3-22-10

EMERGENCY PROVIDER RECORD

46

Neuro Symptoms / Deficit

03 10 M053082 6
V021223581 BD:03/16/43
PARVIN, MARY JEAN
MCAB PHYSER ER

Aortic / Carotid Dissection / Ramsay-Hunt / Guillain-Barre / Botulism / IVDA / Lyme / Syphilis

TIME SEEN: 12⁴⁰ ROOM: ____ __ EMS Arrival

HISTORIAN: patient family EMS ____

UNABLE TO OBTAIN HISTORY DUE TO: ____

HPI onset ____

chief complaint: weakness paresthesia facial droop falling difficulty standing / walking impaired speech ____
Confused

onset / duration: PTA

gone now better continues in ED
greater than 3 hours cannot confirm onset

timing:
sudden / gradual onset
constant / intermittent
noted on awakening

severity: mild moderate severe ____

context: insect / tick bite / falling injury: head ____

Today Drug Remember Nonsense
Here

character of deficit(s):
new weakness ____
• RUE RLE LUE LLE R / L facial general (diffuse) ascending
altered sensation ____
• RUE RLE LUE LLE R / L facial
vision problem / glaucoma ____
impaired speech / swallowing • difficult unable ____
decreased ability to stand / walk / falling ____
• weak difficult off balance cannot walk cannot stand
• bed-ridden unable to sit ____

baseline

Cognitive:
alert, oriented x3
alert but disoriented
alert but confused
poor alertness
memory loss

Gait:
walks w/o assistance
uses a cane / walker
walks only w/ assistance
stands for transfers
unable to walk

associated symptoms:
fever / chills / sweaty ____
chest pain ____
neck / back pain ____
headache ____
fainted / seizure ____

altered mental status ____
unchanged from baseline
disoriented confused agitated
trouble concentrating / thinking
decreased responsiveness
unresponsive

Similar symptoms previously No

Recently seen / treated by doctor No

ROS

CONST (see HPI)
recent illness ____
EYES (see HPI) / ENT
sore throat / dental problems ____
CVS / PULMONARY
palpitations ____
cough bloody / productive ____
hurts to breathe ____
GI / GU
nausea / vomiting / diarrhea ____
abdominal pain ____
black / bloody stools ____
trouble urinating ____

FEMALE GENITAL
LNMP ____ preg post-menop
MUSCLE SKELETAL / SKIN / LYMPH
neck pain ____
joint pain ____
rash / swelling ____
swollen glands ____
NEURO / PSYCH
dizziness ____
vertigo lightheadedness
depression / anxiety ____

☐ all systems neg except as marked

PAST HX

RELATED PAST HX
cardiac disease ____
Afib angina CHF CAD MI ____
CVA / TIA bleed deficits ____
headaches / migraines ____
neuro disease MUSCLE SKELETAL
seizures ____
diabetes Type 1 Type 2 ____
diet / oral / insulin neuropathy ____
__old records reviewed / summary: ____

back injury ____
cancer chemo rad tx ____
chronic pain ____
hyperlipidemia ____
hypertension ____
immunosuppressed AIDS ____
lung disease asthma COPD ____

HIGH RISK TIA CRITERIA: crescendo TIA / TIA on anti-platelet therapy / young age / possible cardioembolic disease / possible dissection / unreliable follow-up / greater than 3 ABCD2 score.
ABCD2 Score for TIA[3]: Age: 60 yrs or older (1) / BP: systolic 140 or greater (1) / diastolic 90 or greater (1) / Clinical: unilateral weakness (2) / speech disturbance (1) / Duration: 60 mins or greater (2) / 10-59 min (1) / diabetes (1) Score: ____
Risk for Stroke 0-3 – Low 4-5 – Moderate 6-7 – High

Surgeries / Procedures __none
__any recent surgery ____
back surgery ____ cholecystectomy ____
CABG / stent / pacemaker ____ appendectomy ____
carotid endarterectomy ____ hysterectomy / BTL / C-section ____

Imaging prior CT / MRI / US date ____ Dayton, Pacing
☐ Immunization UTD ____

Medications __none see nurses note
aspirin clopidogrel warfarin LMWH ____
NSAIDs acetaminophen Diovan
Lasix, coreg, Synthroid

