

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12975



5 - SUMMARIES

000001

1/5

CONSULTATION RECORD

CONSULTING PHYSICIAN: [REDACTED]

DATE: 01/04/98

TIME: 1830

HISTORY:

[REDACTED] is 23 years old. He is right-handed. He is studying business administration at the [REDACTED] in [REDACTED]. He has been working at the [REDACTED] Dairy during the winter holidays. He was seen for a neurologic evaluation regarding a seizure. The history was reviewed with the patient and his parents who are present at the bedside.

On the day before admission he went to bed at about 3:00 or 4:00 a.m. At about 9:00 a.m. his mother woke him up because he had a phone call from [REDACTED] Dairy. He talked to them. They wanted to find out if he was going to work that day. The patient told them that he had other plans and was not going to work. He went back to sleep. At about noon time his mother heard a loud noise from his upstairs bedroom. At first she did not pay any attention to it but then she heard a second loud noise. She went upstairs to check on him. He was in bed thrashing around. He had a bruise on his hand and his right. Apparently he had hit his night stand. There was a strange look in his eyes. He looked as if he was frightened. He would not respond to his mother. He had been incontinent of urine. He had bitten his tongue. He was quite restless. She became frightened and called her husband. They tried to keep him in bed but he would resist them. Finally, they called 911 and the ambulance crew arrived. At that time he was still confused. The patient says that he remembers going to bed and the next thing he remembers is waking up with the ambulance people around him. He was confused for quite sometime, at least 15-20 minutes. When he arrived in the emergency room, he knew his name. He did not know who had won the football game which he had watched a couple of nights ago. He was given 1 gram of Dilantin. A head CT scan was done which was normal. He was admitted to the medical floor. He has been started on Dilantin. His dilantin level today was 6.5. Dr. [REDACTED] has increased his dosage to 200 mg t.i.d. He has not had any further seizures.

For the last one year or so he has had intermittent episodes when he just stares and blanks out. If he were to be talking, he would stop suddenly and then stare. He would then resume his activities within 15 seconds or so. The patient does seem to be aware of this but he just cannot control himself. These spells have been also noted by his sister and both of his parents. There is no history of early morning mild clonus but there is some history of early morning clumsiness upon awakening in the morning.

He has never had a seizure in the past otherwise. He does not have any other medical problems. He is quite athletic and works out regularly. He uses

PT. [REDACTED]

M.R.#/RM. [REDACTED]

DR. [REDACTED]

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some Chinese herbal medications and "diet fuel" tablets which contain large doses of caffeine and ephedrine. He also uses Rogaine locally for hair loss.

He had a left knee injury while playing football when he was in junior high and underwent knee surgery for repair of a torn medial collateral ligament. He has no history of prematurity meningitis, head injury or any other exposures. There is no family history of epilepsy. He has been otherwise healthy. He was diagnosed to have peptic ulcer disease via an upper GI study a few months ago and was treated with Flagyl, Biaxin and some other medication which he does not know the name of.

He drinks alcohol occasionally and smokes cigarettes occasionally.

NEUROLOGICAL EXAMINATION:

He is alert, awake, pleasant and cooperative. He does not appear to be in any acute distress. The mental status is normal to history taking. The pupils are equal and reactive. The fundi are normal. The eye movements are full. There is no nystagmus. There is a slight bruise in the corner of the right eye. There is a laceration of the tongue on the right side. The facial expressions are symmetric. Facial sensations are normal. The tongue protrudes in the midline. He is right handed. The motor examination does not reveal any focal deficits. Reflexes are 2+ and symmetric. The plantar reflexes are flexor. The sensory examination is normal. There is no ataxia. The rapid alternating movements are normal. There is no extinction upon double simultaneous stimulation testing.

A head CT scan without contrast is normal.

IMPRESSION:

[REDACTED] presents with a history of a probable generalized tonic-clonic seizure with a prolonged postictal state. He also gives a history of staring spells for the last one year. Whether these represent absence seizures or whether they represent partial complex seizures is to be determined. If these are absence seizures, then he is quite likely to have the juvenile myoclonic epilepsy of Janz.

RECOMMENDATIONS:

Various anticonvulsants were discussed. With a combination of staring spells and generalized tonic-clonic seizures Depakote would probably be the best choice but the patient is quite concerned about losing hair. This can be one of the side effects of Depakote. He prefers to stay on Dilantin which may be effective. He was told that if he continues to have staring spells, we might have to make a switch to Depakote. The side effects were discussed. The importance of dental and gingival hygiene was stressed. He was advised to take a multivitamin tablet a day. The effects on hematologic and hepatic systems were discussed and the need for regular monitoring of CBC, liver function studies and Dilantin levels was discussed.

For now he will continue with Dilantin. Since his level today was 6.5, I have written orders so that he will get Dilantin 400 mg p.o. now and then 400

PT. [REDACTED]

M.R.#/RM. [REDACTED]

DR. [REDACTED]

M.D.

