Internal Medicine Presentation

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History of Present Illness

69 y/o M w/ PMHx HTN, HLD, A.fib on Xarelto, w/ severe aortic stenosis s/p TAVR (02/22/24) presents to the ED with right lower extremity pain and swelling x2-3 days. Patient states that symptoms began 3 days s/p TAVR. Pain and swelling began in the RT foot and ascended over the course of 3 days. Patient was not able to describe pain during admission but reports that pain “lasts the entire day” and makes it difficult for him to walk. Denies any alleviating factors but endorses worsening pain with ambulation. States that pain radiates from foot to anterior medial surface of lower leg (shin). Rates pain a 7-8/10. Doppler US performed in ED came back negative for DVT. Denies fever, chills, chest pain, palpitations, SOB, or syncopal episodes.

Pt has been transferred to ETAP. Interview difficult during this time as patient is agitated and stating he wants to go home. Patient removed IV, packed his belongings, and dressed himself. 2 mg Ativan has been administered and patient is placed on 1:1 as it has been determined he is AOx1. Interview resumed at later time in which patient is determined to be AOx2. He states he feels dizzy, describing the dizziness as “the room feels like it is spinning”. States that dizziness began shortly before being transferred to ETAP the night before. As per patient, dizziness comes and goes with multiple episodes lasting “a few seconds” at a time. Patient unable to quantify how many episodes he has had since onset of dizziness. CT performed during admission revealed infarct involving the RT temporal lobe either old or subacute w/ no signs of hemorrhage or mass effect. Denies any aggravating or alleviating factors. Pt has no prior hx vertigo or similar episodes of dizziness.

Review of Systems

General: Denies ever, chills, night sweats, fatigue, weakness, loss of appetite, recent weight gain or loss

Skin, hair, nails: Reports bruising on the inside of the upper LT thigh . Denies changes in texture, excessive dryness or sweating.

Head: Reports dizziness. Denies headache, vertigo, head trauma, unconsciousness, coma, fracture

Eyes: Denies use of contacts or glasses. Denies visual disturbances, fatigue, lacrimation, photophobia, pruritus, last eye exam unknown

Ears: Denies deafness, pain, discharge, tinnitus, hearing aids

Nose/Sinuses: Denies discharge, epistaxis, obstruction

Mouth and throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures, last dental exam

Neck: Denies localized swelling/lumps, stiffness/decreased range of motion

Pulmonary system: Denies dyspnea, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND

Cardiovascular system: HTN. Denies Chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, known heart murmur

Review of Systems

Gastrointestinal system: Denies any changes in appetite, intolerance to foods , nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool

Genitourinary: Denies any urinary frequency, incontinence, dysuria, nocturia, urgency, oliguria, polyuria

Males: Last prostate exam/PSA: unknown. Denies hesitancy, dribbling

Musculoskeletal System: Reports RLE pain and swelling. Denies deformity, erythema, or arthritis.

Peripheral Vascular System: Denies intermittent claudication, coldness of trophic changes, varicose veins, peripheral edema, color change

Hematologic System: Denies anemia, easy bruising or bleeding, lymph node enlargement, history of DVT/PE

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

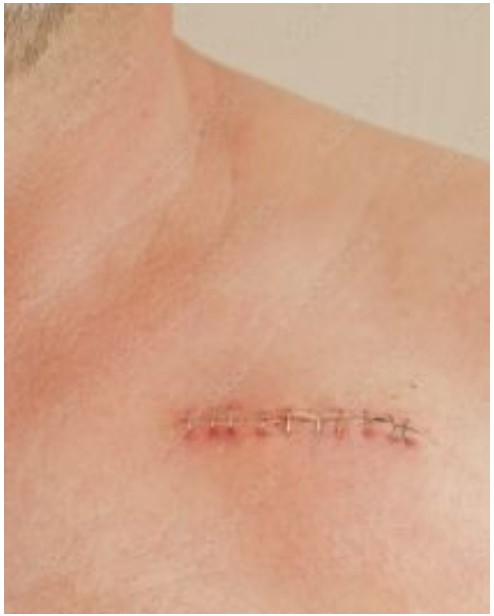
Nervous System: Denies seizures, loss consciousness, sensory disturbances (numbness, paresthesia, dysesthesias, hyperesthesia), ataxia, loss of strength, change in cognition/mental status/memory, weakness

Psychiatric: Reports depression/sadness. Specifically states “I am angry because my life is hopeless and meaningless”. Patient reports loss in interest of activities he previously enjoyed

Pertinent Physical Exam Findings

Skin and Nails

9x7 cm area of gross ecchymosis noted in the upper inner thigh with surrounding yellow hue.



