Transcription Report
Inpt Consult

Observation Date : March 07, 2022

Status : F

Reported Date : March 07, 2022

Summary Data :

NEU-Final
*** Final Report ***

Neurology Consult
Wedgewood, Spencer Terry
MRN: 334-6104
D.O.B. Aug-19-1998

Mar 07, 2022

PATIENT INFORMATION
Patient Identifier (MRN) 3346104
Patient Name WEDGEWOOD, SPENCER
Gender M
Date of Birth (DOB) Aug 19, 1998
Encounter Date Mar 4, 2022
Admit Physician Vyas, Manav
Attending Physician Muccilli, Alexandra
Primary Care Provider No fam dr,
Staff Physician/Nurse Practitioner Muccilli, Alexandra

March 7 2022

I was asked by Dr. Vyas to see and take over the care of this 23 year-old gentleman with demyelinating disease. I reviewed the history and physical examination in-person and went over the management plan with Spencer and his mother.

PAST MEDICAL HISTORY:
1. Mono as a child, was ill for 1 month.
2. Ankle fracture.

MEDICATIONS:
None

He has not been immunized for COVID-19 and is not interested in getting vaccinated.

ALLERGIES:
NKDA

SOCIAL HISTORY:
He does not have a partner. He lives with brothers (1 older, 1 younger) and parents. He owns and manages a landscaping/snow clearing and operates equipment.

He is a 1/2 PPD smoker and drinks alcohol on weekends. No recreational drug use.

FAMILY HISTORY: Father has sarcoidosis (pulmonary), and has been treated with steroids and immunisuppresion. Grandmother had aortic aneurysm.

HISTORY OF PRESENTING ILLNESS:
Spencer was in his usual state of health until just after Christimas when he awoke feeling dizzy. When he looked to the side, nystagmoid eye movements. He was seen by an optometrist who thought his eyes were normal, but referred him for vision therapy due to the eye movement abnormalities (Spencer did not attend this as it is not covered by his insurance). Spencer was also seen by his family physician who suggested he refrain from drinking alcohol and clean up his lifestyle. This "dizziness" persisted for a month or so and then resolved.

However, shortly after (February 2022) he developed a binocular horizontal diplopia with forward gaze. Around the same time, he noted his left leg was dragging. He gait became unsteady and he had clear weakness in the leg. It also sounds like he had a Lhermitte's sign. No associated sphincteric dysfunction.

He eventually underwent imaging of the brain and spine that demonstrate a significant burden of demyelinating disease with both enhancing and non-enhancing lesions. I have given him a diagnosis of relapsing remitting MS today and I do not think any further investigations need to be done at this point.

NEUROLOGICAL EXAMINATION:
Spencer is alert, oriented and cooperative. Language is normal.

On cranial nerve examination, EOM are full with no INO. Saccades are normal. The face is symmetric.

On motor exam, bulk and tone are normal. There is no pronator drift, though his left arm does shake. I think there is some functional weakness in the left arm. In the lower extremities, power is 5 out of 5 throughout with the exception of left hip flexion 4+/5, knee flexion 4+/5. Deep tendon reflexes are brisk throughout, more so in the left leg with evidence of clonus at the ankle.

I did not test for vibratory and proprioception sensation today, but understand the reduced vibratory thresholds at the toes.

He does have some mild ataxia in the left leg.

EDSS 2.0

Labs:
Na 138; k 4.1; Cr 91; Glucose 4.9
WBC: 6.51; Hgb 170; PLT 232
ESR: 4; CRP: 0.3
TSH normal 1.18

Imaging:
MRI brain/spine:
FINDINGS:
BRAIN There are multiple T2/FLAIR hyperintense lesions in supratentorial brain including juxtacortical and deep white matter with early confluence on the right side, also involving hypothalamus more prominent on the right. Lesions involve corpus callosum perpendicular to the ventricular surface. Some show mild rim diffusion restriction suggestive for active lesion. There are several infratentorial lesions, involving posterior cerebellar hemisphere, right middle cerebellar peduncle and pons. No mass effect or midline shift. No hydrocephalus or extra-axial fluid collection. Normal flow-void within the major intracranial arteries and dural venous sinuses. Visualized extracranial structures appear unremarkable. SPINE There are multiple short segment high T2 signal intensity lesions involving the cervical cord extending down to the T1 level and a tiny possible lesion within the left aspect of lower thoracic cord (series 19-image 8). Cauda equina nerve roots appear unremarkable. Cervical, thoracic and lumbar alignment and vertebral body heights are preserved. No concerning bone marrow signal change. No significant degenerative changes identified. No canal or foraminal stenosis. MPRESSION: Extensive T2/FLAIR hyperintense lesions in supratentorial and infratentorial brain and cervical cord, mostly keeping with demyelinating process which meets McDonald's criteria for dissemination in space.

MRI brain and c spine with GAD:
IMPRESSION:
Redemonstration of the demyelinating lesions in the brain parenchyma and the cervical cord, most of which demonstrate contrast enhancement in keeping with active demyelinating disease/multiple sclerosis.

ASSESSMENT AND PLAN:

In summary, Spencer is a pleasant 23-year-old gentleman who developed what sounds like an INO in December 2021 and then had a partial myelitis in February 2022. His imaging shows a significant burden of demyelinating disease with several enhancing lesions in the brain and spine. Overall, his diagnosis is one of a relapsing remitting multiple sclerosis and I have communicated this with him and his mother today. He has a number of negative prognostic factors including that he is a male, presented with brainstem and spinal cord attack, some residual deficits on exam today, significant lesion burden and enhancing lesions. As result, I think we should proceed with high efficacy treatment. He has not been vaccinated for COVID-19 and I am a bit concerned about this I discussed the options including both Tysabri and the B-cell therapies. Given that his disease is very active and that he has had 2 attacks in the last 2 months, I think we should move forward with Tysabri given its fast onset. I did discuss the risk of PML but that this is high only after at least a year on treatment if the JC virus index is elevated. We will test him today and start Tysabri in the very near future. If his JC virus is positive, we will plan to transition to a B-cell therapy in about a year or so.

I have also stressed that he should quit smoking as soon as possible as this is increases the risk of progressing to a secondary progressive form. He seems to understand.

I took the time to answer his questions as well as his mother's and reassured them about the future.

I will see him in follow-up in my clinic in 3 to 4 months time. I also discussed that he should call us sooner if he develops any new or concerning neurological symptoms in the interim.

Thank you for involving me in this patient's care.

Alex Muccilli

Case reviewed 10:30-11:45.

Electronically signed by Alexandra Muccilli Mar 07, 2022 01:13 pm

Alexandra Muccilli, MD

D: Mar-07-2022 01:13 P T: Mar-07-2022 EVR447940 Doc: 5617893