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10/24/1996 12:00:00 AM
RIGHT MIDDLE CEREBRAL ARTERY INFARCT .
Unsigned
DIS
Report Status :
Unsigned
DISCHARGE SUMMARY
NAME :
FINGER , ASHA
UNIT NUMBER :
424-76-57
ADMISSION DATE :
10/24/96
DISCHARGE DATE :
Halloween
PRINCIPAL DIAGNOSIS :
Right middle cerebral artery infarct .
ASSOCIATED DIAGNOSIS :
Urinary tract infection .
CLINICAL INFECTIONS :
Urinary tract infection , E. Coli .
PRINCIPAL PROCEDURE :
MRI / MRA .
OTHER PROCEDURES :
Echocardiogram , neurovascular ultrasound .
HISTORY :
Patient is a 73-year-old retired cook with a history of cervical myelopathy , who is admitted for new left hemiparesis .
He had undergone C-spine surgery for spinal stenosis with a question of myelopathy and radiculopathy in 1992 with residual spastic paresis and monoparesis of the left upper extremity , but was ambulatory until a day prior to admission .
At his baseline , he was able to perform limited tasks with his left upper extremity , and was clearly able to move his hand and able to ambulate .
He also at baseline has had urinary and fecal urgencies / incontinence .
His history is now that he has had a week of progressive left upper extremity weakness , to the point of being unable to move the left hand and one day of being unable to walk secondary to left leg weakness with a marked tendency to fall leftward .
PAST MEDICAL HISTORY :
Notable for anemia , hypercholesterolemia , narcolepsy for the past 6 years on Dexedrine , impotence with decreased testosterone , status post implant , peptic ulcer disease , status post duodenal resection , cervical stenosis , status post decompression '92 , hernia , status post herniorrhaphy .
ALLERGIES :
No known drug allergies .
MEDICATIONS ON ADMISSION :
Dexedrine 5 mg per day and Motrin 600 mg tid .
PHYSICAL EXAMINATION :
On admission , older , black gentleman in no acute distress with left upper extremity flex across his chest .
His temperatureis 98.9 .
His pressure is 150/90 .
Rate 76 .
Respirations 16 .
He was edentulous .
He had mild copper wiring .

He has a I / VI systolic murmur at the right upper sternal border .
Heart sounds were normal and regular .
Breath sounds were equal bilaterally with course rhonchi .
He had a midline abdominal scar and a reducible umbilical hernia .
Abdomen was otherwise soft and nontender .
He had 2+ carotids , no bruits .
He had gynecomastia .
Rectal was guaiac negative with brown stool , good tone but unable to squeeze .
Extremities :
1+ right posterior tibialis , 2+ left posterior tibialis , no edema , ichthyotic changes were present .
He had 0 left wrist flexion or extension while his left proximal muscles were 4 including his biceps and triceps .
His right arm muscles were also in the range of 4/5.
His hip flexion was 4+ on the right and 4- on the left ; extension 5 on the righ t , 4+ on the left ; knee flexion evidently trace on the right and 4- on the lef t with knee extension 5- on the left , 5 on the right ; knee flexion 4- on the l eft , trace on the right ; ankle dorsi flexion 4- on the left , trace on the rig ht .
Reflexes 4+ overall in the upper extremities and 3+ overall in the lower extremi ties , an upgoing left toe and a down going right toe .
His tone was increased on the left side and he had diminished pin prick and ligh t touch in his left upper extremity and slightly in his left lower extremity wit h a similar finding for vibratory sense , but in an unreliable pattern .
He occasionally had extinction in his left upper , greater than lower extremity , but this was fluctuating .
Mental state :
He was awake , occasionally sleepy but easily aroused , oriented to self , Oaksg ekesser/ Memorial Hospital and the date .
He was mildly perseverative and inattentive .
Coordination :
his fine finger movements and rapid alternating movements were within normal lim its .
He was unable to stand without extensive assistance .
LABORATORY DATA :
Sodium 141 , potassium 3.6 , BUN 14 , creatinine 1.1 , hematocrit 37% , platelet s 177 , white blood count 4.1 .
Chest x-ray showed degenerative joint disease , an ill defined left hemi-diaphra gm without air space disease .
On the lateral view , surgical clips in the abdomen .
EKG showed normal sinus rhythm , no ST or T wave changes .
HOSPITAL COURSE AND TREATMENT :
Mr. Finger was admitted for what appeared to be a stroke syndrome involving his left middle cerebral artery territory .
He underwent neurovascular doppler studies which showed no significant change in either common carotid or in the left common internal ophthalmic system .
However , there were hemodynamic changes which raised the question of right siph on disease .
He had normal cervical vertebral arteries .
Transcranial dopplers showed no abnormalities in the ophthalmic siphon systems , distal vertebrals , or proximal basilar artery .
The proximal , middle , anterior and posterior cerebral arteries , however , cou ld not be insinuated .
Over the course of the first hospital day , the patient 's exam deteriorate d in a manner that appeared to be blood pressure dependent .
He had been started on Heparin from the time of his admission .
A computerized tomography scan had showed multiple lacunes , right greater than left , and the deep gray and white matters suspicious for proximal middle cerebr al artery stem occlusion or stenosis .
MRI / MRA was performed with diffusion weighted images , showing subcortical whi

