Case A

Mr Holly is an 82yo M who presents to the ED via EMS with his daughter who he lives with. She states that he has been weak for two weeks and had 3 falls in the last 5 days. The last witnessed fall was last night and he required assistance getting up. There was no LOC and he denies head injury. There was no seizure activity nor appreciable facial/limb weakness.

Mr Holly states that he feels 'dizzy', especially on standing. Apart from feeling more off balance at times and weak, he is otherwise well. There are no infectious symptoms, palpitations, CP nor SOB. He is eating and drinking well.

Mr Holly's daughter prepares meals for him, cleans, and assists him in showering twice a week. He ambulates independently with a cane, and walks around the block most days, however this has become less frequent. He states it is because of the cold.

<u>Past Medical History</u>
Type 2 Diabetes
Chronic Kidney Disease
Hypertension
Gout
Heart murmur

<u>Medications</u>
ASA 81mg PO
Metformin 1g PO BID
Allopurinol 200mg PO daily
Ramipril 5mg PO daily
Metoprolol ER 25mg PO daily
Acetaminophen PRN

<u>Exam</u>
VS: HR 68, RR 13, SpO2 96%, BP 115/68. Orthostatics on standing: BP 108/64, HR 69
CV: systolic murmur with radiation to carotids, otherwise normal HS. Mild symmetrical bipedal edema.
Resp: Good air entry bilaterally. No adventitia. No increased WOB.
Abdo: Soft, non-tender. BS present.
Neuro: Normal speech. Normal EOM. No facial weakness. Power symmetrical through upper and lower extremities. Finger-nose and heel-shin normal.

<u>Investigations</u>: ECG and blood work are unremarkable.

<u>Questions</u>
1) How could the patient's medications be contributing to their problem?
2) It is currently Saturday of a long weekend. What, if any, changes to the patient's medications would you make?
3) How would you counsel the patient/family upon discharge.

Case B

Ms Kringle presents to the ED by herself early in the new year. She is 74yo and is quite tearful when you interview her. She explains that she is unable to sleep for the past two weeks and that you 'must' help her. On further history she admits that her sister unexpectedly passed away a few weeks earlier. She travelled to Europe for her funeral, and ever since returning home she has been unable to sleep. She has a diminished appetite, but is drinking well. She also endorses some chest tightness and palpitations which are worse at night. She blames jet lag and is requesting sleeping aids.

She saw a GP who prescribed her Zoplicone but states this does not help, and that her GP is off until next week. She states that she has no family as they are in Germany, and no friends that she can talk to.

After taking a thorough history and examining her you believe she is having a bereavement reaction in addition to her anxiety. Her investigations including ECG and bloods are unremarkable and have no acute medical concerns. She is not a risk to herself nor others.

<u>Past Medical History</u>
Anxiety disorder
Osteoarthritis
Osteoporosis
TIA
Atrial Fibrillation

<u>Medications</u>
Rivaroxaban 10mg PO daily
ASA 81mg PO daily
Escitalopram 10mg PO daily
Zoplicone 5mg PO qhs
Clonazepam 0.5mg PO daily (uses 2x on 'bad' days)
Melatonin 10mg SL qhs
Tylenol Arthritis PRN
Vitamin D
Calcium

<u>Questions</u>

1) What, if any, changes to the patient's medications would you make?
   Please be specific and explain your answer/reasoning.
2) It is Saturday the 29th of January - both the GEM nurse and SW are not available over the holiday. How would you counsel/ what else would you do for this patient?

Case C

Ms Rose is 88yo. She presents with her son to the ED with concerns regarding a rash. She was seen at a walk-in clinic 3 days prior and was diagnosed with a contact dermatitis secondary to some new shampoo she received at Christmas time. She does not participate in the history much, and drifts off to sleep intermittently, however on questioning she denies infectious symptoms, headaches, and pain.

Her son is with her, and has concerns that although her rash appears to be improving with her new medications, she has worsened. He states that she is more drowsy during the days but not sleeping at night. Her retirement home reports that she is not attending her meals. He believes at times she is more confused. She continues to scratch constantly and he wonders if this is keeping her up at night.

Ms Rose lives in a retirement home where her meals are provided for her. She receives assistance with cleaning and bathing. She ambulates well with a walker. Her son lives nearby and visits 2-3x weekly.

<u>Past Medical History</u>
Osteoporosis
CAD - MI with 3 stents 7 years ago
COPD
Mild cognitive impairment

<u>Medications</u>
Combivent inhaler
Risedronate 35mg PO weekly
Vitamin D
Calcium
Diphenhydramine 50mg PO q6h PRN (new)
Prednisone 25mg PO daily x 7d (new)
Acetaminophen PR

<u>Exam</u>
VS: HR 75, RR 16, SpO2 96%, BP 142/78.
CV: Normal HS. Mild symmetrical bipedal edema.
Resp: Good air entry bilaterally. No adventitia. No increased WOB.
Abdo: Soft, non-tender. BS present.
Skin: Diffuse maculopapular rash covering neck, torso and buttocks in keeping with contact dermatitis. Excoriations present. No evidence of secondary infection. No MM involvement. In keeping with atopic dermatitis.
Neuro: Drowsy but easily rousable. Oriented to place, month and year. Normal speech. Normal EOM. No facial weakness. Power symmetrical through upper and lower extremities. Finger-nose and heel-shin normal.

<u>Investigations</u>: ECG, blood work and urinalysis are unremarkable.

1) How could the patient's medications be contributing to their problem?
2) What, if any, changes to the patient's medications would you make?
3) How would you counsel the patient and her son?