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PARKINSON and apos ;S DISEASE .
Unsigned
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Report Status :
Unsigned
DISCHARGE SUMMARY
NAME :
BATH , JUANARI C
UNIT NUMBER :
746-22-50
ADMISSION DATE :
10/14/97
DISCHARGE DATE :
10/20/97
PRINCIPAL DIAGNOSIS :
Parkinson 's Disease .
ASSOCIATED DIAGNOSIS :
dementia ? secondary to Alzheimer 's disease ; benign prostatic hypertrophy .
DOCTOR 'S DISCHARGE ORDERS :
digoxin 0.25 milligrams po / daily ; proscar 5 milligrams po / daily ; cardura 1 milligram po / daily ; colace 100 milligrams po / daily ; sinemet 25/100 one PO t.i.d. times two days , then q.i.d. for the next three days , then five times daily until further orders ; ativan 1.0 milligrams po / qhs whenever necessary .
HISTORY OF PRESENT ILLNESS AND REASON FOR ADMISSION :
Mr. Bath is a 77-year-old retired psychologist who was admitted because of a fall .
He has a history of failing memory and difficulty with gait , dating back to 1993 when he had a cat scan which was said to be unremarkable , however , over the past year he has progressively deteriorated in terms of his memory and mental function and over the past six months has rapidly deterioratedwith his gait so that it has recently been very difficult for him to maintain his balance and walk unassisted .
Finally , he fell in his bath tub and was unable to get up .
A nursing assessment thought that it was unsafe for the patient to be at home so he was admitted to the hospital for evaluation .
PHYSICAL EXAMINATION :
there was no evidence of serious trauma .
His general examination revealed a blood pressure of 145/80 ; pulse of 72 and regular .
He was in no acute distress .
His neck was supple .
The chest was normal .
The cardiovascular examination revealed a regular rate and rhythm with no murmurs noted .
The carotids were normal .
There were no bruits .
There was some paravertebral tenderness over the lumbar sign but this was not severe .
The abdomen was soft and non-tender and slightly distended but bowel sounds were present .
There were no masses noted .
The Extremities examination revealed no edema .
Pulses were palpable .
The neurological evaluation revealed that the patient spoke with slow speech wit

h a paucity of expression and monotonal quality .
He was attentive and concentrate but did not perform serial addition or subtract ion normally , although it was fair .
He was oriented as to the date and place and some historical details were mainta ined .
He was unable to ambulate without assistance .
His tone was cog wheeling in the upper extremities and there was a lead pipe typ e rigidity in the lower extremities .
There were also a few myoclonic jerks .
He also had some frontal lobe signs .
LABORATORY DATA :
upon admission included electrolytes which were normal .
BUN and creatinine were 17 and 1.0 ; digoxin level of .8 ; sugar of 154 ; white blood count of 7.4 ; platelet count of 180,000 ; hematocrit level of 35% .
The electrocardiogram demonstrated an old right bundle branch block , otherwise normal .
The head cat scan was negative .
The lumbar spine films showed an old L-9 compression fracture which was confirme d on cat scanning .
HOSPITAL COURSE AND TREATMENT :
The patient was evaluated by Dr. Doll Grendbly from the Neurology Service who th ought that there was a good possibility that he had Parkinson 's Disease wi th certainly some Parkinsonian features to his picture .
However , some of his features could be explained by normal pressure hydrocephal us although the normal head scan seemed to exclude that .
There was also a question of Alzheimer 's Disease to explain his dementia .

Dr. Block recommended a trial of Sinemet therapy which was begun in the hospital and he was then transferred to are habilitation hospital for vigorous physical therapy and further evaluation of his Sinemet trial .
He will be followed closely in the out-patient department by both Dr. Block and his primary care physician , Dr. Curling .
DISPOSITION :
Addows Hospital .
REYAZA R. BATH , M.D.
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