

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

ARMS#

13203



5 - SUMMARIES

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DISCHARGE SUMMARY

PATIENT: [REDACTED] ACCT#: [REDACTED] MR#: [REDACTED]
PHYSICIAN: [REDACTED] MD ROOM#: [REDACTED]

DATE OF ADMISSION: 11/13/98
DATE OF DISCHARGE: 11/19/98

FINAL DIAGNOSIS: 1. Hypertension, possibly secondary to Ma-huang and St. John's wort.

This is a 46 year old white female who presented with severe headache, double vision and fever on 11/13/98. She awoke Sunday night with double vision. She saw Dr. [REDACTED] ophthalmology, on Monday. There was no pathology found in the eyes. She was seen in my office with a blood pressure of 200/130, fever of 101 degrees F, pulse of 128, respirations 20, weight 166 1/2.

PAST MEDICAL HISTORY: TGA.

No known allergies.

MEDICATIONS: Advil, aspirin, St. John's wort about five in the evening and Metabolife which contains the Ma-huang about four in the morning.

She had a fractured clavicle in 1965.

FAMILY HISTORY: Negative.

SOCIAL HISTORY: Negative.

Physical examination revealed a mild degree of horizontal nystagmus. Pupils equal and reactive to light and accommodation. EOMs within normal limits. TMs were clear. Neck was supple. Thyroid smooth without nodules. Heart-tachycardia without murmur. Lungs clear. Abdomen was soft and non-tender. Bowel sounds were active. There were no bruits heard. Extremities within normal limits. NP within normal limits.

The patient was kindly seen in cardiology consultation by Dr. [REDACTED]. His impression-hypertensive urgency, headache, diplopia, tachycardia, possible hyperthyroidism, possible occult infection, questionable catechol secreting tumor such as a pheochromocytoma or carcinoid. Recommendations-at this point with her elevated blood pressure and persistent headache, would favor discontinuing Norvasc and

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Vasotec and going with beta alpha blockade with Labetalol. Recommended 20 mg. IV loading dose followed by 200 mg. b.i.d. as needed. Await thyroid function testing. Blood cultures have apparently been drawn. If her symptoms persist over the next 24 hours, should have an echocardiogram done to rule out endocarditis. 24 hour urine for metanephrine, catecholamines and VMA as well as HIAA. I would consider empiric antibiotic therapy institution.

Dr. [REDACTED] kindly saw the patient in neurology consultation. Impression- the episodic diplopia does not appear to be of a malignant etiology. The fact that it is has really resolved over the past few days is a good sign although it is conceivable that a rapidly elevating blood pressure could sometimes produce some horizontal diplopia. The possibility of an intracranial lesion producing diplopia and headache must be considered and for that reason an MRI has been ordered but in view of the otherwise normal examination and the overall presentation, the index of suspicion for such a lesion must be considered to be fairly low. With the normal white blood count and the absence of any neck stiffness, meningitis or encephalitis would be unlikely especially with a normal neurologic examination. She has had some fever which could produce a headache and it should be noted that a rapidly elevating blood pressure can also sometimes produce some headache as well. Conservative management for the headache would seem appropriate.

Dr. [REDACTED] kindly saw the patient in infectious disease consultation. She has had multiple testing done. Of particular interest was a typhoid 8 salmonella antibody of greater than 1:320 and, in addition, paratyphoid B titer of 1:80; however, she also has had numerous blood tests. The sedimentation rate was normal. CBC and differential was normal. Blood cultures were normal. MRI of the brain was normal. The febrile agglutinins, he believes, are very nonspecific and can be seen in a variety of illness. At this point, would favor simply observing the patient with regard to her fever since she has had none for 24 hours. Will repeat a CBC and a differential. The particular test in question could represent any number of illnesses. Since she does work with sheep including rickettsial illness, leptospirosis; however, the patient improving would tend to simply observe her clinically.

SIGNIFICANT LABORATORY DATA: Glucose 106, BUN 14, creatinine 1.1, sodium 132, potassium 4.6, chloride 102, calcium 9.5, total bilirubin 1.1, total protein 7.2, albumin 4.0, SGOT 11, alkaline phos 62. Cholesterol 166, triglycerides 101, HDL 47, LDL 99, VLDL 20, cholesterol/HDL ratio 3.5.

