**Identifying Data:**

Full Name: C.S.

Sex: Female

DOB: XX/XX/1986

Race/Nationality: Hispanic

Primary Language: Spanish

Address: Queens, NY

Date & Time: 11:00PM 11/19/22

Location: NYPQ

Source of Information: Medical records

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** BIBEMS after being found at the bottom of 20 steps

**HPI:**

36 y/o male BIBEMS after an unknown bystander reported witnessing him fall down approximately 20 steps in an apartment building. Patient is acutely intoxicated and denies remembering what happened or if he had a LOC. GSC score of 11 per EMS. Collateral information unavailable at this time. Vomit is noted on patient’s clothing. Admits to headache and head pain. Patient denies vomiting, chest pain, SOB, palpitations, back pain, extremity pain, weakness, tingling, decreased sensations, blood from ears, dizziness, or visual disturbances.

**Past Medical History:**

* Pt denies PMHx, no collateral information able to be obtained

*Immunizations*

* Unknoen immunization status

**Past Surgical History:**

* Surgical abdominal scar noted in LUQ, pt admits to having abdominal surgery but is unsure what for

**Current Hospital Medications:**

* Acetaminophen 10MG/ML 1000mg IV injection
* lactated ringer's bolus 1,000 mL IV
* Levetiracetam 500 MG/5ML 1000mg IV infusion
* Ondansetron 8mg IV injection

**Family History:**

* Unknown

**Social History:**

* General – Pt found at bottom of apartment steps in Jackson Heights. Unknown if this is his place of residence.
* Habits – Acutely intoxicated. Pt denies tobacco or illicit drug use
* Travel – Denies recent travel
* Occupation – Occupation and current employment status unknown
* Marital History – single
* Diet – no dietary restrictions
* Sleep – unknown sleep habits
* Sexual History – Unknown sexual history

**Review of Systems:**

* General
	+ Denies generalized weakness/fatigue, weight loss, loss of appetite**,** fever/chills/night sweats
* Skin, hair, nails
	+ Denies rash, pruritis, excessive sweating, changes in pigmentations, moles, change in hair distribution.
* Head
	+ **Admits to head pain, headache, and new head trauma**
	+ Denies vertigo
* Eyes
	+ **Denies visual disturbances or photophobia.**
* Ears
	+ Denies pain, discharge, tinnitus, hearing loss, hearing aids, or feeling of fullness
* Nose/Sinuses
	+ **Denies epistaxis**, congestion, or discharge
* Mouth and Throat
	+ Denies bleeding gums, sore tongue/throat, mouth ulcers, voice changes, or dentures. Last dental exam unknown
* Neck
	+ Denies swelling/lumps, stiffness, or decreased ROM
* Pulmonary System
	+ **Denies SOB**, cough, wheezing, dyspnea, hemoptysis, cyanosis, orthopnea, or PND
* Cardiovascular System
	+ **Denies chest pain, known murmur, palpitations, irregular heartbeat, or syncope**
* Gastrointestinal System
	+ **Admits to vomiting without nausea**
	+ Denies decreased appetite, intolerance to specific foods, Constipation, mild abdominal pain,diarrhea, dysphagia, pyrosis, flatulence, jaundice, changes in bowel habits, hemorrhoids, rectal bleeding/blood in stool.
* Genitourinary System
	+ **Denies incontinence,** changes in frequency, nocturia, oliguria, polyuria, abnormal color of urine, flank plain, or dysuria
	+ Sexual History – refer to Social Hx
* Nervous System
	+ **Denies generalized weakness, loss of strength, changes in cognition/mental status, changes in memory, seizures, loss of consciousness, & ataxia**
* Musculoskeletal System
	+ Denies deformity, swelling, redness, pain of extremities and joints
* Peripheral Vascular System
	+ Denies intermittent claudication, coldness/trophic changes, varicose, or color change
* Hematologic System
	+ No Hx of DVT/PE, anemia, or lymph node enlargement
* Endocrine System
	+ Denies polyuria/polydipsia/polyphagia, heat/cold intolerance, excessive sweating, or hirsutism
* Psychiatric
	+ Denies Hx of anxiety, depression, obsessive/compulsive disorder, or other psychiatric illnesses

**PHYSICAL EXAM**

Vital Signs:

BP: 135/99mmHg – lying supine, L arm RR: 20 breaths/min Pulse: 107 bpm

T: 36.4C(oral) O2 SAT: 98%

Height: 5’11 Weight: 144 lbs BMI: 20.03 kg/m2

General Appearance: **Alert and oriented x1. Appears acutely intoxicated with mild agitation. Follows simple commands**

Head: **normocephalic. Traumatic. No step-off or crepitations noted.**

Eyes:  **PERRLA**. No strabismus/exophthalmos. Sclera white, cornea clear, conjunctiva pink. No erythema of lacrimal sack. EOM intact with no nystagmus. Not wearing glasses. **No periorbital ecchymosis.**

Ear: Appropriate in size. No lesions/masses/trauma visualized on external ear. **No hemotympanum or CSF noted.**

Nose: Symmetrical, no external masses/lesions/deformities/trauma/discharge.

Mouth & Throat:

Lips Pink and moist, no foreign bodies visualized. No cyanosis, lesions, or ulcerations. No dental caries. **Uvula midline.**

Neck: Trachea midline, no goiter. No lesions/pulsations noted. No stridor noted. No cervical adenopathy. No carotid pulses/thrills/bruits heard on auscultation.

Cardiovascular: PMI located at the 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits. RRR. No murmurs. Normal S1 & S2. No splitting of S2 or friction rubs appreciated.