Allergies __NKDA
see nurses note
antibiotic ____

SOCIAL HX smoker ____ drugs ____
alcohol (recent / heavy / occasional) ____ occupation ____
living situation alone family friend group care facility ____

FAMILY HX stroke migraines CAD ____
CNS cancer cerebral aneurysm ____

☐ Nursing Assessment Reviewed ☐ Initial Vital Signs Reviewed ☐ Telemetry
BP ____ HR ____ RR ____ Temp ____
Pulse Ox ____% __RA ____ O_2 Interp __nml __hypoxic ____

PHYSICAL EXAM

EXAM LIMITED BY: ____

General Appearance __mild / moderate / severe distress ____
__appears well __lethargic / obtunded ____
__alert __apneic ____


TFORMS

20229304621

HEENT
- ✓ head atraumatic — __tenderness / swelling / ecchymosis
- ✓ EOM's intact — __scleral icterus / pale conjunctivae
- ✓ PERRL — __EOM palsy / nystagmus
- ✓ visual fields nml — __unequal pupils 'R ___ mm L ___ mm
- __ ENT inspection nml — __abnml funduscopic / papilledema
- ✓ pharynx nml — __ TM blood
- ✓ airway intact — __deprsd gag reflex / poor handling of secretion
- ✓ oral exam nml — __pharyngeal erythema / exudate
- __dry mucous membranes

NECK
- ✓ supple — __cerv. lymphadenopathy
- ✓ non-tender — __stiff neck / meningismus
- ✓ no carotid bruit — __carotid bruit

RESPIRATORY
- ✓ no resp. distress — __respiratory distress
- ✓ breath sounds nml — __wheezes / rales / rhonchi

CVS
- ✓ reg. rate & rhythm — __tachycardia / bradycardia / irreg. irreg. rhythm
- ✓ heart sounds nml — __JVD present
- __murmur *grade* ___ /6 *sys / dias*
- __gallop (S3 / S4)
- __pulse deficit (R / L)

ABDOMEN / GI
- ✓ non-tender — __guarding
- ✓ no organomegaly — __hepatomegaly / splenomegaly / mass

RECTAL EXAM
- __nml rectal exam — __decreased rectal tone
- __heme neg. stool

EXTREMITIES
- ✓ non-tender — __pedal edema
- ✓ nml ROM — __Homan's sign
- ✓ no pedal edema — __cords

NEURO
- ☐ see 46a for NIHSS

higher functions
- __nml cognition — __abnml serial 7's / inattentive / memory loss
- __oriented x3 — __disoriented to *person / place / time*
- __nml speech — ~~__abnml response to commands~~
  - *no response eyes open slow inappropriate*
- V.F ↓ RT — __abnml response to pain
  - *withdraws flexor extensor none*
- __speech abnml
  - *dysarthria aphasic expressive / receptive*

cranial nerves-
- ✓ nml as tested — __facial palsy *forehead: involved spared*
- __tongue deviation (to R / L)

cerebellar-
- __nml as tested — __abnml Romberg / finger-nose test / heel - shin
- __abnml gait / ataxia

sensorimotor-
- ✓ motor nml — __weakness / hemiplegia / dyspraxia
- ✓ sensation nml — __pronator drift (RUE / LUE)
- ✓ reflexes nml — __altered light-touch / pin-prick / 2-pt discrimin.
- __tremor / abnml movements
- __Babinski reflex (R / L)

PSYCH
- ✓ mood / affect nml — __depressed mood / flat affect

SKIN
- ✓ color nml, no rash — __cyanosis / diaphoresis / pallor
- ✓ warm, dry — __ecchymosis
- __rash / embolic lesions
- __decubitus

XRAYS

CXR
☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/ radiologist ☐ read by radiologist
__*nml / NAD* __*no infiltrates* __*nml heart size* __*nml mediastinum*
Old CXR- __*unchanged* *date:*

♦**CT Scan / MRI** *brain*
☐ *nml / NAD* Lt Temporal infarct

Other

LABS & EKG

pg. of stroke exclusion crite

**Normal lab value ranges are included on the original lab report*

CBC	Chem		Enzymes
nml except	*nml* except	sed rate	*nml* except
WBC	Na	PT	Troponin
Hgb	K	INR	CKMB
Hct	CO2	PTT	Troponin
Platelets	Gluc		CKMB
bands	BUN		Troponin
	Creat		CKMB
			CSF findings

