

Date: 02/13/26

Chief complaint: "Hypoxia and altered mental status x 1 hour"

HPI:

Patient I.C. is an 88-year-old female with a past medical history significant for Type 2 Diabetes Mellitus, hypertension, hyperlipidemia, and Atrial Fibrillation on Eliquis who presents to the ED via EMS at 4:00 PM for evaluation of acute altered mental status, hypoxia, and hemodynamic instability. Nursing home staff state they found her in her bed at 3:00 PM unresponsive and "blue"; the exact time of onset and preceding events are unknown. EMS reports initial vitals were significant for a BP of 52/30 mmHg, HR of 48 bpm, SpO2 of 56% on RA, and a rectal temperature of 30.4°C. The patient is currently A&O x 0 (baseline A&O x 3) and is non-verbal and non-mobile. There is noted central cyanosis and unpalpable radial pulses. Daughter, who visits every week, confirms the patient is Full Code and was in her usual state of health two days ago. History is provided by nursing denying recent infection, urinary changes, bowel movement changes, vision changes, or recent trauma per nursing home records.

Past Medical History:

Type 2 DM

Essential HTN

HLD

Chronic Kidney Disease (CKD) Stage IV (not currently on maintenance dialysis)

Atrial Fibrillation

Past Surgical History: Myomectomy (2023), Appendectomy (1975). (from chart)

Current Medications: (per nursing facility records)

Lisinopril 10mg PO daily

Metformin 500mg PO BID

Atorvastatin 40mg PO daily

Eliquis 5mg PO BID.

Social History: Lives in a skilled nursing facility. Daughter visits weekly.

Smoking: Denies tobacco use (per nursing facility records)

Alcohol: Denies alcohol use (per nursing facility records)

Illicit drugs: Denies (per nursing facility records)

A&Ox3 at baseline, requires assistance with ADLs.

Family History:

Unable to obtain family history

Review of Symptoms:

Note: Patient is A&O x 0; ROS is limited and obtained via collateral from EMS, SNF records, and family.

General: Profound hypothermia, cyanosis, and loss of consciousness noted. No recent fever or chills per SNF.

Cardiovascular: Severe hypotension and bradycardia noted on arrival per EMS.

Pulmonary: Acute respiratory failure and hypoxia. No recent cough according to nursing home.

Neurological: GCS 3, fixed pupils, and negative oculoccephalic reflex. No history of recent falls or trauma per SNF.

All other systems: Unable to assess due to patient's clinical state.

Vital Signs:

BP: 46/24 (Manual)

Temp: 30.4°C (Rectal)

HR: 44 bpm

RR: 8 (Agonal)

SpO2: 56% on RA

Weight: 40 kg (estimated)

Physical Exam:

General: Elderly female, cachectic looks unkempt. Appears stated age. GCS 3 (E1V1M1). Patient is unresponsive to painful stimuli and in severe respiratory distress. Central cyanosis noted to the lips, tongue, and nail beds.

Skin: Cold and clammy to the touch; mottled extremities bilaterally. Significant tenting noted (poor turgor). No rashes, petechiae, or purpura appreciated.

HEENT: Normocephalic, atraumatic. Sclera non-icteric. Mucous membranes are dry and pale. Pupils 4–5 mm bilaterally and non-reactive to light. Negative oculoccephalic (doll's eyes) reflex.

Cardiovascular: Profound bradycardia with regular rhythm. Heart sounds faint in the setting of low cardiac output; no murmurs, rubs, or gallops appreciated. No palpable radial, brachial, or pedal pulses. Carotid pulse is faint; blood flow confirmed via bedside Doppler. Capillary refill is severely delayed (>5 seconds).

Pulmonary: Agonal, shallow respirations at 8 breaths per minute. Lungs are clear to auscultation. No wheezing or rales.

Abdominal: Flat, soft, and non-distended. No scars or pulsation noted. No masses or hepatosplenomegaly appreciated on light palpation.

Extremities/Peripheral Vascular: Extremities are cold and cyanotic to the level of the mid-forearm and mid-calf. No peripheral edema noted.

