ED QUICK QUIZ

WHAT IS THE DIAGNOSIS ?

BACKGROUND

Mrs T is a 76-year-old lady brought to A&E from her day centre with a collapse.

Background: Vascular Dementia, Hypertension, Type 2 DM, CKD, IHD

Meds: Lisinopril, BFZ, Doxazosin, Metformin, Bisoprolol, Aspirin, Simvastatin, Co-codamol 30/500, Lactulose

Lives alone, carers BD and day centre 3 times a week. Zimmer mobility.

During lunch looked unwell/pale and then collapsed. LOC for a few minutes, vomited and incontinent of urine. Minor twitching of arms and legs. When she came round was drowsy and nauseated and more confused than normal. BM was 11.8. She didn't want to come into hospital but was persuaded to by the day centre staff.

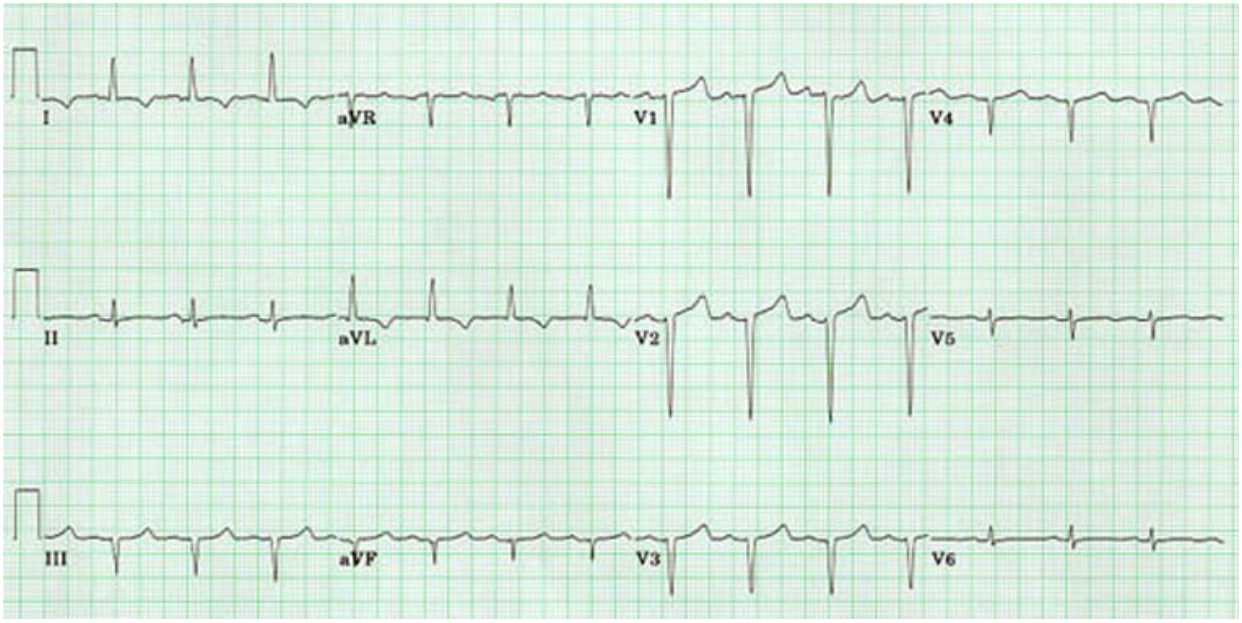
On assessment

AMT 2/4. Alert, confused and agitated. BP 162/78, pulse 70 and regular, RR 16, Sats 96% air. BM 9.4. Urine dip 1+ glucose, 1+ protein

No focal neurology. Systolic murmur. Chest clear. Abdo soft and non-tender.

Able to walk to toilet with supervision.

Bloods – Ur 13.8 Cr 192. Hb 10. WCC 12 CRP 13



QUESTIONS

1. What is the differential diagnosis?
2. How will you manage her?

ANSWER & DISCUSSION

1. What is the differential diagnosis?

She has had an episode of transient loss of consciousness (T-LOC)

- non syncopal causes – seizure/metabolic
- syncope – simple or situational faint/orthostatic hypotension/arrhythmia/structural heart disease

In the elderly – as with most things – the clinical picture may not be as clear cut.

2. How will you manage her?

You call her daughter for more information. She comes straight to the department. She has Power of Attorney for her mum.

She tells you that her mum has had several of these episodes over the past few years, and also sometimes gets dizzy spells. Her blood pressure is always up when the GP checks it and her medications have been altered recently.

Her mum's cognition has been declining more rapidly recently and the CPNs are involved. She is well supported at home and is managing (on the days she doesn't go to day centre her family are there during the day). Her mum has a fear of hospitals and finds attending them very difficult. She thinks her current behaviour is usual for her in this situation.

From portal her bloods are at baseline and her ECG unchanged (old anterior MI). You ask for lying and standing blood pressures to be checked and there is a 15 mmHg drop. You send urine for culture but don't start any antibiotics.

You think the most likely diagnosis is orthostatic hypotension/situational syncope brought on by eating related to her BP meds, but convey to the daughter that there are features (abnormal ECG, murmur) which require further assessment. The daughter is very keen to avoid admission as her distress is very difficult to manage in hospital and will stay with her tonight. You advise a reduction in antihypertensives and discharge with OP 72 hour tape, echo and soon follow up at the falls OPD.

Learning Points

- In the elderly clinical presentations are not always clear-cut.
- For people with dementia the risk of hospital admission (falls, delirium, functional decline) is much greater than for those without
- Care should be personalised and risks and benefits of admission weighed up
- Information from families as to baseline condition and the persons wishes can be vital
- Families may also be able to provide extra support to avoid admission
- A range of facilities to support assessment in the community are available – if you are unsure if a patient needs admission you can speak to the on call geriatrician (via switch) for advice
- And finally - protein in the urine does not = UTI (but you knew that already!)