CASE #1

44 year old woman returns for follow up having been last seen one year ago. History of grand mal seizures following a MVA 4 years ago. Reports having two nocturnal seizures (witnessed by her husband) since her last visit. She may have missed medication doses prior.

The patient continues to take levetiracetam and has noted no side effects.

She has no medical problems.

Neurological examination shows a normal mental status, normal cranial nerves and a mild left hemiparesis and is unchanged from a year ago.

Impression: Post traumatic epilepsy – doing well on present medication

Plan: 1) Continue present medication
2) Discuss medication adherence issues: done
3) Discuss driving and safety issues: done

CASE #2

Current visit: 23 year old man returns for follow up having been last seen six months ago. He reports no change in his seizure control with approximately 1 to 2 seizures per month. They continue to consist of episodes of lip smacking with clouded consciousness lasting less than a minute.

The patient continues lamotrigine and valproate without problems.

The patient has no medical problems.

Neurological examination is unremarkable.

Impression: Partial seizures – doing well

Plan: 1) Continue lamotrigine and valproate
2) Return in 6 months or prn change in seizure frequency

Prior visit: 23 year old man returns for follow up having been seen 8 months ago. He continues to have fewer than 1seizure per week consisting of episodes lasting up to a minute of lip smacking and scratching hand movements for which he does not have a clear memory. Continues medications without problems.

Meds: Lamotrigine and Valproate

The patient has no other medical problems.

Neurological examination is unremarkable.

Impression: Complex partial seizures.

Plan: 1) Continue present meds
2) Return in 6 months.

CASE #3

The patient is a 25 year old woman with a history of febrile seizures as a child who presented six months ago with absence spells brought on by a particular memory from her past. The patient had a full work-up at that time which showed a right temporal spike focus on EEG and a normal brain MRI scan. The patient was started on phenytoin. She reports no further spells on treatment but complains that the medication sedates her and causes "foggy thinking."

The patient has no other medical problems.

The patient's physical examination and neurological examination are entirely normal.

Impression: Partial seizures well controlled on phenytoin

Plan: 1) Discuss medication side effects and alternative treatments - done
2) Lamotrigine 300 mg/day starting with 50 bid and escalating dose
3) Taper phenytoin
4) Return in 3 months

CASE #4

This 35 year old woman, with a seizure history, is referred for advice regarding becoming pregnant. She brings with her medical records documenting a generalized seizure at age 20. Workup at a local hospital revealed a right parietal mengioma that was surgically removed. She was treated with carbamazepine for 5 years with no further seizure activity and then medication was stopped. Three months after stopping the medication she had a grand mal seizure and was put back on carbamazepine which she continues to take. She would like to become pregnant in the next year.

General medical and neurological examinations are unremarkable.

Discussed issues related to the risks of seizures during pregnancy versus the risks of continuing carbamazepine versus the risks of changing medications.

Impression: Seizure disorder secondary to meningioma, well controlled on carbamazepine

Plan: Continue carbamazepine
Begin folate supplements
Return once pregnant or prn.

CASE #5

The patient is a 38 year old woman with a history of seizures since birth who arrives with her sister. She is otherwise in good health. Her current diagnosis is temporal lobe epilepsy. Her aura is a very brief "strange sensation." She is amnesic for the ictal period but family members report that she becomes quiet with a blank stare and then yells “Jesus help me” several times while pulling at her clothing. Occasionally family will report that she developed tonic-clonic activity and rarely she has been incontinent. After the seizure she is fatigued and confused and often has a headaches.

Since she was last seen 3 months ago she has had spells of vocalization and automatisms almost every day but no tonic clonic seizures.

Phenytoin, phenobarbital, valproic acid, and experimental medications have been tried in the past. Her current medications include carbamazepine and topiramate, with lorazepam as needed. She also takes an over-the-counter multivitamin and, occasionally, acetaminophen for headache. Her sister has been instructed on administering lorazepam when she is experiencing several consecutive seizures that occur over a 15-minute period or after her second bilaterally evolved focal seizure for the day. Her sister administers the lorazepam approximately once every 2 weeks but there is no regular pattern to it. One week, she may not require any lorazepam; the next week, she may require it several times.

On examination the patient is pleasant and cooperative. Mental status testing reveals poor calculations and difficulty with abstract thinking. Motor and sensory examinations are unremarkable.

Impression: Focal seizures with secondary generalization. Sub-optimal response to therapy

Plan: 1) Continue carbamazepine, topiramate and lorazepam
2) Discuss referral to epilepsy center – done – patient and sister will consider it but is concerned about the cost
3) Return in 3 months or prn

CASE #6

55 year-old right handed male who sees you for the first time for follow-up from a recent hospitalization. He presented to the hospital with right-sided weakness, was found to have a small left-frontal lobe hemorrhage on MRI scan. His hospital course was complicated by several seizures that was treated with phenytoin. Repeat imaging a week later did not detect any underlying abnormalities. His stroke risk factors consist of smoking and uncontrolled hypertension. He presents now to your clinic with the main question of whether he needs to continue his anti-epileptic medications.

