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08/07/2002 12:00:00 AM
Discharge Summary
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Report Status :
Signed
DISCHARGE SUMMARY NAME :
PANDEPROB , ORINNEREEN
UNIT NUMBER :
961-90-81
ADMISSION DATE :
08/07/2002
DISCHARGE DATE :
08/15/2002
HISTORY OF PRESENT ILLNESS :
This is a 70-year-old woman with a history of end-stage renal disease , on hemodialysis and peritoneal hemodialysis for ten years , transferred from Ton University Hospital for further evaluation of change in mental status .
She was admitted to Aper Hospital for change in mental status on 7/19/2002 .
Initial work up was unrevealing .
She was discharged to rehabilitation and developed disorientation , confusion , incoordination , and apparent paranoia .
She was diagnosis with a urinary tract infection and perineal inflammation and was transferred to the hospital and treated with IV Tequin for urinary tract infection .
Throughout her admission , she experienced occasional low-grade temperatures to 99 Fahrenheit with persistent leukocytosis .
There was a reported examination of her peritoneal fluid when fluid was being drawn for culture .
A catheter was subsequently placed for treatment of _____ for three days of ceftazidime .
Herperitoneal fluid cultures have all been negative and showed only 3 polys .
There was a question of 3 x 4 collection around the peritoneal catheter that was investigated with an I+ abdominal CT scan that was not conclusive .
She was switched , however , to hemodialysis from peritoneal dialysis .
Alumbar puncture of on 07/31/2002 was significant for an opening pressure reported as 12 cm of water .
Only 1 white blood cell was detected , and the fluid was culture and gram stain negative .
Work up also included a negative PPD , Clostridium difficile toxin , blood cultures , and head CT scan .
An electroencephalogram showed nonspecific , left greater than right slowing , without epileptiform spikes .
A Speech and Swallow evaluation initially deemed her an aspiration risk , and she was taken of PO 's .
Her erythrocyte sedimentation rate was found to be 48 .
Lupus anticoagulant was weakly positive , as was a D-dimer .
PAST MEDICAL HISTORY :
Notable for end-stage renal disease secondary to chronic urinary tract infections and pyelonephritis with vesicoureteral reflux .
Peritoneal dialysis x ten years , resulting from that .
And status post right nephrectomy , status post cholecystectomy , _____th yroidectomy .
MEDICATIONS ON TRANSFER TO THE BRI HEALTH FROM APER HOSPITAL :
Aspirin 81 mg qd , Epogen 10,000 units tiw , folate 4 mg qd , K-Dur 20 mEq , magnesium oxide 400 mg po qd , Phenergan 12.5 mg q4h prn , Prinivil 5 mg qd , Renag

el 20 mg po qd , vitamin E 400 IU bid , pamidronate 30 mg IV q3months .
ALLERGIES :
Include SULFA , CODEINE , TETRACYCLINE , NITROFURANTOIN .
SOCIAL HISTORY :
Not available at the time .
At baseline by report the patient was self-sufficient and aided in the care of h
er husband .
She denies the use of tobacco or ethanol .
She was raised in the Delaware and spent many years on an organic farm .
FAMILY HISTORY :
Noncontributory .
PHYSICAL EXAMINATION :
The patient was afebrile at 98.7 , blood pressure 128/64 , heart rate 96 , respi
ratory rate 22 , 02 s 96% on room air .
In general , she was well appearing in no apparent distress .
The pupils were equal and reactive to light and accommodation .
The oropharynx was moist .
The jugular venous pressure was 6 cm .
There was no palpable lymphadenopathy .
The chest was clear bilaterally .
The heart had a regular rate and rhythm , normal S1 and S2 , no murmurs , rubs ,
 or gallops .
The abdomen was soft , nontender , nondistended with good bowel sounds .
There was no hepatosplenomegaly .
There was no erythema around the catheter site .
There was only mild suprapubic fullness that was not tender .
There was no guarding or rebound .
There was no peripheral edema .
On neurologic examination , the patient followed only simple commands .
She moved all extremities .
She had decreased strength bilaterally .
She missed her nose with both hands when asked to touch her nose .
There was a questionable positive Babinski on the right side .
The toes were downgoing on the left .
She answered appropriately to yes-no questions , but _____
She appeared to understand questions , but then could not come up with the answe
rs , or where she was , and she could not give her name , but did respond when h
er name was used .
