Weakness, Falls, and Dizziness

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Learning Objectives

- Develop a diagnostic approach to these common presentations
- Understand cost effective care approaches to include diagnostics and treatment plans
- Navigate the inpatient setting with these complaints/presentations

Learning Style: Morning Report is Back!

- Meet our "Residents"
  - Dr. Mellisa Gaines, Dr. Bill Logan, and Dr. Mary Dohrmann.
- Will plan to present cases, 3-4 cases
- Ongoing discussion, and "pimping" by proctor AND the crowd (the "attendings" in the room)

Case #1

36 year old female presents to the ER with complaints of Lightheadedness and dizziness. Symptoms started upon waking and persisted throughout the day. Symptoms were associated with nausea at times without emphasis. And were more pronounced with walking and moving. They were relieved by sitting still. She denies any recent illness, fevers, chills, cough, chest pain or abdominal pain.

Med Hx: HTN, HLD, Seasonal allergies, GERD

No Surg Hx

Meds: Amlodipine, pravastatin, Zyrtec, and Prilosec

No pertinent family hx

Nonsmoker or etoh use

Differentials???

Reasoned Diagnostics??

Case #1 continued...

Physical Exam

- Temp 98.4
- HR 86
- BP 148/82
- RR 16
- O2 sat 96% RA
- HEENT: WNL
- CV: RRR, no r/g/m, warm, peripheral pulses
- Pulm: CTAB, no wheezing, normal work of breathing
- Abd: soft, nontender, normoactive bowel sounds

Labs/Imaging/EKGs

- CBC – Wnl
- BMP/CMP - Wnl
- CXR – normal, needed???
- Head CT – normal, needed??
- Epley - positive
- Echo - ???? Needed??
- EKG – not obtained, needed??
- UA negative

Case #1 conclusion

- Benign Paroxysmal Positional Vertigo

- What tests are needed in this workup?
- When do you consider hospital admission?
- If admitted, what are some treatment strategies?

Case #2

87 year old male admitted for hyponatremia. Initial workup revealed SIADH thought secondary to history of COPD. Was placed on fluid restriction and sodium began improving on hospital day #2, from 128 to 132. but in the afternoon while working with therapy was noted to get lightheaded and dizzy. Denied any other symptoms per therapy and nursing reports. And symptoms apparently resolved 20 minutes after his therapy session. No other report was given by nursing staff or therapy. Pt seen by provider within 1-2 hr or event and had no complaints at that time. But his therapy is hindered by this per the PT/OT notes.

Med Hx: HTN, HLD, COPD on 2 lpm NC baseline, CAD s/p 3v CABG, CHF, Parkinsons, SIADH, Hx of tobacco abuse, Afib and malnutrition

Surg Hx: CABG, knee replacement, ICD placement

Meds: plavix, eliquis, crestor, coreg, Entresto, Lasix, aldactone, Imdur, Sinemet

No pertinent family hx

Current nonsmoker, hx of 40pk yr use, no etoh use

Differentials???

Reasoned Diagnostics??

Case #2 continued...

Physical Exam

- Temp 98.4
- HR 58
- BP 104/58
- RR 20
- O2 sat 92% 2lpm NC

- HEENT: WNL
- CV: Brady with soft systolic murmur, warm, peripheral pulses
- Pulm: scant expiratory wheezing in all fields, slight increased work of breathing with accessory muscle use
- Abd: soft, nontender, normoactive bowel sounds

Labs/Imaging/EKGs

- CBC – Wnl UA - neg
- BMP/CMP - Na 132, remainder normal
- CXR – chronic emphysema changes, No acute findings
- Head CT – no acute changes, chronic small vessel disease
- Echo - 1 month ago was EF of 30%, mild/mod Aortic stenosis, mild mitral stenosis, mild pulm HTN suggested
- Walk test – no worsening of chronic hypoxia with exertion
- CT PE – not obtained & EKG – no acute changes

Case #2 conclusion

- Patient was later found to have postural orthostasis and recumbent HTN during subsequent exams and therapy sessions.
- Infectious workup also negative
- Eventually diagnosed w/
- Autonomic Dysfunction 2/2 to Parkinsons Disease

- Was this a valid inpatient diagnosis?
- How can this impair discharge from an inpatient setting?
- What are some treatment strategies to improve and assist hospital throughput?

