

Her Glistening Eyes

Ahmed Z Obeidat, MD, PhD

Perm J 2016 Fall;20(4):15-227

E-pub: 09/23/2016

<http://dx.doi.org/10.7812/TPP/15-227>

It all started with a clot. Large portions of our patient's dominant hemisphere were damaged. She was intubated and too sleepy to even open her eyes. Her family gathered around her, anticipating a moment of life. Together we reviewed her brain images. "It was a large stroke that deprived segments of her left brain of oxygen and nutrients," I said.

Her family craved answers. They asked, "Will she ever wake up?" "Will she recognize us again?" "If she does, will she talk, walk, eat, or be able to live on her own?"

"It is too early to know. Let's give her some time," I replied.

A few days after her admission to the hospital, she opened her eyes and was successfully extubated, but she was not moving her right side, and her eyes were looking to the left. She was unable to vocalize or engage with her surroundings. Her family was starting to accept the minimal chance of her recovery. However, they remained at her bedside all the time, talking to her as if she could respond.

One morning, as part of my daily checks on her, I walked into her room and greeted her son who was sitting on a bed next to her. He had a smile on his face and said, "She is improving. Last night she appeared more awake; she opened her eyes and seemed to be 'mindful.'" I was excited as I performed my neurologic exam. The results were largely unchanged, however, with the exception of a new look in her eyes, I read it as an expression of life. That same day, she was transferred from the intensive care unit to the regular floor. I continued to check on her every morning. She remained sleepy and poorly interactive, but she started to move her right forearm in a sporadic and frail manner. I noted that despite her somnolence and continued silence, she started to follow some instructions. In spite of my perception of her slight improvement, she could not participate in physical therapy and remained too sleepy to swallow. Chart notes continued to describe her as drowsy and at high risk of aspiration. Her nasogastric feeding tube was not a permanent access, and we planned for the placement of a gastrostomy tube. The Social Work Department had found her a place at a nursing home near her family residence, and her discharge from the hospital was imminent.

One day, as the end of our patient's hospital stay neared, her son grasped my attention with these words: "Last night, she mentioned my name, touched my head, and pulled me close to her heart as if I were her baby again. She smiled and followed my steps around the room." I was surprised to hear that she was so different at night—she kept her eyes closed during most of my morning visits and could hardly move her unaffected side. I inquired about that. Her son answered, "My mother became a night person after her stroke."

That night I felt guilty and stayed up late thinking about her. "Is she more awake?" "Shall we reassess her now?" "Shall we

repeat the swallow evaluation at night?" "What if she is able to?" "What if she qualifies for rehabilitation?" I felt like I should do something. I wanted her to go to rehabilitation. I wanted her to go home. I wanted her taste buds to enjoy food again. I could see hidden potential beneath her glistening eyes.

The next morning, I expressed my concerns to the team. We all agreed to do our best to wake her up. To help her, we administered amantadine and asked all other teams to reassess her as late as possible that day. I was pleasantly surprised to witness her gain a soft diet and participate in physical therapy. In fact, she was evaluated by our Physical Medicine and Rehabilitation Department, passed their assessment, and was transferred to a rehabilitation center on the basis of their recommendation. There, she participated in an intensive exercise plan and was later discharged home in good condition. Her glistening eyes were inspiring. Her great family support and our teamwork had indeed been successful.

I believe that this case made me a better physician—I learned that patient recovery is far beyond a signed daily progress note. I now check on all my patients at least twice, in the morning and later in the evening just before I leave work. Being a busy resident doesn't justify overlooking such details in patient recovery. Brain pathologies can affect sleep patterns and distort arousal.¹ These changes can indeed confound the journey toward true recovery and can result in suboptimal outcomes.

Finally, I wonder how many patients are just like her. Being sleepy is one thing, but failing the poststroke assessment is another. Daytime hypersomnia has been described in patients following acute stroke.¹ Several mechanisms for hypersomnia have been proposed, ranging from alterations in sleep physiology to changes in respiratory function including central sleep apnea.¹

This case serves to remind us of the possibility of a sleep-wake inversion following acute stroke and the potential impact of this change on patient disposition and ultimate outcomes. Further prospective studies aiming to investigate an association between acute hypersomnia, posthospitalization disposition, and functional outcomes are likely to unravel novel interventions to improve poststroke recovery. ❖

Disclosure Statement

The author has no conflicts of interest to disclose.

How to Cite this Article

Obeidat AZ. Her glistening eyes. Perm J 2016 Fall;20(4):15-227. DOI: <http://dx.doi.org/10.7812/TPP/15-227>.

Reference

1. Bassetti CL. Sleep and stroke. *Semin Neurol* 2005 Mar;25(1):19-32. DOI: <http://dx.doi.org/10.1055/s-2005-867073>

Ahmed Z Obeidat, MD, PhD, is a Resident in the Department of Neurology at the University of Cincinnati Medical Center in OH. E-mail: ahmed.obeidat@uc.edu