



1/05/26 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Sair Ahmad Case Discussants: Dr. Helen Shi (@) & Vale (@valeroldan23)
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Sarah B)
CC: 55 year-old-male with **dizziness** for a couple of days.
HPI: 55-year-old male was referred to the ER complaining of **new-onset weakness, dizziness**, especially with standing and walking, vertigo, and **slurred speech** for the last couple of days. Symptoms persist lying down or sitting.

ROS: He denies headaches, abdominal pain, fever, recent illness, medication change, nausea, vomiting, double vision, photophobia, any urinary complaint, or diarrhea. No history of syncope, presyncope.

PMH:
Hypertension, grand mal seizures (last ~3y), anxiety, chronic hyponatremia (baseline 132),

APLS, adrenal insufficiency d/t blood clot, stroke, MI, DVT, hypothyroidism, GERD, hypertension, ET, Raynaud's, sleep apnea.

Meds: warfarin,

Oxcarbazepine, lamotrigine, escitalopram, clonazepam,

dexamethasone, fludrocortisone, levothyroxine, pantoprazole, losartan, metoprolol, verapamil, B12, ferrous sulphate, primidone, on CPAP.

Vitals: T: 98.4 HR: 54 BP: 131/86 RR: nl Sat: 96% BMI:
Exam: **Gen:** normal appearance
HEENT, CV, Pulm, Abd: nl
Neuro: Patient awake and oriented to person, place, and time. Speech was normal, language was fluent, with no aphasia. Attention and concentration were normal.
Cranial nerves: all within normal range. **Motor strength:** 5/5 in all limbs. **Sensory examination:** normal light touch, pinprick, vibration, and proprioception.
Coordination: finger to nose test, rapid alternating movements, and heel to shin tests, were normal bilaterally without dysmetria. **Gait:** not tested. **HINTS:** not performed.

Notable Labs & Imaging:
Hematology: WBC: nl Hgb: nl Plt: nl MCV: nl
Chemistry: Na: 125 SOsm: 257 UOSm: 360 UNa: 62
K: nl HCO3: nl Cr, BUN: nl Glucose: nl Ca: nl Mg: nl
AST: nl ALT: nl Alk-P: nl Bili: nl Albumin: nl Total Protein: nl

Imaging:
EKG: normal sinus rhythm
Patient was moved to the ICU for management of hyponatremia.

MRI Brain: showed a 1 cm x 3.5cm chronic infarct posteriorly in the right cerebellar hemisphere, a 4mm chronic lacunar infarct posterior in the left centrum semiovale, and mild chronic microvascular ischemic gliosis in the supratentorial white matter.

Additional Labs: TSH, morning cortisol were normal.
Oxcarbazepine level: elevated

Dx: Syndrome of inappropriate ADH likely due to oxcarbazepine
Management: The patient was managed by discontinuing IV fluid, fluid restricted to 1500 ml per day, and initiated a salt tablet of 1 gram. Neurology changed his oxcarbazepine to lacosamide resulting in resolution of hyponatremia and symptoms.

Problem Representation: 55 year-old-male with PMH of stroke, grand mal seizures on oxcarbazepine, lamotrigine, and clonazepam, and chronic hyponatremia presented with acute weakness and constant dizziness without focal features on exam. He was found to have Na 125 and labs consistent with SIADH due to oxcarbazepine.

Teaching Points (Seeme)
Approach to Dizziness /Vertigo:
-We can think about vascular causes and look for exposures (medication/ trauma). Sometimes patients having feeling of environment spinning, we can think about central or peripheral cause of vertigo.
-central vertigo is persistent while peripheral vertigo is episodic. Orthostatic vertigo can be secondary to steal syndrome.
Approach to weakness and slurred speech:
-Worse on standing can make us think about cardiovascular cause of weakness.
-presence of many symptoms makes us think about brainstem issue, we think about infection/ vascular problem /mass.
Approach to PMH:
The patient's history such as past history of stroke and APLs makes us think about high risk of recurrent stroke.
-Meds like carbamazepine and oxcarbazepine can cause cerebellar atrophy
Approach to Exam findings and Lab findings:
-Gait exam can help us figure out about asymmetrical weakness or give clues of truncal ataxia.
-Head impulse test can be used to test for vestibulo-ocular reflex
-We can look for sensorimotor and conductive hearing loss and look for vesicles in ear as well.
-Oxcarbazepine, lamotrigine and adrenal insufficiency can contribute to hyponatremia.