RESULT REVIEW REPORT
HUNTSVILLE HOSPITAL
101 SIVLEY ROAD
HUNTSVILLE, AL 35801

Patient:

Age: 56 Sex: M

Report Name: Emergency Room Type: TRX

IV Fluids and/or Medications Continued on Admission: (-)Yes, (+)No.
Restraints continued on admission: (+)Not Applicable, (-)Yes, (-)No
Intake Output (See Table)

Created: 10/15/2012 3:53am Last Entry: 6:20am

H&P (ALTERED MENTAL STATUS) EMERGENCY DEPARTMENT

>>>> History not limited

Transferred from: Not transferred

>>>> HPI: History obtained from patient and Nurses Notes. Patient presents with a chief complaint of 2hrs prior to arrival, while sitting, a sudden and constant onset of neuro symptoms: WAS SITTING AND DEVELOPED diaphoresis, generalized weakness dyspnea nausea calls emswas sitting watching tc, no new syx priro feels dizzi all the time has a very flat affect and seems to ve in a depressed state
Last Known Well Verified few hours earlier
Other Symptoms: (-)recent exposure to contagious illness, (-)headache, (+)nausea, (-)vomiting, (-)seizure/abnormal movement, (-)head injury, (-)fall, (-)trauma, (-)disoriented, (-)confused, (-)agitated, (-)difficulty concentrating, (-)difficulty thinking, (-)decreased responsiveness, (-)unresponsive, (+)difficulty standing, (+)difficulty walking, (-)ETOH ingestion, (-)drug ingestion, (-)overdose, (?)overmedicated. Glucose check: not applicable to patient
Symptom(s) are continues in ED and are mild in intensity. Baseline status: alert and oriented, and walks without assistance.
(+)Symptoms worsened by nothing.
(+)Symptoms improved by nothing.
Pt has had multiple similar episodes over past years, with frequency of occurring occasionally.
(+) Patient was recently treated/seen by Physician type in.
(+)recent hospital admission. recent adm w neuro and cards eval , neg r and left heart cath , small PFO,

>>>> PREHOSPITAL CARE: See Nursing Notes.

>>>> ROS: (-)visual changes, (-)dizziness, (+)unsteady gait, (-)difficulty swallowing, (-)sore throat, (-)cough, (-)dyspnea, (-)chest pain, (-)palpitations, (-)abdominal pain, (-)diarrhea, (-)bloody stools, (-)dysuria, (-)fever, (-) rash, (-)joint pain, (-)exposure to tick/insect bite, (+)anxiety, (-)depression, (+)all other systems negative. Other pertinent symptoms addressed in HPI.

>>>> LMP:

>>>> LNMP:

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>>>> PMH List (See PMH Table) anxiety, cva frontal lobe, pfo, hyperlipidemia
>>>> PSH List (See PSH Table)
>>>> FH: (-)DM, (-)HTN, (-)cancer
>>>> PSYCH SOCIAL: (-)tobacco, (-)alcohol, (-)drugs
>>>> VITALS: (+)Nurse's Note Reviewed, (-)Febrile, (-)Tachycardia, (-)Hypotensive, (+)Hypertensive
>>>> PHYSICAL EXAM: Physical Exam not limited
GENERAL APPEARANCE: well nourished, acting strangely, cooperative, no acute distress
MENTAL STATUS: speech slow, oriented X 3, flat affect, responds slowly
NEURO: (+)hypotonia, cranial nerves 2 - 12 intact, (+)motor intact, (+)sensory intact.
HEAD: (-)swelling, (-)tenderness
EYES: (+)PERRL, (+)EOMI, conjunctiva clear.
NOSE: no nasal discharge.
MOUTH: (-)decreased moisture, no lacerations inside mouth.
THROAT: no airway obstruction.
NECK: (-)nuchal rigidity, no neck tenderness, (-)thyromegaly.
BACK: no back tenderness.
LUNGS: (+)lungs clear, no wheezing, no rales, no rhonchi, (-)accessory muscle use
HEART: normal rate, normal rhythm,
ABDOMEN: normal BS, soft, no abd tenderness, (-)guarding, (-)rebound, no organomegaly, no abd masses.
RECTAL:
EXTREMITIES: good pulses in all extremities, (-)swelling, (-)tenderness
SKIN: (-)ulcers, (-)decubiti, warm, dry, good color, no rash.
>>>> DIFFERENTIAL Dx: During the assessment and evaluation, the following were considered.
NEURO Dx: volume depletion, hyponatremia, hypernatremia, hypoglycemia, chronic dementia, stupor. psych issues
>>>> RESULTS REVIEWED:
Laboratory:
TROPONIN: unremarkable.
CK-MB: unremarkable.
CPK: unremarkable.
BMP: unremarkable.
CBC: normal.
Radiology:
CHEST X-RAY(portable): Study was radiologist reading and the Radiologist interpretation was reviewed, and the following was noted:, negative.

