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Discharge Summary
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Report Status :
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DISCHARGE SUMMARY
NAME :
SIEHFREIERM , NAETTE B
UNIT NUMBER :
719-77-05
ADMISSION DATE :
03/19/2005
DISCHARGE DATE :
03/20/2005
PRINCIPAL DIAGNOSIS :
Aseptic meningitis .
ASSOCIATED DIAGNOSIS :
Hypertension , hyperparathyroidism .
OPERATIONS / PROCEDURES :
Lumbar puncture .
HISTORY AND REASON FOR HOSPITALIZATION :
43-year-old woman with meningitis .
This is a 43-year-old lady with history of multiple surgeries including Roux-En-Y gastric bypass , ventral hernia repair with wound dehiscence in 08/06 who presented with headaches x4 days , lumbar puncture consistent with meningitis .
The patient reports headache began Monday , 3/15/05 , around 4 PM .
Later that night , she took Tylenol , but headache persisted through 3/16/05 .
On 3/17 , with headache not better , tried sinus medication , but no relief .
Finally went to Aubratjen Medical Center on 3/18 where she noted her headache was improving .
She was given medications for nausea and Fioricet , for possible migraine , went home and napped , awoke feeling worse .
Tried another Fioricet , but no relief so she came to the Emergency Department as she had been instructed by Co Hospital to do so .
She reported some chills , positive photophobia , neck pain starting around 17th of March , some nausea , no vomiting .
She did have a temperature to 100.8 on 3/18 prior to going to the ED .
She denies any abdominal pain , cough , or dysuria .
The patient denies any recent sick contacts or travel .
ED COURSE :
Initial vitals , blood pressure 134/92 , pulse 72 , temperature 38.7 .
Head CT was negative , LP was done and surprisingly came back with 650 WBC 's in tube 1 , 810 WBC 's in tube 4 , both with 99% lymphocytes .
CSF showed sugar of 49 , total protein 103 .
Patient received vancomycin 1 gm , ceftriaxone 2 gm , while CSF gram stain was still pending , she also received IV fluids , Reglan and morphine sulfate .
PAST MEDICAL HISTORY :
1. Hypertension .
2. Anxiety .
3. Depression .
4. Vitamin D deficiency .
5. Hyperparathyroidism .
6. Diverticulosis .
7. Hemorrhoids .
8. Status post cholecystectomy .

9. Status post Roux-En-Y gastric bypass .
10. Status post ventral hernia repair and abdominoplasty .
ALLERGIES :
Vicodin - nausea , dizziness .
Tylenol with codeine - nausea , dizziness .
MEDICATIONS AT HOME :
1. Multivitamin daily .
2. Colace , 100 mg tid prn constipation .
3. Flurazepam , 15 mg prn insomnia .
4. Calcium .
5. Vitamin D .
6. Zoloft , 100 mg PO qd .
7. Hydrochlorothiazide , 25 mg PO daily .
SOCIAL :
Lives with her husband , no smoking , no drugs , social alcohol .
FAMILY HISTORY :
Unknown .
PHYSICAL EXAMINATION :
Vitals :
108/67 , pulse of 80 , temperature of 98.5 , satting 98% on room air .
General :
Lying in bed , uncomfortable , but not toxic appearing .
HEENT :
Neck supple , moist mucous membranes , able to touch her chin to her chest .
Chest :
Clear to auscultation bilaterally .
Coronary :
Regular , 1/6 soft systolic murmur , heart sound .
Abdomen :
Obese , soft , nontender , nondistended .
Extremities :
No edema .
Skin :
No rashes appreciated .
RADIOLOGICAL AND LABORATORY DATA IN THE HOSPITAL :
On discharge , the patient 's Chem-7 was sodium 135 , potassium 3.5 , chlor
ide 98 , CO2 30.2 , calcium 8.9 , phosphorous 3.7 , magnesium 1.5 , BUN 8 , crea
tinine 0.6 and plasma glucose of 91 .
Her CSF sugar was 49 .
CSF total protein 103 .
The CSF differential count is included in the body of this discharge summary .
CBC on discharge was a normal WBC count of 6.2 , hematocrit 38.2 , platelets 255
.
Her rheumatoid factor was less than 30 , antinuclear antibody was positive at 1:
40 and 1:160 .
ANA pattern was speckled .
Her anti-Ro , anti-La antibodies were negative .
Her CMV antibody , heterophile antibody , Lyme antibody and RPR card tests were
all negative .
CMV antigenemia was serous negative .
Blood cultures were negative .
CSF gram strain showed abundant mononuclear cells with no polys or organisms .
No growth in CSF .
Negative for HSV nucleic acid type I and type II .
CT of the brain :
No evidence of an intracranial mass , acute hemorrhage or territorial infarct .
No evidence of acute intercranial hemorrhage or fracture .
HOSPITAL COURSE :
The patient was diagnosed with aseptic meningitis .
She was given supportive care .

She was ambulatory .
She was continued on 24 more hours of antibiotics and as the cultures and gram s tains were negative , the antibiotics were discontinued .
Initially she was treated with opioids for pain , which was later switched to no n-steroidal anti-inflammatory drugs .
She was given Zofran prn for nausea and Colace and Senna for constipation .
She was discharged home in stable condition .
CONDITION ON DISCHARGE :
Stable .
DISCHARGE ORDERS :
Diet :
Low cholesterol , low saturated fat .
MEDICATIONS :
Percocet , 1-2 tabs PO q4-6h ; Reglan , 10 mg PO qid ; Advil , 800 mg PO tid .
ADDITIONAL ORDERS :
Do not walk around if you feel lighted or dizzy , contact your primary care phys ician .
Please contact your primary care physician if your symptoms persist despite adeq uate therapy , which is being prescribed .
If you develop worsening sensitivity to light , headaches which are worse or cha nge in character , any weakness or numbness , tingling of the limbs , or worseni ng neck stiffness , please return to the Emergency Room immediately .
Several of your lab tests ordered to workup your meningitis are pending at the t ime of discharge .
Please insure that you follow-up with your PCP and these studies .
THEABIMA A. CHAMBER , M.D.
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