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Urine volume 24 hours was 2325. Hemoglobin 13.9, hematocrit 40.8, white cells 5,600. Sed rate 2122. Protine 14.0. C reactive protein less than 0.4. RPR was non-reactive. Urinalysis was slight bacteria, specific gravity 1.025, ketones greater than 80, small bilirubin, cloudy, protein 30. Blood cultures times two-no growth after five days of incubation. Metanephrine fractionated, normetanephrine 327, metanephrine 118, total metanephrine 445-all these were normal. VMA pending. 5-HIAA was 4 which is normal. Third generation TSH was 1.607. VMA was 6.9 which is normal. Antinuclear antibody was less than 1:40. ASO quantitative 136 which was normal. MRI of the brain was normal. Chest x-ray-calcified granuloma in the right middle lobe. Impression-no acute lung process. IVP-pyelocalyceal and ureteral systems as well as urinary bladder are unremarkable. Impression-the nephrographic phase shows no asymmetry between the two kidneys to suggest a severe renal artery stenosis. The remainder of the examination is unremarkable. CT scan of the abdomen was normal. Chest was normal by CT. Normal renal Captopril scan. Echocardiogram-this is a technically adequate 2D, M mode and Doppler study. The left ventricular size is normal. The LV wall thickness is upper limits of normal; however, there is no definite left ventricular hypertrophy. Right ventricular size is normal. The mitral, tricuspid and aortic valves are structurally normal. There is trivial MR and trivial TR. PA pressure was estimated at 25 mmHg which is normal. There were no effusions, masses or thrombi seen. EKG-poor R wave progression V1 to V3, sinus tachycardia, otherwise normal.

The patient responded very well. The blood pressure was controlled. She was discharged on 11/19/98 on the same medications. She will see Dr. [REDACTED] in one week and see me in two weeks.

\: [REDACTED] /: [REDACTED] DD: 12/10/98 JOB: [REDACTED]
 ID: [REDACTED] DT: 12/14/98 [REDACTED]
 cc: [REDACTED] MD [REDACTED]
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CONSULTATION REPORT

PATIENT: [REDACTED] ACCT#: [REDACTED] MR#: [REDACTED]
ATTENDING PHYSICIAN: [REDACTED] MD ROOM#: [REDACTED]
AGE: 46Y

CONSULTANT: [REDACTED] MD

DATE OF CONSULT: 11/13/98

REASON FOR REFERRAL: Headache, diplopia and temperature elevation.

HISTORY: [REDACTED] is a pleasant 46 year old woman who had been well until Sunday night when she awoke during the night and noted some double vision. It did not seem to last very long but it lasted long enough that she was fully awakened by it and it took a while to clear. When she got up on Monday morning, she had some double vision again which she believes was horizontal and which she believes was resolved by covering either eye. It did resolve later and has not returned. She did develop some headache that day which she describes as an occipital headache and she has continued to have some occipital headache since then.

Starting on Monday night and then following, she has had fever and chills. This has persisted for a few days. She did see an eye doctor on Monday with diplopia and apparently no abnormalities were noted by Dr. [REDACTED]. On the day of admission, she was seen and noted to have fever and a markedly elevated blood pressure and thus admission was recommended. She denies any diplopia now has she had any diplopia prior to that reported this week. She does note that she has had a few migraines in the past but it has been a long time since she has had one. The migraines could be associated with visual sparkles but again she hasn't had that visual symptom in a long time either. The headache she has now is more dull and mild than with the migraines she has had in the past but she does report getting occasional mild headaches from time to time. She does not feel this headache is particularly bad although it is annoying. It does not radiate. It was not abrupt in onset. Although she has had fever, she does not note any area where there is special pain associated with the fever, nor is she having cough, sore throat or urinary symptoms. She denies head trauma, stroke, seizure, meningitis, brain tumors or passing out spells.

MEDICAL HISTORY: Otherwise non-contributory and she is on no medication.

[REDACTED]

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PATIENT: [REDACTED]

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FAMILY HISTORY: Non-contributory.

SOCIAL HISTORY: Non-contributory.

REVIEW OF SYSTEMS: Unremarkable.

PHYSICAL EXAMINATION: She is a well appearing woman in no distress.

HEAD: Normocephalic and atraumatic.

NECK: Supple with full range of motion.

EXTREMITIES: Without cyanosis, clubbing or edema. She is alert and cooperative. Speech is clear, fluent and appropriate.

HEENT: Visual fields are full. The fundi are benign. The pupils are symmetric and reactive. Extraocular movements are full and there is no nystagmus. Cranial nerves 5 and 7 through 12 are intact and symmetric. There is no pronator drift. Muscles are normal in bulk, tone and strength. Deep tendon reflexes are 2+ and symmetric. Plantar responses are downgoing. Sensation is intact. Romberg test is negative. She is able to tandem walk without difficulty.

