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

ARMS#

12713

5 - SUMMARIES

[redacted]

[redacted]

DISCHARGE SUMMARY

PATIENT NAME: [redacted]
DATE OF BIRTH [redacted]
PHYSICIAN: [redacted] M.D.

ROOM #:
UNIT #: [redacted]
ACCOUNT #: [redacted]

PATIENT: [redacted]

DATE OF ADMISSION: 11/26/97 DATE OF DISCHARGE: 12/04/97

PRINCIPLE DIAGNOSIS:

Unspecified cerebral artery occlusion with cerebral infarction.

SECONDARY DIAGNOSIS:

1. Intracerebral hemorrhage.
2. Atrial fibrillation.
3. Unspecified hemophagia.
4. Aphagia.
5. Essential hypertension.
6. Dysphagia.
7. Unspecified acquired toe deformity.

HOSPITAL COURSE:

The patient was admitted to the ICU with the diagnosis of stroke. She is begun on the following medication: Heparin drip at 1000 units per hour. PTT is monitored appropriately. Dynacirc 5 mg b.i.d. The patient underwent a carotid ultrasound which showed no evidence of significant extra cranial carotid stenosis. She underwent a CAT scan of the brain which showed a left temporal parietal intracerebral hemorrhage with surrounding edema and mass effect. The Heparin was discontinued. The patient was found to have a negative gag reflex. All of her oral medications were held. Her blood pressure was treated with IV Aldomet. Consultation was called with Dr. [redacted] who followed the patient from a neurological standpoint. The patient was found to be in atrial fibrillation. The patient was started on Pronestyl at 2 mg per minute drip as well as Digoxin. The patient was begun in physical therapy as well as speech therapy. Consultation was

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AE#12713, Cp'l #NYK-3416
FLA-DO memo 5/11/98 SB/AEK
EX/ATT: 1 4 146

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DISCHARGE SUMMARY

PATIENT NAME: [redacted] ROOM #:
DATE OF BIRTH: UNIT #: [redacted]
PHYSICIAN: [redacted] M.D. ACCOUNT #: [redacted]

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called with Dr. [redacted] because of the decrease gag reflex. Consideration was given to PEG placement but this was held until the patient has speech/swallow evaluation. It was decided that the patient would be started on pureed diet and thickened liquids. It was decided that the patient's anticoagulation would be held at least two weeks from the time of her hemorrhagic CVA to begin anticoagulation. She did convert to normal sinus rhythm before being discharged. She continued to improve and she was transferred to a rehab facility on 12/4/97.

[redacted] M.D.

[redacted] D:12/10/97 09:27:14 T:12/15/97 08:28:14
JOB: [redacted]

PC: [redacted] M.D., FAX #[redacted]

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AE#12713, C[illegible]416
[illegible]A-DO memo [illegible]/AKC
EX/ATT: 1 5 146

HISTORY AND PHYSICAL REPORT

Mailbox

PATIENT NAME:
DATE OF ADMISSION: 11/27/97
UNIT #:
ROOM #:
ACCOUNT #:
DOB:

CHIEF COMPLAINT:

Stroke.

HISTORY OF PRESENT ILLNESS:

This 64 year old white female presented to the Emergency Room via Emergency Medical Services unresponsive. She became increasingly more responsive while she was there but was noted to have an expressive aphasia and right sided weakness. CT Scan of the brain revealed a possible early left cerebrovascular accident. She has had a history of prior transient ischemic attack with a negative cardiac and carotid work-up in the past. She is being admitted for stroke in evolution.

PAST MEDICAL HISTORY:

Prior transient ischemic attacks, history of well controlled hypertension.

ALLERGIES:

None known.

MEDICATIONS:

Inderal, Dyna-Circ and enteric coated aspirin.

REVIEW OF SYSTEMS:

Not obtainable.

AE#12713, Cplt.#NYK-3416
ELA-DO memo 5/11/98 AKR/AKR
EX/ATT: 1 pg 2 of 146

PHYSICAL EXAMINATION:

Alert female who is aphasic. In no acute distress. She had a right hemiparesis, right facial droop, upgoing right plantar response.

