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

ARMS#

12733

5 - SUMMARIES

[redacted]

DISCHARGE SUMMARY

Patient.: [redacted]

Adm Date: 12/22/97
Dis Date: 01/21/98
Fin #: [redacted]
MR #:
Room:

Doctor..: [redacted] M.D.

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*Discharge Date: 01/21/98

*DISCHARGE DIAGNOSES:

1) Left hemiparesis secondary to intracerebral bleed.
2) Dysphagia.
3) Dysarthria.
4) Left hemisensory loss.
5) Hypertension.

*HISTORY OF PRESENT ILLNESS:

This is a 47-year-old married white male admitted to [redacted] 12/13/97 for intracerebral hemorrhage. The patient has a history of hypertension. He showed improvement and was admitted for comprehensive inpatient rehabilitation. For additional information please see initial History and Physical.

*HOSPITAL COURSE:

The patient was admitted medically stable. His blood pressure remained stable. The patient has intermittent complaints of calf pain. This was treated symptomatically. There is no evidence of (DVT) deep vein thrombosis. The patient continued to improve throughout rehab efforts. He is still persistent with some left-sided neglect. Towards the time of discharge he was stand-by-assist for grooming and hygiene, moderate assist for bathing, minimum assist for toileting, stand-by-assist for transfers, he was ambulating 30 feet with a straight cane at moderate assist. He remained with a good mood and functional cognition. The patient was discharged home in stable condition.

*DISCHARGE DIET: Mechanical soft.

*DISCHARGE MEDICATIONS:

1) Vasotec 10 milligrams 1 b.i.d.
2) Maxzide 1 q. day.

The patient is to receive outpatient P.T., O.T. and Speech Therapy in [redacted]. The patient is to follow-up with Dr. [redacted] in two to three weeks, Dr. [redacted] as needed, and me in two to three months as needed.

[redacted] M.D.

I AUTHORIZE MY TYPED NAME TO SIGNIFY THAT I AUTHENTICATED THIS REPORT.

[redacted] 1:59 pm
D: 02/05/98 T: 02/13/98

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[redacted]

ADMISSION HISTORY AND PHYSICAL SUMMARY

Patient: [redacted]

Date: 12/13/97
Fin #: [redacted]
MR #:
Room:

Doctor..: [redacted], M.D.

*HISTORY:

The patient is a 47 year old right handed male who at 8 p.m. on December 12, 1997, wife noted that while sleeping he was unable to move his left leg. She questioned him more closely and noticed he had ---------- breathing, and was less responsive. He was evaluated in the [redacted] and noted to have a left hemiparesis. The (CT) computerized tomography scan of his head performed in [redacted] was remarkable for an intracerebral hemorrhage.

*PAST MEDICAL HISTORY:

Past medical history is positive for hypertension in the past, though not currently on meds.

*MEDICATIONS: None.

*PAST SURGICAL HISTORY: None.

*HABITS: No tobacco or alcohol use.

*SOCIAL HISTORY: The patient works in a plastic factory.

*FAMILY HISTORY: Unremarkable.

*REVIEW OF SYSTEMS: Remarkable for the above complaints.

*PHYSICAL EXAM:

An overweight white male. The patient will, however, answer questions appropriate, and follow directions.
Temperature is 98.1; blood pressure is 180/110; respiratory rate is 16; pulse is 80; heart regular rate, no murmur.
Lungs: Clear.
Abdomen: Protuberant.
Extremities: No cyanosis, clubbing or edema.
Neurological: Cranial nerves are remarkable for a persistent gaze to the right, unable to passively move passed the midline. (PERRL) Pupils equal, round and reactive to light. She has some left facial weakness. The remain cranial nerves are intact. On sensory-motor exam, the patient has a dense left hemiplegia. Reflexes: Right/Left 1+/1+, flexor plantar response on the right, extensor on the left.

[redacted]

ADMISSION HISTORY AND PHYSICAL SUMMARY

Patient: [redacted]

Doctor..: [redacted] M.D.

Date: 12/13/97
Fin #: [redacted]
MR #:
Room:

The (CT) computerized tomography scan of the head is remarkable for intracerebral hemorrhage of the right basal ganglia 2.5 x 4 centimeters, and 5 percent effacement ------- ------- ventricle.

Platelet count is 248,000. The (PT) pro-time is 12.9. The (PTT) partial thromboplastin time is 22.9.

*IMPRESSION: Intracerebral hemorrhage.

*PLAN:

1) Admit to (MIC) medical Intensive Care, closely follow exam.
2) Followup of blood pressure.

SIGNATURE:
[redacted] M.D.

[redacted]
[redacted] 8:08 am
D: 12/13/97
T: 12/13/97

12-22 I Vout 1W 177 now

[redacted]

REPORT OF CONSULTATION

Patient: [redacted]

Date: 12/21/97
Fin #: [redacted]
MR #:
Room:

ATTENDING PHYSICIAN: [redacted]

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cc: [redacted] M.D.

*CONSULTING PHYSICIAN: [redacted] M.D.

