

DISCHARGE SUMMARYST. JOSEPH REGIONAL
MEDICAL CENTER

Lewiston, Idaho

NAME: McRae, David RM: 2A08

HOSPITAL #: 03-95-54

PHYSICIAN: T.W. HILL, MD

ADMITTED: 10-15-89

DISCHARGED: 11-17-89

TRANSFER SUMMARY

FINAL DIAGNOSIS:

1. Severe head injury with cerebral swelling and left temporal lobe contusion with swelling.
2. Pneumonitis and pulmonary complications of severe head injury with bilateral pneumothoraces.

HOSPITAL COURSE:

This 21 YO Caucasian male who was involved in a motor-cycle accident was rendered unconscious at the scene. He was transferred by ambulance to SJRMC and remained comatose. He was evaluated in the ER by Dr. Moreno and myself. He did not have any evidence of serious abdominal trauma. CT scan revealed diffuse cerebral edema. The patient on admission had decerebrate posturing and occasional decorticate posturing of his left upper extremity. He had slightly unequal pupils during transportation. He was intubated in the ER, hyperventilated and I shaved his head and placed Camino intracranial pressure monitor through a small drill hole on the right side of the head. He remained intubated and on a ventilator and had some problems of pneumonia as well as evidence of Staph growing in his blood.

The patient was treated with antibiotics and Dr. Jane Cline followed him, an internist. Shortly after admission his intracranial pressure began to rise. He was treated with Mannitol and hyperventilation as well as steroids and eventually barbiturates. This initially controlled his intracranial pressure but subsequently his intracranial pressure continued to rise. Repeat CAT scans were obtained and showed focal swelling increasing in the left temporal lobe in addition to the diffuse edema.

I discussed very carefully and openly with his family the options of further care. I explained to them that by operating on him and removing the anterior 5 cm. of his left temporal lobe that he may survive but not wake up. He might be in a persistent vegetative state. After very thorough discussion with the family, they felt that they would prefer that he undergo craniotomy with subtotal temporal lobectomy and I carried out the procedure on the 20th of October. Following this he had mild elevations in his intracranial pressure but these were readily controlled with medications. He was started on feedings but his feeding tubes became obstructed and so a percutaneous gastrostomy tube was placed by Dr. Dettwiler and he was started on feedings through this.

He appeared to begin to open his eyes but has not followed commands. Repeat CAT scan showed that the edema was resolving. He had some bifrontal subdural fluid collection but I felt that this was ex-avacuole fluid collection but I felt that this was an ex-avacuole fluid collection rather than subdural fluid causing increasing pressure. EEG's showed severe cortical dysfunction and Dr. Stockard felt that based on the EEG he was unlikely to wake up. This was reviewed with the family and they are very uncomfortable with that statement. I discussed with them the fact that he has not made significant progress. They feel that almost any little motion is a sign of improvement and are still hopeful that he will awaken and participate in rehabilitation. I have told them that if he did not show any signs of improvement by 6-8 weeks, then I thought that he should be placed in an extended care facility.