Patient #033

Chief Complaint: This 20 year old black male was admitted from an outside hospital with the complaints of headache and slurred speech.

History of Present Illness: This previously healthy patient was transferred from an outlying hospital after presenting with a one day history of occipital headaches and slurred speech. The headache began the day prior to admission and the patient felt well enough to visit his girlfriend that night. His girlfriend noted the onset of slurred speech and weakness in the patient's right arm. She took him to the local emergency room. The patient complained of chills, dizziness, shortness of breath, fatigue and constipation. He denied fever, cough, chest pain or cold symptoms. He further denied rashes or a sore throat. There was no history of vomiting, melena, or dysuria.

Past Medical History: The past medical history was unremarkable. There was no past history of illness or operations. There were no known allergies. He was taking no medications.

Social History: The patient smokes occasional marijuana.

Family History: There was no family history of sickle cell disease.

Physical Examination: The temperature was 100.6^{o} F (38.1^{o}C), blood pressure 150/78, pulse 96, respirations 24. He appeared as a well developed, well nourished, black male in no distress. The pupils were equally round, reactive to light and accommodation. The mucus membranes were moist and the oropharynx appeared normal. The neck was supple; there was no thyromegaly or adenopathy. There was a III/VI systolic ejection murmur at the left upper sternal border. The lungs were clear to auscultation. The abdomen was soft, non-distended, non-tender. There was no organomegaly. The distal pulses were 2+ and equal bilaterally. There was no cyanosis, clubbing, or edema. The patient was alert and oriented x3. His speech was clear. The strength was 5/5 throughout. The deep tendon reflexes were 2+ and equal bilaterally. Cranial nerves were intact. The sensory exam was also normal.

Laboratory Data:

			Normal
CBC	Hct	22	*38-47 %*
	Hgb	7.4	*12.3-15.7 g/dl.*
	MCV	100	*81-97 fl*
	MCHC	33	*32-36 g/dl*
	RDW	22.1	*12-15 %*
	WBC	8.4	*4-12 X $10^{9/L}$*
	platelet count	25	*150-440 X 10^{9}/l*

Blood smear: anisocytosis, macrocytosis, polychromasia, schistocytes and spherocytes.

Chemistries	sodium	141	*135-145 mmol/l*
	potassium	4.2	*3.5-5.0 mmol/l*
	chloride	103	*100-111 mmol/l*
	CO2	26	*24-30 mmol/l*
	creatinine	1.6	*0.8-1.5mg/dl*
	BUN	15	*8-20 mg/dl*
	bilirubin, total	2.5	*0-1.2 mg/dl*
	bilirubin, direct	.5	*0-0.2 mg/dl*
	calcium	8.3	*8.5-10.2 mg/dl*
	protein, total	6.9	*6.8-8.3 g/dl*
	albumin	4.3	*3.5-5.0 g/dl*
	AST (SGOT)	51	*11-40 U/L*
	ALT (SGPT)	16	*10-52 U/L*
	LDH	1,058	*108-215 U/L*
	ALP	72	*39-117 U/L*
Coag studies	PT	12	*10-13 sec.*
	APTT	28	*21.5-31.9 sec.*

Urinalysis: 3-8 WBCs, 3-10 RBCs, and 3-10 squamous epithelial cells per HPF. 1+ protein, and increased urobilinogen present.

Chest X-ray : normal

Toxic screen: normal

Other tests: **Haptoglobin** <5 mg/dl (nl 30-215)

ANA: positive with a speckled pattern and a titer of 1:40.