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#1 EKG(my reading): NSR, normal QRS, normal ST, normal T, unremarkable EKG.
Rhythm Strip:
Other:
Pulse Ox: 99% RA, SaO2 interpretation: normal saturation.
(+)Nursing Notes Reviewed
Old Records Reviewed. Changes noted from previous records.. very complete w/u in past which has been neg w recent neg brain mri scan
>>>> ED COURSE: will not stand
>>>> MEDICATIONS FLUID RESUSCITATION:
Patient received IV NS bolus. Patient with improvement of condition.
>>>> PAIN MANAGEMENT:
>>>> RESPIRATORY CARE:
>>>> PROCEDURE:
>>>> DISPOSITION:
Uab School Of Medicine - Int. Med. consulted who will come see pt.
>>>> CRITICAL CARE TIME: not requested

Created: 10/15/2012 3:53am Last Entry: 3:53am

Physician Note:
MUSCULOSKELETAL: Pulses present on all extremities, no swelling\tenderness on the extremities , no edema

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Created: 10/15/2012 6:19am Last Entry: 6:20am

Physician Note: i suspect syx are anxiety w hypervent , ? repeat brain MRI will ask uab to readmit

Orders

Orders (MDM)

Order	Sched D/T	In Prog D/T	Comp D/T	MD
GLUCOSE, PCX/POC	10/15/2012 3:39am		10/15/2012 3:39am	Or Ou
CBC WITH DIFF (CBC/DIFF)	10/15/2012 3:51am		10/15/2012 4:09am	Fi Wi

Orders (MDM) (continued)

RESULT REVIEW REPORT
HUNTSVILLE HOSPITAL
101 SIVLEY ROAD
HUNTSVILLE, AL 35801

Patient:

Age: 56 Sex: M

Report Name: BASIC METABOLIC PANEL Type: LAB

BASIC METABOLIC PANEL - STATUS: Final

Ordered By:

Perform Date: 15Oct12 03:30
Ordered Date: 15Oct12 03:51
Last Updated Date: 15Oct12 04:25
Department: CHEM

Facility: HHM

Findings

Result Name	Result	Abnl	Normal Range	Un
SODIUM	139		(133-145)	ME
POTASSIUM	3.9		(3.5-5.0)	ME
CHLORIDE	103		(96-108)	ME
CO2	24		(22-29)	ME
BUN	9		(6-20)	MG
CREATININE	0.9		(0.5-1.2)	MG
GLUCOSE	126	H	(70-100)	MG
CALCIUM	10.1		(8.6-10.2)	MG
ANION GAP	12		(7-17)	
CALC OSMOLALITY	278			MO
BUN/CREAT	10		(10-20)	
GFR AFRICAN AMERICAN	>60		(>60)	GF
GFR NON-AFRICAN AMERICAN	>60		(>60)	GF
CHEM COMMENT	NONE			

Additional Providers

Additional Information
HL7 RESULT STATUS : F
External IF Update Timestamp : 2012-10-15:04:24:33.000000

RESULT REVIEW REPORT
HUNTSVILLE HOSPITAL
101 SIVLEY ROAD
HUNTSVILLE, AL 35801

Patient:

Age: 56 Sex: M

Report Name: CBC WITH DIFF (CBC/DIFF) Type: LAB

CBC WITH DIFF (CBC/DIFF) - STATUS: Final

Perform Date: 15Oct12 03:30
Ordered Date: 15Oct12 03:51
Last Updated Date: 15Oct12 04:10
Facility: HHM Department: HEMA