Pulmonary: Chest symmetrical with no deformities or trauma. Lat/AP diameter 2:1. Normal chest expansion and diaphragmatic excursion. Lungs clear throughout. No adventitious sounds.

Abdomen: Abdomen soft and non-distended. LUQ horizontal surgical scar noted approximately 3cm. No striae or pulsations present. Bowel sounds are normoactive in all four quadrants. No aortic/renal/iliac/femoral bruits heard.

Skin: Warm and moist. Non-icteric. No tattoos noted. No visible moles. **Frontal scalp laceration noted, approximately 4cm in length and 3cm deep without visible foreign body, oozing blood. Left knee noted to have scrape with contusion.**

Hair: Average distribution with appropriate quality and quantity. No seborrhea/lice/dandruff noted

Nails: Capillary refill <2 seconds in bilateral upper and left lower extremities. Appropriate color, shape, and thickness.

Musculoskeletal: Normal muscle bulk and tone without atrophy, tics, or fasciculations. Sensations appear to be intact. Unable to accurately assess strength secondary to poor effort. No visible deformities.

Peripheral Vascular: Warm to touch bilaterally. 2+ pulses throughout. No edema or ulcerations. Calves equal in circumference. No palpable cords bilaterally. No palpable epitrochlear adenopathy.

Neurological: Alert and oriented x1 to self. Patient able to follow simple commands. Unable to assess pronator drift, coordination, or gait secondary to poor effort.

Glasgow Coma Score

Eye opening: 4 - Opens eyes on own

Verbal: 4 - Seems confused, disoriented

Motor: 6 - Follows simple motor commands

GCS Total: 14

**Labs:**

*Completed 11/13/22*

1.6

130\*\*130

105

98

0.80

22

4

14.6

8.96

230

42.1

|  |  |
| --- | --- |
|  |  |

**Imaging:**

CT Head without Contrast

*Findings:*

Vasculature: Unremarkable

Brain & Intracranial structures: Hemorrhagic contusion in the inferior

right frontal lobe measuring up to 1.5 cm and in the anterior right

temporal pole measuring up to 1.4 cm. Acute subdural hematoma

overlying the right cerebral convexity measuring up to 9 mm on the

coronal reformatted images. Acute extra-axial

hemorrhage anterior and inferior to the right temporal lobe measuring

up to 7 mm in the axial images; this may reflect subdural or epidural

hematoma. Extra-axial hemorrhage along the posterior left occipital

lobe measuring up to 7 mm thickness adjacent to the calvarial fracture

with convex margins suspicious for epidural hematoma. Right cerebral

subarachnoid hemorrhage most pronounced in the right frontotemporal

lobes. Scattered left cerebral subarachnoid hemorrhage most pronounced

in the inferior frontal lobe. Probable thin subdural hematoma along

the right side of the falx anteriorly measuring up to 3 mm.

Subarachnoid hemorrhage is noted in the basilar cisterns, surrounding

the pons, and extending into the foramen magnum to the upper cervical

canal. Subarachnoid hemorrhage also noted in the left greater than

right cerebellum. Right subdural hematoma results in mass effect,

sulcal effacement, and 2 to 3 mm leftward midline shift.

Extracranial structures & Soft tissue: Left parieto-occipital scalp

hematoma with overlying skin staples.

Osseous structures: Nondisplaced left occipital calvarial fracture

extending to the skull base. Mild scattered paranasal sinus mucosal

thickening. Mastoid air cells are clear.

 Impression:

* Multi compartmental acute intracranial hemorrhage including hemorrhagic contusions in the right frontal and temporal lobes, supratentorial and infratentorial subarachnoid hemorrhage, right cerebral convexity subdural hematoma measuring up to 9 mm, and 7 mm
* posterior left occipital lobe extra-axial hemorrhage suspicious for epidural hematoma.
* Associated mass effect and 2 to 3 mm leftward midline shift.
* Nondisplaced left occipital calvarial fracture with overlying scalp hematoma.

**Differential Diagnosis:**

1. Traumatic Brain Injury
	1. Subdural hemorrhagic
	2. Epidural Hemorrhage
	3. Seizure
	4. Concussion
	5. Spinal cord injury
2. Intoxication
	1. Alcohol intoxication
	2. Opioid intoxication
	3. Electrolyte disturbance
	4. Meningitis
	5. Brain lesion

**Assessment:**

C.S. is a 36 y/o M, unknown PMHx with acute alcohol intoxication and unknown LOC with witnessed fall down 20 steps. Patient is A&Ox1 with GCS of 14, vomitus noted on shirt, admitting to headache/pain. Primary survey intact, e-FAST exam negative, secondary survey only w/ 4cm occipital scalp laceration/hematoma, small left knee abrasion, C-collar in place.

**Plan:**

* Intracranial Hemorrhage
	+ Neurosurgery consulted – External ventricular drain placed at bedside. No other neurosurgical intervention recommended at this time.
	+ Begin Keppra for seizure prophylaxis
		- STAT 1mg dose, then 500mg BID x7 days
	+ Head of bed at 30 degrees
	+ Maintain normal systolic blood pressure
	+ Avoid hyponatremia
	+ Follow up with radiology on official CT head report
	+ Repeat CT head in four hours to monitor ICH
	+ Monitor C-collar to make sure it remains in place
	+ Labs: CBC, BMP, T&S, Urine toxicology, Blood alcohol level, POC glucose
	+ Admit to SICU
	+ Begin LR fluid bolus
* Vomitus
	+ Begin IV Zofran to prevent further vomiting as it may increase ICP
* Pain
	+ Begin IV acetaminophen for pain relief as needed
* Scalp laceration
	+ Repair laceration with thorough irrigation/cleansing and staple placement