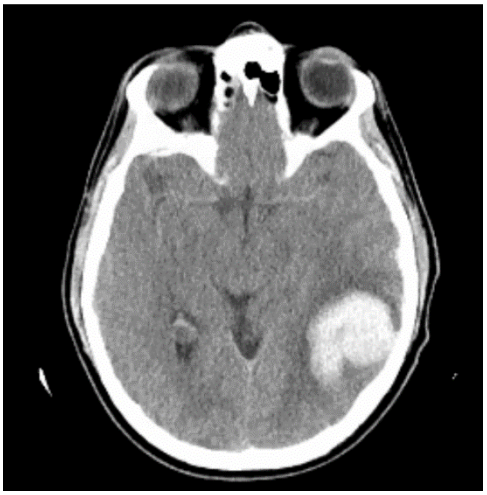
SAMPLE CASE SUMMARY (Actual)



XX is a 30 y/o male with a PMHx of depression (controlled with Lexapro), migraines with aura (managed with Excedrin), and possible HTN who was transferred to UCMC from an OSH on 3/31 with a non-traumatic left temporoparietal ICH approximately 35 cc in volume. His symptoms began 8 days earlier as recurrent headaches that acutely worsened with associated confusion the morning of 3/31. He is a 1-2 ppd smoker with occasional marijuana use. His family history is only significant for HTN, with no history of neurological or vascular disorders. Upon admission to the NSICU, he was hemodynamically stable with an elevated BP at 153/86. His exam at presentation was significant for a GCS of 15, NIHSS of 1, ICH of 1, AOx2 (could not recall time or place), and mild aphasia with word finding difficulties. He was otherwise neurologically intact. His initial laboratory results showed a leukocytosis to 18.1, no significant electrolyte derangements, a normal PT-INR, and a UDS presumptive positive for opiates and THC.

He was initially placed on Nicardipine gtt and Keppra 500 mg q12. Neurosurgery was consulted; repeat stability CT at 6 hours showed an intraparenchymal hematoma measuring up to 5-cm in the left temporoparietal region with no evidence of AVM, venous sinus thrombosis, or other hemorrhage source and an unchanged mild rightward midline shift measuring 3-mm. It also showed multiple stenotic segments that most likely represented areas of vasospasm. With no increased mass effect, midline shift, or active extravasation, no neurosurgical intervention was emergently required.

In attempts to elucidate the source of his ICH, a DSA was eventually performed by the interventional neuroradiology team which displayed smooth segment luminal irregularities along virtually all intracranial vessels that are responsive to intracranial verapamil infusion, consistent with reversible cerebral vasoconstriction syndrome.

On the morning of 4/4, JC began displaying right-hemispheric symptoms: optic and motor apraxia, aphasia, left sided neglect and was eventually classified as developing Gerstmann Syndrome secondary to recurrent vasoconstrictive episodes. In total, he received four angiograms with IA verapamil.

To address his RCVS, he was weaned from Nicardipine to PO verapamil, but was transitioned to Nimodipine due to SBPs in the 110s. He was also started on IV magnesium and transitioned to PO magnesium during this admission. He was transferred from the NSICU to the step-down status on 4/11 following several days of stable exams.

This sentence makes a total of 400 words. Hello, everyone.

EXAMPLE ASSESSMENT & PLAN

1. Left-Sided Temporoparietal ICH

Currently hemodynamically and neurologically stable with an ICH score of 1, NIHSS score of 1, and GCS of 15. Mild aphasia and confusion are not progressing. Initial CT described ICH volume of 35 cc with 3mm rightward midline shift. He is not displaying any signs of seizure or herniation. Current treatment plan should focus on BP control, seizure prophylaxis, assessment for potential re-bleed, and elucidating the source of the hemorrhage. Current DDx includes aneurysm (more likely to cause SAH, however), AVM, RCVS, bleeding disorders (although normal H/H, PT-INR), and drug-induced hemorrhage (UDS only presumptive + for opioids and TCH).

- Head-of-bed at 30 degrees
- Nicardipine gtt with target SBP below 160
- Keppra 500 mg q12
- Neuro exam q1 until repeat CT, then q4 if stable
- Stability CT scan 6 hours after admission
- MRI and MRA to find source of bleed
- Consult neurosurgery for management of extravasation if unstable
- NPO until neurosurgery consult, will consider recs
- mIVF at 75 ml/hr

2. Leukocytosis with Left Shift

Initial CBC displayed leukocytosis to 18.1. UA, CXR, blood negative for infection. Pt has been afebrile since presentation with no additional signs of an infective source. Currently attribute leukocytosis as secondary to ICH; this response has been well-established.

- Follow-up blood cultures
- Monitor vitals
- Repeat CBC qd

3. Depression

Pt is well-mannered and appropriate given his condition. He is not endorsing any signs of depression; it appears his home medication is managing his depression well.

- Continue home Lexapro 20mg PO qd

4. PPx

- SCDs for DVT prophylaxis (no anticoagulation)

5. Dispo

- NSICU until stability scan at earliest; follow serial neuro exams