9/21/26 Mainstream Monday with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Dadmehr (@dadmehr_y)* ***Case Discussants****: Rahul (@RahulPottabath1) & David (@davserantes)*

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

Scribing (Chris & Lera):
CC: 96F with a ground level **fall**
HPI: While trying to walk out of the bathroom, denies LOC. Daughter reports decreased oral intake over couple weeks, 2-3 days prior new anti HTN medications been added.

ROS: generalized weakness, otherwise negative

PMH:
Resistant HTN

Meds:
Losartan
Carvedilol
Amlodipine
Spironolactone [new]

Fam Hx: —

Social Hx: —

Health-Related Behaviors: —

Allergies: —

Vitals: **HR:** 90s **BP:** 105/60 **RR:** 20
Exam: **Gen**: AO x 4 **Neuro**: no FND
HEENT: dry, peeling skin, no JVD
CV: known systolic murmur along R and L sternal borders
Pulm, **Abd**: nl **Extremities/skin**: no edema

Notable Labs & Imaging:
Hematology: WBC: 9 Hgb: 12.7 Plt: 200

Chemistry: **Na**: 115 K: 4.1 Cl: 83 BUN: 15 **Cr**: 0.23
Glu: 150 **SOsm**: 242 **Uric acid:** 1.8 **UOsm**: 362
TSH, Cortisol: nl

UA: SG 1.008, trace ketones and WBCs
U Na: 34 **UK:** 21 **UCl:** 33 **U urea:** 444

HCO3: 16 **VBG:** pH 7.36, pCO2 41
BHB: 0.37 **Lactate:** nl

EKG: nl **TTE**: mild -> moderate AS, mild diastolic dysfunction
CT head: nl **MRI brain**: no acute findings

-> 100 mL 3% saline + 15 mmol sodium phosphate
-> improved oral intake, increase in urine output & spontaneous upward Na trending, AG normalization. D5W administered subsequently to moderate correction

Final Dx: multifactorial hypotonic hypoNa & mild starvation ketosis

Problem Representation: 96 y/o female with ground level fall without LOC found to be hyponatremic

Teaching Points

Elderly individual with a fall has a multifocal etiology.It is important to check drug history and evaluate Cardiac System.

-Hyponatremia-acute vs. chronic? Always concerned about cerebral edema.
-Suspected SIADH investigation for the cause include a chest x-ray

-Hypotonic hyponatremia you would expect a low uric acid and high urine sodium.

-Normal anion gap is 12

-SGLT2 cause euglycemic DKA

-elevating anion gap check for a hx of drinking to rule out alcohol ketoacidosis

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