±±{0|4|1}

DOCTORS HOSPITAL OF SARASOTA
5731 BEE RIDGE ROAD
SARASOTA, FL 34233

JOB: 1175

DATE OF VISIT: November 6, 2005 ER ADMISSION

CHIEF COMPLAINT:
Right sided arm and leg weakness and slurred speech.

HISTORY OF PRESENT ILLNESS:
The patient is an 87-year-old female that comes to the Emergency Room via EMS rescue for evaluation of slurred speech and weakness. The granddaughter, who is at the bedside, states that she was last seen normal at approximately three o'clock this afternoon. When she woke up from a nap at approximately 4:30 or 5 p.m., she stated that she noticed that her grandmother was having difficulty walking with weakness to the right arm and right leg and with thick and slurred speech. There were no falls, no injuries, no fevers or chills, no chest pain or shortness of breath. They do state though that they have been having difficulty with her blood pressure over the last couple of weeks, that they are trying to prepare her for ophthalmologic cataract surgery but they really have been unable to reel in her blood pressure, as it has been somewhat out of control. Today, the patient does state that she has had a mild low-grade headache throughout the entire head. No chest pain, no double vision, no blurred vision, no nausea or vomiting, no skin rashes, no falls, no diarrhea.

REVIEW OF SYSTEMS:
All other systems otherwise reviewed and negative.

PAST MEDICAL HISTORY:
Paroxysmal atrial fibrillation, hypertension, coronary disease, mild dementia, hard of hearing hyperlipidemia.

SURGICAL HISTORY:
Hysterectomy and ankle surgery.

SOCIAL HISTORY:
Negative for tobacco or alcohol. She lives locally with her granddaughter.

FAMILY HISTORY:
Appears to be noncontributory other than maybe heart disease and cancer in the father.

MEDICATIONS:
Metoprolol, clonidine, aspirin, and something for cholesterol.

JOAQUIN J ARISTIMUNO

DD: 11/06/05 TD: 1906
DT: 11/06/05 TT: 2231
REP: 1106-0148

WOICHOWSKI, HELEN B
D000228592
D10404247

LOCAL PHYSICIAN:
Dr. Bonnie Gabriel.

PHYSICAL EXAMINATION:
GENERAL: The patient is a well-developed, elderly female who does not appear to be in any significant distress, although she does have a slight slurring to her speech, mildly hard of hearing, and appears to have slight difficulty with lifting her right arm and right leg.

VITAL SIGNS: Blood pressure upon arrival is 199/89, pulse 76, respirations 18, temperature afebrile, and 96-98% saturated on several liters of nasal cannula.

HEENT: The pupils are equal, round and reactive to light. Extraocular movements appear to be normal. Fundoscopic examination is not readily visible secondary to thick cataracts. The oropharynx is moist and clear. The soft palate elevates symmetrically. The tongue has slight deviation to the right.

NECK: Supple without any significant jugular venous distention or bruits. No nuchal rigidity.

LUNGS: Clear to auscultation without any wheezes or crackles.

HEART: Regular rate and rhythm without any significant murmurs, gallops or rubs. Occasional ectopic beat is heard. No murmurs, gallops or rubs.

ABDOMEN: Soft and nontender.

EXTREMITIES: 2+ pulses without any evidence of cyanosis or edema.

NEUROLOGIC: Cranial nerves II-XII appear to be grossly intact. There appears to be a very subtle facial droop on the right side. Motor strength on the right side is 3/5. She has a pronator drift on the right hand and finger-to-nose is not able to be done because her hand is slightly weak. Heel-to-shin also on the right side is slightly abnormal because of weakness to the leg. The deep tendon reflexes are 2+ and equal. Toes are both downgoing as of this time.

SKIN: Warm and dry without any rashes.

DIFFERENTIAL DIAGNOSIS:
Hypertension, rule out bleed, cerebrovascular accident.

ORDERS:
Head CT, EKG, chest x-ray, cardiac enzymes, chem-7.

JOAQUIN J ARISTIMUNO

DD: 11/06/05 TD: 1906
DT: 11/06/05 TT: 2231
REP: 1106-0148

WOICHOWSKI,HELEN B
D000228592
D10404247

DOCTORS HOSPITAL OF SARASOTA
5731 BEE RIDGE ROAD
SARASOTA, FL 34233

DATA BASE:
Laboratory results reveal a head CT read by the radiologist as having a thalamic bleed on the left side. Glucose 118, BUN 19, creatinine 1, sodium 137, potassium 4.1, chloride 103, CO2 30. Troponin 0.3, myoglobin 52. INR of 0.99. White count of 7.2, H&H of 14 and 43, platelets 188. EKG, interpreted by myself, shows a normal sinus rhythm at a rate of 88. There does not appear to be any evidence of ST segment depression or elevation, no acute changes, no flip Ts. I do not have an old EKG for comparison at this time.

EMERGENCY DEPARTMENT COURSE:
The patient had an IV established, placed on pulse ox, monitor and oxygen. Immediately upon arrival here to the Emergency Room, it was thought that the patient may have been within the three hour window for neuro thrombolytics. However, given that her head CT has blood in it, she disqualifies herself for that particular treatment and management.

DISPOSITION:
I did speak with Dr. Ruffing, who is on call for Dr. Concha, who had been recommended by Dr. Creevy, who is covering for Dr. Gabriel this evening, for neurology. Dr. Ruffing, at this point, recommended only controlling blood pressure to approximately 180 or so systolic with Labetalol, close neurologic checks in the ICU, and Dr. Creevy will be admitting for Dr. Bonnie Gabriel this evening.

FINAL DIAGNOSIS:
1. Acute cerebrovascular accident, bleed.
2. Hypertension with moderate to poor control.
Electronically Signed by JOAQUIN J ARISTIMUNO on 11/07/05 at 0019

JOAQUIN J ARISTIMUNO

DD: 11/06/05 TD: 1906
DT: 11/06/05 TT: 2231
REP: 1106-0148

WOICHOWSKI,HELEN B
D000228592
D10404247

EMERGENCY ROOM - Additional copy