Rhythm Strip Rate ____ Rhythm *NSR / PVC*

EKG *interp by ED provider* Rate ____ __NSR __A-fib
__*nml intervals* __*nml axis* __*nml QRS* __*non-specific ST/TW changes*
diagnosis __*nml* __*abnml*

PROGRESS

☐ see additional template *46a 51a*
☐ neuro consult ____ time:
Time ____ unchanged improved re-examined

Memory ↓ V.F cut on Rt
Unknown Duration
Suspect Lt Brain Stroke,

Pt c/c Acute CVA Lt Temp. Hx of V.F Cut on Rt
with call Hospitalist

☐ swallow test ordered
☐ patient ambulating / mentating at pre-event baseline
Discharge VS: BP ____ *HR* ____ *RR* ____ *Temp* ____
__Discussed with Dr. Hospitalist Time: ____
will see patient in: ED / hospital / office

Counseled patient / family regarding:
lab / rad. results diagnosis need for follow-up
__prior records ordered
☐ Rx given

Additional history from:
family caretaker paramedics
__holding orders written

CRITICAL CARE *(excluding time for other separate services)*
TIME ☐ *30-74 min* ☐ *75-104 min* ____ *min*

CLINICAL IMPRESSION

DYSPHASIA	Carotid / Vertebral Dissection
GAIT DISTURBANCE	♦Cerebrovascular Accident / Transient Ischemic Attack
WEAKNESS / NUMBNESS L / R	Epidural Abscess / IVDA
VERTIGO	Guillain-Barré Syndrome
Aortic Dissection	Intracranial Bleed
Bell's Palsy	Ramsey Hunt Syndrome
Botulism	

TIA
CVA

Present On Admission *decubitus / UTI w/ foley*

Disposition Order Time 2:00 pm
DISPOSITION- ☐ home ☐ admitted ☐ OBS ☐ expired
☐ AMA *(see AMA template #73)* ☐ transferred
CONDITION- ☐ unchanged ☐ improved ☐ stable
Care transferred to ____ MD / DO / MLP Time: ____

____ ***NP / PA***

IDX Provider # ____

☐ I was personally available for consultation in the emergency department. I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan, and disposition.

☐ I saw and personally evaluated the patient discussed with the MLP, and agree with the findings and management.

____ ***MD / DO***

IDX Provider # ____ ☐ Template Complete
☐ Written Addendum

[1] *Johnston SC, et al, "Validation and refinement of scores to predict very early stroke risk after transient ischemic attack" Lancet 369:283-292, 2007.*

♦ Quality Measure Initiative

20229304622

3-22-10

A/PT 3

Lodi Memorial Hospital
975 S. Fairmont • Lodi, CA 95240
(209) 334-3411

EMERGENCY DEPARTMENT RECORD

Resuscitative Emergent Urgent Routine

03/22/10 M053082 67 /F
V021223581 BD:03/16/43
PARVIN, MARY JEAN
MCAB PHYSER ER

RAV

NAME - LAST	FIRST	DATE
Parvin	Mary Jean	3-22-10

TIME | CHIEF COMPLAINT

NURSE

TIME IN ROOM	NURSES SIGNATURE / INITIALS	BROUGHT BY:	ENTERED:
1213		☒ SELF ☐ PARENT ☐ RELATIVE ☐ POLICE ☐ BLS ☐ ALS ☐ OTHER	☐ CARRY ☐ WALK ☒ W/C ☐ GURNEY

VITALS

TIME	O2 Sat	T	P	R	BP
12:08	98	36.6	73	18	184/125

ALLERGIES: SULFA

PHYSICIAN'S REPORT TIME:

DM on Insulin, HBP
CAD.

MI 05

DISCHARGE IMPRESSION ▶ Acute TIA (Resolved.)