All you have is the hospital discharge summary which indicates only the performance of neuroimaging. When you ask the patient whether he had an EEG performed, he says that he can’t remember because there were so many tests performed in the hospital.

He currently lives at home with his wife. He is currently driving.
His medications include phenytoin, lisinopril, hydrochlorothiazide, and atorvastatin.
On exam, he continues to have elevated blood pressure of 160/90. He has midline gaze, mild dysarthria without aphasia, decreased fine finger motion on the right, and increased reflexes on the right. He is able to ambulate without difficulty.
Assessment: Seizures secondary to hemorrhagic stroke
Plan: Continue anti-seizure medication. Perform EEG 6 months after seizure. Return to clinic for reassessment of the need for AEDs.

CASE #7

18-year old right-handed female presents with a first-time seizure. She is a college student who says that she stayed up all night studying for an exam. Early the next morning, her roommate was awakened by the patient having a seizure. The patient did not experience an aura. Patient amnestic to the event. Patient does not believe that she fell asleep prior to the event.

The patient says that she has occasional jerking movement s in the morning when brushing her teeth. The patient says that seizures do run in her family. The patient wants to know whether she needs to take medications to prevent these events from recurring. Patient does not drink alcohol. She has a history of migraines that are treated with NSAIDs.

A physical examination is unremarkable. There are no focal neurological findings on exam.
Assessment: First-time seizure. Given symptoms and family history, strong suspicion for juvenile myoclonic epilepsy.

Plan: Perform EEG. Patient counseled on the risks and benefits of AED. Patient offered depakoate, but patient declines at this time. Patient counseled to stop driving, and she agrees. Patient warned against bathing or swimming alone. Return to clinic after EEG.

CASE #8

Patient is a 40-year old right handed female who presents for 3-month follow-up for management of epilepsy. Patient is currently taking levetiracetam and topirimiate for the past year. Patient last had a seizure three weeks ago. Patient has a warning before seizures so she can protect herself. No urinary or fecal incontinence. Patient amnestic to event and is lethargic for several hours. Patient is not interested in changing medications at this time.

Seizure history shows a first seizure at age 30. They are partial complex, secondary generalized seizures. The semiology consists of an aura of gastric discomfort, head turning to the right, some autonomisms of hand movements, then loss of consciousness and tonic-clonic movements. Some auras do not progress to secondary generalization; all tonic-clonic seizures are preceded by an aura. The frequency of seizures is about once every month. She has been taking combination therapy of anti-epileptic medications, but they have not been able to achieve a seizure –free period for more than several months or have resulted in fatigue. Exacerbating factors are stress and illness. Patient has undergone an extensive workup, highlighted by a hospitalization for video-EEG telemetry and neuroimaging, but the epilepsy team could not definitively identify a surgical lesion for resection.

Patient is not driving. Patient lives with her husband.
Patient has a history of migraine. Her migraine frequency is has been much reduced with the use of topirimate to about a few times per year.
Patient has no focal neurological findings on examination. No nystagmus or ataxia noted. Patient able to ambulate without difficulty.

Laboratory tests show normal CBC and live function tests.
Last MRI was performed 5 years ago.

Assessment: Refractory partial complex seizures with secondary generalization. Patient does not want to change medications at the current time.
Plan: Follow-up in 6 months.

CASE #9

Chief Complaint: Patient presents with: Headache

HPI

40 y/o Obese AAM w Hx of Migraine HA since age 18, chronic back pain, CHF(last EF 55% on 2014), Bipolar, Anxiety and neuropathic pain presents today for chronic progressive HA management.

Pt reports being diagnosed with Migraine since age 18 and being prescribed with medication (he does not know the name) which did not help at that time.

Pt then continues to have chronic HA for 20 years with worsening of severity in the last couple of months.

He is referred by his out pt NP for Migraine evaluations.

The pain varies 4-10/10 and partially improves by OTC NSAIDS. He uses Fioricet when OTC meds do not work. Pain is constant and pt does not have any periods being HA free. Pain is mostly throbbing, b/l frontal and behind the eyes, + photosensitivity, +N/V. He is also very depressed and has insomnia. HA worsened with stress, not having enough or good sleep and also with light and noise.

He is unemployed and lives with his mother. He is very depressed but denies SI. He also complains of chronic back and neck pain for which uses Gabapentin with some improvement.

Past Medical History

Hypertension, Headache, Bipolar affective disorder

Family History

Diabetes

Social History

Smoking: Yes, 1 ppd.

Alcohol: Denies.

