History and Physical –2

Siddharth Shah

Identifying Data

November 21st, 2023 – 1:00 pm
GS, 66, Indian
Location: Queens Hospital Center Emergency Department
Informant: Patient, reliable
Transport: BIB son, and husband

Chief Complaint: "generalized weakness"

History of Present Illness:

66 y/o F with PMHx of HTN, HLD, DM2, Hypothyroidism, and CAD presents to the ED c/o generalized weakness, altered mental status, and difficulty walking for 2x days. Patient had a cardiac angiogram done at St. Franics Hospital on 11/17/2023 as told by son. Son notes since patient came home from the hospital on 11/17/2023 she has been "slow to respond", and originally thought it was due to coming off from anesthesia. However, since the procedure patient has not returned to baseline, and has been having difficulty walking, and reportedly dragging her left leg. Patient felt weak this morning, and fell onto her buttocks, but was caught by her husband. Son notes that the patient has not been compliant with medication. Patient denies fever, chills, syncope, facial droop, dysarthria, vision loss, chest pain, shortness of breath, palpation, and dizziness. Son notes after cardiac angiogram, cardiologist recommends patient gets a CABG,

Past Medical History:

- Hypertension
- Hyperlipidemia
- DM2
- Hypothyroidism
- CAD

Past Surgical History:

- No surgical history

Medications:

- Plavix
- Metformin
- Lisinopril

Allergies:

- NKA

Family History:

- Son alive, and well

Review of Systems:

General: Denies any recent weight loss or gain, loss of appetite, night sweats, fever, or chills

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

Head: Denies headache, and vertigo.

Eyes: Denies visual disturbances, double vision, blurriness, excess tearing or dryness, photophobia, or pruritis.

Ears: Denies hearing loss, tinnitus, discharge, earache.

Nose and sinuses: Denies discharge, obstruction, allergies, or epistaxis

Mouth and throat: Denies sore throat, bleeding gums, ulcerations.

Neck: Denies localized swelling, lumps, stiffness, or decreased range of motion.

Pulmonary: Denies shortness of breath, denies wheezing, or productive cough. Denies hemoptysis, cyanosis.

Cardiovascular: Denies chest pain and palpations.

Gastrointestinal: Denies abdominal pain, N/V/D

Genitourinary: Denies dysuria, pain, and frequency. Denies hematuria.

Neuro: **Generalized weakness, "slow to respond", Altered Mental Status**

Musculoskeletal: Denies any musculoskeletal pain

Endocrine: Denies heat/cold intolerance, excessive sweating

Psychiatric: Negative history of depression and anxiety. Denies having SI/HI

Physical Exam:

General: Laying in bed comfortably and not in acute distress.

Vitals:

- BP(bed): R – 151/46
- P: 73 bpm, regular
- R: 16 breaths/min,
- T: 97.8 F, oral
- O_2 Sat: 98% on room air

Skin: Warm and moist throughout. No erythema. No jaundice.

Hair: Average quantity and distribution.

Nails: No clubbing, capillary refill <2 seconds in all four extremities

Head: Normocephalic, atraumatic, nontender to palpation throughout.

Eyes: Sclera white, cornea clear, conjunctiva pink, EOMI.

Ears: No masses, lesions, or deformities on external ears. No discharge or foreign bodies in external auditory canals AU. TM's white and intact with light reflex.

Neck: Trachea midline. 2+ Carotid pulses, no stridor, thrills, or bruits noted bilaterally.

Thyroid: Nontender to palpation, no masses, no bruits noted.

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

Lungs: Clear to auscultation bilaterally. No adventitious sounds.

Heart: Rate & Rhythm are regular, no murmur, no gallops, S1, and S2 present

Abdomen: Abdomen is symmetric without striae, no pulsations. Bowel sounds normoactive in all four quadrants. Non-tender to palpation or percussion throughout. No guarding or rebound tenderness. No CVA tenderness.

Peripheral Vascular: Extremities are normal in color and temperature. Pulses are 2+ bilaterally in upper and lower extremities. Non-tender lower extremities. No, clubbing, cyanosis or edema bilaterally. .

Neuro:

Mental Status: Patient is alert.

Cranial Nerve: No dysarthria or facial asymmetry
Sensory; Sensory deficit is present.
Motor: LUE strength is 4/5, decreased sensation compared to RUE.
RUE strength 5/5
LLE Strength 4/5
RLE 5/5
Coordination: Finger-to-nose is normal

Differential Diagnosis:

1. Stroke
2. TIA
3. Post-operative Delirium

Assessment: . 66 y/o F with PMHx of HTN, HLD, DM2, Hypothyroidism, and CAD presents to the ED c/o generalized weakness, altered mental status, and difficulty walking for 2x days. Neuro deficits on exam, motor, and sensory deficits to LUE, and RLE. Possible subacute stroke from cardiac angiogram.

Plan:

- Stroke protocol – Consult Neuro and admit patient.
- CBC:
  - Unremarkable
- CMP:
  - Unremarkable
- Medication:
  - Aspirin 325 mg
  - Atorvastatin 80mg
  - Clopidogrel 300mg
- CT Scan without contrast:
  - Impression: Areas of low attenuation predominantly along the expected course o the left anterior cerebral artery likely represents a subacute to chronic infarct with an additional small area also seen adjacent to the left caudate nucleus/ganglia. Consider follow-up MRI examination of the brain. Otherwise, no acute hemorrhage, hydrocephalus or additional large territorial infarcts.

External Notes from St. Francis Hospital from 11/17/2023:
- **Cardiac Cath**: Angiograph revealed EF of 55% Coronary Angiography revealed a 70% mid LAD lesion. Circumflex has a 95% OM 1&2 lesions.
- **U.S Carotids:** Less than 50% stenosis of the bilateral carotid arteries.

Pt transferred to St. Francis Hospital:
- MRI: Multiple scattered acute infarcts along the left ACA territory including the genu of the corpus callosum. No hemorrhagic infarct. Local mass effect without midline shift or herniation.