*HISTORY OF PRESENT ILLNESS:

This is a 47-year-old right-handed married white male from [redacted] which is near [redacted] who was admitted December 13, 1997, with left-sided weakness. The patient was admitted by Dr. [redacted] where (CT) computerized tomography scan showed an intracerebral hemorrhage of the right basal ganglia. The patient was admitted to Medical Intensive Care Unit for closure monitoring. Repeat computerized tomography scan of the head December 15 showed stable parenchymal hemorrhage in the right basal ganglia and with mass effect. There was no significant midline shift. The patient initially had a right gaze preference and left-sided weakness. The patient's level of consciousness improved and he was transferred to a regular floor. The patient has been seen by Speech Therapy where video swallow study showed no evidence of aspiration. The patient has been changed to a dysphagia level III diet. The patient has persisted with left-sided weakness and mild dysarthria. He has developed some skin breakdown of the left buttock and has been placed on a Ken-Air mattress. The patient has been seen by Physical Therapy, sitting with moderate assist, transferring with two people assist. The patient is nonambulatory.

*PAST MEDICAL HISTORY: Hypertension.

*LABORATORY:

The patient's fingerstick glucoses have been monitored and have ranged from 130 to 180. Urinalysis was negative for pyogenic culture. Chem-7 has remained normal with exception of elevated glucose. Thyroid studies are normal.

*CURRENT MEDICATIONS:

1) Maxzide.
2) Vasotec.
3) Axid.
4) Catapres patch.

*ALLERGIES: None.

*SOCIAL HISTORY:

The patient lives near [redacted] He lives with his wife and two sons, ages 17 and 20. Prior to admission the patient was working a plastics factory. His wife is very supportive. Discharge plans are to ultimately return home. The patient was completely independent in the activities of daily living of mobility and driving.

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[redacted]

REPORT OF CONSULTATION

Patient: [redacted]

Date: 12/21/97
Fin #: [redacted]
MR #:
Room:

ATTENDING PHYSICIAN: [redacted] M.D.

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*REVIEW OF SYSTEMS:

Family denies any coughing or choking no meals. There is no chest pain. No shortness of breath. Patient is continent of bowel and bladder. Foley catheter has been removed.

*PHYSICAL EXAMINATION:

This is a large, short white male in no acute distress, lying in bed. He is awake and alert.
HEENT: Atraumatic - normocephalic. Pupils are equal and reactive. Extraocular muscles are full. Patient with a mild left-sided facial weakness. He is really unable to close his left eye fully upon command over 50% of the time. Tongue protrudes to midline. Speech is mildly slurred.
Neck: Supple.
Heart: Regular rate and rhythm.
Chest: Normal excursion.
Abdomen: Nontender, nondistended, obese.
Extremities: Air compression hose are in place. Calves are nontender. There is no edema noted.
Musculoskeletal: Patient with 4/5 strength throughout right upper and lower extremity. Left upper extremity is with absent strength at the shoulder and elbow. Patient with 2/5 grip strength. In the left lower extremity, patient has antigravity strength at the hip, knee and ankle.
Neurologic: The patient is awake and alert, oriented times three. Cranial nerves II-XII with aforementioned facial nerve deficit on the left. No gaze preference is noted. No visual field cut is noted. The patient does have decreased sensation in the left upper and lower extremity. He has right/left discrepancy problems noted. Speech is mildly dysarthric. Content is good, though he tends to ramble occasionally. He is able to follow single step commands well. No ataxia is noted in the right upper extremity. Babinski is negative in the left foot. Clonus is negative. Deep tendon reflexes are absent at knee and biceps compared to right.

*IMPRESSION:

1) Left hemiparesis secondary to basal ganglia intracerebral bleed. Patient's arm is affected more than leg.
2) Mild dysarthria.
3) Left hemisensory loss.
4) Hypertension.

[redacted]

REPORT OF CONSULTATION

Patient: [redacted]

Date: 12/21/97
Fin #: [redacted]
MR #:
Room:

ATTENDING PHYSICIAN: [redacted] M.D.

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*PLAN:

The patient appears to be a good candidate for inpatient rehabilitation. He has a very good family support system. I answered most questions about inpatient rehabilitation, prognosis, etc. I will discuss with rehab case management and admit as soon as possible.

Thank you.

[redacted] M.D.

I AUTHORIZE MY TYPED NAME TO SIGNIFY THAT I AUTHENTICATED THIS REPORT.

[redacted] 3:45 pm
D: 12/21/97
T: 12/22/97

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[redacted] M 47
MR#: [redacted] ACCT#: [redacted]
SERV: [redacted]
MD: [redacted] MD ADM: 12/22/97
DX: LEFT HEMIPARESIS SECOND DE
==========

Med Records

REQ#: [redacted]

HISTORY & PHYSICALS [redacted]

Abdomen is nontender, nondistended, obese. Bowel sounds are positive.
Heart is regular rate and rhythm without murmur.
Her extremities are nontender without edema.

*IMPRESSION:

1) Left hemiparesis, secondary to (CVA) cerebrovascular accident.
2) Mild dysphagia.
3) Mild dysarthria.
4) Left hemisensory loss.
5) Hypertension.

*PLAN:

Admit patient for comprehensive inpatient rehabilitation to include physical, occupational, and speech therapy. I will continue transfer medications. I will continue a kinair until his groin improves, and he is more mobile. Estimated length of stay is three to four weeks.

I have discussed at length goals and procedures of Rehab unit with the wife, and possibly might shoot for a pass on the Christmas weekend.

[redacted], M.D.
I AUTHORIZE MY TYPED NAME TO SIGNIFY THAT I AUTHENTICATED THIS REPORT.

[redacted]
[redacted] 5:26 am
d: 12/23/97
t: 12/23/97

LAST PAGE

CONFIDENTIAL INFORMATION. FURTHER DISCLOSURE IS PROHIBITED.