CUNY York College Physician Assistant Program
Spring 2020
Mariyanthie Linaris
Internal Medicine Rotation – North Shore University Hospital

History and Physical

Identifying Data:

Name: PS
Age: 69 years
Sex: Female
Race: Caucasian
Date & Time: 3/10/2020, 11:00 AM
Date Admitted: 3/8/2020
Location: North Shore University Hospital
Source of Referral: None
Source of Information: Self (limited)/Family (when available)
Mode of Transport: EMS

Chief Complaint:

Unable to respond to questions x 3 days

History of Present Illness:

PS is a 69-year-old unreliable Caucasian female with a significant past medical history of hypertension and osteopenia presents to the ED after a family member called EMS because she suddenly became unable to understand them and respond to questions while on the phone x 1 day. Her family noted that they were speaking on the phone when PS's speech became altered and she "was not making any sense." They note that she did not sound distressed on the phone. They called EMS and PS was promptly brought to the NSUH ED. Her family reports that she had another episode of aphasia 1.5 weeks ago while in California, which resolved within 3 hours. A stroke code was initiated upon arrival to the ED, where she was assessed and found to have an NIHSS of 6. PS was excluded from IV tPA because there was no clear last-known-well time. Her head CT was negative and the CTA of the head and neck showed patent arterial vessels, but with suggested presence of a left medial transverse sinus thrombosis. She was found to have a receptive aphasia likely but appears to be able to respond affirmatively or negatively to questions regarding her condition with unclear reliability. She denies fever, chills, headache, nausea, vomiting, diarrhea, coughing, wheezing, chest pain, palpitations, dysuria, urinary frequency or urgency, pain, or any other symptoms. Today, her aphasia appears much improved and she appears to be able to understand and answer questions more appropriately.

Past Medical History:

Present illness:

- Hypertension x unknown years
- Osteopenia x unknown years

Past illness:

- Unknown

Hospitalizations:

- Patient and family deny any past hospitalizations

Immunizations:

- PS's family reports that she receives the influenza vaccine annually but is unsure of whether she received the pneumonia vaccine.

Screening:

- PS's family is unsure the dates of her last mammogram, pap smear, and colonoscopy. They note that she has never had abnormal results in the past

Past Surgical History:

- Denies any surgeries, injuries, or blood transfusions in the past

Medications:

1. Acetaminophen (Tylenol) 650 mg PO Q6hours PRN
2. Atorvastatin (Lipitor) 10 mg PO QD at bedtime
    a. Last dose last night
3. Enoxaparin (Lovenox) injectable 70 mg SC BID
    a. Last dose this morning

Allergies:

PS's family denies any known allergies to medications, foods, or environmental factors.

Family History:

PS's family is unavailable to provide family history, but the patient chart reports a familial history of Factor V deficiency.

Social History:

Habits:

PS's family reports that she does not smoke tobacco or take any illicit drugs to their knowledge. She drinks alcohol socially (1-2 glasses of wine on holidays).

Travel:

PS recently returned from a trip to California 1 week ago.

Marital History:

PS is a widow.

Sexual History:

Unable to obtain.

Home:

PS lives alone.

Diet:

PS eats a regular diet and mostly cooks for herself.

Review Of Symptoms:

General:

Denies fever, chills, night sweats, fatigue, weakness, loss of appetite, and recent weight loss or gain.

Skin, Hair, Nails:

Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution.

Head:

Denies headache, vertigo, head trauma, or loss of consciousness.

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Eyes:

PS wears glasses for myopia. She denies visual disturbances, fatigue, lacrimation, photophobia, or pruritus. She is unable to recall her last eye exam.

Ears:

She denies any deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses:

She denies any discharge, epistaxis, or obstruction.

Mouth and throat:

She denies any bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures.

Neck:

She denies localized swelling/lumps, stiffness, or decreased range of motion.

Breast:

She denies any lumps, nipple discharge, or pain.

Pulmonary:

She denies dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, and PND.

Cardiovascular:

She has a history of hypertension. She denies chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, and a known heart murmur.

Gastrointestinal:

She denies any changes in appetite, intolerance to foods, nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, or flank pain.

Genitourinary:

She denies any frequency, changes in the color of her urine, incontinence, dysuria, nocturia, urgency, oliguria, polyuria, anorgasmia, sexually transmitted infections, or use of contraception.

