CUNY York College Physician Assistant Program Spring 2021
Chaya Newfield
Internal Medicine Rotation – NYPQ

History and Physical 1

Identifying Data:

Name: JP
Age: 54 years
Sex: Male
Race: Korean
Date & Time: 4/7/2021, 10:00 AM
Location: NYPQ
Source of Referral: Self
Source of Information: Self
Mode of Transport: EMS

Chief Complaint:

"My left side felt weak and numb for a few hours"

History of Present Illness:

JP is a 54-year-old Korean male with a no reported significant past medical history as per patient who states he has not been seen by a doctor in over 15 years, presents to the ED from home with complaint of new left sided weakness, numbness and slurred speech. Patient reports at 21:00 he noted some weakness in his left leg and decreased sensation at home. He was able to ambulate at this time and take a shower on his own. By 23:00 he reports he noted inability to move the left leg or arm.

STROKE ACTIVATED 00:19 . Patient Arrived to ED by EMS 00:24

In the ED, upon arrival patient BP elevated to 235/152. HR 106, OX 94% on nonrebreather mask. Patient AO X2 and able to provide his own history. Patient denies any dizziness, headache, nausea, vomiting, or blurry vision. He denies any history of similar symptoms. He denies any known family history significant for stroke, MI, PE/DVT or bleed but admits that he may be uninformed regarding his family history. On exam patient seen dysarthric and with left arm paralysis and left leg weakness/drift.

Past Medical History:

Present illness:
- Denies

Past illness:
- Unknown

Hospitalizations:
- Denies

Immunizations:
• Patient admits he is not up to date on immunizations, is unsure of his immunization status
Screening:
•Denies colonoscopy.
Past Surgical History:
• Denies

Medications:
Unknown/ uncompliant

Allergies:
Denies any known allergies to medications, foods, or environmental factors.
Family History:
Denies any known family history significant for stroke, MI, PE/DVT or bleed
Social History:
Habits:
Denies any history of drinking, smoking, or illicit drug use.
Travel:
No recent travel.
Marital History:
JP is married and lives at home with his spouse.
Sexual History:
Sexually active, monogamous with wife.
Home:
JP lives in a private residence.
Diet:
JP admits to a diet with high fat and sugar content (McDonalds and fast food suppers)
Review Of Symptoms:
General – Pt admits to loss of appetite, new left sided weakness. Pt denies fever and chills or night sweats.
Head – Denies headaches, nausea, blurry vision
Pulmonary –Denies wheezing, cough, dyspnea.
Cardiovascular – Denies palpitations, chest pain, edema/swelling of ankles or feet, syncope.
Gastrointestinal –. Denies abdominal pain, constipation/diarrhea.
Genitourinary – Denies dysuria.
Nervous – Admits to new left sided weakness, numbness and slurred speech.
Musculoskeletal system – Admits to inability to move left arm or leg
Psychiatric – Denies depression/sadness, anxiety.

Physical Exam:
Vital Signs:
Blood Pressure: 235/152 (right arm, supine)
Heart Rate: 91 beats/minute (regular)
Respiration Rate: 28 breaths/minute (nonlabored)

Temperature: 37.0 C (oral)
O2 Sat: 93% (on NRB)
Height: 5’6’’
Weight: 219 lbs
BMI: 35.3
General Appearance:
54-year-old casually-groomed male lying supine in hospital bed. No indications of acute distress.
Skin:
Warm and moist/dry, good turgor, noncitric, no thickness/opacity, no notable lesions, rashes, scars, or tattoos.
Eyes:
Symmetrical OU without evidence of strabismus or ptosis. Sclera white, conjunctiva and cornea clear. EOMI, PERRL.
Ears:
Symmetrical and normal size. No evidence of lesions, masses, or trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TMs pearly gray and intact with light reflex in appropriate position AU
Nose: Symmetrical without obvious masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa pale & well hydrated.
Mouth and Pharynx:
Lips: Pink, moist, no evidence of cyanosis or lesion.
Neck: Supple, no JVD, thyroid nontender/not enlarged
Chest: Normal breathing effort. Symmetrical, no deformities, no signs of trauma. Lateral:AP diameter 2:1. Non-tender to palpation.
Lungs: Clear to auscultation bilaterally without rales, rhonchi, or wheezes.
Cardiovascular: Regular rate and rhythm (RRR); S1 and S2 are normal. No S3, S4, splitting of heart sounds, friction rubs or other extra sounds
Abdomen: Soft, non-tender, non-distended, bowel sounds present
Genitourinary: Not assessed.
Rectal: Not assessed.
Peripheral Vascular: Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower, no LE edema. No stasis changes or ulcerations noted.
Musculoskeletal: 2/5 strength in LUE/LLE, 5/5 strength in RUE/RLE
Neurological: AOx3, L sided facial droop. (+) pronator drift left side. Decreased sensation left side. (+) dysarthria
Mental Status:
Alert and oriented x 3
INITIAL STROKE TEAM EVALUATION:
Initial Stroke Evaluation:
· Last seen well within 6 hrs of arrival
· Date symptoms discovered: 06-Apr-2021
· Time symptoms discovered: 21:00
· Arrival (Door) Time 07-Apr-2021 00:24

· Seen by MD (goal 10 minutes from arrival) 07-Apr-2021 00:24
· Seen by Stroke Team (goal 15 minutes from arrival) 07-Apr-2021 00:24
· CT Done (goal 25 minutes from arrival) 07-Apr-2021 00:44
· CT Interpreted (goal 45 minutes from arrival) 07-Apr-2021 00:50
· Activase (Alteplase) administered: No

