

Dementia/Sensory Impairment Case

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HPI: Mrs. S is an 82 y.o. woman with diabetes mellitus and hypertension who is brought in by her son because over the past 3 months she has refused to go to the senior center. She had been attending three times a week since the death of her husband eight years ago. When asked why she suddenly stopped going to the center, she says she is “tired” and “doesn’t feel like it”. She says she feels “just fine” otherwise and doesn’t know why her son is making such a fuss. The son says she seems more forgetful lately, in fact, she left something on the stove recently.

PMH: Type II DM x 10 years, HTN x 20 years fairly well-controlled by enalapril and diltiazem.

SH: Lives with son who has prostate cancer. One daughter with colon cancer. HS education. Worked as lens crafter for optics firm and retired at 65. Widowed. No longer going to church.

Meds: NPH insulin 20 units q a.m. with 6 units of regular insulin, enalapril 20 mg, extended release diltiazem 240 mg qd, MVI, CaCo3 500mg TID.

IADLs: son does all shopping, cooking, cleaning, transportation, finances, laundry, meds

ADLs: help with bathing, otherwise independent

ROS: has had a few falls during the night on the way to the bathroom; nocturia 1-2 times; denies memory px or incontinence

PE: somewhat inattentive, but when you speak up is more engaged

BP 160/84, P 72 R, R 16

HEENT: bilateral cataracts, fundi not visualized; decreased hearing bilaterally

Chest: clear

Cor: S1 and S2 WNL with S4, no rubs, murmurs

Abd: nl BS, no HSM, mass, or tenderness

Ext: absent DP and PT pulses, stasis changes but no edema

Neuro: MSE alert and oriented to place-- “the doctor’s”; motor-- -5/5 throughout except for 4/5 L hand abductors and flexors; sensory--decreased pinprick, proprioception and

vibration; gait-“get up and go intact”, “cruises” and looks down when she walks;
cerebellar grossly intact; DTRs 2+

Recent labs: nl electrolytes, BUN 28, Creat 1.5, HbA1C 8.8, Hct 33% with MCV 98, nl
WBC

Questions:

1. What other history would you get from the patient/family?
2. Is there anything else you would add to her physical?
3. What is the differential diagnosis of her son’s “chief complaint”—i.e. refusing to go to the senior center?
4. What is the appropriate workup as indicated by the history and focused physical exam?
5. What is the appropriate management?