**Fredrique Green** **Internal Medicine: H&P 3**
**Chief Complaint:** R-sided weakness and numbness

**History of Present Illness:** M.D. is a 56-year-old F with no reported PMHx who presented to the ED today for complaints of R-sided weakness for 1 day. Patient reported that at approximately 10 am yesterday (4/30/24), she was working at a hair salon, washing someone's hair, when she suddenly had R arm and R leg weakness and numbness. Symptoms improved significantly but did not resolve, which prompted her to come to the ED. She denied any history of similar symptoms in the past. Denied chest pain, SOB, visual changes, slurred speech, headache, or dizziness. Denied history of CVA, falls, trauma, or recent travel. Does not take any medications and is not on OCPs. Denied any chiropractor visit or massage. She reported no other associated symptoms. NIHSS stroke scale: 5. CT head negative for acute stroke; patient admitted for further workup.

**Allergies:** NKDA
**Medications:** denies
**PMHx:** denies
**PSHx:** denies
**Social Hx:**

- Tobacco: denies, never smoker
- Alcohol: denies
- Diet: reports a healthy diet of fresh fruits and vegetables
- Exercise: walks 20 minutes daily

**FHx:**

- Mother: deceased (CVA, age 47)
- Father: deceased (CVA, age 76)
- Sister: alive, HTN

**<u>Review of Systems</u>:**
**General:** denies fever, chills, headache, fatigue, lightheadedness
**Skin/hair/nails:** denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, change in hair distribution
**Head:** denies dizziness, headache, trauma
**Eyes:** denies discharge, dry eye, eye pain, double vision, blurry vision
**Ears:** denies ear pain, tinnitus, fullness, eye discharge, hearing loss
**Nose:** denies sinus pain, decreased sense of smell, epistaxis, nasal discharge
**Mouth/throat:** denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures
**Neck:** denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures
**Respiratory:** denies cough, shortness of breath, sputum production, wheezing, hemoptysis, paroxysmal nocturnal dyspnea
**Cardiovascular:** denies chest pain, palpitations, irregular heartbeat, edema, syncope, known heart murmur
**Gastrointestinal:** denies abdominal pain, nausea, vomiting, constipation, diarrhea, change in bowel habits, rectal bleeding, loss of appetite, hemorrhoids

**Musculoskeletal:** admits RUE and RLE weakness, denies muscle pain, joint pain, swelling, deformity, redness
**Peripheral vascular:** denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change
**Hematologic:** denies anemia, easy bruising/bleeding, history of DVT/PE
**Genitourinary:** denies change in frequency, urgency, hesitancy, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain, dyspareunia, anorgasmia, vaginal bleeding, vaginal discharge
**Endocrine**: denies temperature intolerance, excessive thirst
**Neurologic:** admits RUE and RLE weakness. Denies paresthesias, ataxia, seizures, sensory disturbances change in mental status, memory loss
**Psychiatric:** denies feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideation, anxiety

**Physical Exam:**
**Vital Signs:**
**BP:** 179/96
**Pulse:** 933
**RR:** 21
**Temp:** 36.9 C
**SpO2:** 96%

**NIHSS:**
Interval: initial evaluation
Level of Consciousness (1a.): alert, keenly responsive
LOC Questions (1b.): answers both questions correctly
LOC Commands (1c.): performs both tasks correctly
Best Gaze (2.): normal
Visual (3.): no visual loss
Facial Palsy (4.): minor R paralysis (+1)
Motor Arm, Left (5a.): normal symmetry
Motor Arm, Right (5b.): drift, but doesn't hit bed (+1)
Motor Leg, Left (6a.): no drift
Motor Leg, Right (6b.): no drift
Limb Ataxia (7.): finger-to-nose and heel-shin ataxia in 2 limbs (R UE, R LE) (+1)
Sensory (8.): mild-moderate loss: less sharp/more dull (R UE, R LE) (+1)
Best Language (9.): no aphasia
Dysarthria (10.): normal
Extinction and Inattention (11.) (Formerly Neglect): no abnormality
*NIH Stroke Scale: 5*

