. Notes mild claudication but stable. Eats low-fat diet, wife helps with pillbox adherence. Recently traveled to see grandchildren—tired afterward but no medical issues.

**Past Medical History:**

* AAA (stable)
* CAD
* Hypertension
* Hyperlipidemia
* Peripheral vascular disease
* Former smoker

**Medications:**

* Aspirin 81 mg
* Rosuvastatin 40 mg
* Losartan 50 mg
* Metoprolol 50 mg

**Social History:** Retired; lives with spouse.

**Review of Systems:** Negative except mild claudication.

**Physical Exam:**

* Vitals: BP 136/78, HR 70
* Abd: Pulsatile mass
* Neck: Right carotid bruit
* Neuro: Nonfocal

**Assessment & Plan:**76M with bruit + AAA — repeat carotid U/S + AAA surveillance, continue meds, encourage exercise, RTC 6 mo.

## 

## **Chart 16**

**History of Present Illness:**71-year-old woman with hx of amaurosis fugax (3 mo ago), DM2, HTN, HLD presents for follow-up. No recurrent visual symptoms. Describes improved diet and walking program—lost 5 lbs. BP logs improved. Denies chest pain, neuro deficits, claudication. No recent ER visits.

**Past Medical History:**

* Amaurosis fugax
* Diabetes
* Hypertension
* Hyperlipidemia

**Medications:**

* Aspirin 81 mg
* Atorvastatin 80 mg
* Lisinopril 10 mg
* Metformin 1000 mg BID

**Social History:** Lives independently; no tobacco/alcohol.

**Review of Systems:** Negative for neuro or cardiac symptoms.

**Physical Exam:**

* Vitals: BP 124/72, HR 68
* Neck: Left carotid bruit
* Neuro: Normal exam

**Assessment & Plan:**71F post-amaurosis fugax — repeat carotid U/S, continue ASA/statin, goal BP <130/80, RTC 4 wk.

## 

## **Chart 17**

**Follow-up After Carotid Surveillance**

**History of Present Illness:**74-year-old man with CAD (s/p stent), T2DM, HTN, HLD, and bilateral carotid stenosis presents for follow-up. Reports he’s been “pretty good overall” and says mornings start with oatmeal “unless there’s leftover pizza.” Walks most mornings with his neighbor unless it rains, then they “mall-walk and critique sneakers.” No chest pain, dyspnea, palpitations, or syncope. No neuro symptoms. Mentions mild head-rush when standing but resolves by the time he gets to the kitchen. Diet mostly healthy, sugars okay at home. No hospitalizations. Admits missing a pill “here and there.” Side story: says he once brought a tennis racquet to pickleball league and got teased so badly “the exercise was from laughing, not playing.”

**Past Medical History:**

* CAD, s/p PCI
* Bilateral carotid stenosis (L 50–69%, R <50%)
* T2DM
* Hypertension
* Hyperlipidemia
* GERD

**Medications:**

* Aspirin 81 mg
* Rosuvastatin 40 mg
* Lisinopril 20 mg
* Metoprolol succinate 50 mg
* Metformin 1000 mg BID
* Omeprazole 20 mg

**Social History:** Retired accountant; occasional wine; former smoker.

**Family History:** Father MI 60s.

**Review of Systems:** Negative for CP, neuro symptoms, claudication.

**Physical Exam:**

* Vitals: BP 130/76, HR 66
* Neck: Left carotid bruit
* CV: RRR, no murmurs
* Neuro: Intact

**Assessment & Plan:**74M with bilateral carotid stenosis (L 50–69%, R <50%) in the setting of multiple vascular risk factors including diabetes, CAD, and hypertension. He is currently asymptomatic from a neurological standpoint but remains at elevated risk for future cerebrovascular events given the degree of stenosis and his overall atherosclerotic burden. It is reasonable to repeat a bilateral carotid duplex ultrasound at this time to assess for any progression of disease compared to prior studies, as progression beyond 70% stenosis may prompt discussion of revascularization versus continued medical management. Continue antiplatelet therapy with aspirin 81 mg daily for secondary prevention, and maintain high-intensity statin therapy aiming for LDL <70 mg/dL to slow plaque progression. Blood pressure control is critical — encourage adherence to lisinopril and lifestyle modification including low-sodium diet, daily exercise, and weight management. Reinforce the importance of medication adherence, daily home BP checks, and timely follow-up. RTC in 6 months or sooner with any new neurologic symptoms, syncope, or signs suggestive of TIA/stroke.

## 

## **Chart 18**

**Follow-up After TIA**

**History of Present Illness:**79-year-old woman with prior TIA (6 months ago), CAD s/p CABG, AFib, CKD3, HTN, HLD presents for surveillance. She proudly wears her medical alert bracelet “even at bingo,” complains of mild ankle swelling at night. No recurrent neuro symptoms. BP logs “pretty good except when I get salty chips at bingo.” No chest pain or syncope. Side story: says a bingo caller mispronounced “B-12” and she laughed so hard she hit her step goal.