IMPRESSION: The episodic diplopia does not appear to be of a malignant etiology. The fact that it has really resolved over the past few days is a good sign although it is conceivable that a rapidly elevating blood pressure could sometimes produce some horizontal diplopia. The possibility of an intracranial lesion producing diplopia and headache must be considered and for that reason an MRI had been ordered but in view of an otherwise normal examination and the overall presentation, the index of suspicion for such a lesion must be considered to be fairly low. With the normal white blood count and the absence of any neck stiffness, meningitis or encephalitis would be unlikely, especially with a normal neurologic examination. She has had some fever which could produce a headache and it should be noted that a rapidly elevating blood pressure can also sometimes produce some headache as well. Conservative

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management for the headache would seem appropriate at this point as well as identifying the source of fever and treatment thereof as well as treatment of the blood pressure.

Thank you for the interesting referral.

[REDACTED]

[REDACTED] MD

\: [REDACTED] /: [REDACTED] DD: 11/14/98 JOB: [REDACTED]
ID: [REDACTED] DT: 11/14/98
CC: [REDACTED] MD
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[REDACTED]

CONSULTATION REPORT

PATIENT: [REDACTED] ACCT#: [REDACTED] MR#: [REDACTED]
ATTENDING [REDACTED] MD ROOM#: [REDACTED]
AGE: 46Y

CONSULTANT: [REDACTED] MD

DATE OF CONSULT: 11/13/98

REQUESTING: Dr. [REDACTED]

REASON FOR CONSULT: Patient with hypertensive urgency, fever, and tachycardia.

CARDIOLOGY CONSULTATION

HISTORY : Mrs. [REDACTED] is a very pleasant 46 -year-old white female. She denies any past medical history at all. She apparently this past Sunday developed diplopia which lasted approximately one day. She subsequently developed the next evening fever and chills. She has felt poorly throughout the week leading today to her presentation to Dr. [REDACTED] office for evaluation. She has been having fever and chills and also flushing skin. She was apparently evaluated by an ophthalmologist who felt that she had no etiology for her diplopia which had resolved. She was, however, found in Dr. [REDACTED] office to be markedly hypertensive with blood pressure of 200/130, pulse rate of 128, and respiratory rate of 20. The patient was treated with IV Vasotec as well as Norvasc. She has really not had significant decrease in her pressure with her current diastolic still 116. She was also evaluated by neurology who ordered an MRI scan which was read as being apparently normal. The patient is presently febrile. Her laboratory tests show a normal cholesterol panel and RPR which is nonreactive. A white blood cell count of 5.6, H&H of 13 and 40, platelet count of 268, normal cell parameters. A U/A which is positive for 30 mg. total protein, small blood, some bilirubin, ketones, and urine which is slightly cloudy. Negative for nitrates, negative for leukocytes.

U/A does show slight bacteria. Electrolytes are normal with a BUN of 14, creatinine of 1.1, glucose of 106, potassium 4.6, normal electrolytes, normal LFTs. Differential is normal.

Thyroid function test presently pending. Patient denies a history of no cardiovascular problems, denies chest pain, heaviness, tightness, or shortness of breath. No orthopnea or PND. No peripheral edema. She has not noticed any changes on her skin of late either. She portrays herself as being a normally very active person. She does have contact

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with farm animals and particularly sheep. She was traveling in Europe, England, and Ireland earlier in October. She was not sick during this time and returned on approximately October 12th. She has not had any cheese products or goats milk.

ALLERGIES: None.

PAST MEDICAL HISTORY : None.

FAMILY HISTORY: Negative for cardiovascular disease or other abnormalities.

MEDICATIONS : None.

SOCIAL HISTORY: Nonsmoker, nondrinker. Energetic 46 -year-old female.

REVIEW OF SYSTEMS: As noted above.

PHYSICAL EXAM : Well-developed, healthy appearing 46 -year-old female who appears younger than stated age. Blood pressure is 170/113 with a pulse rate of 125. Her skin is warm and she has an erythematous rash across the throat. She has no JVD. Her carotid pulse is 1+ bilaterally without bruits.

Her LUNGS are clear to auscultation throughout with good air movement in the upper and lower lung fields with no rales, rhonchi, or wheezes.

Her CARDIAC EXAM is hyperdynamic. Regular rate and rhythm. Increased S1. No clear murmurs are noted.

ABDOMINAL EXAM: Positive bowel sounds, non-tender and supple. No pulsatile masses or bruits.

Femoral pulses 1+ bilateral bruits. Distal extremity without edema. Reflexes are 1+ and very brisk, almost hyperreflexic.

EKG - Sinus tachycardia. Normal axis. Loss of anterior R wave voltage with symmetric T waves throughout the anterior leads. Nonspecific ST wave changes.