**General Survey:** AO3, NAD
**Skin, nails:** warm and moist, good turgor, nonicteric, no lesions, no rashes, capillary refill <2 sec in UE and LE b/l
**Eyes:** PERRLA, EOM intact, white sclera, pink conjunctiva, no conjunctival injection, pallor, or scleral icterus

**Cardiovascular:** regular rate and rhythm, normal S1 and S2, no S3 or S4, no murmurs, no friction rubs, no gallops
**Lungs:** clear to auscultation b/l, no labored breathing, accessory muscle use
**Musculoskeletal:** full UE and LE ROM, no deformities, erythema, warmth, crepitus
**Extremities:** UE and LE symmetric in color, size, T b/l, all extremities pulses 2+ b/l, no clubbing, cyanosis, edema, or ulcerations in UE or LE b/l
**Neurologic:** AO3

- Cranial nerves:
    - CN I: not tested
    - CN II: full visual fields
    - CN III, IV, VI: PERRLA, EOM intact b/l
    - CN V: sensation intact b/l
    - CN VII: slight R facial asymmetry (slightly flattened R nasolabial fold)
    - CN VIII: hearing intact to finger rub test b/l
    - CN IX, X: uvula midline and rises with soft palate
    - CN XI: intact shoulder shrug
    - CN XII: tongue midline without atrophy or fasciculations
- Strength:
    - Normal muscle bulk and tone, no tremor observed
    - RUE: 5/5 shoulder abductor, elbow flexor/elbow extensor, wrist flexor/wrist extensor
    - LUE: 5/5 shoulder abductor, elbow flexor/elbow extensor, wrist flexor/wrist extensor
    - RLE: 5/5 hip flexor, knee flexor/knee extensor, dorsiflexion/plantarflexion
    - LLE: 5/5 hip flexor, knee flexor/knee extensor, dorsiflexion/plantarflexion
- Sensory:
    - RUE: intact to light touch and pinprick
    - LUE: intact to light touch and pinprick
    - RLE: intact to light touch and pinprick
    - LLE: intact to light touch and pinprick
- Reflexes: reflexes 2+ and equal throughout
- Coordination:
    - Finger-to-nose: R-sided dysmetria
    - Heel-to-shin: R-sided dysmetria
- Gait: not tested

**Labs/Procedures:**

- CBC with differential: WNL
- CMP: WNL
- Coagulation factors: WNL

**Imaging:**

- CT head without contrast: IMPRESSION: No CT evidence of acute intracranial abnormality. The need for further imaging with MRI should be determined clinically.

**Assessment:**

M.D. is a 56-year-old F with no reported PMHx who presented to the ED today for sudden onset RUE and RLE weakness and numbness that has persisted for 1 day. Physical exam revealed minor R facial paralysis, slight R arm drift, finger-to-nose and heel-shin ataxia in RUE and RLE, and mild-moderate sensation loss in RUE and RLE. M.D. does not have known HTN but BP on presentation is hypertensive. NIHSS stroke scale score: 5. Patient is outside of the window for either tenecteplase or thrombectomy. CT head negative for acute stroke. Her presentation is concerning for acute stroke.

**Plan:**

#Stroke:

- CT angiography to evaluate for emboli
- MRI for further detailed imaging
- EKG to rule in/out cardiac emboli source
- TTE to rule in/out cardiac emboli source
- Troponins to rule in/out CAD
- Lipid panel to rule in/out ASCVD
- Aspirin load 325mg then ASA 81 mg qd
- Statin
- Admit to stroke unit
- DVT prophylaxis: enoxaparin 40mg qd
- Neurological assessment q 4h
- Diet: regular

#HTN:

- Permissive hypertension