Identifying Data:

Full Name: OA

Address: Queens, NY
Date of Birth: 6/20/1930
Date & Time: November 22, 2022 @ 10am
Location: NYPQ, Flushing, NY
Religion: Not Identified
Source of Information: daughter
Reliability: unreliable

Mode of Transport: Ambulance

Code status: Full

Chief complaint: Dizziness and vomiting x 5 hours

HPI: 92yo Udo speaking woman from Nigeria with pmhx of right eye blindness, NIDDM brought in by EMS with AMS and vomiting. EMS activated by daughter who states her mother started vomiting and complaining of dizziness around 6am this morning. Her last known usual state was 9pm on 11/21 before going to bed. After multiple episodes of emesis and complaining of nausea, pt grandchildren urged their mother to call 911. Per daughter pt was answered question while in transit of EMS but became more lethargic and is now unable to converse. In ED, stroke was activated at 10:42am when patient became obtunded, not able to follow commands or talk. BP was 210/119 FS: 214, pt only opened eyes to physical stimuli or repeated verbal in Udu but remained non-verbal. Unable to obtain ROS. Daughter denies any hx of HTN, sick contacts, fever, chest pain, falls, jerky movements or LOC. Daughter states that at base line pt ambulates at home without assistance, ambulates with walker outside, and is dependent with some ADL. Daughter states her mother would not know what year it was or month as she is "uneducated" but daughter denies dementia.

PMHX:

- Non-insulin dependent diabetes mellitus (NIDDM)
- R eye blindness

PMSX:

Medications:

- Metformin 250mg, oral BID

Allergies

- No known allergies

Social history:

- Was a spice trader in Nigeria when she was little
- Has no formal education
- Lives at home with her daughter and grandchildren

Tobacco Use: Never

Smokeless tobacco: Never

Alcohol use: Never

Drug use: Never

Review of Systems

Constitutional: unable to obtain from patient. Daughter denies any complaints of chills, fever, change in appetite.

HENT: unable to obtain from patient. Daughter denies any complaints of congestion, cough or sore throat.

Eyes: unable to obtain from patient. Daughter states patient is blind in R eye and has blurry vision in L.

Respiratory: unable to obtain from patient.

Cardiovascular: unable to obtain from patient. Daughter denies any complaints of chest pain, palpitation or leg swelling.

Gastrointestinal: unable to obtain from patient. Daughter states positive for nausea and vomiting. Daughter denies any complaints of anal bleeding or blood in stool.

Endocrine: unable to obtain from patient.

Genitourinary: unable to obtain from patient. Daughter denies any complaints of dysuria, flank pain, urgency, change in vaginal discharge

Musculoskeletal: unable to obtain from patient. Daughter denies any complaints of arthralgias and myalgias.

Allergic/Immunologic: unable to obtain from patient.

Neurological: unable to obtain from patient. Daughter denies any complaints of tremors, syncope, numbness or headaches

Hematological: unable to obtain from patient.

Psychiatric/Behavioral: unable to obtain from patient.

Physical Exam:

Vitals:

11/22/22 1045

BP: 210/119 R arm, supine 195/98, L arm, supine

Pulse: 78, normal

Resp: 22, unlabored

Temp: 36.5 °C, oral

SpO2: 97% on room air

Physical exam:

General appearance: Older African American female is laying in bed obtunded with dark brown vomitus on night gown

HENT:

Head: Normocephalic and atraumatic.

Eye: Unable to illict visual acuity; Negative ptosis; R eye: sclera and lens are dark grey; L eye sclera is white but lens is cloudy. Pupil unable to assessed in R eye, 3mm in L eye. Negative corneal reflex bilaterally.

Mouth: lips cracked; no lesions, non-tender palpation

Teeth: 5 teeth still presents, sign of dental caries due to discoloration.

Neck: Trachea midline. No masses; lesions; scars; pulsations noted.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Pulses: Normal pulses.

Heart sounds: Normal heart sounds. No murmur heard.

No friction rub. No gallop.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No stridor. No wheezing, rhonchi or rales.

Abdominal:

General: Abdomen is flat. There is no distension.

Palpations: Abdomen is soft. There is no mass.

Tenderness: There is no abdominal tenderness. There is no guarding or rebound.

Hernia: No hernia is present.

Skin:

General: Skin is warm and dry.

Coloration: Skin is not jaundiced or pale.

Findings: No bruising, erythema or lesion.

