STATUS: YCC

THE ROUGE VALLEY HEALTH SYSTEM
Rouge Valley Centenary

Consultation Report

Patient: HIPPE,ARTHUR
Unit #: Y1121047
Accnt #: YF00037/10
Gender: M
DOB: 22/12/1943
ADMIT: DISCHARGE:

CONSULTATION DATE: June 22, 2010

This 66-year-old man is seen in the Emergency Department at Centenary Hospital at 9:00 a.m. He was sent for review of his neurological situation and recent left MCA infarct.

He originally came to Centenary Hospital on May 29th with apparently symptoms of being confused and having trouble speaking. His wife got a call the next morning that he was being discharged. It appears that he may have been referred to the Rapid Medical Referral Clinic. However, because he continued to have difficulty speaking and was confused his wife took him to Ajax-Pickering Hospital. He was unable to communicate well. He did not seem to have any problem moving his right side.

In the course of investigation his CAT scan showed a few scattered hypodensities in the left hemisphere which did not appear enough to cause his current situation. However, when he had an MRI done subsequently in June this did show a fairly sizeable left MCA territory infarct.

He has been somewhat drowsy intermittently throughout his stay at Ajax, on reviewing the notes, and I note that he has been receiving Haldol for some sedation. His wife noticed that he was particularly sedated and this lasted a long time after receiving Lorazepam for his MRI result. The presumed mechanism of the stroke is atrial fibrillation as he had atrial fibrillation and was supposed to be on Coumadin but had an INR of only 1.05 on arrival.

His past history includes a right thalamic and right occipital CVA in April of 2009 affecting his left arm and left leg and hemi-neglect and atrial fibrillation was discovered then. An MRA of intracranial vessels last year showed some irregularities in the arteries and echocardiogram last year was normal in terms of stroke cause. Carotid doppler last year did not show any significant cause.

Other past medical history includes hypertension. There is apparently a history of chronic renal insufficiency with slightly elevated creatinine.

Medications at home were Norvasc 10 mg daily, Avapro 150 mg daily, Monocor 2.5 mg daily and Coumadin 3 mg a day as well as AndroGel. Medications in hospital currently, with regards to his stroke, include enteric-coated ASA daily.

On examination today he is alert and awake. At times he follows commands. At times he speaks reasonably clearly but his speech does not make sense and at other times a full sentence will come out. There is no consistency. There are no carotid bruits. His heart sounds are normal. Cranial nerves reveal sharp optic discs, equal and reactive pupils and normal extraocular movements. It is difficult to assess his visual field. He does not always blink to threat on either side. Presumably, based on his previous CT right occipital stroke, he should have a left hemi-field deficit. Motor examination reveals normal right upper extremity strength and right lower extremity strength of at least 4-/5 although sometimes it is hard to get him to move the leg voluntarily. I though his left upper extremity strength was 2/5. However, unobserved he voluntarily lifted the arm against gravity and bending it, giving it 3/5. Some of this

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perceived weakness may be neglect. There is also increased tone in the left arm. The left lower extremity withdraws to pain at 3/5. Sensory examination is very difficult to test. He appears to feel tickle in all four extremities. Detailed cerebellar testing could not be done. Right brachioradialis, biceps and triceps are 1+. Left brachioradialis, biceps and triceps are 2+. Right knee jerk is 1+, left knee jerk 2+, ankle jerk is absent, right Babinski equivocal and left extensor.

I reviewed his CT scans. Firstly, his right vertebral artery shows heavy calcification both in 2009 and June 2010. It is quite possible that his earlier stroke was either thrombotic at that level or perhaps an embolus into the level of calcification which likely indicates stenosis. An old right occipital infarct is seen. This was not seen on his April 20, 2009 scan but was probably not evident yet. In addition he now has some new left MCA territory hypodensities. He has a number of areas in the circle of Willis and the proximal MCA which look a bit unusual with more hyperdensities perhaps related to calcification.

His MRI from 2009 and from June 2010 were also reviewed. The 2009 MRI angiogram demonstrates a right posterior cerebral artery that is small and poorly visualized. There were also atherosclerotic changes in the skull base and a cavernous sinus cyst particularly on the left.

IMPRESSION:
This man has clearly had a recent acute left ischemic CVA. However, despite the location of this it is far enough back that it seems to have not affected his motor function significantly on the right but rather more language skills.

To summarize:
(1) Since he does have atrial fibrillation Warfarin is indicated long-term again in place of aspirin. However, before instituting this a CT scan of his head should be done to make sure there is no small amount of acute blood around and if none, anticoagulation should be started.
(2) I think a significant extent of his drowsiness and poor functioning is related to use of Haldol which may have been used because he was agitated. However, given the previous stroke and the current stroke particularly affecting his visual and language areas, the Haldol is likely to have a much greater effect on him than someone with a normal brain without damage. Therefore, I would minimize its use as much as possible and any sedative medication for that matter.
(3) Although the presumed mechanism is likely atrial fibrillation he should have a repeat carotid doppler to ensure no carotid stenosis has developed and he should have a repeat echocardiogram to see that there is no intracardiac clot.
(4) Finally, his wife noted that he had a brief spell the other day where he seemed to almost shudder and blink and briefly lose concentration. He is here for an EEG today to rule out seizure and I think this is appropriate.

In summary, this gentleman has had a left CVA affecting mainly his language skills. His right side is not affected. His language skills were likely improved somewhat but there is fairly extensive infarct there and there may be less than full recovery. I told Mrs. Hippe that all strokes do have some recovery but it is difficult to predict whether they are going to have, for example 10% recovery or 60% recovery. Given the degree of aphasia that he has now I expect that he will have modest to moderate recovery of his speech. However, aphasia recovery does occur for quite a while, anywhere from one to three years, if the brain can rewire itself. Therefore, he should receive intensive physiotherapy and speech therapy. I would also suggest that he has a PEG tube and I have explained to her that the benefit of this is close TPN. She asked about hyperbaric oxygen and treatment for stroke and I told her that we do not have access to this and there is no indication for it in this case.

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