Date of visit: January 22nd, 2026

Location: NYP Queens, Flushing, NY
Source of information: Self
Reliability: Reliable
Source of referral: Self
Mode of transport: EMS

Chief complaint: "I was not feeling well all day, and then I went to get up, fell and woke up on the ground."

HPI: S.K is a 79 YOF with PMHx of HTN, HLD, CAD, T2DM, HFpEF, and Afib sp ablation on 1/20/26 who presented to the ED sp witnessed syncopal episode. Pt states she was feeling nauseous, light headed and short of breath all day yesterday (1/21/26). Around 9 pm last night, she stood up from the couch to go into the kitchen, lost consciousness, and woke up on the ground. The episode was witnessed by her husband who states she hit her head on a chair that was nearby. Pt was able to get up with the assistance of her husband, but was unable to ambulate after. She was not confused upon regaining consciousness. Husband called EMS who transported the pt to the ED. Upon further questioning, pt states she took her home dose of Metoprolol in the morning after checking her HR was in the 50s. Pt denies cough, fever, chills, chest pain, palpitations, diaphoresis, headache, abdominal pain, vomiting, or bowel/bladder incontinence. Per husband, there was no shaking or jerking movements, sudden muscle rigidity, or blank stare prior to fall. Pt was admitted to medicine floor in stable condition for syncope evaluation and work up.

Past Medical History

- Coronary artery disease x present, controlled
- Type II diabetes mellitus x present, controlled
- Hypertension x present, controlled
- Hyperlipidemia x present, controlled
- HFpEF x present, controlled
- Afib x present, controlled
- Osteoarthritis x present, controlled
- Overactive bladder x present, controlled
- Irritable bowel syndrome with constipation x present, controlled
- GERD x present, controlled
- Neuropathy x present, controlled

Immunizations: up to date on all immunizations

Past Surgical History

- Parathyroidectomy in 2003, no complications.
- Cholecystectomy on 06/13/2025, no complications.
- Ablation for Afib on 1/20/2026, no immediate complications.

Medications

- Acetaminophen 325 mg tablet, one tablet every 6 hours PRN
- Alirocumab 100 mg injectable every 7 days
- Amlodipine 2.5 mg tablet daily
- Eliquis 5 mg tablet every 12 hours
- Aspirin 81 mg chewable tablet daily
- Atorvastatin 40 mg tablet at bedtime
- Ezetimibe 10 mg tablet daily
- Gabapentin 400 mg capsule 2x per day

- Jardiance 10 mg daily
- Metoprolol tartrate 50 mg tablet every 12 hours for 30 days
- Omeprazole 40 mg capsule DR
- Tenapanor HCl 50 mg tablet
- Vibegron 75 mg tablet

Allergies
No known drug or food allergies.

Family History
No known significant FHx

Social History
Habits: Denies smoking, alcohol or illicit drug use. No caffeine intake.
Diet: patient is able to eat and drink as normal.
Exercise: does not exercise, but is able to walk without a cane.
Travel: no recent travel.
Sleep habits: endorses healthy sleeping patterns.
Marital status/living situation: married to husband who she lives with.

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Hair, skin, nails: denies rash, itching, excessive sweating or dry skin, new moles, change in existing moles, hair loss, change in hair texture or nail changes
HEENT: (+) lightheadedness; denies headache, visual changes, double vision or blurriness, tinnitus, discharge from ears, nose bleed or discharge, congestion, sore throat, mouth ulcers or bleeding gums
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Pulmonary: (+) SOB, denies cough, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: hx of HTN; denies chest pain, palpitations, or swelling of legs or feet
Gastrointestinal: (+) nausea; denies vomiting, diarrhea, decreased appetite, abdominal pain, heartburn or pain with swallowing
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Neurological: (+) syncope; denies weakness, seizures, numbness, tingling, memory loss or changes in gait or mental status
Musculoskeletal: denies muscle/joint pain, redness, deformity, or trauma
Peripheral Vascular: denies claudication, coldness or swelling of extremities or color change in extremities
Hematologic: denies hx of anemia, easy bruising, blood transfusions or hx of DVT/PE
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: denies depression, anxiety, mood changes, new difficulty sleeping, difficulty concentrating or suicidal ideations

Physical Exam
General: 79 year old female, well nourished, well developed and well groomed. Pt appears stated age; appears distressed/anxious upon evaluation, but AOx3 to person, place, and time.

Vital Signs:
Blood pressure: 126/71 mmHg
Respiratory rate: 17 breaths per minute, unlabored
Pulse: 51 beats/min, regular rate & rhythm, 2+
Temperature: 36.6 degrees C, oral

SpO2: 96% on RA
Height: 156 cm
Weight: 165.8 lbs
BMI: 30.9

Skin: warm and moist, good turgor. Nonicteric, no lesions.
Nails: no clubbing. Cap refill <2 seconds in upper and lower extremities.
Head: normocephalic; **left side facial abrasions, left cheek abrasion, ecchymosis, swelling, and tenderness to left side of face.**
Eyes: symmetrical OU. No strabismus, nystagmus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink. PERRLA, EOMs intact.
Ears: Symmetrical and appropriate in size. No lesions, masses, trauma on external ears. No discharge or foreign bodies in external auditory canals bilaterally.
Nose: **superficial left nasal bridge abrasion**; symmetrical; no masses, lesions, or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. Septum midline. No foreign bodies noted.
Throat: lips pink and moist, no cracking or cyanosis. Mucosa pink and well hydrated. Oropharynx with no injection, exudates, masses, lesions, or foreign bodies; tonsils without injection or exudates; uvula pink and midline, no edema.
Pulm: respirations unlabored, no paradoxical respirations or use of accessory muscles. Lungs clear to auscultation; chest rise symmetrical.
CV: **bradycardia to 50s**, otherwise normal rhythm, distinct S1 and S2, with no murmur, S3, or S4 on auscultation. No splitting of S2 or friction rubs appreciated.
Abdomen: round and symmetric with no scars or pulsatations. BS normoactive in all 4 quadrants with no bruits. Soft, non tender to palpation. No guarding, rebound, hepatosplenomegaly, or CVA tenderness noted.
Peripheral vascular: Extremities have good color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted.
MSK: no swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout. FROM of all upper and lower extremities bilaterally.
Mental status/neuro exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to person, place, and time. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Strength and sensation intact.