**Past Medical History:**

* TIA (6 mo ago)
* CAD, s/p CABG
* AFib
* HTN
* CKD stage 3
* HLD

**Medications:**

* Apixaban 5 mg BID
* Clopidogrel 75 mg
* Atorvastatin 80 mg
* Metoprolol tartrate 50 mg BID
* Lisinopril 10 mg

**Social History:** Widowed; lives with daughter.

**Family History:** Noncontributory for stroke.

**Review of Systems:** Mild ankle edema, otherwise negative.

**Physical Exam:**

* Vitals: BP 138/78, HR 70 irregular
* Neck: No bruits
* Ext: 1+ ankle edema
* Neuro: Nonfocal

**Assessment & Plan:**79F with history of TIA, AFib, and multiple cardiovascular comorbidities, presenting for surveillance. Her current presentation is reassuring, with no recurrence of neurological symptoms, stable vital signs, and exam notable only for mild dependent edema. Given her prior TIA, she remains at substantial risk for recurrent cerebrovascular events, particularly with concomitant atrial fibrillation and chronic kidney disease. Recommend repeat bilateral carotid duplex ultrasound to evaluate for progression of stenosis, as significant progression could change management toward surgical or interventional therapy. Continue apixaban for cardioembolic stroke prevention, as she remains in AFib and has CHA₂DS₂-VASc ≥4. Maintain high-intensity statin therapy with goal LDL <70 mg/dL. Address mild edema with sodium restriction, leg elevation, and consider low-dose diuretic adjustment if worsening. Provide stroke education and discuss importance of rapid ED presentation for any new neuro symptoms. Plan follow-up in 3 months or sooner if symptoms recur.

## 

## **Chart 19**

**Follow-up After Neuro Event**

**History of Present Illness:**67-year-old man with HTN, HLD, T2DM, OSA presents after right arm numbness lasting ~20 min last week. Says episode was “perfect timing” because his teenage son ended up unloading groceries. No recurrent symptoms, no chest pain or syncope. Uses CPAP nightly, adherent to meds (dog associates pill alarm with treat time). Walks daily unless humid.

**Past Medical History:**

* HTN
* HLD
* T2DM
* OSA (CPAP)
* GERD

**Medications:**

* Amlodipine 10 mg
* Atorvastatin 40 mg
* Metformin 1000 mg BID
* Pantoprazole 40 mg

**Social History:** Former smoker; occasional weekend beer.

**Review of Systems:** Negative except for single episode of arm numbness.

**Physical Exam:**

* Vitals: BP 136/82, HR 72
* Neck: Left carotid bruit
* CV: RRR
* Neuro: Nonfocal

**Assessment & Plan:**67M with probable TIA, characterized by transient right arm sensory-motor symptoms, in the context of vascular risk factors and a left carotid bruit on exam. This presentation is concerning for possible ipsilateral carotid disease and justifies urgent workup to exclude high-grade stenosis. Order bilateral carotid duplex ultrasound as first-line study, followed by CTA or MRA if ≥50% stenosis is noted or if results are equivocal. Also obtain brain MRI/MRA to exclude acute infarct and evaluate intracranial vasculature. Begin aspirin 81 mg daily immediately for secondary prevention, provided no contraindication. Continue statin therapy and optimize antihypertensive regimen to achieve BP <130/80 mmHg. Reinforce CPAP adherence as untreated OSA is an independent stroke risk factor. Provide stroke/TIA education, emphasize need for emergent evaluation for recurrent symptoms. Follow up in 2 weeks to review imaging results and escalate to vascular surgery consult if severe stenosis (>70%) is found.

## 

## **Chart 20**

**Annual Carotid Follow-up**

**History of Present Illness:**80-year-old man with AAA, CAD, PVD, HTN, HLD here for annual check. Reports walking daily, beating his grandson at chess (“finally!”). No neuro symptoms, CP, or claudication change. Weight stable, salt shaker “banished.” Notes faint ear “whoosh” at night but not bothersome. Med adherence excellent thanks to color-coded pillbox. Side story: ordered 20 bananas by accident again—smoothies for a week.

**Past Medical History:**

* AAA (stable)
* CAD
* PVD
* HTN
* HLD
* CKD stage 2

**Medications:**

* Aspirin 81 mg
* Rosuvastatin 40 mg
* Losartan 50 mg
* Metoprolol succinate 50 mg
* HCTZ 25 mg

**Social History:** Retired; lives with spouse; former smoker.

**Family History:** Father MI, brother with AAA.

**Review of Systems:** Negative for neuro, CP, edema.

**Physical Exam:**

* Vitals: BP 128/74, HR 64
* Neck: Right carotid bruit
* Abd: Pulsatile AAA
* Neuro: Normal

**Assessment & Plan:**80M with right carotid bruit and known AAA, CAD, and diffuse atherosclerotic disease. His current status is stable but he remains at elevated risk of both cerebrovascular and cardiovascular events. Recommend repeat bilateral carotid duplex ultrasound to evaluate progression of carotid stenosis, as degree of stenosis will guide continued medical management vs potential surgical referral. Order repeat AAA surveillance ultrasound to confirm stability of aneurysm size and determine timing of next imaging interval. Continue aspirin for secondary prevention, high-intensity statin for plaque stabilization, and current antihypertensive regimen to maintain target BP <130/80 mmHg. Encourage ongoing adherence to lifestyle modifications including regular walking, dietary sodium restriction, and medication compliance. Provide education about signs/symptoms of TIA, stroke, and AAA rupture, with instructions to seek immediate emergency care if they occur. RTC in 6 months or sooner for new symptoms.