Findings

Result Name	Result	Abnl	Normal Range	Un
WBC COUNT	7.13		(4.8-10.8)	X1
RBC COUNT	5.17		(4.7-6.1)	MI
HEMOGLOBIN	16.4		(14.0-18.0)	G/
HEMATOCRIT	47.5		(42.0-52.0)	%
MCV	91.9		(80-98)	FL
MCH	31.7		(27-34)	PG
MCHC	34.5		(32-36)	G/
RDW	12.6		(11-14)	%
PLATELET COUNT	270		(130-400)	X1
MPV	11.4		(9.4-12.4)	UM
NEUTROPHIL	73.9		(43-75)	%
LYMPHOCYTE	17.3		(15-43)	%
MONOCYTE	7.4		(5-15)	%
EOSINOPHIL	0.7		(0-5)	%
BASOPHIL	0.7		(0-1.5)	%
ABSOLUTE NEUTROPHIL COUNT	5.27		(2.09-6.07)	X1
ABSOLUTE LYMPHOCYTE COUNT	1.23		(1.20-3.40)	X1
ABSOLUTE MONOCYTE COUNT	0.53		(0.11-0.80)	X1
ABSOLUTE EOSINOPHIL COUNT	0.05		(0.00-0.70)	X1
ABSOLUTE BASOPHIL COUNT	0.05		(0.00-0.20)	X1
DIFF TYPE	AUTOMATED			

Additional Providers

Additional Information
HL7 RESULT STATUS : F
External IF Update Timestamp : 2012-10-15:04:09:01.000000

PROGNO

The following Ancillary documentation is in iCare and on the MD Patient Profile Report.
- Speech Therapy/Pathology notes related to Swallowing Studies and Speaking Valve Evaluations
- Dietitian notes from provider generated orders

Providers click on iCare "Ancil Docum" chart tab to see documentation

DATE	TIME	
10/15/12	0525	Pt is a 55 yo WM c̄ h/o CVA 1 yr ago who was recently discharged from
		the UAB TM service who presents back to the ER c̄ numbness of entire body,
		SOB, and unsteady gait. Pt says he was sitting awake in bed when he felt
		numbness, 1st in chest that spread to the extremities. Wife says she mainly
		noticed SOB. Pt says he had "shaking" of lower extremities, but this was ⊖
		witnessed by wife. VSS, slightly hypertensive. Orthostatic vital signs attempted
		but pt unable to stand (neg supine → sitting). On exam, CN II-XII are grossly
		intact. 5/5 strength × 4. 2+ patellar reflexes Ⓑ. Sensation intact × 4 ext c̄
		microfilament. ⊖ dysmetria. Labs in ER unremarkable. CXR neg. Pt says
		ataxia has ⊖ improved since last admit. Neuro exam remains non-focal. CT 10/11/12
		normal; MRI @ that time showed non-specific white matter hyperintensities. ~~Pt is~~
		Transcranial doppler & carotid imaging negative last admission. ? hyperventilation vs.
		anxiety. Consider Ψ evaluation as pt recently started on SSRI for anxiety d/o.
		Will admit for observation. Neuro checks q 4° × 3. Supportive treatment. Will
		defer to 1° team Re: further imaging & Ψ evaluation.

15Oct2012

M 55 HH, EMERGENCY

FORM#288675
3/2012

HH Health System

ALABAMA

HISTORY AND PHYSICAL

M.D.,RES.
Date of Admission: 10/15/2012 Patient Type: Outpatient

ATTENDING PHYSICIAN: Dr. Centor.

Primary care physician is . Neurologist is .
Cardiologist is Emergency room physician was

CHIEF COMPLAINT: Shortness of breath with numbness.

HISTORY OF PRESENT ILLNESS: 55-year-old white male with past medical history of CVA in 2011, tinnitus, anxiety disorder, discharged from UAB internal medicine service approximately a week and a half ago, presents again with symptoms of shortness of breath with numbness all over his body. Patient states he was sitting in his chair watching TV at one o'clock this morning when he felt "hot," became dizzy, became short of breath, and developed "shaking" that was not witnessed by his wife, and then had numbness beginning in his chest and spreading all over his body including upper extremities, neck and hip. He states he was unable to stop the shaking and was concerned about his breathing and he asked his wife to call HEMSI for evaluation. Wife states he was slurring his speech, could not walk well. However, he has had balance issues/dizziness since the CVA in 2011. In the emergency room, he was unable to obtain orthostatic blood pressures due to inability to stand due to balance. He was given Zofran and IV normal saline bolus. At the prior admission, he was evaluated with CT and MRI of the head and echocardiogram, and diagnosed with panic/anxiety disorder, dizziness secondary to vasovagal syndrome.

PAST MEDICAL HISTORY: Nephrolithiasis with lithotripsy, BPH, tinnitus, CVA in 2011, hyperlipidemia, patent foramen ovale, left hip replacement x 2 in 2011.