Labs/Imaging:
WBC: 10.9
H/H: 11/36
Na: 132
K: 5.2
Cr: 1.32 (baseline 1)
AST: 104, ALT: 72
BNP: 986
Trop: 2663
INR: 1.5

RPP negative

CXR: pulmonary vascular congestion. Minimal atelectasis or scar at the left lung base. No definite pleural effusions, no signs of infection
Pelvic XR: mild to moderate bilateral hip joint space narrowing, otherwise no obvious pathology
CT head without IV contrast: no evidence of acute intracranial pathology; chronic microvascular

ischemic disease and chronic cerebellar infarcts
CT C spine without IV contrast: no evidence of acute cervical spine fracture
CT maxillofacial: left facial soft tissue swelling and hematoma; no evidence of acute facial bone fractures

EKG: sinus bradycardia

Assessment

Patient is a 79 YOF with PMHx of HTN, HLD, CAD, T2DM, HFpEF, and Afib sp ablation on 1/20/26 who presented to the ED two days post procedure sp witnessed syncopal episode upon standing, preceded by nausea, lightheadedness, and SOB. She was noted to be bradycardic to low 50s on presentation and had taken Metoprolol at home despite HR in the 50s yesterday morning. Concern for cardiogenic syncope, likely secondary to symptomatic bradycardia in setting of recent Afib ablation and beta blocker use. CT head was negative for acute intracranial pathology.

Differential Diagnoses

1. Symptomatic bradycardia secondary to Metoprolol vs post ablation procedure
    A. Pt was bradycardic to low 50s on presentation, and EKG showed sinus bradycardia. She took her home dose of Metoprolol yesterday morning despite checking her HR was already in the 50s. Bradycardia can reduce cardiac output enough that cerebral perfusion falls, which can lead to syncope, especially in older patients who can't compensate well.
    B. Pt is sp Afib ablation 2 days ago, which can cause SA or AV node dysfunction and increase susceptibility to symptomatic bradycardia. Although the EKG was only notable for sinus bradycardia, a single EKG does not equal continuous rhythm assessments.
2. Orthostatic hypotension
    A. A drop in BP upon standing may lead to transient cerebral hypoperfusion and subsequently syncope. Older patients have slower baroreceptor reflexes, making them more vulnerable. Pt had lightheadedness throughout the day, and syncopized after standing from a seated position. Further, she is on Metoprolol which limited compensatory tachycardia and Amlodipine which causes vasodilation.
3. Acute decompensated HF with reduced cerebral perfusion
    A. Pt complained of SOB and nausea/lightheadedness the day of the syncopal event. Her CXR showed pulmonary vascular congestion, which supports volume overload/congestion. Her BNP was elevated to 986, supporting HF strain. She also has a history of HFpEF, making her prone to poor tolerance of hemodynamic shifts. Especially when combined with bradycardia, reduced cardiac output can contribute to syncopal episodes.
4. Arrhythmogenic syncope
    A. Although EKG showed sinus bradycardia, her syncope could still be due to an intermittent arrhythmia not captured on a single EKG, especially with her history of Afib and recent ablation, as well as CAD and HFpEF.
5. ACS/NSTEMI
    A. Although troponin is likely elevated due to recent ablation, ACS must be considered, especially in elderly women with diabetes due to atypical presentations (SOB, nausea). Ischemia can provoke arrhythmias or transient pump failure which can lead to syncope.
6. Seizure
    A. Although very unlikely given no witnessed tonic-clonic movements, post-ictal phase or incontinence, seizure should be ruled out in any person with transient loss of consciousness.

Plan/Workup

- Place on telemetry monitoring to evaluate for intermittent arrhythmia or conduction abnormalities
- Will obtain orthostatic vital signs
- Monitor finger stick given history of T2DM
- Carbohydrate controlled and cardiac diets

- GI prophylaxis with Protonix PO daily to reduce risk of upper GI bleeding, gastritis, and PUD given AC and AP use

Meds
- Hold on Metoprolol given bradycardia
- Hold on anticoagulants given facial hematoma
- Give Lasix 20 mg IV x1 due to CXR showing pulmonary vascular congestion and elevated BNP

Labs
- Lipid panel for CV risk stratification
- TSH to evaluate for thyroid dysfunction contributing to bradycardia or arrhythmia
- A1C to assess long term glycemic control
- Follow up BMP to assess sodium and potassium levels
    - Trend Cr given mild AKI
- Trend CBC and follow up anemia panel given Hg of 11
- Trend LFTs given transaminitis
- Trend troponin
- RPP (-); will follow up UA given mild leukocytosis

Imaging
- Limited TTE to assess for new wall motion abnormalities vs newly reduced EF vs pericardial effusion post ablation
- Carotid doppler to r/o stenosis
- MRI brain in setting of syncope with + head strike
- Renal US to r/o urinary obstruction/post-renal AKI

Consults
- EP recommendations were appreciated: hold Metoprolol due to bradycardia
- Cardiology
- Neurology

Patient education:
Pt was educated on appropriate Metoprolol use, including monitoring HR prior to dosing, holding medication and calling doctor if HR <60 BPM or if symptomatic, and not discontinuing abruptly without medical guidance.