Case Scenario 1: Neuroradiology

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CC: Headache

HPI: A 35-year-old black male was in his usual state of health until 30 minutes ago when he experienced the sudden onset of a severe headache. He is brought to the emergency department by his wife. Although clearly in significant discomfort, he is able to give you a limited history. He states that he was at home cooking dinner when the headache began very suddenly, out of nowhere. It is very severe ("12 out of 10"), all over, sharp, and unrelenting. Nothing seems to make it better or worse. During the interview, the patient becomes too uncomfortable to continue answering questions and is becoming obviously more lethargic.

MEDS: Unavailable. "BP pill" per his wife.

ALLERGIES: Unknown

PMH: His wife states that he has had "trouble with his kidneys" for many years, and that it "runs in the family."

FH: High blood pressure, kidney problems.

SH: Married with one child. Works as a hotel manager. Does not smoke or drink. No illicit drug use.

<u>VITALS</u>
BP 220/120
HR 80
RR 16
SaO2 99%
Temp 99.0

<u>EXAM</u>

General:	Awake but increasingly lethargic. Lying uncomfortably in bed, eyes clenched, tense. Oriented to time, place, and person.
HEENT:	EOMI, PERRL. Unable to cooperate for fundoscopic exam. Moist pink mucosa.
Neck:	3+ carotid pulses equal bilaterally. No bruits. No JVD. No thyromegaly.
Chest:	PMI displaced toward the left. RRR. Lungs clear.
Abdomen:	Benign
Extremities:	Moves all extremities well. No edema.
Neuro:	Reflexes 2+ and symmetric. No focal sensorimotor deficits. Speech is somewhat incoherent.