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[REDACTED]

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mg in three hours.

Repeat Dilantin level in the morning. If it is therapeutic, he may be discharged.

MRI scan of the brain with contrast as an outpatient. The patient is to call me after discharge for these arrangements and further follow-up.

EEG which may be done as an outpatient.

He should see me in the office after the MRI scan and EEG are performed.

Dilantin level in one week. Please call results to me.

He was advised not to drink alcohol and not to use the diet fuel or any other such medications. He was also advised not to drive. The [REDACTED] law about not driving for six months after having had a spell was explained to him. He cannot drive even if he has just the staring episodes. He should not use any of the diet drugs. He should avoid situations whereby he can injure himself or others. Should he have a spell as such, he should not climb ladders, be around moving heavy machinery, etc.

Thank you for this consultation.

[REDACTED]

[REDACTED]

D 01/04/98
T 01/05/98

cc: [REDACTED], M.D.

PT. [REDACTED]

M.R.#/RM. [REDACTED]

DR. [REDACTED]

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CONSULTATION RECORD

[REDACTED]

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CONSULTATION RECORD

CONSULTING PHYSICIAN: [REDACTED]

DATE:

TIME:

ADDENDUM TO PREVIOUS DICTATION:

[REDACTED] sister came and told me that [REDACTED] forgot to tell me that about a month ago there were two different occasions when he woke up in the morning with sores in the insides of his mouth. He did not understand how they had appeared. Retrospectively, he believes that he may have bitten the inside of his mouth. He did go to a clinic and was given Zovirax. It is possible that he may have had seizures at that time, although we cannot be absolutely sure.

[REDACTED]

[REDACTED]

D 01/04/98
T 01/05/98

cc: [REDACTED] M.D.

PT. [REDACTED]

M.R.#/RM. [REDACTED]

DR. [REDACTED]

M.D.

MEDICAL RECORD

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CONSULTATION RECORD



CONSULTATION RECORD

REQUEST - To be completed by requesting physician.

CONSULTING PHYSICIAN

DATE 1/3/98 TIME 2056

REASON FOR CONSULTATION Seizure Act

CONSULTATION PRIORITY: STAT (Within 4 hours) URGENT (Within 12 hours) OTHER (Within 24 hours)

CONSULTANT MAY ASSUME CARE IN HIS FIELD: Yes No WRITE ORDERS: Yes No

CONSULTANT NOTIFIED: Ans servio SIGNATURE OF REQUESTING PHYSICIAN

Date: 1/3/98 Time: 2056 By: [Redacted] Date: _____ Time: _____ By: _____

REPLY: FINDINGS: Date: 1.4.98 Time: 6:30pm PATIENT EXAMINED RECORD REVIEWED REPORT DICTATED

Consult dictated

Imp: Probable generalized tonic clonic seizure
with prolonged post ictal state.
Episodes of "staring" - last 1 yr
? Absence Sz
i.e. ? Juvenile myoclonic epilepsy
? Partial complex seizures

CT: WNL

Rec: Various anticonvulsants discussed.
For now, he will stay on dilantin.
Keep levels in therapeutic ranges
MRI brain \bar{c} contrast as outpt - pt to call
my office for arrangements
EEG - may be done as outpt
See me in the office after MRI, EEG
Dilantin level in am - if therapeutic \rightarrow discharge
" " in 1 wk \rightarrow results to me.
No driving / alcohol / diet drugs
Dc "Diet Fuel"

DIAGNOSIS:

RECOMMENDATIONS:

Thanks
[Redacted] mo

CONSULTANT ACCEPTS CARE IN HIS FIELD: YES NO

PT [Redacted] SIGNATURE OF CONSULTANT

MR # RV 000006 MEDICAL RECORDS DO NOT WRITE ON THE BACK OF THIS FORM

CR [Redacted] CONSULTATION RECORD

HISTORY AND PHYSICAL EXAMINATION

DATE OF ADMISSION: 01/03/98

CHIEF COMPLAINT:

Seizure.

HISTORY OF PRESENT ILLNESS:

The patient is a 23-year-old white male who complains of seizures yesterday. The patient was very sleepy yesterday. He went to sleep. When he woke up he had a sore tongue and bruises on head and hands. He also bit his tongue, especially on the right side. Then his parents came to his room and saw him having a generalized tonic-clonic seizure. Paramedics were called, and the patient was brought to the hospital. Family states the patient gets blank looks once in a while lately.

PAST MEDICAL HISTORY:

None significant. The patient is a body builder and uses *Diet Fuel* and also uses something called Ciewafee which is a Chinese herbal medication. Also, he uses multivitamins and also has history of herpes simplex in the past.

MEDICATION(S):

As above.

ALLERGIES:

ALUMINUM AND ZIRCONIUM.

SOCIAL HISTORY:

The patient smokes and uses alcohol sometimes, occasionally on the weekends. There is no history of any drug abuse.

FAMILY HISTORY:

Unremarkable. There is no history of seizures in the family. The patient has a sister and both parents who are healthy.

