Discharge Summary

Created: 2021/06/24 15:12

Status: Pending Completion

Discharge Facility: NHI

[redacted] F 41Y
COOLEN, SUSAN LEIGHANNE HI 7.4
[redacted] NS EXP:
[redacted] NOVA SCOTIA
[redacted] DH [redacted]
AP: GUBITZ, GORDON J NLG STROKE SERVICE
FP: NO, FAMILY DOCTOR

Admit Date	2021/06/20 08:44	**Discharge Date**	Pending
Attending Physician	GUBITZ, GORDON J		
Hospital Service	NLG STROKE SERVICE	**Location**	HI 7.4
Office/Clinic Phone	902-473-5423	**Fax**	902-473-4438
Discharge Destination:	Home		

Admission Diagnosis: Right MCA ischemic stroke

Diagnosis Responsible for the Greater Part of Patient's Length of Stay: Right MCA ischemic stroke
Extensive arterial thrombus

Discharge Diagnoses: Right MCA ischemic stroke
Extensive arterial thrombus

Allergies: Penicillin

Past Medical/Surgical History, Co-Morbid Illness and Risk Factors: Factor V Leiden Mutation | PE 2007

Brief Summary of Course in Hospital: 41F presented early June 20th as an acute stroke protocol with right arm pain and numbness. Her husband also noted slurred speech and left sided facial droop. This progressed to include a mild headache and left sided weakness. They presented to the emergency department and CT/CTA demonstrated multiple lesions involving the right hemisphere with multiple thrombi in the right arm. Vascular surgery wasconsulted and did not feel that any surgical intervention was required. The patient presented out of the window for acute intervention and did not receive tPA or EVT.

Hematology was consulted and the patient was started on a heparin drip. It was felt that her Factor V Leiden mutation was not the cause of these arterial clots, as this is associated with increased venous clotting. As such, a hypercoaguable workup was ordered including testing for anti-phospholipid antibody syndrome and a CT CAP to check for occult malignancy. The CT did not demonstrate any obvious malignancy and most of the laboratory results were pending at the time of this report. The patient also had an echo but the views were suboptimal and TEE was suggested. A holter was also ordered and it was felt this, along with the TEE could be completed as an outpatient given the patient's clinical stability and resolution of her neurologic symptoms. Hematology was contacted for advise with respect to ongoing anticoagulation and the patient was started on daily fragmin.

In terms of her vascular risk factors her HbA1C was 5.5, her blood pressure was below target and her LDL was 5.59, so she was started on high intensity statin therapy. She does have a history of migraine.

Followup will be arranged with hematology and the neurovascular clinic.

Completed Tests and Investigations:
Initial CT/CTA
Small right posterior MCA territory embolic stroke and possibly also a small ischemic lesion in the left cerebellar hemisphere. This is in the setting of mural thrombus in the
aortic arch and great vessel origins. There is some free-floating thrombus in the brachiocephalic artery. There is no intracranial large vessel occlusion at this time.

CTA:
1. Nonocclusive thrombus within the aortic arch and extending into the origins of the brachiocephalic (mild stenosis), left common carotid (mild stenosis), and left subclavian arteries (moderate to severe) most in keeping with in situ thrombosis. Note that a dedicated CTA of the carotids and vertebral arteries is reported separately.
2. Occlusion of the proximal right ulnar artery with reconstitution more distally. Occlusion of the proximal right radial artery with no distal reconstitution. Note that the patient's right arm and hand was assessed at the time of the study by the interventional radiology staff, Dr. Rivers-Bowerman. The right hand was mildly dusky with preservation of motor and sensation and capillary refill less than 2 seconds. Vascular surgery was subsequently consulted

ECHO:
Normal echocardiographic study. No cardiac source of embolus identified on TTE.
Given the patient's age a TEE and/or bubble study may be warranted.

CT CAP
IMPRESSION:
1. No evidence of malignancy.
2. Stable appearance of the nonocclusive thrombus within the aortic arch. Small, eccentric focus of low attenuating material is seen just proximal to the aortic bifurcation. This may represent a small focus of soft plaque although adherent thrombus is also possible.
3. Focal area of hypoattenuation within the anteroinferior aspect of the spleen in keeping
with a splenic infarct.
4. Area of ground glass opacity in the left lung is likely inflammatory.

Operations and Procedures:
Not Applicable

Complications: Not Applicable

Outcome of Care and Condition Upon Discharge or Transfer: Stable with no neurologic deficits

Follow-up Plan, Recommendations and Pending Results at Discharge:

Follow-up Action	Date for Action	Action Status	Person Responsible for Action
Neurovascular Clinic		Arranged	
Hematology		To Be Arranged By	Heme

Recommendations: No Recomendations

Pending Results at Discharge:

Hypercoagulable labs

Patient Goals / Preferences of care: Full Code

Education and Instructions Given to Patient, Family or Authorized Representative: No special education or instructions are required

Medication on Discharge (DMR): Attached

Report to be faxed to

Attending Physician	GUBITZ, GORDON J	PMB	11528
Family Physician	NO, FAMILY DOCTOR	PMB	97008

Adhoc Faxes

Name	Fax Number	PMB	Office Cd	Office Desc
SUE ROBINSON	902-473-4447	7397	PRI	