Medications

Current Outpatient Prescriptions

buPROPion (WELLBUTRIN SR) 200 MG tablet

gabapentin (NEURONTIN) 300 MG capsule

ziprasidone (GEODON) 80 MG CAPS

nicotine (NICODERM CQ) 14 MG/24HR patch

zolpidem (AMBIEN) 10 MG tablet

lisinopril (PRINIVIL;ZESTRIL) 10 MG tablet

benzoyl peroxide (DUAC) 5 % GEL gel

ARIPiprazole (ABILIFY) 15 MG tablet

cyclobenzaprine (FLEXERIL) 10 MG tablet

divalproex (DEPAKOTE) 500 MG tablet

Furosemide (LASIX PO)

traMADol (ULTRAM) 50 mg tablet

ibuprofen (MOTRIN) 400 MG PO tablet

TraZODone (DESYREL) 50 MG PO tablet

Fioricet

Allergies

No Known Allergies

Review of Systems

Constitutional: Negative for fever, chills, weight loss and malaise/fatigue.

HENT: Negative for ear pain, hearing loss and tinnitus.

Eyes: Positive for photophobia. Negative for blurred vision, double vision and pain.

Respiratory: Positive for cough. Negative for hemoptysis and sputum production.

Cardiovascular: Positive for chest pain and palpitations.

Gastrointestinal: Negative for heartburn, nausea, vomiting and abdominal pain.

Genitourinary: Negative for dysuria and urgency.

Musculoskeletal: Positive for back pain and neck pain.

Psychiatric/Behavioral: Positive for depression. Negative for suicidal ideas.

Physical Exam

Head: Normocephalic.

Cardiovascular: Normal heart sounds.

Pulmonary/Chest: Effort normal.

Abdominal: Soft.

Neurologic Exam

Mental Status

Oriented to person, place, and time.
Level of consciousness: alert

Cranial Nerves

Cranial nerves II-XII were normal.

Motor Exam
Muscle bulk: normal
Overall muscle tone: normal

Strength
Strength 5/5 throughout.

Sensory Exam
Light touch normal.
Pinprick normal.

Gait, Coordination, and Reflexes

Gait

Gait: normal

Reflexes
Right biceps: 2+, Left biceps: 2+, Right patellar: 2+, Left patellar: 2+

Assessment and Plan

Mr Jacobs 40 y/o Obese AAM w Hx of Migraine HA since age 18, chronic back pain, CHF (last EF 55% on 2014), Bipolar, Anxiety and neuropathic pain presents today for chronic progressive HA management. Pain is constant as mentioned on HPI, which suggests status Migrainosus as most possible diagnosis.

CT head to rule out tumor.

Different treatment options would be inpatient admission and IV therapy, or adding other migraine preventing agents including Topamax which is done in this patient currently.

Pt can also be started on steroids if no improvement is noted on current agent. For now, he can use Fiorcet if OTC meds do not work.

Pt is educated about Ha hygiene and to have Ha diary for better characterization of his HA. Pt has multiple other underlying risks for continuation of HA including, depression, anxiety, smoking and obesity which addressed on this visit.

Will see pt in 2 months.

CASE #10

Chief Complaint: Seizures

History of Present Illness

A 73 yo man with PMH of right sided stroke with residual left sided weakness, COPD, and seizure-like activity who presents for his 3 month follow up for his seizure-like activity. His typical seizures lasts 1 to a few minutes and is associated with generalized body shaking without urinary or bowel incontinence. He had 2 seizure-activities on Christmas. First time he sitting on end the bed. He was shaking and fell. He was aware and said to call 911. No urinary or bowel incontinence. Paramedics said this was not a seizure. Second time he was coming down stair and started to shake and was caught by his daughter. The shaking lasted 10 minutes. When he came out of it he said to call 911. He was responsive. He has been compliant with his medications. He was also recently admitted in mid December after having a COPD exacerbation. Other than shortness of breath when walking which is chronic, he denies any other symptoms.

Past Medical History:

He has a past medical history of COPD; Right CVA (Cerebral Infarction) With left hemiparesis (9/4/2009); HTN (9/4/2009); Hyperlipidemia (9/4/2009); Depression (9/4/2009); Elevated hemoglobin A1c; Elevated PSA, less than 10 ng/ml; H/O asbestosis; Smoker unmotivated to quit; and Seizure.

Past Surgical History:

he has past surgical history that includes anesthesia arthroscopic shoulder disarticulation and carotid endarterectomy.

