Patient #102

Chief Complaint/History of Present Illness: This 49 year old white professor of history was in an auto accident and suffered a basilar skull fracture. He was admitted to the hospital for observation. His blood pressure was recorded at 132-150/80-98 and his heart rate 84-98/min in the hospital. He then developed lightheadedness particularly upon standing. His BP was then 220/110 and his heart rate 120-150. The episode lasted a matter of minutes and spontaneously subsided.

Previous Medical History: His blood pressure had been borderline high for years and in the past year his diastolic pressure was 90 or slightly above. No family history of hypertension was mentioned. He had had a colon biopsy 8 years before but no diagnosis was made.

Physical Examination: Vital signs were BP 140/90 supine, 115/84 standing; HR 88 supine, 98 standing. His fundi showed minimal if any changes of hypertension. There were no other abnormalities except deafness in his right ear related to the trauma.

Laboratory Data:

			Normal
CBC	Hgb	15.6	*14.0-18.0g/dl.*
	WBC	15.9 (no differential)	*4-10 X $10^{9/L}$*
	platelet count	466	*200-400 X 10^{9}/L*
Chemistries	sodium	142	*136-146mmol/l*
	potassium	4.8	*3.5-5.0 mmol/l*
	chloride	101	*99-111 mmol/l*
	CO2	31	*24-34 mmol/l*
	creatinine	1.0	*.9-1.3 mg/dl*
	BUN	16	*8-20 mg/dl*
	glucose	123	*73-115 mg/dl*
	bilirubin, total	0.6	*.1-1.1mg/dl*
	AST (SGOT)	32	*2-35 U/L*
	ALT (SGPT)	19	*0-45 U/L*
	LDH	215	*60-200 U/L*

ALP	111	*30-96U/L*
PT	11.5	*10-13 sec.*
APTT	24.9	*20-30sec.*

EKG: normal