4/17/20 Morning Report with @CPSolvers

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CC: Headache

HPI: 70W with HTN and obesity presenting to urgent care with **6-10 days of a headache that localized to the frontal region.**

In addition, she had **sinus pain and neck pain**. She denied fevers, chills, and weight loss. She had no vision changes. **She had one episode of word finding difficulty.**

She had a mild response to Tylenol and limited response to sinus sprays.

She denied chest pain, diaphoresis, and palpitations. **This headache felt different than prior migraines.**

PMH:
HTN
Obesity
Migraine

Meds:
None

Fam Hx:
Non contributory

Soc Hx:
No alcohol, tobacco, or recreational drug use.

Vitals: **T:** 98.5 **HR:** 76 **BP:** 177/101 (baseline 140/90)
RR: 16 **SpO_2:** 96% RA
Exam:
Gen: Non-toxic appearing
HEENT: Unremarkable
CV: Normal
Pulm: Normal
Abd: No tenderness
Neuro: CN II-XII normal. FNF normal. Reflexes symmetric and normal.
Extremities/Skin: No rashes. No edema.

Notable Labs & Imaging: (After referral to ED)
CBC: WBC: 9.1, Hgb: 12.3, Plt: 430
CMP: Normal
EKG: NSR, No LVH, No ischemic changes

Imaging:
Non-con CT head: Abnormal edema in the right superior parietal lobe with extension into the right occipital lobe. Findings consistent with a suspected mass of the occipital lobe.

MRI Brain: Multifocal areas of infiltrative mass concerning for high grade glioma vs. less likely lymphoma.

Pathology: Glioblastoma (WHO Grade IV)

Problem Representation: Older woman w/ hx of HTN, migraines presents with new subacute frontal headache, sinus/neck pain and transient word finding difficulty found to have an abnormal CT head and MRI with findings suggestive of an occipital mass diagnosed with grade IV glioblastoma

Teaching Points (Moses):
Headaches: primary vs. secondary (Big picture: space occupying, inflammation (infection, inflammatory), bleed, MSK, HTN-related)
- *What to do next:* consider imaging (parenchyma, vasculature), LP, blood work (vasculitis)
- *Intrinsic vs. extrinsic:* think anatomically: parenchyma, vessels, meninges, surrounding structures
- **Red Flags = SNOOP: S**ystemic inflammation, **N**: neuro deficit, **O**: onset (sudden), **O**: older age (>50), **P**: positional/pattern change (eg. high ICP, new sx)

HTN + Headache overlap: Malignant HTN, SAH. Look out for Cushing's reflex as clue for increased ICP (mass vs. vascular)
PRES: often not posterior! May be secondary to severe HTN (eclampsia, acute GN, etc.), meds (e.g., tacrolimus), SLE, HUS, TTP etc.
Vitals: are vital! But should be considered in clinical context: PMHx (HTN), meds (beta-blockers), etc.
Imaging pearls: look for midline shift → triage, gadolinium can help investigate malignant etiologies. Infiltrative, multi-focal, crosses midline = concerning for malignancy
Mass lesions: mets (lung, breast, kidney, melanoma, lymphoma > primary Ca (including primary CNS lymphoma). Up to 48h of steroids is usually OK in terms of diagnostic yield.
Glioblastoma: IDH mutations now have targeted therapy. Temozolomide tx is backbone of chemotherapy.