Menstrual and Obstetrical:

PS is menopausal and states that her last period was “a long time ago.”

Obstetrical History:

G2P202

Musculoskeletal:

She denies any muscle/joint pain, deformity or swelling, redness, or arthritis.

Peripheral Vascular:

She denies any intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, or color changes.

Hematologic:
She denies any history of anemia, easy bruising or bleeding, lymph node enlargement, or history of DVT/PE.

Endocrine:
She denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, and hirsutism.

Nervous System:
Her family reports an episode of aphasia 1.5 weeks ago that resolved within 3 hours and a second episode at 11:00PM on 3/7/2020 for which she was brought to the ED. She denies any history of seizures, loss consciousness, numbness, paresthesia, loss of strength, or weakness.

Psychiatric:
She denies any depression/sadness anxiety, obsessive/compulsive disorder, or history of seeing mental health professionals.

Physical Exam:
Vital Signs:
Blood Pressure: 125/79 (right arm, sitting)
Heart Rate: 74 beats/minute (regular)
Respiration Rate: 18 breaths/minute (nonlabored)
Temperature: 97.7F (oral)
O_2 Sat: 97% (room air)
Height: 5'5''
Weight: 154 lbs
BMI: 25.6

General Appearance: 69-year-old well-groomed female. A/O x 2. She appears her stated age. In no acute distress.

Skin:
Warm and moist/dry, good turgor, noncitric, no thickness/opacity, no notable lesions, rashes, scars, or tattoos.
Nails: No clubbing, no infection, capillary refill <2 sec throughout.
Hair: Average quantity and distribution, no signs of alopecia, seborrhea, or lice.

Head:
Normocephalic, atraumatic; nontender to palpation throughout. No signs of alopecia, seborrhea, or lice.

Eyes:
Symmetrical OU without evidence of strabismus or ptosis. Sclera white, conjunctiva and cornea clear. Visual fields full bilaterally. PERRLA. EOMI without nystagmus.
Visual Acuity: Unable to identify the letters on the Snellen Eye chart; appears frustrated because she feels like she should know them.
Fundoscopy: Not assessed.

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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. Auditory acuity intact to whisper AU.

Nose:

Symmetrical without obvious masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa pale & well hydrated. Clear discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No evidence of foreign bodies.

Sinuses:

Nontender to palpation and percussion over bilateral frontal and maxillary sinuses.

Mouth and Pharynx:

Lips: Pink, moist, no evidence of cyanosis or lesion.
Mucosa: Pink; well hydrated. No masses. Lesions noted. No evidence of leukoplakia.
Palate- Pink, well hydrated. Palate intact with no lesions, masses, or scars.
Teeth: Good dentition without obvious dental caries.
Gingiva: Pink and moist without evidence of hyperplasia, masses, lesions, erythema or discharge.
Tongue: Pink, well papillated. No masses, lesions or deviation noted.
Oropharynx: Well hydrated without evidence of injection, exudate, masses, lesions, or foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink without edema or lesions.

Neck:

Trachea midline. No masses, lesions, scars, pulsation noted. Supple, nontender to palpation. FROM no stridor noted. Thyroid non-tender, no palpable masses, no thyromegaly.

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. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds. Carotid pulses are 2+ bilaterally without bruits.

Abdomen:

Flat and symmetrical without evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. Tympanic to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Breast:

Symmetric, no dimpling, no masses, nipples without discharge. No axillary nodes palpable

Genitourinary:
Not assessed.

Rectal:
Not assessed.

Peripheral Vascular:
Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted.

Musculoskeletal:
No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. Non-tender to palpation and without crepitus throughout. FROM in all upper and lower extremities bilaterally.

Neurological:
Mental Status:
Alert and oriented to person and place. Memory and attention intact. She demonstrates improving receptive aphasia, phonemic aphasia, verbal perseveration. She displays significant semantic paraphasia (i.e., substituting "friend" for "cousin" or "doctor" and "she" instead of "he"). Expressive abilities intact with logorrhea. She is unable to name common items when shown (like a straw) but is able to mime what to do with these items. She cannot recognize words on a page and appears increasingly frustrated, stating that "she should know this." Her insight appears intact (asking, "I am going to get better, right?"). She follows some simple commands (hold your arm out in front of you) but not all (hold up 2 fingers).

