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THE THOUSAND AND ONE FACES OF SODIUM

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PERSONAL HISTORY AND REASON FOR INQUIRY:

82-year-old patient. Allergy to Penicillins. Previous independent life, lives with relatives at home.

- High blood pressure.
- Dyslipidemia.
- Moderate chronic obstructive pulmonary disease.
- Accident hemorrhagic cerebrovascular 10 years with annual monitoring by neurosurgery.

Usual treatment: Losartan, simvastatin and metered demand.

It goes to emergency room accompanied by relatives by box of 24 hours of evolution of somnolence with headaches back and repeat without associated fever vomiting.

PHYSICAL EXAMINATION:

Patient with preserved general status, light tachypnea of rest without work of breathing. Dryness of the oral mucosa. No cyanosis.
TA: 110/55. FC: 80 BPM. Baseline O2 saturation 96%. Afebrile.
Head and neck: palpable carotid pulse.
Cardiac auscultation: Rhythmic and Regular puffs systolic multifocal II/IV.
Respiratory auscultation: MVC. Scattered Roncus both chest.
Lower extremities: no swelling or signs of DVT.
Neurological examination: isocoricas and normoreactivas pupils. Normal cranial. Drowsiness. Other noteworthy findings.

COMPLEMENTARY TESTS:

- Chest x-ray: normal ICT. Without images of condensation or infiltrators. Parahiliar bilateral bronchial thickening.
- ECG: RS at 80 BPM. Unaltered driving or the Repolarization.
- TAC's skull: atrophy corticosubcortical with ventricular dilatation (similar to previous studies)
- Analytical income: normal blood count. Biochemistry with 1.8 creatinine mg/dl and highlights, sodium 120 mg/dl.

EVOLUTION:

The patient enters the area of observation for treatment with clinical judgment of severe acute hyponatremia, improve symptomatically after administration of intravenous treatment and entering to continue care later in internal medicine.

CONCLUSIONS:

The history of the patient with existence of secondary hemorrhagic stroke to aneurysm and the clinical presenting the patient, made us think in the first place as a presumptive diagnosis in a new episode of spontaneous intracranial hemorrhage. The existence of vomiting in the clinical picture was focused as a possible result of a so-called bleeding and not as a cause of the appearance of severe acute hyponatremia that subsequently justified the neurological clinic of the patient.