NIH STROKE SCALE:
NIHSS:
· Date & Time of Exam 07-Apr-2021 00:24
· Interval Baseline

NIH Stroke Scale:
· 1a. Level of Consciousness (0) Alert; keenly responsive.
· 1b. LOC Questions: (0) Answers both questions correctly.
· 1c. LOC Commands: (0) Performs both tasks correctly.
· 2. Best Gaze: (0) Normal.
· 3. Visual: (0) No visual loss.
· 4. Facial Palsy: (0) Normal symmetrical movements.
· 5a. Right Arm Motor (0) No drift; limb holds 90 (or 45) degrees for full 10 seconds. 5/5 motor strength
· 5b. Left Arm Motor (4) No movement.
· 6a. Right Leg Motor (0) No drift; leg holds 30-degree position for full 5 seconds. 5/5 motor strength
· 6b. Left Leg Motor (1) Drift; leg falls by the end of the 5-second period but does not hit bed. falls to bed <2sec
· 7. Limb Ataxia: (0) Absent.
· 8. Sensory: (1) Mild-to-moderate sensory loss; patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick, but patient is aware of being touched. decreased sensation to left face, arm and leg compared to right
· 9. Best Language: (0) No aphasia; normal.
· 10. Dysarthria: (1) Mild-to-moderate dysarthria; patient slurs at least some words and, at worst, can be understood with some difficulty.
· 11. Extinction and Inattention (formerly Neglect): (0) No abnormality.
· Total Score 7

Differential Diagnosis

1. Hemorrhagic stroke
2. Ischemic Stroke
3. Subdural hemorrhage
4. Brain mass/lesion
5. Complex/atypical migraine
6. Meningitis

Labs: (at 00:45)

141 | 103 | 19.8
--------------------< 209   Ca: 9.1   Anion Gap: 14
3.6 | 24 | 1.03

WBC: 7.36 / Hb: 15.2 (MCV: 80.0) / Hct: 46.1 / Plt: 189
-- Diff: N:60.9% L:29.30% Mo:7.3%

PT: 11.9 / PTT: 29.5 / INR: 1.00

Troponin: <0.010

Imaging:

CT HEAD/BRAIN W/O CONT

VASCULATURE: Intracranial arterial calcifications.

BRAIN/INTRACRANIAL STRUCTURES:

Acute intraparenchymal hemorrhage measuring 2.1 x 2.1 cm in transaxial dimensions centered in the right thalamus and posterior capsular region with surrounding edema and localized mass effect resulting in 4 mm leftward midline shift. There is intraventricular extension of the hemorrhage into the right lateral ventricle.

Nonspecific hypodensity in the subcortical and periventricular white matter typical of mild to moderate chronic microvascular ischemic changes. No extra-axial collections are evident. No evidence of hydrocephalus.

IMPRESSION:

2.1 cm acute intraparenchymal hemorrhage centered in the right thalamus and posterior capsular region with intraventricular extension and 4 mm leftward midline shift.

CT Angiogram of Head and Neck:

No evidence of large vessel occlusion. Punctate hyperdense focus within the right thalamic hemorrhage could reflect a coursing vessel or a small focus of active hemorrhage. Partially imaged soft tissue density in the expected location of the left ventricle most likely reflects nonopacified or contracted/hypertrophic left ventricle rather than a mass.

Assessment:

54 year old male with no PMHx per patient, but does not see a doctor regularly, presents to the ED from home with complaint of new left sided weakness, numbness and slurred speech. STAT CT Head performed confirmed 2.1 cm acute intraparenchymal hemorrhage centered in the right thalamus and posterior capsular region with intraventricular extension and 4 mm leftward midline shift.

Plan:

#Acute Intraparenchymal hemorrhage
initial BP 235/152 s/p IV Labetalol 20mg repeat 214/147
NIH SS= 7
repeat head CT
-start Keppra BID
-keep HOB elevated 30 degrees
-q1hr neurochecks

-no acute surgical intervention required at this time

-when patient is stable begin PT/OT rehabilitation

#Cardiovascular
- initial BP 235/152 s/p IV Labetalol 20mg repeat 214/147
-strict blood pressure control to keep SBP < 160
- transition to nicardipine ggt
- place arterial line for close BP monitoring

#PULM
- patient is on nonrebreather mask
- monitor oxygen levels

#GI
- NPO for now, until patient is cleared by speech pathologist for swallow test

#RENAL
- no acute issues
- trend bmp; replete electrolytes prn
-keep Na > 145-155

#ENDO
- monitor FS q6h while NPO
- goal 120-180

#HEME/ONC
- H/H stable
- venodynes for dvt ppx for now

#ID
- no leukocytosis, fever, or localizing sxs concerning for infection at this time.

tubes -
lines - arterial line
drips - nicardipine
dvt ppx – venodynes
gi ppx - none indicated
ethics - full code
dispo - admit to MICU

Patient education: Explain to patient that he had a bleed in his brain, likely due to longstanding uncontrolled high blood pressure and other risk factors including obesity and a diet high in salty, fried foods. He will now remain in the ICU in the hospital so he can be monitored for changes in his neurologic status and will be started on medication to control his blood pressure. Explain to patient that he is at risk for falls and should not try to ambulate or get out of bed on his own at this time. When he is medically cleared, he should begin rehabilitation to regain muscle strength and learn how to manage daily activities again. Other lifestyle changes should also be implemented, including diet and medication adherence. It is vital that the patient understands the need for further follow up with doctors and allied health service providers to have the best outcome for recovery.