Cranial Nerves:
I – Not assessed.
II- Unable to assess visual acuity because she cannot recognize letters on the Snellen Eye Chart. Visual fields by confrontation full. Fundoscopy not assessed.
III-IV-VI- PERRLA, EOM intact without nystagmus.
V- Facial sensation intact, strength good.
VII- Facial movements symmetrical and without weakness.
VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.
IX-X-XII- Swallowing intact. Uvula elevates midline. Tongue movement intact without deviation.
XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar:
Full active and passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength 5/5 throughout. No limb drift. Gait normal with no ataxia. Fine finger movements intact.

Sensory:
Intact to light touch, sharp/dull, and vibratory sensation.

Reflexes: 2+ throughout.

Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.

Labs:

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          12.8
5.63) ---------- (175
          39.7

140 | 105 | 11
----------------- (106
 3.9 |   23 | 0.65
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Calcium: 9.3

Hemoglobin A1C: 5.6%

LDL: 78 / HDL: 115

TPro 7.4 / Alb 4.3 / TBili 0.4 / AST 23 / ALT 19 / AlkPhos 61

PT/INR 10.6/0.93
PTT 30.5 sec

Urinalysis (Basic):
Color light yellow / Appearance clear / SG 1.027
Ketones negative / Bili negative / Urobili negative
Protein negative / Nitrite negative
Leuk Esterase negative / RBCs 2/ WBC 1/ Bacteria negative

Imaging:

CT Head Without Contrast:
Asymmetric hypodensity in the left transverse sinus corresponds to the dural venous sinus thrombosis on the CTA. Decreased visualization of sulci in the left temporal lobe is suspicious for subtle mass effect, probably due to venous hypertension. No hypodensity or venous infarct is visualized in the left temporal lobe.
No CT evidence of acute intracranial hemorrhage or a large acute territorial infarct.

CTA Neck:
Patent cervical vasculature. No hemodynamically significant carotid stenosis or flow-limiting vertebral artery stenosis. No evidence of dissection.

CTA Brain:
Approximately 4 cm long filling defect in the medial (proximal) aspect of the left transverse sinus is compatible with venous sinus thrombosis. The thrombus appears hypodense on noncontrast CT raising the possibility that is chronic. There is short segment opacification at the junction of the left transverse sinus and left sigmoid sinus, however, the distal aspect of the left sigmoid sinus and left jugular bulb appear thrombosed.

Numerous small asymmetric vessels surrounding left temporal lobe with extension to cortical veins, the left lateral ventricle, left cerebellar tentoria, and through the left foramen ovale into the infratemporal fossa are compatible with collateral venous drainage pathways. The possibility of a dural AV fistula is not excluded.

No vessel occlusion, flow limiting stenosis, or aneurysm is identified about the circle of Willis.

MRI/MRV Brain:

The constellation of imaging findings on the brain MRI and brain MRV are most consistent with a chronic left transverse sigmoid sinus thrombosis, dural AV fistula formation, and left temporal parietal thalamic venous infarction with petechial hemorrhagic transformation.

Chest X-Ray:

Clear lungs.

Assessment:

69-year-old female with a significant past medical history of hypertension and osteopenia presented for evaluation via EMS after speaking on the phone with her family member on 3/7/2020 who notices that she was unable to understand or respond to questions. She was found to have a severe receptive (Wernicke's) aphasia. Imaging is consistent with probably venous infarction of the left temporal lobe and left thalamus, related to chronic venous sinus thrombosis and a dural AVM.

Plan:

1. Chronic venous sinus thrombosis and dural AVM
    a. Continue close monitoring for neurological deterioration with neuro checks Q4hours
    b. Started on low-dose atorvastatin
    c. Plan for embolization of AVM and stent likely on 3/12/2020 with Dr. Katz
        i. NPO after midnight on 3/12/2020 and discontinue anticoagulation
    d. Continue lovenox (apart from above, resume when appropriate after procedure) due to chronicity and DVT prophylaxis
        i. Aspirin not indicated because infarction is due to venous hypertension rather than thrombotic phenomenon
2. Hypertension
    a. Medications held for now
3. Check TTE
4. Check hypercoagulability panel
5. Disposition: subacute rehab as per PT/OT
6. Serum sodium goal > 135
    a. Continue IV normal saline
    b. Monitor BMP daily
    c. Monitor urine output
7. Dysphagia screen passed
    a. Regular diet