DISPOSITION VIA ▶ ☐ HOME ☒ HOSPITAL ☐ TRANSFER ☐ CORONER ☐ OTHER ☐ WALKED ☐ CARRIED ☐ WC ☐ GURNEY ☐ AMBULANCE

CONDITION: Stable
WITH:

CALLED	ARRIVAL	TIME / INITIAL
PHYSICIAN	RESPOND	

OTHER INSTRUCTIONS

☐ DICTATED ☐ CALL BACK ☐ COMPLETE

PHYSICIAN'S SIGNATURE M.D. | P.A. SIGNATURE | DATE 3 22 10

PHYSICIAN'S ORDERS

ORDER TIME	X-RAY
	☐ CXR ☐ CXRP
	☐ CERVICAL SPINE
	☐ LUMBAR SPINE
	☐ PELVIS ☐ ABD
	☐
	☐

ORDER TIME	ULTRASOUND
	☐ LEG
	☐ PELVIC/OBUS
	☐ GALLBLADDER/ABD US

ORDER TIME	CT	CONTRAST
1240	☒ HEAD	⊕ ⊖
	☐ CHEST	⊕ ⊖
	☐ ABD/PELVIS	⊕ ⊖
	☐ SPINE ☐C ☐T ☐L	

ORDER TIME	PROCEDURES
	☐ EKG ☐ MONITOR
	☐ FOLEY ☐ NG TUBE
	☐ I & O CATH
	☐ IV
	☐
	☐
	☐

ORDER TIME	LAB TESTS
1215	☒ CBC
1215	☐ BMP ☒ CMP
	☐ BC x 1 ☐ BC x 2
	☐ LACTIC ACID
	☐ AMI ☐ TROPONIN
	☐ BNP
	☐ AMYLASE ☐ LIPASE
	☐ HEPATITIS AB PANEL
	☐ FREE T4, TSH
	☐ D-DIMER
	☐ PT ☐ PTT
	☐ URINE DIP
1215	☒ URINE MICRO ☐ C&S ☐
	☐ URINE HCG Results: + or –
	☐ QUANT. HCG
	☐ CHLAMYDIAL C&S
	☐ GC C&S
	☐ WET MOUNT
	☐ SPUTUM AFB
	☐ SPUTUM GRAMSTAIN C&S
	☐ ABG
1215	☒ FSBS Results: 252
	☐ T&C ____ UNITS PRBC
	☐ ABO/RH; ANTIBODY SCREEN IF RH NEG
	☐ T&C FFP
	☐ EtOH
	☐ AMMONIA
	☐ ACETAMINOPHEN LEVEL
	☐ SALICYLATE LEVEL
	☐ DIGOXIN LEVEL
	☐ DILANTIN LEVEL
	☐ DEPOKOTE LEVEL
	☐ TEGRETOL LEVEL
	☐
	☐

7010-28 (7/15/09)

CHART COPY

Patient Name: PARVIN,MARY JEAN
Unit No: M053082

3-22-10

EXAM#	TYPE/EXAM	RESULT
000980702	CT/HEAD W/O CONTRAST	

History: Stroke.

Study is done without intravenous contrast material. Ventricles, and cisterns show no acute abnormality. There is increasing edema present in the left temporal lobe since the last examination. No hemorrhage is seen. No midline shift is noted. Bone windows are unremarkable.

Impression: Left temporal lobe linear zone of decreased density is seen suggesting developing stroke since the examination of 1/26/2010 . No blood is identified. No additional abnormality is seen.

D/T: RV/
Date Dictated: 03/22/2010 13:14:15
Date Transcribed: 03/22/2010 14:09:05
Doc ID: 115522
Job ID: 148346

This document was electronically signed by Roger Vincent, M.D. on 03/22/2010 14:14:15.

** REPORT SIGNED IN OTHER VENDOR SYSTEM 03/22/2010 **
Reported By: VINCENT,ROGER P MD

CC: Silverstein,Phillip MD

Technologist: FERNANDEZ,TEREZA
Transcribed Date/Time: 03/22/2010 (1415)
Transcriptionist: EWS
Printed Date/Time: 07/07/2010 (1321)

Name: PARVIN,MARY JEAN
Phys: Silverstein,Phillip MD
DOB: 03/16/1943 Age: 67 Sex: F
Acct No: V021223581 Loc: 376 A
Exam Date: 03/22/2010 Status: DIS IN
Radiology No: 00003311

3.22.10

LODI MEMORIAL HOSPITAL
DISMISSAL SUMMARY

This is a 67-year-old white female, history of congestive heart failure, ejection fraction of 25%, was brought in by family member with complaint of altered mental status described as
For admission this is a 67 years old, white female, history of congestive heart failure, ejection fraction of 25% was brought in by family member because complete complaint of altered mental status described as decreased memory, confused, disoriented, and does not engage in conversation. In the ER the patient got a head CT done and was found to have left temporal lobe CVA with right hemianopsia. For that reason, the patient got admitted to medical floor with telemetry monitor.

