Case Scenario #5: Neuroradiology

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CC: Confusion

HPI: Patient is an 85 year old female who is brought in by her daughter for increased confusion and difficulty speaking after sustaining a fall 1 week earlier. The patient has been reportedly been living independently, and doing well taking care of herself. Approximately one week earlier, she reportedly fell from standing in her kitchen, and sustained minor bruising to her arm and buttocks. She tried to encourage her mother to go to the doctor, but she refused and said that she was fine. Since that time, she has noticed her mother having increasing confusion, with increased difficulty with word finding and some slight slurring of her speech, and brought her in today for evaluation. Her daughter has also reported some increasing gait instability and worsening of her baseline mild urinary incontinence. She seems to be weaker on her right side, however the patient's daughter thinks that is the side she fell on. Upon direct questioning of the patient, she seems confused. She is complaining of a mild headache.

PMH: HTN

MEDS: Atenolol 25 mg QD, ASA 81 mg QD

ALLERGIES: None.

SH: Per daughter, very rare occasional wine, no tobacco or illicit drug use; Widowed, lives home alone, but daughter lives nearby and visits daily, Retired school teacher, loves to cook and garden

FH: Mother died of stroke at age 72, Father died of heart attack at age 91. Has 3 children, all in relatively good health, except high blood pressure.

ROS: Difficult to obtain from the patient

PHYSICAL EXAMINATION:

VITAL SIGNS:
Blood Pressure: 130/80
Pulse: 86
Respirations: 20

GENERAL: The patient seems lethargic, and is intermittently lucid enough to answer questions, intermittently oriented to time and place. She is slurring her words slightly.
HEENT: Normocephalic, atraumatic. No bruising or scalp contusions seen.
CARDIOVASCULAR: Regular rate and rhythm, without murmurs, rubs or gallops.
LUNGS: Clear to auscultation bilaterally
ABDOMEN: soft, nontender, nondistended, NABS, without hepatosplenomegaly.

BACK: No costovertebral angle tenderness. No tenderness with palpation of spinous processes.
JOINTS: no erythema, redness, or swelling. Full range of motion is present in all joints.
EXTREMITIES AND SKIN: Bruising and ecchymoses over the right arm, without underlying deformity or significant point tenderness to suggest fracture. Slight ecchymosis of the right buttocks region, again, without underlying deformity appreciated.

NEUROLOGIC:

MENTAL STATUS: Fluctuating orientation, with speech slurring as described above.

CRANIAL NERVES: Examination difficult, but appear grossly intact bilaterally.
Fundoscopic exam is difficult due to cataracts, but pupils and extraocular muscles appear intact.

MOTOR: Strength: seems decreased, 4/5 within the right upper and lower extremities

SENSATION: Difficult to assess due to patient's mental status.

MUSCLE STRETCH REFLEXES:
Reflexes are brisk and symmetric in the upper and lower extremities.

GAIT AND STATION:Gait instability, unable to walks on heels, toes or perform tandem gait.