72 Y/M WITH SUDDEN LOSS OF CONSCIOUSNESS

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CASE

- 72Y/M known DM on insulin, HTN on medication brought in with h/o sudden loss of consciousness for about 20 minutes.
- Collapsed while teaching. Hit his head on a desk.
- Regained consciousness on the way to the hospital.

Emergency assessment and management

Airway and C-spine	Able to support the neck, airway patent with no secretions. Patient was able to speak No neck tenderness	Cervical collar not used as there was no suggestive cervical spine injury
Breathing	RR 16bpm, SPO2 95% on RA, chest normal shape, bilaterally rising with respiration, equal air entry bilaterally with vesicular breaths sounds and no added sounds	
Circulation	warm peripheries, CRT<2, Bradycardic, pulse 41bpm, BP 60/43 mmHg, mild pallor	2 large bore cannulae, Iv fluids NS 1L start Blood samples for CBC, RFTs and electrolytes. RBS 24.1mmol/L

cont’d

Disability	**GCS 14/15 E-4,V-4, M-6, PEARL, Normal reflexes, tone, bulky. No FND**	**RBS 24.1mmol/L Soluble Insulin 20 IU**
Exposure	Small hematoma on the right parietal area about 5cm diameter, tender	IV paracetamol 1g Consider non contrasted head CT

S	Signs and symptoms	Sudden loss of consciousness, lightheadness and blurring of vision prior to the collapse. palpitations, easy fatigability. No chest pain, DIB, orthopnea, PND. No convulsions, headache
A	Allergies	No food and drug allergies
M	Medications	Mixtard PB 25/PS/15, metformin 1 g B.D, Losartan H 50/12.5mg O.D, Nebivolol 20mg O.D, Atovastatin 20mg O.D, pregabalin 75mg O.D
P	Past medical history	DM, HTN, This was index episode of sudden LOC, last admission in Jan for Diabetic foot 4th and 5th toes amputated
L	Last meal	Had break fast (Milk tea and chapati)
E	Events	Hit head on desk during collapse

Problem List

- Sudden loss of consciousness
- Palpitations
- Dehydration
- Hypotension
- Bradycardia
- Hyperglycemia
- ?head trauma

Investigations

- RBS: 24.1mmol/L
- Urinalysis: prot ++, glu ++, ket Nil, Leu Nil, blood Nil, pH 6.0
- CBC: WBC 5.6, Neu 3.7, Hb 11.4g/dL, PLT 152
- RFTs and electrolytes: cre 1.1, Na 134mmol/L,K 4.6mmol/L
- ECG: sinus bradycardia, with 1st degree AV bloock
- CT: Normal brain parenchyma,

Treatment and follow up

- 2 large bore cannulae,
- Stop antihypertensive and monitor bp and blood sugar 2hourly
- IV fluids: 1L NS stat, then 3L in 24 hours
- Insulin: 20 IU of soluble insulin in 500ml NS

Follow up

Stable, BP raised 112/78mmHg, GCS 15/15 with no confusion.

Antihypertensives changed to Lorsatan 50mg alone