081039790 EH
05861967
2214142
7/23/2003 12:00:00 AM
SUBARACHNOID HEMORRHAGE
Signed
DIS
Admission Date :
07/23/2003
Report Status :
Signed
Discharge Date :
08/05/2003
Date of Discharge :
08/05/2003
ATTENDING :
FLOW VIZEUBELB M.D.
PRINCIPAL DIAGNOSIS :
Anterior communicating artery aneurysm , subarachnoid hemorrhage .
OTHER PROBLEMS :
None .
HISTORY OF PRESENT ILLNESS :
This is a 52-year-old female who complains of 5 days of headache that has worsened over the past 2 days .
She has complained of nausea and vomiting since Wednesday , and currently , the headache is 9/10 with photophobia .
She called her primary care physician who originally thought that the nausea and vomiting were suggestive of a cold .
PAST MEDICAL HISTORY :
Polio as a child , history of alcohol abuse but quit in 1993 , and hypertension no longer on medications .
SOCIAL HISTORY :
The patient denies ethanol since 1993 .
She is married .
She denies tobacco history and is currently taking no medications .
LABORATORY DATA :
Sodium 137 , potassium 3.4 , chloride 102 , bicarb 26 , BUN 11 , creatinine 0.7 , and glucose 126 .
The UA was negative .
PHYSICAL EXAMINATION :
Vital signs :
Temperature 97.3 , pulse 77 , blood pressure 125/71 , respiratory rate 18 , and sating well .
On exam , the patient is lying with eyes closed , oriented x3 , following commands , and speech is fluent .
The pupils were 2.5 to 1.5 bilaterally .
Extraocular motions intact .
Face is symmetric to sensation as well as motor .
There is no tongue deviation .
Strength is 5/5 in all extremities .
Sensation is grossly intact , and the neck is supple .
There is no pronator drift .
DIAGNOSTIC STUDIES :
Head CT from the outside hospital showed blood in the basal cisterns .
HOSPITAL COURSE :
In summary , this is a 52-year-old female with a history of hypertension who presents with a severe headache and phonophobia , neurologically intact , consistent with a Hunt and Hess grade II , Fischer grade II subarachnoid hemorrhage .
She was admitted to the neurosurgical service directly to the ICU .
She was begun on nimodipine for vasospasm .

It was controlled with p.r.n. antihypertensives for blood pressure control with a goal of less 130 systolic .
An LP was performed to check the pressure .
Decadron was begun , and a CT angiogram was ordered .
A few hours after admission , the patient began to become drowsy and an external ventriculostomy drain was placed in the left frontal area without complications confirmed by CT .
On 07/24/2003 , a right triple-lumen catheter central venous access line was placed in aseptic fashion for hemodynamic monitoring as well venous access .
There were no complications .
CTA revealed anterior communicating artery aneurysm .
On 07/24/2003 , Dr. Flow Vizeubelb performed a right frontal craniotomy and microdissection of the anterior skull structure in the skull base followed by clipping of the aneurysm .
There were no complications .
Intraoperative angiogram showed no residual aneurysm and good flow into the anterior cervical arteries bilaterally .
Postoperatively , the patient was awake ; alert ; oriented to name , Totonleyash Clandsdallca Center , and 2003 ; and following commands .
The speech was fluent with mild naming difficulty , which improved over the subsequent few hours .
The pupils are reactive .
Face symmetrical .
Tongue midline .
She is moving all extremities without a drift .
Strength is 4 in all extremities .
By history , she was at this point post-bleed day 7 , therefore within the vasospasm peak .
She was vigilantly monitored for neurological status and followed by serial transcranial Dopplers daily .
Her external ventriculostomy drain following the OR was kept at 10 cm above the tragus and open .
She was maintained in a well-hydrated state , euvolemic , with IV fluids , crystalloid , and albumin as needed .
On 07/31/2003 , a repeat angiogram was performed , which revealed no residual aneurysm , no abnormalities , and no vasospasm .
There were no complications to this procedure .
The patient was then transferred back to the ICU in stable condition .
Postprocedure , the patient was alert and oriented x3 and following commands .
Speech was fluent .
Pupils reactive .
Face was symmetrical with no tongue deviation .
She is moving all extremities without drift .
Strength is 4 in all extremities .
The patient was doing very well after the negative angiogram , and the cardiovascular and neuro parameters were liberalized .
She was able to out of bed to chair and was continuing the EVD , and the EVD was clamped to see if she would tolerate no ventricular drainage .
On 08/01/2003 , the EVD was clamped for a 24 hours .
The patient had a mild headache and complained of mild nausea and vomiting .
A CT was obtained , which showed mildly increased ventricular size , and the external ventriculostomy drain was pulled .
On 08/03/2003 , the patient continued to complain of mild headache , now improving .
A lumbar puncture was performed to evaluate the pressure of the cerebrospinal fluid .
The opening pressure was 11 cm .
There were no complications of this procedure .
Based on this , the patient was transferred from the ICU to the floor and underwent PT and OT planning .

The patient is to be sent home with services .
The patient is leaving the hospital in neurologically stable condition .
DISCHARGE MEDICATIONS :
Include Percocet 1-2 tabs p.o. q.4h. p.r.n. , Motrin 600 mg p.o. q.8h. , and Dil
antin 100 mg p.o. t.i.d.
eScription document :
9-4443854 AIPlkbn
Dictated By :
KOTEJESC , NAE FARIETTEJARRED
Attending :
VIZEUBELB , MANSHIRL
Dictation ID 2434925
D :
08/05/03
T :
08/05/03
[report_end]