REVIEW OF SYSTEMS:

GENERAL: No loss of weight, loss of appetite or loss of sleep.

HEAD, EYES, EARS, NOSE AND THROAT: No headaches, earache, nasal discharge or dysphagia.

CHEST: No cough or phlegm production.

CARDIOVASCULAR: No chest pain, shortness of breath, palpitations or syncope.

GASTROINTESTINAL: No nausea or vomiting, abdominal pain, diarrhea or constipation.

GENITOURINARY: No dysuria or hematuria.

NEUROPSYCHIATRIC: No headaches. The patient had seizures as above. No weakness, paralysis or numbness.

SKIN: No rashes.

MUSCULOSKELETAL: No joint pain or swelling.

PT. [REDACTED]

M.R.#/RM. [REDACTED]

DR. [REDACTED] M.D.

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MEDICAL RECORD

HISTORY AND PHYSICAL EXAMINATION

[REDACTED]

HISTORY AND PHYSICAL EXAMINATION

ENDOCRINE: No polyuria, polyphagia or polydipsia. No heat or cold intolerance.

PHYSICAL EXAMINATION:

GENERAL: Alert and oriented times three, in no acute distress.

VITAL SIGNS: Blood pressure 128/60, pulse 78, respirations 18, temperature 98.1°F.

SKIN: Temperature, turgor and color of the skin are normal. No abnormal rash or pigmentation.

HEAD, EYES, EARS, NOSE AND THROAT: Pupils were equal, round and reactive to light., not jaundiced, not anemic. Mucous membranes are well hydrated. The patient has small lacerations on both sides of the tongue, especially on the right side. There is no open wound that needs to be sutured present at this time. The patient has slight bruises on the left side of the scalp.

NECK: Supple. No jugular venous distention or thyromegaly.

LYMPHATIC: No cervical lymphadenopathy.

CHEST: Clear to auscultation. Air entry is equal bilaterally. No crackles or rhonchi.

HEART: S1 and S2 heard normally. No murmur or gallop.

ABDOMEN: Soft and nontender. Bowel sounds are present. No palpable masses.

EXTREMITIES: No edema.

NEUROLOGICAL: The patient is alert and oriented times three. No focal neurological deficit.

MUSCULOSKELETAL: No joint effusion or tenderness.

LABORATORY DATA AND X-RAY FINDINGS:

Sodium is 138, potassium 3.7, chloride 101, bicarbonate 29, BUN 18, creatinine 1.1, blood sugar 94. Dilantin 6.9. White blood cells are 9.8 from 12.7. Hemoglobin is 14.9 from 15.4. Platelets are 165. Urinalysis negative.

ASSESSMENT:

1. New-onset seizure.

PLAN:

Admit the patient to a medical floor. Increase Dilantin to 200 t.i.d. Dilantin level. Neurological consult. Discussed with the parents and the patient.

[REDACTED]

[REDACTED]

D 01/04/98

T 01/04/98

cc: [REDACTED] M.D.

PT. [REDACTED]

M.R.#/RM. [REDACTED]

DR. [REDACTED] M.D.

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MEDICAL RECORD

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HISTORY AND PHYSICAL EXAMINATION

[REDACTED]



DATE 1/5/98 TIME _____

DISCHARGE FORM

DISCHARGE ORDER

Patient discharge to: Home Exempt Rehab ECF Exempt Psych Other acute care facility Other

DISCHARGE INSTRUCTIONS:

Diet General

Activity / Restrictions As tol.

DRESSING / TREATMENTS ⊕ Driving X 6 months

FOLLOW-UP CARE Follow up Dr. [redacted] in 3-4 days. Dilantin level on 1/12/98
Call Dr. [redacted] if in MRIBSSG

DISCHARGE MEDICATIONS

DISCHARGE MEDICATIONS	DOSE	FREQUENCY	Rx TO PT.	DISCHARGE MEDICATIONS	DOSE	FREQUENCY	Rx TO PT.
Dilantin 200mg Po BID			<input type="checkbox"/>				<input type="checkbox"/>
Augmentin 500mg Po TID X 1 week			<input type="checkbox"/>				<input type="checkbox"/>
May take Centrum TID			<input type="checkbox"/>				<input type="checkbox"/>
⊕ other over the counter meds for now			<input type="checkbox"/>				<input type="checkbox"/>
			<input type="checkbox"/>				<input type="checkbox"/>
			<input type="checkbox"/>				<input type="checkbox"/>
			<input type="checkbox"/>				<input type="checkbox"/>
			<input type="checkbox"/>				<input type="checkbox"/>
			<input type="checkbox"/>				<input type="checkbox"/>

Patient Physical Status at Discharge (Mental Status if appropriate)

Stable

DISCHARGE DIAGNOSES:

New onset grandmal seizure.
Tongue infection & cellulitis.

DISCHARGE PROGRESS NOTE:

Physician Signature: _____
Copy to Referring Physician: _____

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