Case #3

65 returning to the ER for evaluation of Lightheadedness and dizziness from his cardiac rehab facility. Patient had recently undergone PCI six days prior and was in cardiac rehab. Denied any fevers or chills. Was on the treadmill when he stated felt as if " heart is racing" and during the exam it's still complaining of dizziness and palpitations.

Med Hx: HTN, HLD, DM2, CAD s/p 2v PCI, CHF, Hx of Lung CA

Surg Hx: PCI, partial lung resection

Meds: plavix, aspirin, crestor, metopolol, norvasc, lasix, entresto, Jardiance

No pertinent family hx

Current nonsmoker, no etoh use

Differentials???

Reasoned Diagnostics??

Case #3 continued...

- Temp 98.4
- HR 186
- BP 88/48
- RR 18
- O2 sat 92% RA

Physical Exam

- HEENT: WNL
- CV: Tachycardiac, irregular rhythm, no murmurs can be appreciated, cool peripheral extremities, faint distal pulses
- Pulm: slight increased RR but good air movement to bases, fine crackles at bases
- Abd: soft, nontender, normoactive bowel sounds

Labs/Imaging/EKGs

- CBC – Wnl
- BMP/CMP - K3.3, Mag 1.7, rest WNL
- BNP – 1200K
- Trop – 32
- CXR – Mild vascular congestion
- Echo - post pci 5 days ago, EF 50%, Mod aortic stenosis, dilated atria
- CT PE – not obtained
- EKG – Afib with RVR

Case #3 conclusion

- New Onset AFib with RVR

Case #4

102 yo male presenting to ED from home after frequent falls as witnessed by family. Patient lives with son and daughter in-law who assist with care, however patient is independent with walker primarily. Pt or family deny any loss of consciousness or head injuries during these falls. And they reports nearly 3-5 falls per week for the last 3 wks and feal they can no longer care for him given his frequent falls and they are concerned something is wrong. He denies any pain or injury or complaints on interview. ED requests admission given he is unsafe to return home.

Med Hx: HTN, HLD, DM2, CAD, CHF, , Afib, CKD 3b, Malnutrition, urinary retention (straight caths at home),

Surg Hx: PCI, joint replacements (knee and shoulder, years ago)

Meds: plavix, eliquis, crestor, metopolol, norvasc, entresto

No pertinent family hx

Current nonsmoker, no etoh use

Differentials???

Reasoned Diagnostics??

Case #4 continued...

Physical Exam

- Temp 98.4
- HR 64
- BP 98/66
- RR 14
- O2 sat 92% RA

- HEENT: WNL
- CV: irregular, harsh systolic murmur
- Pulm: shallow but clear bilaterally
- Abd: soft, nontender, normoactive bowel sounds

Labs/Imaging/EKGs

- CBC – Wnl UA negative
- BMP/CMP - WNL
- BNP – 4K (baseline compared to past)
- Trop – 18 (similar to past)
- CXR – Mild vascular congestion
- Echo - 2 years ago EF 40%, severe aortic stenosis, repeat today unchanged EF and stenosis (no significant worsening)
- CT head – Hx of old subdural, otherwise no acute changes
- EKG – Afib, no ischemic changes

Case #4 conclusion

- Failure to thrive, Age related functional decline/debility

During stay was found to be near max assist with therapy with very limited rehab potential.

Eventually discharged to SNF with subsequent LTC transition

Valid Diagnosis??

- Where do you go from here
- Discharge planning??
- When to start Goals of Care in this scenario??

Closing remarks from our Residents!

Big Thanks to our Panelist for enduring the Hot seat today!!

Questions???