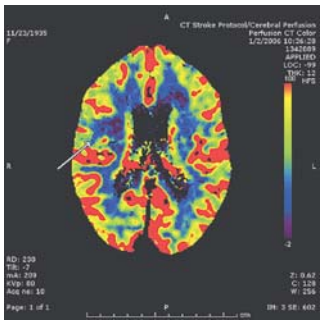
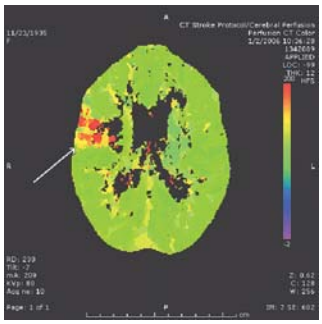
Stroke Case Study

NON-CONTRAST CT SCAN





CT PERFUSION STUDY SHOWING RIGHT POSTERIOR LATERAL REGION.

PATIENT HISTORY

Patient is a 69 y/o female with a history of diabetes and hypertension. The patient began experiencing difficulty with speech and left sided weakness. She called EMS and was transported to the hospital. She arrived at 25 minutes since symptom onset. Her NIH Stroke Scale Score was 6 at this time. She underwent a CT stroke protocol which showed no hemorrhage or signs of infarct on the non-contrast CT, and a perfusion defect in the posterior lateral right frontal region.

NON- CONTRAST CT SCAN

CT Perfusion study showing right posterior lateral region.

TREATMENT COURSE

The patient received standard dosage of tPA (.9 mg/kg) since she was at one hour and 15 minutes, and her stroke symptoms were still present. She was admitted to the Intensive Care Unit where she received frequent neurological assessment, close monitoring of the blood pressure, and tight control of her blood glucose.

HOSPITAL COURSE

The patient remained stable throughout her hospital course. The day after admission, the patient had almost complete resolution of symptoms, with only a slight left sided weakness present on Day 1. While being monitored she developed atrial fibrillation. A cardiology consult was called. On Day 3 she underwent a follow up CT Scan which remained normal, without evidence of a stroke.

OUTCOME AND FOLLOW UP

The patient was discharged home, without any need of further rehabilitation. She was discharged on Plavix for atrial fibrillation (was not a candidate for Coumadin). She was to follow up in the Stroke Clinic for further assessment and treatment of her hypertension. She was to follow up with her endocrinologist for follow up on her Diabetes.

BRAIN & SPINE CENTER
SETON Neurosciences at Brackenridge Hospital
A member of the SETON Healthcare Network
512-324-7782 • www.brainandspine.net