Peripheral Neurologic

Point localization and extinction inconsistent. Intact to light touch, sharp/dull.

Mental Status

In ED patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to name, date, time, and location. Speech and language ability intact, with normal quantity, fluency, and articulation. Conversation progresses logically. Insight, judgement, cognition, memory, and attention intact.

In ETAP patient is appears agitated & frantic, alert & orientated to place and person only. Speech and language ability intact. Conversation does not progress logically, and patient requires reorientation on multiple occasions to answer questions

Peripheral Vascular

RLE is more swollen that LLE. Skin is warm to touch in RLE Mild erythema noted around the ankle. Dorsalis pedis 2+ in b/l lower extremity.

Laboratory and Imaging Studies

Na (Sodium) *(02/29)*	135
K (Potassium) *(02/29)*	3.8
Cl (Chloride) *(02/29)*	99
Co2 *(02/29)*	21
BUN *(02/29)*	18.1
Creatinine *(02/29)*	1.17
Glucose *(02/29)*	116
Anion Gap *(02/29)*	15
Ca (Calcium) *(02/29)*	9.0
APTT Clotting Time *(02/29)*	> 200.0
BNP	2,445
WBC *(02/29)*	7.98
RBC *(02/29)*	12.6
CRIT *(02/29)*	38.2
PLT *(02/29)*	202

US Venous Doppler Lower Extremity – Bilateral

IMPRESSION:

No evidence of deep venous thrombosis within the visualized portions

CT Head without IV Contrast

IMPRESSION:

Infarct involving the RT temporal lobe either old or subacute. No hemorrhage or mass effect. Old bilateral cerebellar infarcts present previously

CXR 1-View AP Portable

IMPRESSION:

Overlying external defibrillator device limits evaluation. No acute infiltrates or effusions. No pneumothorax.

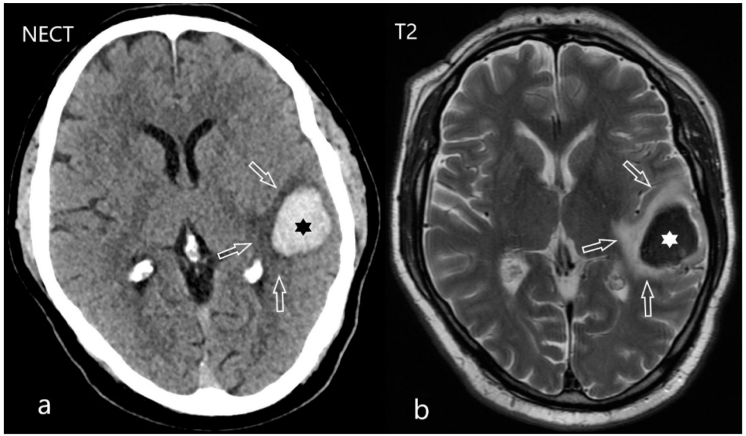
Assessment with Differential

Assessment:

69 y/o M w/ PMHx HTN, HLD, A.fib on Xarelto, w/ severe aortic stenosis s/p TAVR (02/22/24) presents to the ED with right lower extremity pain and swelling x2-3 days. On day of admission, LE doppler US was performed on affected leg which came back unremarkable. On the following day, the patient was transferred to ETAP where he became agitated and AOx1, insisting that he needed to go home. Patient was given 2mg Ativan and was later re-evaluated as he was determined to be AOx2. Patient was able to converse but required reorientation on various occasions. Non-contrast CT was unremarkable. Patient is being admitted to determine etiology of RT lower extremity pain and swelling and awaiting MRI to r/o acute CVA.

Differentials:

1. Cerebrovascular Accident
2. Transient Ischemic Attack
3. Undiagnosed Mood Disorder
4. Viral Infection
5. Complex Focal Seizure



Post-TAVR Cerebrovascular Accidents

Post-TAVR stroke is a significant complication associated w/ increased morbidity & mortality.

Purpose of the study was to determine the incidence of post-TAVR stroke within 30 days of the procedure

101, 430 participants were selected from the Society of Thoracic Surgeons/American College of Cardiology Transcatheter Valve Therapy (STS/ACC TVT) Registry which includes 524 US hospitals. Selection took place from November 9, 2011 – May 31, 2017.

