Identifying Data:
Full Name: JM
Address: White Plains, NY
Date of Birth: December 6, 1958
Date & Time: November 9, 2021 @ 10am
Location: NYP, Flushing, NY
Religion: Not Identified
Source of Information: Self
Reliability: Reliable
Mode of Transport: Ambulance called by coworkers

Chief Complaint: " Coworkers thought I was having a stroke" x 36 hours

62yo M smoker with PMH of DM, HTN and HLD seen on internal medicine floor. Pt states that he was driving to work around 11am yesterday, when he started to lose feeling in his R arm. He started to feel weird but the numbness did not go to his legs, so he drove all the way to work. When he got to work, he could not remember his code to get in and banged on the door. Patient states that he does not remember what happened from there, but his coworkers say he was not making sense and was "white as a ghost". Ambulance was called and he was admitted from the ER. Pt states that the numbness in his R arm is better, with full feeling back. Pt states that this has never happened before, and was not exerting himself when it happened. Pt denies any change in gait, balance, memory or motor movement prior to this event. Pt denies any recent trauma or pain at any other sites. Pt denies any syncope during the event or any chest pain, SOB, or diaphoresis. Pt denies any current pain or paresthesia in any limbs/extremities. Pt was not taking any new medication but did recently stop his diabetes and hypertension medications for the past 3 months.

Past Medical History
DM x 10-12 years, uncontrolled
HTN x "a while a go", no currently taking medication
HLD x "a while a go"
Childhood immunizations up to date
No Flu vaccine
Covid vaccination in 2021

Past surgical history
None

Medications
Metformin 100mg BID, has not taken in past 3 months because doctor made him wait too long for follow-up appt and refill
Carvedilol 12.5mg daily , has not taken in past 3 months because doctor made him wait too long for follow-up appt and refill

Allergies:

Denies any food/environmental/medication allergies

Family History
Mother- Deceased, DM/CKD/CA
Father- Deceased, HTN/CKD/HLD
One of five kids, middle child. No know hereditary conditions.
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:
Lives alone in a house in upstate NY was taking care of his mother who was on dialysis until she recently passed away. He was two kids, divorced. Works full time as a technology field engineer and describes his job as active and stressful.
Denies alcohol use.
Smoking: Cigarettes, 47 pack years
Denies drug use.
Drinks 4-5 coffees a day
Diet: Orders Keto meal deliveries
Travel: has not recently traveled anywhere
Exercise: does not exercise but states his job is active enough
Sexual hx: not currently sexually active but "tries". Has never had an STI

Review of System:
General: Denies any fever, chills, weight loss, loss of appetite

Skin, hair, nails: Denies changes in texture, excessive dryness or sweating, moles/rashes, pruritus or changes in hair distribution.

Head : Denies headache, vertigo, head trauma, unconsciousness, or coma

Eyes: Pt states that he wears glasses and had his last eye exam 6 month ago. Denies any visual disturbances, lacrimation, photophobia, or pruritis.

Ears: Denies any deafness, pain, discharge, tinnitus or use of hearing aid

Nose/sinuses: Denies any nasal discharge, epistaxis or obstruction

Mouth/Throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use dentures. Last dental exam 2020, normal.

Neck: Pt has unilateral 2cm tonsillar node lymphadenopathy in R side, pt states that he has had it for years. States he goes to his doctor once a year but she hasn't check it out. Denies any stiffness or decreased range of motion

Breast: Denies lumps, nipple discharge, or pain.

Cardiovascular system: Diagnosed with HTN x " a while ago" but is not currently taking medication due to missing a follow-up appointment. Denies chest pain, irregular heartbeat, edema/swelling of ankles or feet, syncope, diaphoresis, orthopnea, claudication or known heart murmur

Pulmonary system: Denies SOB, cough, wheezing, pleuritic chest pain, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Gastrointestinal system: Denies nausea, vomiting, diarrhea, constipation, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructation, abdominal pain, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool. Has not had a colonoscopy and wants to do Cologuard.

Genitourinary system : Pt states that he does have increased frequency in which he urinates, with hesitancy and dribbling. Denies nocturia, oliguria, dysuria, incontinence, awakening at night to urinate or flank pain.