te matter and basal ganglia infarcts , but preserved middle cerebral artery terr itory cortex .
Because of his blood pressure , dependence of his left sided extremities , the l ower leg specifically , he was transferred to the Intensive Care Unit where he u nderwent hypertensive therapy for several days .
His systolic blood pressure goal was initially 170-190 , which he was able to ac hieve spontaneously for the most part .
However , due to the absence of clear benefit at this level , and further deteri oration in his left sided strength , this goal was increased and Neo-Synephrine was added to his regimen to achieve mean arterial pressures in the 110-120 range .
This strategy and its incumbent risks , particularly in a patient on Heparin , w ere discussed at length with both the patient and his family , who were very cle ar in wanting to proceed with all possible efforts to save the use of his left l eg .
While in the Intensive Care Unit , his strength deteriorated from being able to hold his left leg off the bed up to several inches to loosing virtually all dist al extremity strength , and having a 2-3/5 power in his proximal left leg groups .
He also , as Neo-Synephrinewas tapered , developed mild sensory findings , in pa rticular diminished large fiber sensibility in his left hand , although he at ti mes , including near the end of his Intensive Care Unit stay had a right gaze pr eference .
In terms of exploring his visual space , he was able to look to the left , and i t was not possible to elicit clear evidence for a field deficit .
He was followed by speech and swallowing service , who assisted in the managemen t of po intake which gradually improved , although he clearly had problems with manipulation of food in the left side of his mouth and would tend to accumulate a pouch of food in his left cheek .
I should mention that his blood pressure therapy was at times limited by a sever e headache , although he also had this off the pressor .
He had several repeat imaging studies during his Intensive Care Unit stay which showed further demarcation , but not extension of his prior infarct , both on co mputerized tomography scan and DWI images .
Additionally , he had a perfusion , diffusion MR study earlier on , which sugges ted the presence of viable penumbra , including the overlying cortex .
He was transferred to the regular neurology floor once it became clear that he w as not receiving any significant benefit from hypertensive therapy .
At this time , his neurologic exam is notable for hemiplegia of his left arm , s evere hemiparesis of his left leg , mild large fiber sensory loss in his left ar m , and otherwise fairly intact mental status , cranial nerve function , and rig ht sided motor and sensory function .
We anticipate that he represents a good rehab potential .
He will be discharged to rehab on a regimen of Coumadin 5 mg po today then daily for an INR goal of 2-3 , Ofloxacin 400 mg po bid to be discontinued on 11/05/96 , Dexedrine 5 mg po qd , Omeprazole 20mg po qd , Erythromycin eye ointment OU b id , Heparin at its present rate adjusting per partial thromboplastin time bid , and discontinuing when the Coumadin is therapeutic , Tylenol 650 mg po q4 prn , Colace 100 mg po bid .
Follow up will be with Dr. Tvi Fine of Neurology , and Dr. Doll Grendbly of inte rnal medicine and primary care , shortly after discharge from rehab .
BETHTATCHA W R NEW , M.D.
DICTATING FOR :
TVI SHANEL WASHING , M.D , PhD .
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10/31/96 2:55

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LASDAJENA WASHING , M.D. TELSHEY KO SWATLLEEBTIK , JR , M.D. TVI SHANEL WASHING , M.D. , Ph.D. DOLL MAO GRENDBLY , M.D. BETHTATCHA W R NIQUE DOUETMONES , III , M.D. STAT
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