8/29/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Jeffrey **Case Discussants**: Brandy

https://clinicalproblemsolving.com/present-a-case/

Scribing (Chris & CPS Fam):

CC: 64F presents with AMS and falls for 2 months.

HPI: 3rd time seen for falls(hospitalized twice) in 2 months. Unwitnessed falls, altered but no sure about LOC. Not sure if it was seizure or syncope. Recent falls with evidence of potential incontinence during current episode which hasn't happened before. No recent travel no sick contacts & no difficulty between episodes.

Patient was completely normal between this LOC episodes.

ROS: Neg

PMH: HTN, Lupus 1 yr ago (Diagnosed after lupus cutaneous flare apparently), HLD, cholecystectomy

Meds:

HCQ daily
Losartan
Amlodipine
Metformin
Atorvastatin
Tylenol PRN
Melatonin

Fam Hx: none

Social Hx: 10 packs-years (former), No alcohol

Vitals: T -100.4: HR-124: ,**BP**: 184/102 **RR**: 18 **Sat**: 99% on RA **BMI**: nl

Exam: Gen: Awake, non oriented, non answer questions appropriately. Hallucinations?

HEENT: nl **CV**: nl **Pulm**: nl **Abd**: nl

Neuro: Shaking, jitteriness with intact consciousness, No neuromuscular weakness, stumbling while walking, no FND, no cerebellar signs, reflexes nl, tone nl, no meningismus

Extremities/skin: No rash, No joint pain, no muscle weakness, has long history of Raynaud's (not reproducible on physical)

Notable Labs & Imaging:

ECG: Sinus tachy

Serologies (Lupus): ANA, SSA, DsDNA: +

Blood cultures: Respiratory viral panel: Nl

Urine culture: positive for E.coli

Stat EEG -ve,CT head-clean,Continuous EEG -normal

LP: nl

MRI: nl

Carotid ultrasound: nl

Imaging: EKG & echo: repeatedly nl

- First time categorized as syncope, extensive work up with antibiotic management, final diagnosis on that admission: Orthostatic hypotension
- Second admission, possible UTI, 4 days of antibiotic course, no clear cause identified.

Hematology: CBC: nl

Chemistry: CMP: nl

Final diagnosis: Benadryl (diphenhydramine) toxicity

Problem Representation: 64F presenting with falls x3 and episodic AMS with recent incontinence and possible LOC.

Teaching Points (Jahanvi and Kaleem)

What was the background of falls and AMS, LOC? Check to see what has been worked up in the past visits, poly pharmacy?

-Differentiate it from Syncope and seizure. Preceding aura for seizures or auditory disturbances, weakness, etc. Check CKMB to determine if pt down for extended period.

-Also worry about arrhythmia due to lupus causing cardiac block.

-Urinary incontinence points to seizure. In a background of lupus, r/o CNS Lupus- do further tests like EKG, LP, EEG, telemetry, CT head.

-Rule out carotid artery stenosis to differentiate a stroke/TIA.

-If it is TIA, everytime it recurs- it should most likely have some fingerprints on imaging.

-LP to rule out infection and inflammatory etiologies

-Look at electrolytes to r/o imbalances.

- See if the episodes of AMS are related or have a pattern, for e.g. infection in this case.

-Functional, Inflammatory- if the syndrome is not localizable

-Intermittent symptoms (episodically): vasovagal, seizures, environmental triggers

-If the patient has undergoing stress + outside triggers + superimposed fevers/episodic infections/ episodic AMS: Think about patient taking something from outside—> anticholinergic syndrome (will explain dry mouth too).

-Completely fine and intermittent issues: look at outside trigger

-Not completely fine and intermittent issues: internal trigger