

NEUROLOGICAL ASSESSMENT AND INTERVENTION USING THE *GUIDE TO PHYSICAL THERAPIST PRACTICE*: A CASE REPORT.

This case report represents the course of physical therapy for an 83-year-old male admitted to the hospital with left facial drooping, weakness, slurred speech and lethargy following a fall. He was diagnosed with a right frontal intracranial bleed. Included in the case report is information regarding the use of multiple medications, their side effects, and possible implications for the physical therapist. Additionally, lab values are examined and the implications in physical therapy are discussed. The case is outlined following the *Guide to Physical Therapist Practice* format from examination through outcomes.

The patient has a complex medical history including hypertension, cerebrovascular accident, rheumatoid arthritis, non-insulin dependent diabetes mellitus, hernia repair, depression, cholecystectomy, kidney stones, panic attacks, and myocardial infarction. Based upon medications taken by the patient, it can be assumed that the patient also has benign prostate hypertrophy and dementia. The medications that this patient was prescribed included Labetalol, Reminyl, Flomax, Toprol, Avapro, Prevacid, Xanax (prn), and Dilantin. Several of these medications have should be taken with caution with certain medical conditions (including some conditions in the patient's previous medical history).

Analysis of laboratory values indicate several things that are significant to the physical therapist. For this patient, decreased values for red blood cells, hemoglobin, and hematocrit indicate anemia; increased glucose values indicate Diabetes; decreased creatinine values can indicate a decrease in lean body mass; decreased sodium values can indicate use of diabetic drugs and can result in fatigue, lethargy, nonspecific weakness, and confusion; and decreased calcium values can indicate certain metabolic disorders.

Examination of the patient revealed the following: *Bed mobility*: rolling with supervision. *Transfers*: ranged from minimal assistance to stand by assistance. *Gait*: The patient ambulated 114' with wheeled walker contact guard assistance, demonstrating a slightly flexed posture and needs verbal cues to extend spine. He negotiated four steps with contact guard assistance with bilateral rails. *Balance*: Functional Reach: 5"; Tinetti Balance and Mobility Assessment 13/28; Berg Balance Scale 24/56. *Manual muscle testing*: ranged from 4-/5 to 4+/5 bilaterally.

Problems this patient had include intracranial hemorrhage resulting from fall, complex previous medical history, polypharmacy, irregular lab values, slurred speech, balance deficits, gait deficits, and decreased strength. Using the aforementioned information regarding polypharmacy and irregular lab values combined with a thorough physical examination, the physical therapist can then synthesize information needed to choose appropriate interventions. This patient was discharged five days after admission to the needing only supervision for mobility.