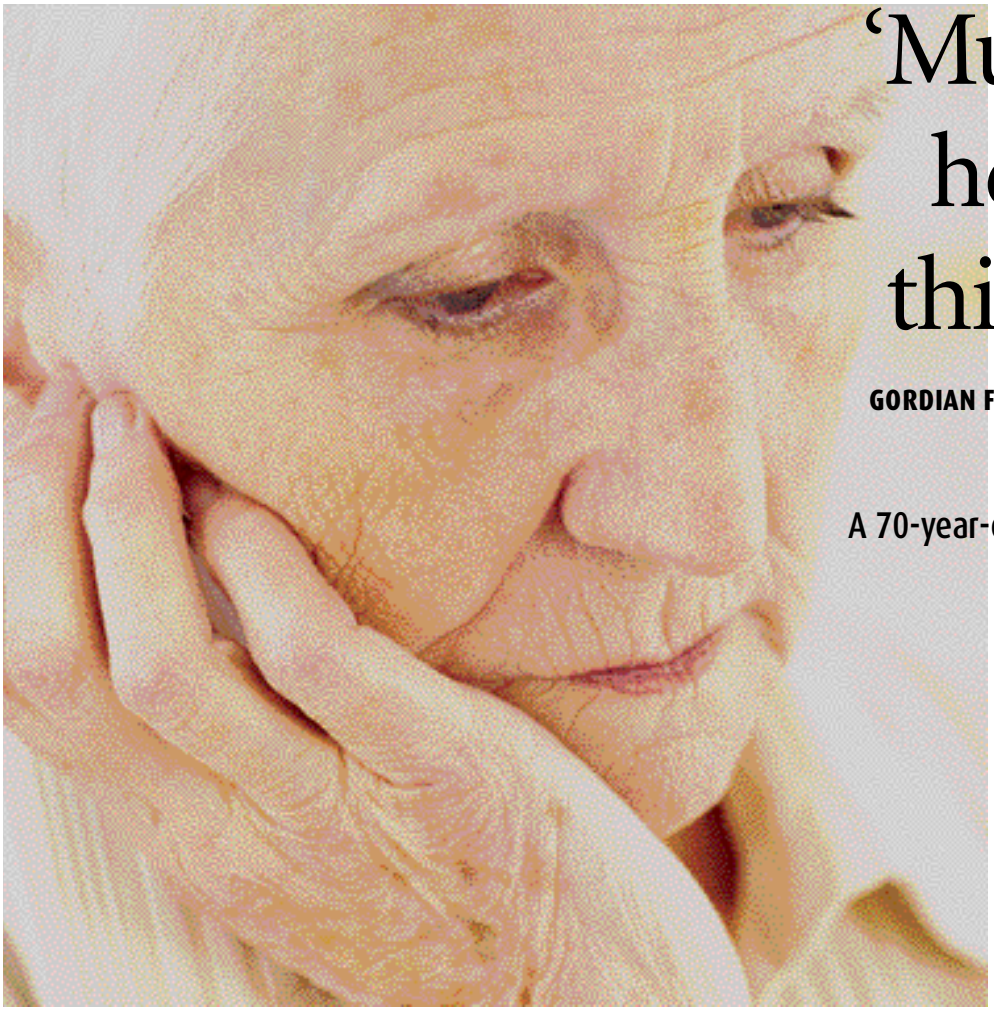

PHOTOLIBRARY

'Mum has lost her memory this morning'

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A 70-year-old woman wakes up with acute confusion and loss of memory.

As a GP also working in your local hospital's emergency department, you get to see and look after patients with a wide spectrum of diseases, both common and rare. You are also acquainted with some patients or their families and this can put extra stress on you.

The case

Arrival at hospital

You had just started your shift and were thinking you had better organise yourself a cup of coffee, as often you just do not get the time, when you were asked to look at an elderly woman who had been brought in by her son whom you happen to know. Over your many years in medical practice you have learnt (at times by the mistake of granting concessions to the 'rules') to always care for all patients (including friends, VIPs, unpleasant patients and relatives) in the same methodical way. So you took the patient's file and some stickers and progress notes to record the history and management and went to meet her.

The patient was a pleasant, well kempt, 70-year-old woman surrounded

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continued

Table. A summary of transient global amnesia

Risk factors
- Affects middle aged and elderly people (usually 60 to 65 years)
- Migraine sufferers may have a predelection
- Can be associated with a valsalva manoeuvre as a trigger
- Affects men and women equally
- Atherosclerotic risk factors do not predispose to transient global amnesia

Clinical features
- Reversible
- Antegrade amnesia is prominent (inability to form new memories after the event, usually lasts for one to 10 hours)
- Retrograde amnesia is common (lack of memory relates to events that occurred before the event, usually lasts for hours to days)
- Disorientation with time – patients often repeatedly ask the same questions about the date and/or environment, despite only being told the answer minutes ago
- Able to perform complex motor task such as driving or playing musical instruments
- Other cognitive functions are normal
- No previous episodes
- Most episodes occur in the morning upon waking
- No other neurological deficit

Diagnosis
- Diagnosis made on the basis of the clinical features present
- All investigations show either normality or incidental findings

Differential diagnoses
- Postictal state (particularly temporal lobe seizures)
- Transient ischaemic attack (extremely rare cause of amnesia)
- Psychogenic amnesia (inability to remember personal details, e.g. own name) – excludes transient global amnesia
- Hypoglycaemia
- Toxins (carbon monoxide, alcohol)
- Infections

Prognosis
- Complete recovery usual
- Recurrence very unusual (<5%)
- No limitation on activities after the event, e.g. driving, flying

by concerned family. The presenting symptoms were acute confusion and loss of memory. The triage nurse, concerned that it may have been an acute stroke, had given an urgent triage category of 2 (to be seen within 10 minutes) – functionally, to be seen straight away.

Apparently, the patient had woken up that morning confused with loss of memory. Her husband had noticed this and had called their son. The patient did not know what day it was, the date, where she was, or that her daughter was pregnant. Also, she could not remember events from the previous night. Of the last 30 minutes, she remembered only some parts – arriving at the hospital but not how or why she was here. Apparently, she had showered and washed her hair that morning but had no memory of it.

Examination and assessment

The patients had no neurological symptoms such as headache, visual disturbances, dizziness or problems with balance when walking. Her vital signs, including temperature and oxygenation, were all normal. A bedside blood sugar level was also normal.

Her past medical history did not reveal any major illness or hospitalisation (other than for child birth and a hysterectomy). Her medications were an ACE inhibitor for mild hypertension and a statin for control of her elevated cholesterol levels.

On examination she was still confused, but a detailed neurological examination found no other abnormality. The remaining examination was normal. The provisional diagnosis was transient global amnesia. However, in situations such as this, it is necessary to exclude a cerebral event. Routine electrocardiogram, haematology and biochemistry were all within normal limits. A noncontrast CT scan of the brain revealed no acute intracranial abnormality.

Discharge and outcome

Over the next few hours the patient improved markedly, and when the neurologist on-call and team came to see her, she was discharged and a follow-up appointment was arranged.

One of the good things about working shifts in the emergency department is that you can usually get a quick tutorial from the specialty registrars or consultants just by asking them at the time. This was especially useful in this case as the initial possibilities included serious pathology (see the Table).

As often happens when a patient and his or her family are very worried about a stroke or other serious pathology and this turns out not to be the case, they are very relieved and grateful to you. The following week, the patient's son dropped by with a bottle of red wine for you and confirmed that his mother remains completely back to normal. MT

Acknowledgement

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