Allergies:

No known drug allergies

Medications

Outpatient Prescriptions Marked as Taking for the encounter (Office Visit

Medication	Sig	Dispense	Refill
• albuterol-ipratropium (DUO-NEB) 0.5-2.5 (3) mg/3mL nebulizer solution	Take 3 mLs by nebulization every 6 hours as needed for Wheezing.	3 mL	0
• albuterol (PROVENTIL) 2.5 mg/3mL nebulization	Take 3 mLs by nebulization every 4 hours as needed for Wheezing.	100 vial	0
• aspirin 81 mg tablet	81 mg.		
• albuterol (PROVENTIL HFA) 108 (90 BASE) mcg/act inhaler	Take 2 puffs by inhalation every 6 hours as needed.	1 Inhaler	0

Social History:

History

Substance Use Topics

- Smoking status: Former Smoker -- 1.00 packs/day for 35 years

  Types: Cigarettes

- Smokeless tobacco: Not on file

  Comment: cut down to 3 cigs/day

- Alcohol Use: Yes

  Comment: occasional beer

Family History:

family history includes Coronary Artery Disease in his father; Stroke in his father.

Review of Systems: Extensive review of systems (10) was significant only for those items mentioned in History of Present Illness.

Physical Examination

Appearance: The patient is a healthy appearing male

V.S.: BP 129/98 | Pulse 123 | Ht 5' 6" (1.676 m) | Wt 111 lb (50.349 kg) | BMI 17.92 kg/m2

HEENT: Normocephalic atraumatic

Neck: No bruits

Card: Regular rate and rhythm without murmur

Extremities: No clubbing, cyanosis or edema

Neurological Examination

MSE: The patient was alert and oriented to person, place and time. Concentration was decreased. Memory: normal registration and short-term recall decreased. Normal language; Normal fund of knowledge.

CN: Cranial nerves II-XII were normal.

Reflexes: 2+ throughout, brisker BUE

Motor: Bulk and tone were normal bilaterally. Muscle strength was 5/5 bilaterally. No pronator drift.

Sensation: Light touch, vibration and temperature sensation was normal in all 4 extremities.

Coord: There was no dysmetria on finger-to-nose.

Gait: Slow steady gait.

Assessment and Plan

A 73 yo man with PMH of right sided stroke with residual left sided weakness, COPD, and seizure-like activity who presents as a followup for his seizures. These seizure-like activities that he had over Christmas do not seem like typical seizures.

#Seizure disorder

- Will get free dilantin level

- Instructed patient not to drive or do any activities that could put him at risk if he had a seizure

CASE #11

Chief Complaint:

Stroke

History of Present Illness

56 y.o. African American right handed male with hx of hypertension, smoking, cocaine use in the past with a L subcortical ischemic stroke s/p IV tPA, due to small vessel disease. He is still getting home PT for his R hand and arm. He has no new weakness, numbness, or speech problem. He has cut down, but continues to smoke. He is walking better without a cane.

Review of Systems:

Extensive review of systems (10) was performed via the patient questionnaire, it was significant for those items mentioned above, as well as: depression.

Allergies:

Review of patient's allergies indicates no known allergies.

Medications:

Outpatient Prescriptions Marked as Taking for the encounter (Office Visit)

Medication	Sig	Dispense	Refill
• atorvastatin (LIPITOR) 80 MG tablet	Take 80 mg by mouth nightly.		
• hydrALAZINE (APRESOLINE) 25 MG tablet	Take 25 mg by mouth twice a day.		
• FLUoxetine (PROZAC) 20 MG capsule	Take 1 capsule by mouth daily.	30 capsule	0
• acetaminophen (TYLENOL) 500 MG tablet	Take 1 tablet by mouth every 6 hours as needed.	30 tablet	0
• aspirin 81 mg tablet	Take 81 mg by mouth daily.		
• NIFEdipine (ADALAT CC) 60 MG tablet	Take 1 tablet by mouth daily. 1 tab(s), by mouth, every day, 30 day(s)	30 tablet	

Physical Examination

Appearance: The patient is a healthy appearing male in no acute distress.

V.S.: BP 149/95 | Pulse 77

HEENT: Oropharynx clear

Extremities: No clubbing, cyanosis or edema; distal pulses were normal

Neurological Examination

MSE: The patient was alert and oriented to person, place and time. Language was fluent without dysarthria. Following cross commands.

CN: Cranial nerves II-XII were normal.

Motor: Bulk and tone were normal bilaterally. Muscle strength was 5/5 except for 4+/5 distally on R arm, and 5/5

proximally and 4+/5 distally on R leg. Fine finger movements slow on R.

Sensation: Light touch was normal in all 4 extremities. No extinction.

Coord: There was no dysmetria on finger-to-nose or heel-to-shin.

Gait: Slight favoring of R leg. Using a R AFO.

Assessment and Plan

A 56 y.o. man with a past hx of uncontrolled HTN, cocaine and tobacco use with a L subcortical stroke s/p IV tPA, here for follow up. He is doing well with improved strength of his R side. We discussed again the importance of smoking cessation. BP is better controlled.

Plan: 1) Smoking cessation, discussed again the importance of it.

2) Continue PT for R sided weakness

3) Continue aspirin and statin