RIGHT HEMIPARESIS (lesion of the ventral pons)

Chief Complaint: The patient is a 59 year old man who developed sudden **difficulty walking**, **right arm weakness**, and **slurred speech.**

History of Present Illness/Past Medical History: The patient has a long history of hypertension and cigarette smoking. He had no other medical problems until the day of admission, when, while walking home from the newsstand he suddenly developed difficulty walking, requiring support from his son. Upon reaching his apartment, he was unable to raise a cup of coffee with his right hand, and his speech was noted to be slurred. His family, therefore, brought him to the emergency room.

Physical Examination: Thin male appearing anxious but otherwise in NAD.
T=97.4 P=92 R=18 BP=130/90; Neck - supple; Lungs - clear; Cardiac - RR no M/G/R
Abd. - nl. BS NT/ND; Ext. - nl. pulses, no edema.
Neuro:

- Mental Status - A&Ox3. **Speech slurred** but with normal fluency and comprehension (i.e. **dysarthric** but not aphasic).
- Cranial Nerves - normal except for **slight flattening of R nasolabial fold.**
- Motor Strength - **4/5 in R arm and leg.** 5/5 in left arm and leg throughout.
- Coord/Gait - **RAM and FNF slowed on R. Gait - req. support (R weakness).**
- Sensation - Normal to all modalities throughout.

HOARSE VOICE & FALLING TO THE RIGHT (lesion of dorsolateral mid-medulla)

Chief Complaint: The patient is a 67 year old woman who presented to her physician with several days of **gait difficulty** and a tendency to **fall to the right side**.

History of Present Illness/Past Medical History: The patient has had diabetes for several years and a history of severe peripheral vascular disease requiring a left BKA (below knee amputation) nine months ago. She had no neurologic illness until several days prior to admission when she developed **dizziness**, **unsteady gait** and a tendency to **fall to the right**. She went to her private doctor who found her to have **right facial numbness**, and **hoarseness** on physical exam, and he then sent her to the hospital where she was seen by the neurology resident in the ER.

Physical Examination: Well developed woman in NAD.
T=98.0 P=80 R=16 BP=130/70; Neck - supple; Lungs - clear; Cardiac - RR; Abd - nl.
Extremities - 2+ distal pulses. Stump without skin breakdown and warm to touch.
Neuro:

- Mental Status - Alert, oriented, non-dysarthric, but with **hoarse voice**.
- Cranial Nerves - EOMI, no nystagmus. Normal fundoscopic exam. **+R ptosis**; **R pupil small, minimally reactive to light**.. **Diminished pain and temperature sensation in R face; preserved touch.** CNs normal otherwise, except **decreased gag reflex on R**.
- Motor Strength - Normal (5/5) throughout.
- Reflexes - 1+, symmetrical throughout. No Babinski.
- Coordination - L hand: good F-N-F. R hand: **+dysmetria**, and **poor RAM**.
- Gait - **wide based, ataxic, with tendency to fall to right.**
- Sensation - **decreased pain and temperature sensation in L arm and L leg, and R face.** Normal position & vibration sense throughout.