# Neurological Associates of Hampton Roads

A Division of
Neurology Consultants of Tidewater, PLLC

Gilbert M. Snider, M.D.
Richard L. Wertheimer, M.D.
Neil L. Pagach, M.D.

Neurology
Electromyography

300 Medical Parkway
Suite 212
Chesapeake, Virginia
23320

Phone: 757.547.0508
Fax: 757.547.8963

1212 Lake James Drive
Suite E-1
Virginia Beach, Virginia
23464

Phone: 757.523.0724
Fax: 757.523.0366

20 Apr 2005

RE:
7/6/1958

2529 Watercrest Pl. 2A
Chesapeake, VA 23324

Freeman, E. T., M.D.
1016 Justis St.
Chesapeake, Va. 23325

Dear Tom:

Thank you for referring for evaluation of her headaches and other symptoms. As you know, she is a 46-year-old right-handed white female who was assaulted three years ago, being kicked in the head with two losses of consciousness that day each for about five minutes. She was also choked on that day and fractured ribs and had her jaw dislocated. She was then tied up and was not able to seek medical attention for a month, which she did at that time because of pain and rhinorrhea. She was diagnosed with a CSF leak and referred to neurosurgeon but she was unable to see the neurosurgeon at that time. The leak spontaneously resolved after one or two months. She does not know whether she had any intracranial bleeding at the time. Subsequently she had constant headaches for three or four weeks which then gradually decreased to a frequency of about twice a month, but at least five months ago they increased again and have developed into a continuously present headache. She also had some confusion and problem with getting lost while driving following the injuries. However, starting around this past August, these symptoms have become considerably worse. She also describes additional symptoms, including hair loss that began last summer but has been accelerated since this past January, a 50 lb. weight gain in the last 5 months even though she works out and has not increased her eating, feeling tired all the time, and having very irregular sleep patterns, such that she can sleep quite excessively, or at other times can sleep for only two hours. She finds that she stumbles at times and is dizzy and off-balance at times. She has been losing things.

Her headaches are a throbbing sensation which affects of the left parietal region although the entire left side of the head can be affected. Severity ranges from 4/10-6/10. There can be associated nausea, photophobia, dizziness, and paraesthesias in the left hand and left side of the face, as well as some left upper extremity weakness. There also be associated diplopia. There is no associated loss of consciousness. The pain is aggravated by physical activity.

She also describes having intermittent episodes of difficulty focusing her vision for 5 or 10

(Continued)

minutes and she says that her eyes will "cross" intermittently. Thesde symptoms began about two months ago. When her headaches are severe she can have some dimness of her vision. She admits to an intracranial noise which she likens to a "rush of water" when the headache pain is severe. She denies pulsatile tinnitus.

She has been using Axert fot the headaches and this will diminish the severity. She did use Imitrex and this would eliminate her headaches for a day buat she has not been able to get any recently. She has tried over-the-counter analgesics and Midrin without benefit.

Three or four years ago she was switched from Estrace to Premarin.

She indicates that she had migraine headaches in her thirties and subsequently would have them on occasion but she did not experience headaches frequently until after her head injury.

**PAST MEDICAL HISTORY:** She is status post hysterectomy.

**MEDICATIONS:** Premarin, Axert, papaya enzyme.

**ALLERGIES:** She is allergic to codeine and iodine.

**SOCIAL HISTORY:** She is a nonsmoker and has one drink per day. She is divorced and works as a Web designer.

**FAMILY HISTORY:** Positive for migraines and cardiac disease.

**REVIEW OF SYSTEMS:** There are number of positives on her review of systems, and these are maintained in her chart.

**PHYSICAL EXAMINATION:**

Vital Signs: Pulse: 76 Blood Pressure: 98/62 Weight: 168 lbs.

**GENERAL:** She is a well-developed, well-nourished white female in no acute distress. Tympanic membranes and nares are normal in appearance bilaterally. Head is normocephalic. There are no areas of tenderness to palpation about the head, face or neck. No audible or palpable abnormalities are appreciated with palpation of the TMJs during mouth opening and closure. Neck is supple. Carotid pulses are 2+ bilaterally with no bruits. Heart rate and rhythm are regular with no murmurs. Lungs are clear to auscultation. Bowel sounds are present. No abdominal masses or tenderness are appreciated. There is no clubbing, cyanosis or edema of the upper or lower extremities. Dorsalis pedis pulses are 2+ bilaterally.

**NEUROLOGICAL:**

MENTAL STATUS: She is alert and fully oriented with intact attention and concentration, language, and recent and remote recall.

CRANIAL NERVES:

(Continued)

II: Optic fundi are benign. Venous pulsations are distinctly present. Visual fields are full to confrontation exam.
III, IV, VI: EOMF. PERRL.
V: Facial sensation is symmetrically intact to light touch and pinprick. Masseter, temporalis and lateral pterygoid strength is intact bilaterally.
VII: Facial movements are normal and symmetrical.
VIII: Hearing is intact to finger rub bilaterally.
IX, X: There is no dysarthria. Palate elevates symmetrically. Gag is intact.
XI: Sternocleidomastoid and trapezius strength is symmetrically intact.
XII: Tongue is midline.

MOTOR: There are no adventitious movements. There is no pronator drift. Muscle tone, bulk and strength are normal and symmetrical throughout the upper and lower extremities.

SENSORY: Sensation is symmetrically intact throughout the upper and lower extremities to light touch, pinprick, vibration and proprioception. Graphesthesia is intact in both hands. Finger-nose test with eyes closed is intact bilaterally.

REFLEXES: Deep tendon reflexes are 2+ and symmetrical throughout the upper and lower extremities. Plantar reflexes are flexor bilaterally. There is no jaw jerk.

CEREBELLAR: Finger-nose-finger and heel-knee-shin are intact bilaterally.

STATION AND GAIT: There is no Romberg's sign. Gait, tandem, toe and heel walk are intact.

**LABORATORY DATA/RECORDS:** Report of an MRI of the brain performed without contrast on 2/25/04 indicates an unremarkable study. Report of an EEG performed on 2/25/05 indicates a normal study. MIDAS headache disability score: 130+ (severe disability range).

**IMPRESSION AND RECOMMENDATIONS:** **Multiple neurological and nonneurological symptoms.** The patient certainly does have history suggestive of migraines, and presently probably has a chronic migraine. However, she has a large constellation of symptoms, some of which suggest possible endocrine dysfunction. She does describe transient visual obscurations and a kind of tinnitus, and has gained 50 lbs. in the last five months. However, she is not substantially overweight, and more importantly, she clearly has venous pulsations on eye exam, and therefore pseudotumor cerebri is unlikely, although possibly a lumbar puncture may be considered in the future depending on what her initial workup and clinical course reveals. I am really not sure how to put all this together at this time, and I discussed this with her today. An MRI of the brain with contrast will be arranged, as well as blood tests including a CBC, CMP, ESR, RPR, B12, folate, TSH, free T4, PT and PTT. I have requested that she be referred for endocrinology and ophthalmology consultations. She will be started on Topamax at a dose of 25 mg q.h.s., to be increased in 25 mg increments at weekly intervals as necessary and as tolerated, up to 100 mg q.h.s. for the time being. Potential side effects of this medication are discussed with her. She is prescribed metoclopramide to use for nausea. She is provided with some Axert samples. I will see her back in one month.

Thank you once again for referring [redacted]

(Continued)

Best regards,

Neil

Neil

cc: Chesapeake Care Clinic