LABORATORY DATA :
On admission included a sodium of 146 , potassium 3.4 , chloride 101 , CO2 31.6
, BUN 8 , creatinine 4.3 , glucose 94 , calcium 10.5 , magnesium 1.5 , phosphoru
s 2.5 .
Her liver function tests were all within normal limits .
Her coagulation factors showed a PT of 13.2 , INR 1.2 , PTT 23.2 .
Her white blood cell count was elevated at 17.6 .
The hematocrit was 43.3 , platelets 425,000 .
The differential was 85% polymorphonuclearleukocytes .
Abdominal CT scan from the outside hospital showed no abscess and left renal atr
ophy with multiple cysts .
The electroencephalogram showed left greater than right frontotemporal slowing t
hroughout the tracing .
Head CT scan on 07/30/2002 showed prominent ventricles , cortical atrophy , and
suggested infarct in the left thalamus , left insular cortex , and decreased att
enuation in the right frontal lobe .
As noted , laboratory data at the outside hospital included a negative Clostridi
um difficile , a weakly positive D-dimer , a weakly positive lupus anticoagulant
 , and an erythrocyte sedimentation rate of 48 .
HOSPITAL COURSE :
The patient 's presentation was a very confusing and complicated one with d
ifferential diagnosis including a neurodegenerative process such as Creutzfeldt-

Jakob disease , a dementia such as Alzheimer 's of a more rapidly progressi ng nature , and other infectious etiologies such as urinary tract infection or a nother fever source .
Work up included from a neurologic perspective brain MRI , brain EEG , lumbar pu ncture .
In concert with the Neurology Service , who followed the patient with us , we or dered an EEG and MRI with susceptibilities and DWI .
An lumbar puncture was performed , in which we measured the opening pressure as unremarkable at 14.5 cm .
In addition , per Neurology recommendations , we sent cerebrospinal fluid for Gr am stain , bacterial culture , fungal cultures , acid-fast bacilli , _____ antigen , 14-3-3 protein for Creutzfeldt-Jakob disease , cytology , and , in add ition , ordered EEGs , MRIs , antithyroglobulin antibody , antithyroid peroxidas e antibody , TSH , ammonia , methyl malonic acid , and , in addition , considere d neoplastic tests from the serum and the cerebrospinal fluid including anti-Ma , anti-Ta , anti-CV2 , anti-Hu , anti-yo antibodies .
In addition , from a renal perspective , the patient was placed on a Tuesday , T hursday , Saturday dialysis schedule .
For her hypertension , shewas given lisinopril .
For her FEN , the patient was able to take PO 's and , per Speech and Swall ow consult , was permitted to take PO 's with one to one supervision .
For prophylaxis , the patient was on subcutaneous heparin and Nexium .
From an infectious disease perspective , the patient remained afebrile and , des pite a transient bump in her white blood cell count over the weekend of 08/10 th rough 08/12/2002 , has had a white blood cell count come back to normal range of 12.0 .
No obvious source of infection was found , with negative cultures from blood , u rine , sputum , the peritoneal fluid , and cerebrospinal fluid .
Excellent suggestions from Dr. Pa of the Renal Service included repeating antica rdiolipin and lupus anticoagulant , given the patient 's weakly positive lu pus anticoagulant in the past and the fact that this could be associated with se vere and rapid cognitive decline that was observed in this patient .
However , these antibodies were both within normal limits .
The patient 's mental status gradually began to improve during the course o fthe weekend from 08/10 through 08/12 and was markedly improved on 08/13/2002 , compared with the day of admission .
However , the patient remains not oriented to time or to place , although she is now able to answer questions and actually carry on simple conversations appropr iately .
The nature of her cognitive decline and change in mental status is still unclear , with most typical and less typical causes of reversible change in mental stat us having been ruled out and no obvious sources of infection from blood , CSF , sputum , urine , or peritoneal fluid .
On the abdominal CT scan , there was a question of an ovarian cystic mass that r aised the possibility of ovarian cancer .
CA-125 levels were within normal limits .
We entertained the possibility of doing a pelvic ultrasound to further character ize this lesion .
We will discuss the case further with the Neurology Service , who will evaluate the case more carefully tomorrow with their attending .
Pending no further suggestions on their part , we have completed the metabolic w ork up for reversible causes of dementia and will likely discharge the patient t o return to the Termarimed pending no further suggestions from Neurology or othe r consultants .
LENNI E. HODGKIN , M.D. , PH.D
DICTATING FOR :
Electronically Signed
LENNI E. HODGKIN , M.D. , PH.D
08/20/2002 07:46
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