Older women were shown to have increased propensity for developing post-TAVR stroke. These patients were also more likely to develop in-hospital A.fib s/p procedure compared to participants who did not develop stroke after the procedure.

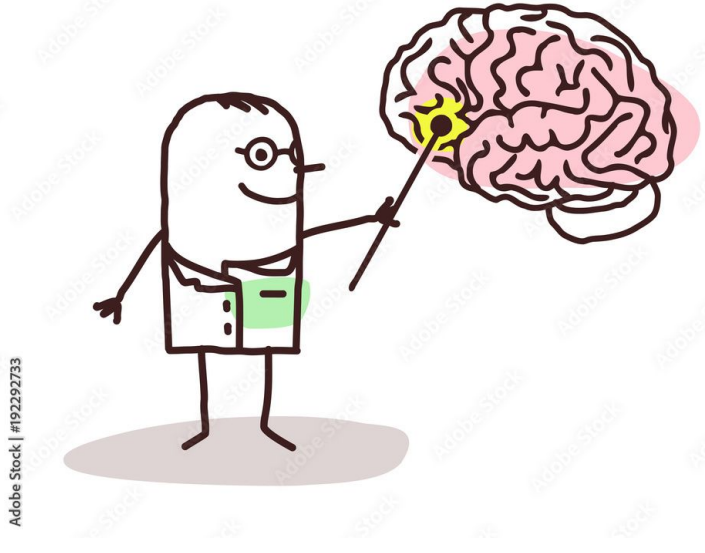
Majority of post-TAVR strokes occurred w/in the first 3 days following procedure. Strokes that occur during the procedure "are potentially modifiable by the use of cerebral embolic protection devices". It was found, however, that this device does not decrease the incidence of developing stroke once the procedure is completed. There is minimal statistical significance between device and control groups.

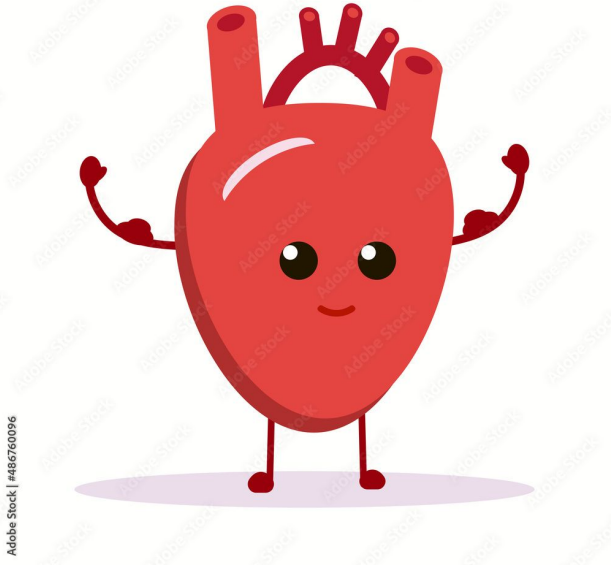
Single antiplatelet therapy after TAVR is as effective as dual antiplatelet therapy to prevent ischemic events and decrease risk of bleeding.

In conclusion, the incidence of 30-day stroke s/p TAVR is considered "stable". 2,290 patients (2.3% of participants) developed a stroke of any kind by day 30.

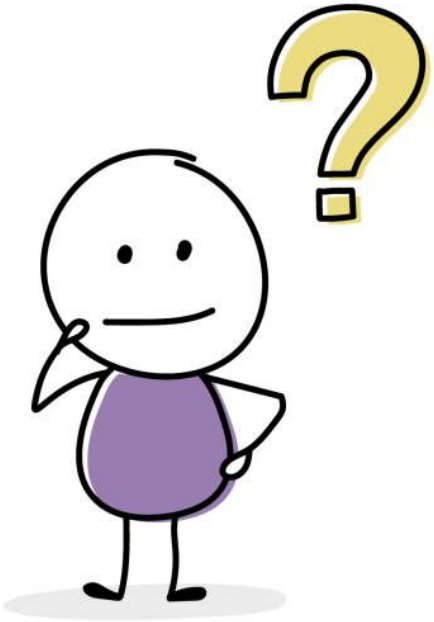
Consults

1. Cardiology and Surgery for management of patient s/p TAVR; unknown compliance w/ DOAC
2. Neuro for change in mental status, pending MRI





Questions?

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