HOSPITAL COURSE
With her clinical presentation, the patient got admitted to a medical floor with telemetry monitor, and she was started on Aggrenox with low-dose aspirin because she was already on Plavix. The patient was also resumed back on her statin as well as her other home medications for her CHF, and she was also added Zetia to her current medications because her cholesterol is not under control. Because of new-onset CVA, the patient got workup with bilateral carotid Doppler described as above, as well as cardiac echocardiogram described as above. The patient was also consulted with Dr. Yao, neurologist, who has no further recommendations, and the patient unable to get MRI done because of she has history of pacemaker. The patient was also evaluated with speech therapist, who recommended therapy 3 to 5 times a week. After being admitted to the hospital and started on new medication, the patient clinically stable and her memory slowly improved over the hospital course, but she still has very bad short-term memory and not back to her baseline mentation. Because of history of diabetes, insulin dependent, and no one at home to help her out except for her sister, who is legally blind, thus she could not help her with insulin subcutaneously, but she is able to do anything else for her. For that reason, the patient was recommended to go to skilled nursing for rehab and diabetic teaching prior to discharge back to home. Otherwise there are no other acute issues for this patient during hospital stay. The patient now deemed to be stable to be transferred to skilled nursing for continuation of rehab.

DISCHARGE CONDITION
The patient hemodynamically stable, clinically stable. No acute distress. She can speak in full sentences but still has memory deficit.

DISPOSITION
Skilled nursing and rehabilitation.

DISCHARGE MEDICATIONS
The patient will be discharged to skilled nursing facility with the following medication.
1. Aspirin 81 mg 1 tablet p.o. daily.
2. Aggrenox 1 tablet p.o. b.i.d.
3. Coreg 12.5 mg 1 tablet p.o. b.i.d.

M053082 V021223581
PARVIN,MARY JEAN
03/16/43 67 F
Att. Dr. Nguyen,Bao Q MD
03/22/10 3S 1
Dict. Dr. Bao Q Nguyen, MD

3.22-10

LODI MEMORIAL HOSPITAL
ADMISSION HISTORY & PHYSICAL

NEUROLOGICAL: Alert, awake, but the patient is confused, amnestic, incoherent, disoriented, but denies any neurological deficits. Denies any visual changes except for incidental finding by ED attending in the ER.

All other review of systems were reviewed and are negative.

PAST MEDICAL HISTORY
1. Cardiovascular disease status post CABG.
2. Congestive heart failure with ejection fraction of 25%.
3. Diabetes mellitus type 2.
4. Stage III chronic kidney disease.
5. Hypertension.
6. Hypothyroidism.
7. Depression and anxiety.

PAST SURGICAL HISTORY
The patient does not recall what prior surgery she had in the past. However, per sister, the patient knew everything about her surgery before all of this happened. The patient had an ICD placement, CABG in 2004, right wrist surgery, and appendectomy.

SOCIAL HISTORY
Denies smoking. Denies drinking. Denies IVDA. The patient is a widow. No children. Currently lives with a roommate and in close contact with her sister by telephone daily.

FAMILY HISTORY
Reviewed, but not relevant.

MEDICATIONS
1. Lasix 80 mg 1 tab p.o. daily.
2. K-Dur 20 mEq b.i.d.
3. Coreg 12.5 mg b.i.d.
4. Levoxyl 100 mcg 1 tab p.o. daily.
5. Lisinopril 20 mg 1 tab p.o. daily.
6. Lovastatin 40 mg 1 tab p.o. daily.
7. Omeprazole 20 mg b.i.d.
8. Clonidine 0.1 mg b.i.d.
9. Plavix 75 mg 1 tab p.o. daily.
10. Nitroglycerin p.r.n.
11. Novolin N 50 units a.m. and 30 units p.m.
12. Novolin R 13 units a.m. and 6 units p.m.
13. Vitamin E.
14. Multivitamin.

ALLERGIES
SULFA.