Neurological:

- Mental Status: A&O x 0; GCS 3.
- Cranial nerves unable to be fully assessed due to coma. Pupils non-reactive bilaterally. Corneal reflexes absent. Oculocephalic reflex absent. Findings may reflect severe metabolic derangement and hypothermia.
- Flaccid muscle tone throughout; no spontaneous movement or withdrawal to pain.
- Neurologic exam limited in the setting of profound hypothermia and metabolic derangement.

Differential Diagnosis:

Uremic Encephalopathy (Primary Diagnosis):

Severe uremia due to acute on chronic renal failure (Stage IV CKD) is the leading diagnosis, given profound neurological depression (GCS 3) in the setting of likely metabolic acidosis. Accumulation of nitrogenous waste and acidemia likely resulted in CNS depression, hypoventilation, and hypoxia. Severe metabolic derangement, potentially including hyperkalemia, may have contributed to cardiovascular instability. Profound hypothermia further exacerbated neurologic and hemodynamic suppression.

Septic Shock:

Remains a strong consideration given the patient's residence in a skilled nursing facility and presentation with profound hypotension. Elderly patients may lack classic infectious symptoms. An occult infection such as urosepsis or pneumonia could have precipitated acute on chronic renal failure and metabolic decompensation.

Intracranial Hemorrhage:

Must be emergently ruled out given advanced age and anticoagulation with Eliquis in the setting of sudden coma (GCS 3) and absent brainstem reflexes. A large intraparenchymal or brainstem hemorrhage could explain fixed pupils and rapid neurologic decline. Emergent non-contrast CT head is required.

Severe Metabolic/Electrolyte Derangement (Hyperkalemia):

Advanced CKD places the patient at high risk for hyperkalemia, which may contribute to bradycardia, hypotension, and cardiac instability. Electrolyte abnormalities may also exacerbate CNS depression.

Severe Accidental Hypothermia:

Rectal temperature of 30.4°C represents severe hypothermia, which independently causes bradycardia, hypotension, and decreased neurologic responsiveness. Neurologic findings may be reversible with rewarming.

Myxedema Crisis:

Though less likely without known thyroid disease, must be considered given hypothermia, bradycardia, and altered mental status.

Plan

1. Airway & Respiratory Management

- Emergent Intubation: Respiratory Therapist (RT) called to the bedside for emergent RSI with ketamine and rocuronium.
- Place on a breathing tube machine to manage respiratory failure and hypoxia.

2. Hemodynamic Support

- Arterial Access: Place a right femoral arterial line for continuous, accurate blood pressure monitoring.
- Vasoactive Medications: Place Norepinephrine infusion titrated to MAP >65 mmHg; Phenylephrine 100 mcg IV push PRN for breakthrough hypotension, may repeat q1-2 min
- Fluid Resuscitation: Aggressive isotonic IV fluids (0.9% Normal Saline) for volume expansion with 2 x 18 gage large bore IV.

3. Empiric Broad-Spectrum Antibiotic Coverage

- Given the patient's residence in a skilled nursing facility, profound hypotension, and undifferentiated shock, empiric broad-spectrum antibiotics are initiated to cover for possible septic shock pending culture results.
- Initiate Imipenem IV for broad gram-negative, gram-positive, and anaerobic coverage, including resistant organisms.
- Blood cultures x2 obtained prior to antibiotic administration.
- Urine culture obtained via sterile catheterization.

4. Rewarming Protocol

- Apply Bair Hugger forced-air warming system to the torso.

5. Diagnostics & Consultations

- Laboratory Evaluation: CBC, CMP, ABG, serum lactate, magnesium, phosphorus, coagulation panel, and TSH/free T4.
- Cultures: Blood and urine cultures to identify a potential septic source.

- EKG to assess for hyperkalemia-induced conduction abnormalities.
- Neuroimaging: Emergent non-contrast CT head to rule out intracranial hemorrhage given anticoagulation with Eliquis and presentation with coma and absent brainstem reflexes.
- Nephrology Consult: Urgent consultation for emergent dialysis or Continuous Renal Replacement Therapy (CRRT) given the diagnosis of uremic encephalopathy in a pre-dialysis Stage IV CKD patient.

6. Disposition

- ICU Admission: Direct transfer to the Intensive Care Unit for continued stabilization and management of multi-organ failure.

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