Nervous: Denies seizures, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Musculoskeletal system: Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system:. Pt has unilateral 2cm tonsillar node lymphadenopathy in R side but states that he has had it for years. States he goes to his doctor once a year but she hasn't check it out. Denies easy bruising or bleeding, blood transfusions, or history of DVT/PE.

Endocrine system: Pt has polyuria, polydipsia, polyphagia. Denies heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric: Pt states that he feels fine, would like to go home but he's okay. However depression is noted to be documented in his chart.

<u>Physical</u>

General: Thin male laying in bed appearing relaxed and younger than stated age. Does not appear in distress, lethargic or agitated.

Vital signs: BP: Supine: 150/65 R
BP: Supine 150/70 L
BP: seated 150/65 R
RR: 14, unlabored
P: 64, regular rhythm (sinus bradycardia)
T: 98.6 F O2 sat: 99% on room air
Ht: 75" Wt: 170 BMI: 21.2

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos. Pt has a nicotine patch on his R arm.
Hair: Patient very little hair quantity.
Nails: no clubbing, capillary refill <2 seconds in upper and lower extremities
Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: Symmetrical eyes. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pale pink.

Visual acuity Correct - 20/60 OS, 20/40 OD, 20/50 OU
Visual fields full OU. PERRLA , EOMs intact with no nystagmus
Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Nose: Symmetrical/no masses/lesions/deformities/trauma. Nasal patent bilaterally. Nasal mucosa unable to be appreciated. Septum midline.

Sinuses: Non tender to palpation over bilateral frontal, ethmoid and maxillary sinuses.

Neck: trachea midline. Unilateral 2cm tonsillar node lymphadenopathy. No other lesions; scars; Carotid pulses not appreciated due to diagnosis of 60% occlusion on R carotid and 90% occlusion on L side. Active ROM intact; no stridor noted. No cervical adenopathy noted

Thyroid : Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Heart: Sinus bradycardia.. S1 and S2 are distinct with no murmurs, S3 or S4 appreciated. No splitting of S2 or friction rubs appreciated; JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses not appreciated due to diagnosis of 60% occlusion on R carotid and 90% occlusion on L side.

Chest: Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.

Lungs : Clear to auscultation bilaterally. Chest expansion and diaphragmatic excursion symmetrical. No adventitious sounds. Lung sounds resonant over all fields.

Abdominal: Non-tender to palpation throughout, no guarding or rebound noted. No pulsations noted, hepatosplenomegaly to palpation, no CVA tenderness appreciated; Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits not appreciated

Peripheral Vascular: The 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.

Neurological:
Mental Status: Awake & Alert; oriented to person, place & time
Cranial Nerves:

- I: nasal patent bilaterally; correctly identified coffee and min odor bilaterally
- II: Visual field full by confrontation; visual Acuity- 20/20 OS, 20/20 OD, 20/20 OU uncorrected, red reflex present, cup:disc 2:1, cream colored with sharp border, no papilledema, hemorrhages, exudates, or cotton wool spots
- III, IV, VI: and III: EOM intact, pupils 3mm OU, reactive to direct and consensual light, no ptosis or lid lag
- V: sensation to light touch, sharp and dull sensations intact bilaterally, corneal reflex intact, jaw muscle strong without atrophy
- VII: correctly identified sweet, salty and sour tastes, facial expression intact, clearly enunciates
- VIII: gross hearing intact up to 2 feet bilaterally; weber: no lateralization, Rhinne AC>BC AU
- IX and X: No. hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing
- XI: Full range of motion of neck with 5/5 strength and strong trapezius in shoulder shrug
- XII: tongue midline without fasciculation, good tongue strength
- Motor System:
    - Symmetric muscle bulk with good tone
    - Full active/passive ROM of all extremities without rigidity or spasticity
    - 5 / 5 strength in all extremities
    - No atrophy, tics, tremors or fasciculation noted
- Sensory:
    - R leg vibration sensation not intact in comparison with the L foot when test
        - Pt also reports paresthesia's in feet at times
    - Intact to light touch, sharp/dull sense throughout
    - Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally
- Reflexes:
    - Reflexes 2+ throughout, negative Babinski, no clonus appreciated
- Meningeal signs
    - No nuchal rigidity noted. Brudzinski's and Kernig's signs negative
- Cerebellar function
    - Coordination by rapid alternating movement and point to point intact bilaterally
    - Gait not able to appreciated due to mobility at this time
    - No asterixis
    - Romberg negative, no pronator drift note