M053082 V021223581
PARVIN,MARY JEAN
03/16/43 67 F
Att. Dr. Nguyen,Bao Q MD
03/22/10 PTU 1
Dict. Dr. Bao Q Nguyen, MD

LODI MEMORIAL HOSPITAL
CONSULTATION REPORT

DATE OF CONSULTATION
03/22/2010

REFERRING PHYSICIAN
Bao Nguyen, MD, hospitalist

REASON FOR CONSULTATION
Possible stroke and altered level of consciousness.

HISTORY
The patient is a 67-year-old obese Caucasian, right-handed female, who woke up this morning not feeling well. The rest of the day she cannot recall very well. Obvously the patient was brought in by family or friends, that she was not focused, unable to concentrate, and no reported focal weakness, numbness, falls, motor convulsions or seizures. The patient was brought in and could not remember much of the day. However, the patient is not comatose. She had a chronic headache, but no significant change with that. She denied dizziness, vertigo, loss of sensation or motor function at this time in the early evening time when I did the consultation. The patient does have remarkable elevation of blood pressure in the 180s/120s on initial admission. However, the patient did not have fevers, chest pain, palpitations or any atrial fibrillation at the initial evaluation. Her head CT without contrast was read as a left temporal lobe linear zone of decreased density is seen suggesting developing stroke. This was compared to the 01/26/2010 study. There is no bleeding, no other abnormalities. The patient told me in January she had headache and this was checked for that reason. She denied any history of stroke or TIA or similar episodes. She denied any epilepsy. At this time, the patient is basically back to normal state, however, she does have problems keeping up her memory, she asked me twice who I was after I repeated telling her I was the consulting neurologist. She cannot tell me her family doctor's name.

On admission, other significant findings included glucose of 247, BUN 24, creatinine 1.19. GFR 45, albumin 3.2. Liver enzymes normal. CBC is basically normal. Sedimentation rate is 24. Urinalysis is remarkable for glucose 500, protein 30, WBC 21-50.

REVIEW OF SYSTEMS
She stated last night when she went to bed, she was in her normal health state. She did not have any fever, chills, chest pain, palpitations, shortness of breath, cough, depression, anxiety, nausea, vomiting, diarrhea, bloody stools or urine.

PAST MEDICAL HISTORY
1. CVD.
2. Congestive heart failure.

	M053082	V021223581
	PARVIN,MARY JEAN	
	03/16/43 67	F
Att. Dr.	Nguyen,Bao Q MD	
	03/22/10 3S	1
Dict. Dr.	Weiping Yao, MD	

neck, shoulders and palate are all symmetrically normal.
MOTOR SYSTEM: There is no drifting, falling, all equal symmetrical appropriate. Reflexes are diffusely hyporeflexia. There is no pathological or upper motor neuron signs including clonus or Babinski, or Hoffmann's signs.

Finger-to-nose and rapid alternating movement shows no ataxia. I did not walk the patient. There is no sensory neglect.

CT of the head outlined in the history section.

ASSESSMENT
Altered level of consciousness and confusion, with a question CT evidence of a left temporal outflow density or stroke. The patient feels like a transient global amnesia. Also, she has right hemianopsia.
The underlying etiology, probably is her
stroke. There are no motor seizures. The other differential diagnosis is chronic headache, associated facial spasms.

The patient had multiple significant stroke risk factors including obesity, poor ejection fraction of cardiomyopathy, hypertension, dyslipidemia, diabetes, hypothyroidism, overweight.

RECOMMENDATIONS
Brain MRI is indicated to clarify the diagnosis.

For secondary prevention, Aggrenox is appropriate because the patient was on aspirin and she tried Plavix before. There is no strong indication for Coumadin at this time.

Other stroke risk factor indication including her metabolic syndrome issues.

If needed, the patient will need to follow up with a cardiologist for further evaluation if any problems.

I discussed the above assessment and recommendations to the patient who vocalized understanding, questions answered. I will check back with the MRI tomorrow for followup.

cc: Primary care physician

Reviewed on: 03/23/2010 22:54

	M053082	V021223581
	PARVIN,MARY JEAN	
	03/16/43 67	F
Att. Dr.	Nguyen,Bao Q MD	
	03/22/10 3S	1
Dict. Dr.	Weiping Yao, MD	