**CLINICAL HISTORY**: This is a 68-year-old, right-handed male, who presents with change in mental status and left-sided weakness. Past medical history is remarkable for coronary artery disease, hypertension, and hyperlipidemia.

**MEDICATIONS**: Norvasc, isosorbide, aspirin, lisinopril, Norvasc, Lipitor, nicotine patch, metoprolol, and digoxin.

**INTRODUCTION**: Digital video EEG is performed in the lab using 10-20 system of electrode placement with one-channel EKG. Hyperventilation and photic stimulation were not performed.

**DESCRIPTION OF THE RECORD**: In the most alert state, the posterior dominant rhythm was 8 to 8.5 Hz in frequency seen in the occipital region, which attenuates with eye opening. There is 6-7 Hz diffuse theta activity seen during wakefulness, which is distributed symmetrically. There is a small amount of low-amplitude frontal central beta activity, which is distributed symmetrically. Drowsiness is characterized by disappearance of the posterior dominant rhythm, slowing of the background, and absence of muscle and eye blink artifact. There are intermittent bursts of bitemporal slowing at F7/T3 and F8/T4 more prominent on the left side or independent left temporal slowing at F7/T3 during wakefulness and drowsiness. Heart rate was 80 beats per minute and regular.

**IMPRESSION**: This is an abnormal EEG due to:

1. Diffuse slowing of the background with theta activity seen in wakefulness and drowsiness, and slowing of the posterior dominant rhythm.
2. Bitemporal slowing, left more than right side seen during wakefulness and drowsiness. No epileptiform abnormalities have been identified in this record.

**CLINICAL CORRELATION**: The above findings could be due to toxic, metabolic, hypoxic, or infectious encephalopathy. Alternatively, it could be due to effect of sedating medication or bilateral cerebral dysfunction or degenerative brain disease. Bilateral temporal slowing that could be due to bilateral structural abnormalities or bilateral cerebral dysfunction. No epileptiform abnormalities or seizures are identified in this record. This does not rule out the diagnosis of epilepsy or intermittent seizures. If clinically indicated, a repeat EEG capturing deeper stages of sleep or continuous bedside EEG monitoring may be helpful.