Patient #093

Chief Complaint: This 46 year old white female presented with a two week history of right maxillary sinus pressure.

History of Present Illness: Three days prior to admission she was awakened from sleep when she felt a "pop" around the right eye. She went to her local emergency room and was told that she had sinusitis and was started on Septra, ibuprofen and hydrocodone. The pressure over the right maxillary and frontal sinuses persisted. She described it as pulsating or "spasm like". She noted blurred vision, swelling and tearing from the right eye. She also gave a history of nausea and vomiting for the three days prior to admission. She complained of right ear fullness.

Past Medical History: She had had headaches in the past and two years ago complained of headaches starting in the left neck radiating to the left shoulder and then back into the head and finally involving the whole head. These lasted for several months before responding to ibuprofen and physical therapy.

She had a past history of depression and had attempted suicide two years ago. Ever since then she had been seeing a psychiatrist and was taking bupropion. Her depression had been under good control. One year ago she was treated conservatively for a C6 radiculopathy. An MRI showed central disc herniation at the level of C5/6. With physical therapy and neck immobilization her pain resolved over several months.

Past Surgical History: She had a hysterectomy 17 years ago.

Social History: She is in her second marriage and has four step children and two of her own. She used to drink heavily but cut back after her depressive episode. She denied smoking.

Family History: Her mother died of colon cancer.

Physical Examination: On physical exam her blood pressure was 162/84 supine with a pulse of 60 and 124/80 with a pulse of 80, standing. The temperature was 99.8^{o} F (37.7^{o} C). She appeared ill and uncomfortable. The skin was normal. There was no

adenopathy. She had ptosis of the right eye. There was no exophthalmus. The right pupil measured 3 mm in diameter and the left pupil 2 mm. Both reacted to light. She had a right exotropia. The tympanic membranes were normal. The oropharynx appeared normal. The neck was supple. The lungs were clear to auscultation and percussion. The heart sounds were normal with no gallops, or murmurs. There were no breast masses. The abdomen was soft, non-tender, without masses, or organomegaly. There was no peripheral edema. The pulses were 2+ and equal bilaterally. The cranial nerves aside from the exotropia and ptosis were all normal. The strength was equal bilaterally. There was no pronator drift. The sensory exam was normal. The deep tendon reflexes were normal bilaterally. The Babinski reflexes were absent. Cerebellar testing was normal.

Laboratory: Data:

			Normal
CBC	Hct	40	*38-47 %*
	Hgb	13.2	*12.3-15.7 g/dl.*
	WBC	9.3	*4-12 X $10^{9/L}$*
	differential	normal	
	platelet count	347	*150-440 X 10^{9}/l*
Chemistries	sodium	135	*135-145 mmol/l*
	potassium	4.2	*3.5-5.0 mmol/l*
	chloride	100	*100-111 mmol/l*
	CO2	23	*24-30 mmol/l*
	creatinine	.9	*0.6-1.2 mg/dl*
	BUN	14	*8-20 mg/dl*

Head CT: No subarachnoid hemorrhage, no masses, no hydrocephalus.