[redacted]

HISTORY AND PHYSICAL REPORT

NECK: Supple without lymphadenopathy, thyromegaly or bruits.
LUNGS: Bilaterally clear to auscultation and percussion.
HEART: Regular rate and rhythm without murmurs, gallops or rubs. No lifts heaves, clicks or thrills.
ABDOMEN: Soft and nontender without hepatosplenomegaly or mass.
EXTREMITIES: no clubbing, cyanosis or edema.

IMPRESSION AND PLAN:

Probable early cerebrovascular accident involving the left temporoparietal area. Plans are specific, please see physicians orders. Initial plan is to control blood pressure to keep up cerebral perfusion, anticoagulation with Heparin. Neurological consultation. For specifics please see physician's orders.

[redacted] M.D.

DD: 11/27/97
DT: 11/28/97
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AE#12713, Cplt.#NYK-3416
FLA-DO memo 5/11/98 AKR/
EX/ATT: 1 pg 13 of 144

Best Quality FDA

CONSULTATION REPORT

[redacted]

CONSULTING SERVICE OR PHYSICIAN

SERVICE REQUESTED:

1) Impression Only _____
2) Impression & Recommendation _____
3) Follow with me & Write Orders _____
4) Assume Total Care _____
5) Accept Transfer _____
6) History and Physical _____

DATE	TIME	REASON FOR CONSULTATION

SIGNATURE OF ATTENDING PHYSICIAN

Chart Reviewed: ✓ Yes _____ No

FINDINGS, SUMMARY AND DIAGNOSIS:

Pt c̄ (L) hemiplegic CVA and intracranial bleeding
c̄ heparin. Pt condition rapidly changed to. AHS
c̄ [illegible] rate last night. was [illegible] Family hx
[illegible] 1) prior TIAs, the first for
for Family [illegible] 12/31/96 - [illegible] and H [illegible]
[illegible]
Already to Family had had AHS [illegible] off
[illegible] 12/31/96 TIA. 2) Epsodic
AHS [illegible] 3) FH of CVA. W/u [illegible]
[illegible] E/D. has been [illegible] of CAD or
[illegible] other than VA [illegible] fils.

Recommend. 1) not [illegible] a [illegible] AHS
[illegible] has [illegible] and off and
[illegible] of [illegible]
[illegible] c̄ heparin.

1. [illegible] to [illegible] LAE.
2. Consider TEE [illegible] LAA [illegible] start
3. [illegible] TEE [illegible] not
4. Consult [illegible] of TEE [illegible] safe,
[illegible] RTA.
5. If [illegible] is considered [illegible] 1) [illegible] of possible
2) [illegible] meds that
will help [illegible]
[illegible] pt [illegible] is NSR.

Date: _____ Time _____

SIGNATURE OF CONSULTANT

CONSULTATION REPORT

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RE#12713, Cp16 [illegible]
FLA-DO memo 5/11/98 [illegible]
EX/ATT: 1 pg 17 of 146

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CONSULTATION REPORT [redacted]

Mailbox [redacted]

PATIENT NAME: [redacted]
DATE OF CONSULTATION: 11/29/97
ATTENDING PHYSICIAN: [redacted]
CONSULTING PHYSICIAN: [redacted]
UNIT #: [redacted] **ROOM #:** [redacted]
ACCOUNT # [redacted] **DOB:** [redacted]

REASON FOR CONSULTATION:

Opinion on possible cardioversion of a patient in atrial fibrillation who has also had a cerebrovascular accident.

HISTORY OF PRESENT ILLNESS:

Ms. [redacted] is a pleasant 64 year old retired female physical education instructor who had been in quite an active state of health until 11/26/97 when she experienced an acute severe left hemispheric stroke and was hospitalized. She was started on heparin and developed intracerebral bleed of minor degree but causing heparin to be discontinued. She has had some recovery from the initial event but still has significant residual including aphasia and hemiparesis right arm.

Her family asked for another opinion concerning appropriate care at this point and further information indicates that she has had a transient ischemic attack 12/31/96 which was predominantly amaurosis fugax and lasted a couple of hours but then resolved. She said she had a similar episode several months later lasting about 10-15 minutes but then said she had no further episodes of these type of events until the one this hospitalization.

PERTINENT MEDICAL HISTORY:

Includes that she had an episode of paroxysmal atrial fibrillation about a year ago but before the transient ischemic attack occurred and she says she has had episodes of palpitations of this type over the last year but did not notice it prior to that.