SUMMARY: 46 -year-old female who is markedly healthy up until this past week when she developed diplopia followed by resolution but with fever and chills with some skin erythema. This seems be more flush with flushing on stroking the skin. She also has had occipital headache and is now with hypertensive urgency. She has been given IV Vasotec without

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response. She also is on Norvasc without response. She presently is feeling somewhat better but remains febrile with markedly elevated blood pressure and tachycardia. At the present time, I do not see where cultures have been drawn. Thyroid function are pending. Her physical exam is noteworthy for tachycardia, hyperdynamic ventricle, otherwise, unremarkable findings except some hyperreflexia suggestive of possible hyperthyroidism.

IMPRESSION:

1. Hypertensive urgency.
2. Headache.
3. Diplopia.
4. Tachycardia.
5. Possible hyperthyroidism.
6. Possible occult infection.
7. Questionable catechol secreting tumor such as Pheo or carcinoid.

RECOMMENDATIONS:

1. At this point with her elevated blood pressure and persistent headache, would favor discontinuing Norvasc and Vasotec and going with Beta-alpha blockade with Labetalol. Recommend a 20 mg. IV loading dose followed by 200 mg. p.o. b.i.d. as needed.
2. If after 20 mg. loading her tachycardia persists as does her blood pressure, would favor IV Lopressor dosing to bring down her heart rate.
3. Await thyroid function testing as this may well be a presentation of hyperthyroidism.
4. Blood cultures have apparently been drawn.
5. If her symptoms persists over the next 24 hours, should have echocardiogram done to rule out endocarditis.
6. Though somewhat atypical with her dramatic presentation, it may reasonable to start collecting 24-hour urine for metanephrine, catecholamines, and VMA as well as HIAA.
7. I would consider empiric antibiotic therapy institution.

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Will follow with you in the evaluation care of this very interesting patient. We appreciate your consultation.

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CONSULTATION REPORT

PATIENT: [REDACTED] ACCT#: [REDACTED] MR#: [REDACTED]

ATTENDING PHYSICIAN: [REDACTED] MD ROOM#: [REDACTED]
AGE: 46Y

CONSULTANT: [REDACTED] MD

DATE OF CONSULT: 11/16/98

I was asked by Dr. [REDACTED] to see patient regarding fever, abnormal febrile agglutinins.

HISTORY : This is a 46-year-old white married female. She is a housewife and also does farming work. She is a nonsmoker, nondrinker. The patient was in her usual state of health until eight days prior to admission. She awoke from sleep for an unknown reason and noted diplopia. This had resolved by the next morning. However, seven days prior to admission in the evening she developed fevers, sweats without true rigors along with headache. This persisted for approximately four days. She presented to Dr. [REDACTED] for further evaluation. During this time she noted no further diplopia. She had been seen by an ophthalmologist. She was admitted to the hospital for recurrent fever along with severe headache and markedly elevated blood pressure. Today she states she is feeling relatively well with minimal symptomatology. Her last temperature was noted to, at 6:30 a.m. 11/15/98, be 38.5 C.

PAST MEDICAL HISTORY : There are no drug allergies.

PRESENT MEDICATIONS: The patient took Advil and Aspirin as an outpatient. She is currently receiving several anti-hypertensive medicines.

PAST HISTORY : Unremarkable. Status post tonsillectomy.

REVIEW OF SYSTEMS : Noncontributory. Last menstrual periods was several months ago. She notes menstrual irregularity.

PHYSICAL EXAMINATION : Afebrile at the present time. Pulse 70, respirations 16, blood pressure 140/80.

ENT: Pupils equal, round and reactive to light. Extraocular muscles intact.

NECK: Supple, no thyromegaly, no adenopathy.

CHEST: Clear to auscultation and percussion.

HEART: Regular, S1, S2. No murmur or gallop.

ABDOMEN: Soft, no organomegaly.

EXTREMITIES show intact pedal pulses, no edema.



[REDACTED]

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NEUROLOGICAL EXAM was normal.

LABORATORY DATA: She has had multiple testing done. Of particular interest to Dr. [REDACTED] was a Typhoid H salmonella antibody at greater than 1:320. In addition, Typhoid B titer of 1:80. However, she also has had numerous blood tests. The sedimentation rate was normal. A CBC and differential was normal. Blood cultures were normal. MRI of the brain was normal. The febrile agglutinins I believe are very nonspecific and can be seen in a variety of illness. At this point would favor simply observing the patient with regard to her fevers since she has had none for 24 hours. Will repeat a CBC and differential. The particular test in question could represent any number of illnesses. Since she does work with sheep including rickettsial illness, leptospirosis or [REDACTED], however with the patient improving would tend to simply observe clinically.

[REDACTED]

[REDACTED] MD

\: [REDACTED]

ID: [REDACTED]

DD: 11/16/98

JOB: [REDACTED]

DT: 11/17/98

cc: [REDACTED]

MD [REDACTED]

, MD [REDACTED]

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