Neurological:

Mental status: obtunded, unable to follow commands or answer questions; responds by opening eyes to painful stimulus and repeated verbal stimulus

Cranial nerves:

- II: left pupil deformed postsurgical, right sclera cloudy, visual fields unable to assess but noted absence of blinking on threat
- no ptosis or nystagmus
- no facial asymmetry
- hearing to voice decreased at base line
- IX, X: XI:XII: unable to assess

Motor:

- Normal muscle bulk and tone
- Moves her upper extremities spontaneously but not on request

Sensory: unable to asses

Coordination: Station/ gait: unable to assess

Reflexes: Not checked

NIHSS: NIH Stroke Scale

Interval: Initial evaluation

- Level of Consciousness (1a.): Not alert, requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped)
- LOC Questions (1b.): Answers neither question correctly
- LOC Commands (1c.): Performs neither task correctly
- Best Gaze (2.): Normal
- Visual (3.): No visual loss
- Facial Palsy (4.): Normal symmetrical movements
- Motor Arm, Left (5a.): No drift
- Motor Arm, Right (5b.): No drift
- Motor Leg, Left (6a.): Some effort against gravity
- Motor Leg, Right (6b.): Some effort against gravity
- Limb Ataxia (7.): Absent
- Sensory (8.): Normal, no sensory loss
- Best Language (9.): Severe aphasia
- Dysarthria (10.): Severe dysarthria, patient's speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric

- Extinction and Inattention (11.) (Formerly Neglect): No abnormality
    - **NIH Stroke Scale**: 14

Modified Rankin Score: 3

Glascow Coma Score: 9

Pertinent Diagnosis tests:

CT without contrast of head:
- negative for ICH or other acute changes

CTA head and neck:
- CTA head and neck negative for LVO or high grade stenosis.

Pertinent labs:
- RPP: negative
- Na: 131
- Troponin: WNL

BMP:

	11/22/22 1105
NA	**131***
K	4.7
CL	**95***
CO2	**20***
BUN	19.3
CREATININE	**1.17***
GLU	**214***
ANOINGAP	16
CA	9.3

ABGs

	11/22/22 1115
PH	7.38
PCO2	**39***
PO2	**64***

	11/22/22 1115
LACTATEWB	**2.85***

Assessment:

92yo Udo speaking woman from Nigeria with pmhx of right eye blindness, NIDDM brought in by EMS with AMS and vomiting. Pt was last seen normal the night before around 9pm. Pt had multiple episodes of vomiting and was complaining of dizziness since 6am this morning. Pt got more lethargic and unable to follow commands or talk in EMS. Pt was obtunded in the ED, unable to follow commands and minimally verbal, only able to say a few words in Edu but inappropriate for questions asked. Pt opens eyes to repeated physical and verbal stimulus. BP was 210/119, FS: 214. Able to move extremities spontaneously but not on request.

Acute Encephalopathy unclear etiology

- N/V x 5 hours
- Lactic acidosis; lactate 2.8
- On metformin
- CT/CTA head and neck: Negative
- HTN emergency: >180/>90 with AMS
- Na: 131
- Glucose: 214 → 246
- WBC WNL
- UA: negative

Possible stroke considering acute onset and vascular risk factors

Possible metabolic/toxic encephalopathy, possible hypertensive encephalopathy

Plan:

Acute Encephalopathy unclear etiology/ Stroke rule out

- MRI without IV contrast
- Admit to stroke unit
- Telemetry with troponin
- Neuro checks Q 4hrs
- TTE
- EEG
- Labs:
    - A1c, Vit B12, Folic acid, Homocysteine, LFT, TSH
- Fluid: NS at 75ml/hr
- NPO until dysphagia screen
- DVT prophylaxis: lovenox

Hypertensive emergency

- Add Amlodipine 10mg, oral daily
    - Goal SBP 130-180
    - Hold unless >180/110 now for adequate perfusion

#lactic acidosis

- Monitor FS; glucagon as needed
- Hold metformin and insulin given NPO status

- creatinine 1.17 on admission, CrCl < 30

Hyponatremia

- send for serum osm, urine osm, urine sodium

Update:

- EEG with triphasic waves typically seen in metabolic encephalopathy
- MRI canceled due to low suspicion of stroke
- outpatient neurology evaluation for Dementia
- Discharged on amlodipine 10mg daily and lisinopril 20mg daily for HTN to be managed as outpatient