She has few other risk factors although she does have hypertension but is apparently well-controlled and she has no

[redacted]
AE#12713, Cplt.#NYK-3416
FLA-DO memo 5/11/98 AKR/AKL
EX/ATT: 1 pg 18 of 146

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CONSULTATION REPORT

Mailbox [redacted]

social risk factors but she does have some family risk factors with her mother dying of stroke.

FAMILY HISTORY:

Includes her mother dying of a stroke, a brother of colon cancer and also had a heart attack but otherwise there is no significant illness.

SOCIAL HISTORY:

She was a smoker years ago but stopped and does not drink alcohol. She's married, has four well children.

ALLERGIES:

No known drug allergies.

MEDICATIONS:

At admission were Inderal, Dynacirc and enteric-coated aspirin.

REVIEW OF SYSTEMS:

Not obtainable.

PHYSICAL EXAMINATION:

GENERAL: She is awake and alert at times but has difficulty expressing herself as she has an expressive aphasia.
NECK: Supple, no jugular venous distention , hepatojugular reflux or carotid bruits or adenopathy or masses.
CHEST WALL: Symmetric.
BREASTS: Not examined.
LUNG FIELDS: Clear.
HEART: Irregularly irregular with no murmurs, rubs or gallops.
ABDOMEN: Flat, nondistended. Normal bowel sounds.
EXTREMITIES: No clubbing, cyanosis or edema.
LYMPHATICS: Negative.
NEUROLOGIC: Shows a right eye paresis on lateral gaze. Pupils react equally. She has no gag reflex. She has a right central facial and the aphasia. The tongue deviates to the left and she is barely able to protrude the tongue. She cannot speak.

[redacted]
AE#12713, Cplt.#NYK-3416
FLA-DO memo 5/11/98 AKR/AKR
BY/ATT: 1 pg 19 of 146

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CONSULTATION REPORT

Mailbox [redacted]

She has flaccidity in the right arm and weakness in the right leg.
SKIN: No ecchymoses.

X-RAYS AND LABORATORY DATA:

Her baseline electrocardiogram at admission shows sinus bradycardia with minor nonspecific ST-T changes. Essentially normal except for rate.

Chest x-ray is unremarkable.

Echocardiogram pending. Current rhythm is atrial fibrillation with a controlled response.

IMPRESSION/PLAN:

This is a 64 year old woman in previously good health with minor medical problems including controlled hypertension who has a history now apparent of transient ischemic attacks and paroxysmal atrial fibrillation who now has experienced a stroke and during treatment experienced also a bleed into the area. The heparin has been stopped and she is now without any coagulation.

Her family desires to have her cardioverted. However, this is not a guaranteed safe procedure in this setting as the heart with paroxysmal atrial fibrillation has to be considered a major possible cause of her current stroke and cardioversion could lead to another unless appropriate anticoagulation steps could be taken.

Although there is some literature support for cardioverting an individual with transesophageal echocardiographic guidance in which if atrial sizes are normal and there is no significant thrombus or hyperechoic blood flow indicating poor flow and if this is not chronic atrial fibrillation, that the patient can be cardioverted with minimal anticoagulation pre- and only two weeks postop. However, this patient cannot endure any anticoagulation at this time.

I've discussed this with the neurosurgeon, Dr. [redacted] and it is his feeling that the patient could be anticoagulated in a couple of weeks with Coumadin. This can be re-evaluated at that time. If this could be possible, then the patient could be suitable

[redacted]
AE#12713, Cplt.#NYK-3416
FLA-DO memo 5/11/98 KKR/AKL
CX/ATT: 1 pg 20 of 144

anticoagulated and cardioverted. If this is done then steps should be taken to ensure that the patient remains in sinus rhythm if at all possible. Given the patient's history of paroxysmal atrial fibrillation, and proven tendency to transient ischemic attacks and stroke, she should probably be anticoagulated long term if at all possible.

Workup for other sources has included carotids which are negative. I would like to also ensure that inflammatory causes and hypocoagulable state are also evaluated, particularly with the patient's family history of stroke.

Thank you very much for the courtesy of consultation; I will discuss with you and we can discuss the appropri for anticoagulation and possible cardioversion.

M.D.

