4/22/20 Morning Report with @CPSolvers

Case Presenter: *Suzanna Hosein* ***Case Discussants:*** *Gurleen Kaur (@Gurleen_Kaur96) & Kirtan Patolia (@KirtanPatolia)*

CC: Weakness and Diarrhea

HPI: 55 year old man with 5 days of diarrhea followed by abrupt onset of neurologic symptoms. Last known normal was hours ago.

This morning, his sister noticed he had slurred speech and a facial droop, as well as word finding difficulty. His weakness prevented him from ambulating to the bathroom and he was found down after having defecated himself.

Other history included recent sinus infection, treated with a course of steroids and clarithromycin

PMH:
Recent admission, but limited history and evaluation available.

Meds:
Amlodipine
Clarithromycin
Prednisone

Fam Hx:
Unknown cancer in mother and father

Soc Hx:
40 pack-year tobacco use.
4-5 oz of alcohol daily.

Vitals: **T:** 97.6 **HR:** 112 **BP:** 145/73 **RR:** 18 **SpO_2:** 100% RA
Exam:
Gen: Petite man, favoring the right side.
HEENT: Dry mucous membranes. PEERL. No papilledema
CV: 3/6 murmur at the RUSB
Pulm: Diminished breath sounds in the Right Upper Lung field.
Neuro: Left facial droop, intact nasolabial folds. No ptosis. Dysarthric but not aphasic speech. ⅘ in RUE and RLE. ⅗ in LUE and LLE. Restricted vertical gaze. Awake, oriented, but fatigued. Sensation intact. Globally diminished reflexes.

Notable Labs & Imaging:
Hematology: WBC: 23.9, Hgb: 17.9, Plt: 417
Chemistry: Na: 125, K: 4.3, Cl: 83, CO2: 26, AG: 16 Gluc: 92, Ca: 9.5, Mg: 1.4, Alb: 4.3. TP: 8.4. AST: 39, ALT: 21, T. Bili: 1.8, Alk-P: 80. Ace-Level: 17. Urine Prot/Cr: 155
Urine Drug Screen: Negative
Micro: Blood Cx negative x 4, C. Diff negative.
Imaging:
CXR: RUL Consolidation. Enlarged Right Hilum.
CT Head without Contrast: No acute hemorrhage or infarct.
MRI Brain: Multi-focal, scattered, acute infarcts in bilateral cerebral and right cerebellar hemispheres
TTE and TEE: Anterior mitral leaflet lesion with mitral regurgitation
CT Chest: Thick walled RUL cavitary lesion with right hilar adenopathy
Bronchoscopy: Pathologic specimen consistent with Small cell lung carcinoma

Problem Representation: 55 year old man with acute onset diarrhea, followed by abrupt onset weakness and dysarthria, found to have a cavitary lung lesion, mitral valve endocarditis, and multifocal cerebral infarctions, ultimately diagnosed with metastatic small lung carcinoma.

Teaching Points (Moses):
CR Venn Diagram: GI/diarrhea (consider tempo! Acute = infectious as 1st consideration) + neuro: 1) localize 2) determine cause 3) reverse pathology.
Infection+Neuro overlap: consider GBS/AIDP, Miller-Fisher and use ascending vs. descending pattern of weakness as clues.
Listeria Rhombencephalitis: tends to affect the hindbrain (brainstem & cerebellum). High morbidity/mortality, tends to affect the elderly.
Endocarditis: consider bacterial & NBTE (autoimmune, malignancy, etc.). Cool derm findings: Janeway lesions (painless) & Osler nodes (painful). Can also see Roth spots, splinter hemorrhages etc.
High embolic, low regurgitation → think Marantic
Paraneoplastic syndromes: can see with small cell lung Ca (+others), and include SIADH, Lambert-Eaton, EPO-driven polycythemia, Cushings etc.
Diagnostic time-out: can a finding explain all features of the syndrome under consideration? In this case, can the endocarditis explain everything? No! → pick an abnormality to serve as central consideration.
Cavitary lung lesions: infection, Ca, autoimmune