Breast exam: Breasts symmetric, No dimpling Peau d'orange or nipple inversion. Appropriate skin color to race, no discoloration, masses, lesion, scars, rashes, scaling, ecchymosis or visible nodules .No nodules, masses, tenderness or nipple discharge on palpation. No axillary nodes palpable

Pelvic exam: Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes Descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.

Rectal: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and non-tender with palpable median sulcus

Assessment

62yo M with hx of DM and HTN uncontrolled admitted for R arm numbness and confusion

1. Stroke (CVA/TIA)
2. Diabetes
3. Hypertension
4. Hyperlipidemia
5. Tonsillar lymphadenopathy
6. Depression
7. Urinary obstruction symptoms

Differential diagnosis:

1. Cerebrovascular accident
    a. Presents how a stoke/TIA with sudden onset Hemiparesis and confusion
    b. Has several risk factors long pack year history, DM, HTN, HLD
2. Intracranial Neoplasms
    a. Hemiparesis could be from intracranial neoplasm
    b. Patient did not complain of headaches
    c. Has risk factors for lung cancer which could have metastasized to brain
3. Nerve dysfunction
    a. Multiple sclerosis
        i. This is unlikely due to only R arm numbness but could be first symptoms, however does not explain the confusion
    b. Cervical radiculopathy,
        i. This is unlikely as no pain ever occupied the R arm numbness, no back pain and does not explain the confusion
4. Peripheral neuropathy
    a. Uncontrolled diabetic for 10+ years and also has R leg paresthesia and lack of sensation to vibration
    b. This would not explain the sudden loss of feeling in R arm or confusion but could an underlying condition as well
5. Tonsillar adenopathy
    a. Pt denies any URI symptoms recently and states it has been there for years
    b. This warrants a CT of chest due to increased risk factor of lung cancer
6. Urinary obstruction symptoms

a. This could be Benign prostatic hyperplasia (BPH) or could be cancerous
    i. Rectal explain could help determine if prostate is enlarged, firm and elastic (BPH) or indurated (possibly malignancy)
    ii. If abnormal, a PSA could be done and a transrectal U/S
    iii. If BPH an alpha blocker, phosphodiesterase inhibitor or a beta 3 agonist could be started.

Plan

1. Stroke (CVA/TIA)
    a. Imaging:
        i. Noncontrast CT head to determine if intracranial neoplasm or bleed is the cause of symptoms
        ii. CT angiography of head/neck with and without contrast
        iii. MRI of brain
    b. Labs
        i. CBC
        ii. CMP
        iii. PT, PTT, INR
        iv. Tropoinin
    c. Medication
        i. Plavix 75mg
        ii. Lovenox 41mg
    d. Activity/diet
        i. Bed rest
        ii. Cardiac/DM diet
    e. Monitoring
        i. Vitals every hour
        ii. Neuro checks q shift
    f. Education
        i. Smoking cessation
        ii. Diet/lifestyle
2. Diabetes
    a. Labs
        i. POC glucose
        ii. A1C
        iii. Glucose check per shift
    b. Medication
        i. Metformin (labs permitting)
        ii. Insulin if BUN/Cr raised
    c. Education
        i. Medication compliance
        ii. Diabetes long term effects
3. Hypertension
    a. Monitoring of BP every hour

b. Imaging
    i. ECG
    ii. Echo
c. Education
    i. Medication compliance
    ii. HTN long term effects

4. Hyperlipidemia
    a. Medications
        - statin
    b. Labs
        - Lipid panel
    c. Education
        - diet
        - medication compliance and complications
5. Tonsillar lymphadenopathy
    a. Imaging
        i. CT of chest and neck
6. Depression
    a. revisit questions about depression
    b. Discuss support system more and possible referral for mental health

7.. Urinary obstruction symptoms
    a. Rectal exam