DD: 11/20/97
DT: 12/2/97
JOB #:

[redacted]

CONSULTATION REPORT

PATIENT NAME: [redacted]
DATE OF BIRTH [redacted]
PHYSICIAN: [redacted] M.D.

ROOM #:
UNIT #:
ACCOUNT #: [redacted]

PATIENT: [redacted]

REFERRING PHYSICIAN: [redacted] M.D.

DATE OF CONSULTATION: 11/27/97

This is a 64-year-old right handed white female with past medical history of hypertension and transient ischemic attack who presented yesterday evening with sudden onset of right sided weakness and speech arrest. The patient was admitted through the emergency room and a cranial CAT scan was performed on admission. This did reveal a left sided sulcal effacement and was negative for hemorrhage. Previous workup for TIA including carotid Duplex studies were negative. Carotid ultrasound performed earlier today was also reported as negative. The patient was started on heparin on admission. The last PTT this morning was equal to 50.2. The patient is currently on 1000 units per hour. Echocardiogram and CAT of the head are planned for tomorrow morning.

According to the husband, who was present during the interview, around 6 o'clock yesterday evening, went to the bathroom and after several minutes she did not come back. Her husband followed her to the bathroom and found her sitting on the toilet unable to communicate or move her right side. The patient was brought to the emergency room and subsequently admitted for evaluation of stroke.

PAST MEDICAL HISTORY:

As above. Previous history of hypertension and transient ischemic attack.

MEDICATIONS:

Dynacirc 5 mg one tablet p.o. b.i.d., Inderal and enteric coated

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[redacted]
AE#12713, Cplt.#NYK-3416
A-DO memo 5/11/98 AKR/AKC
EX/ATT: 1 pg 14 of 146

aspirin.

ALLERGIES:

No known drug allergies.

FAMILY HISTORY:

Noncontributory.

SOCIAL HISTORY:

The patient is married, lives with her husband. She is an exsmoker. She does not abuse alcohol.

PHYSICAL EXAMINATION:

VITAL SIGNS: Reveals the blood pressure to be 160/90. Pulse was 62 an regular. The patient was afebrile.
NECK: Supple, no carotid bruits were auscultated. Carotid pulses were palpable and equal bilaterally.
CARDIOVASCULAR: Revealed sinus rhythm with a few ectopic beat.
LUNGS: Clear to auscultation bilaterally
EXTREMITIES: Without cyanosis, clubbing or edema.
NEUROLOGIC: Revealed the patient to be alert but drowsy. She was able to follow simple commands well. She was able to utter a few sounds and according to the family she spoke several single words this morning.
CRANIAL NERVES: Revealed the pupils to be equally reactive to light. Extraocular motility was intact. Corneal reflexes diminished somewhat on the right side. Mild right facial droop was noted. Gag reflex was absent. No apparent field cut weeks ago noted on confrontation.
MOTOR EXAMINATION: Revealed the flaccid plegia of the right upper extremity. The right lower extremity paresis was noted. The patient was able to flex her right knee and plantar flex or right foot with no difficulty. No evidence of tremor was noted.

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[redacted]

CONSULTATION REPORT

PATIENT NAME: [redacted]
DATE OF BIRTH [redacted]
PHYSICIAN: [redacted] M.D.

ROOM #:
UNIT #: [redacted]
ACCOUNT #: [redacted]

SENSORY EXAMINATION: Revealed no response to tactile stimulation on the right face, arm or leg.
Muscle stretch reflexes were 2+/4 throughout. Negative Babinski. A right sided positive Babinski was noted.

IMPRESSION:

Probable right middle cerebral artery distribution infarct. Workup thus far is negative. An echocardiogram and a repeat cranial CAT scan is planned for tomorrow. In the interium, we will continue heparin and request physical and speech therapy evaluation. The patient will remain NPO until swallow assessment can be performed.

The would like to take the opportunity to thank Dr. [redacted] for this referral and for allowing me to assist him in the care of this patient.

[redacted] M.D.

[redacted] **D:**11/27/97 04:54:17 **T:**12/08/97 04:54:17
JOB [redacted]

PC: [redacted].D., FAX # [redacted]
M.D., FAX [redacted]

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AE#12713, Cplt.#NYK-3416
A-DO memo 5/11/98 AKR/AKC
EX/ATT: 1 PG 16 OF 146