SOCIAL HISTORY: He is a heavy machine operator. However, he has not worked since 10/12/2012. He is married. He lives at home with his supportive wife. He is a social drinker, on rare occasions he states, no more than a six-pack of beer in a six month period. No tobacco and no illicit drug use.

ALLERGIES: No known drug allergies.

MEDICATIONS:
1. Meclizine 25 t.i.d.
2. Pravastatin 40 every day.

3. Midodrine 5 mg t.i.d.
4. Aspirin 81 p.o. every day.
5. Prozac 20 mg every day.
6. Nexium 40 mg every day.
7. Unknown anxiety medicine b.i.d.

FAMILY HISTORY: Positive for coronary artery disease in dad who deceased at 80 years of age. Mom: Hypertension, diabetes mellitus.

REVIEW OF SYSTEMS: Positive for dizziness, tinnitus, shortness of breath, urinary hesitancy, tingling, weakness with difficulty walking and standing secondary to balance. 14-point review of systems is obtained and all other systems reviewed and negative.

PHYSICAL EXAMINATION: Temperature is 97.7, heart rate 90, respirations 20, blood pressure while lying 142/98, sitting 132/104, O2 saturation 98% on room air, weight 102 kilograms.

GENERAL: No apparent distress. He is awake, alert, and oriented x 3 with a flat affect with wife at bedside.

HEENT: Normocephalic and atraumatic. Pupils are equal, round, reactive to light. Extraocular movements are intact. Mucous membranes are moist. No oropharyngeal erythema or edema.

NECK: Supple. No lymphadenopathy. Trachea is midline.

CARDIOVASCULAR: Regular rate and rhythm. S1 and S2. No murmurs, gallops or rubs.

RESPIRATIONS: Clear to auscultation bilaterally. No wheezing, rales or rhonchi and no retractions and no accessory muscle use.

GI: Soft, nontender and not distended. Positive bowel sounds. No hepatosplenomegaly.

MUSCULOSKELETAL: No fasciculations, no atrophy. Normal tone.

SKIN: Warm, dry and intact. No rashes. Capillary refill is less than 2 seconds.

EXTREMITIES: No clubbing, cyanosis, or edema. 2+ pedal pulses.

NEURO: Cranial nerves II-XII are intact. Motor function bilateral upper and lower extremities is 5/5. Sensory bilateral upper and lower extremities is intact. Reflexes: Patella 1+, brachioradialis 1+. Proprioception is intact. Cerebellar: Intact finger to nose and rapid alternating hand movements.

LABORATORY DATA: WBCs are 7.1, H H 16.4 and 47.5, and platelets are 270. Sodium is 139, potassium 3.9, chloride 103, bicarbonate 24, BUN 9,

creatinine 0.9, glucose 126 and calcium is 10.1. Troponin-T is 0.01, CPK 31 and CK MB is 1.7. EKG: Normal sinus rhythm. Portable chest x-ray: No acute findings or cardiopulmonary disease.

ASSESSMENT: 55-year-old white male with anxiety disorder, hyperlipidemia, BPH with recent discharge for dizziness secondary to vasovagal syndrome.

1. Shortness of breath with associated ataxia and paresthesias, likely underlying anxiety disorder with acute trigger overnight causing hyperventilation given the description. EKG is normal with normal cardiac enzymes. O2 saturation is normal excluding cardiopulmonary etiologies. Shortness of breath had improved by the time of my exam. He was not on oxygen. Neuro exam was grossly abnormal. Unable to assess gait, however. He was recently started on SSRI for anxiety. He has upcoming hip surgery, which is a possible source for anxiety, and we will consider a psych evaluation as part of treatment. Previous CT and MRI only showed nonspecific white matter hypersensitive changes. I highly doubt organic etiology for shortness of breath.
2. History of cerebrovascular accident. He appears at baseline with his dizziness and balance/ataxia as symptoms were persistent prior to arrival. He was evaluated by neurology with carotid Doppler study, orthostatics, and echocardiogram. He has had no new changes and no new changes to medications. We will continue his home vertigo medicines, Midodrine and Meclizine.
3. Benign prostatic hypertrophy. Continue home meds.
4. Deep vein thrombosis prophylaxis. TEDS and SCDs, Lovenox 40 mg.
5. History of anxiety disorder. We will continue SSRI and consider possible psych evaluation.

Robert Centor, M.D.

D: 10/15/2012 05:28 A
T: 10/15/2012 03:59 P

cc: Robert Centor, M.D.