Small Group Scenario: AMS

Dispatch: Sunnyside Nursing Home, Elderly M c̄ AMS

General Impression: 77 y/o male presents C&A though confused and disoriented sitting in chair in NAD without complaint.

Primary Assessment: Airway open, breathing appears to be slightly tachypneic with good TV, radial pulse rapid, strong, and irregular. Skin cool, dry, slightly pale. Pt can follow commands.

HPI: SNF staff states that patient has had a 3-day history of worsening AMS, pt normally fully oriented. Today is disoriented to person, place, and time. Pt has had no complaints during this time period, staff denies any c/o CP, SOB, dizz, N/V, abd or back pn, syncope, or weakness. Staff states pt has preexisting R side deficits from previous CVA. Pt with chronic renal failure, receives dialysis 1x/week, received last treatment 3 days ago. Urine output has decreased dramatically over past 3 days. Staff reports that pt usually produces about 1 liter of urine/day, has not produced any x 2 days. Pt has also had traces of blood in stool over same time period, no gross hemorrhaging noted. Pt has received meds via staff. Staff reports BGL = 94 mg/dL, rectal temp 98.8°F. ∅ Hx of falls or trauma.

PMH

- Renal failure c̄ hemodialysis 1/wk
- HTN
- IDDM
- Depression
- Seizures
- CVA

Medications

- Insulin
- Cardizem
- Effexor
- Lorazepam
- phenobarbitol

Allergies

- NKDA

VS:

- RR = 22, GTV, unlabored
- HR = 102 strong, irregular
- BP = 158/100
- SpO_2 = 93% RA, increases to 100% on O_2 2 lpm via NC

Clinical Exam:

- **HEENT/Neck**
  - PEARL
  - ∅ JVD, ∅ trach dev
  - mucus membranes moist
  - R side facial droop noted
- **Chest/Back**
  - LS c̄ slight rales to bases ⊥
- **Abd/Pelvis**
  - Abd SNT
  - ∅ pn with palpation to pelvis
  - ∅ incontinence noted
  - ∅ rectal bleeding noted
- **Extremities**
  - CSM intact & WNL x 4 ext
  - + R side arm weakness
  - Skin cool,dry,slightly pale

Treatment:

- **Call ALS**
- **O_2 via NC @ 2 lpm**
- **Sit pt up (has fluid in lungs)**
- **Rapid transport to ED**

1. From the list to the right, identify the most likely cause of the patient's presentation. Be sure to be able to state why you think other possible diagnosis are less likely to be the cause.

Hypoxia
CHF
Alcohol
Hypoglycemia
Hyperglycemia
Drug/Med OD
Head trauma
Infection
Psychosis (Delerium)
Dementia
Sepsis
Stroke
Renal failure
Hypothermia
Hyperthermia
Seizure/Postictal

This patient is in renal failure. He has a history of renal insufficiency for which he receives dialysis 1x per week. Something happened that put him into total renal failure, as evidenced by his lack of urine output for the past 2 days. He is slightly hypertensive because he has excessive fluid volume in his cardiovascular system. He has rales because some of this volume is spilling over into his lungs. This also accounts for his slightly low SpO_2 that is corrected with oxygen. Also on the list of possibilities is stroke. He has had one before, and could have had another. The fact that he has existing deficits from a previous stroke can make it difficult to perform an assessment. There could also be an issue with medication OD, as an OD of lorazepam (valium) could result in AMS.

2. What is the Pt's GCS? **4/4/6 = 14**

3. Is this patient stable or unstable? What is your transport priority? Be prepared to defend your decision with information from the case. **AMS = unstable & rapid transport. A real issue in patients with renal failure is cardiac dysrhythmia and cardiac arrest.**

4. Is this patient in shock? If so, what category, and what stage? **Nope, not in shock.**

5. List your management plan for this patient in the “Treatment” area above. Here, explain exactly how each part of your management plan will benefit the patient.