5/15/20 Morning Report with @CPSolvers

Case Presenter: *Avi O'Glasser (@aoglasser)* ***Case Discussants***: *Rabih Geha (@rabihmgeha) Reza Manesh (@DxRxEdu)*

CC: "failure to thrive" → weakness

HPI: 75M with ESRD on HD & mild RA admitted with "failure to thrive" s/p uneventful elective umbilical hernia repair

- POD7: PCP dx **C. diff diarrhea** → PO flagyl
- POD14: Presents to ED "generalized **weakness** and not doing well"

Reports **more falls**, **5-10 lb weight loss** (over last month), trouble "taking care of himself"
Declining over 3 mo (previously independent in ADL/IADL)
Progressive weakness starting in the lower extremities → all 4 extremities
ROS: no syncope/lightheadedness, exertional/resting CV/SOB sx, no cough/sputum/night sweats, nausea/emesis, fevers/chills. **1 week of diarrhea**. No myalgias/arthralgias No new extremity pain, paresthesias, no rashes. **Poor PO intake.** No anorexia, taste changes. **"Trouble feeding himself"** no memory/speech changes or subjective confusion
1-2 mo prior: referred to neurologist. Told nothing abnormal Weakness on day of surgery. **Arrived in wheelchair.** Rapidly worsening weakness. **+ back/buttock pain** (no neck pain)

PMH:
ESRD 2/2 HTN on PD → HD (now nearly anuric w/ temporary tunneled line - no recent issues)
Mild RA
No prior surg
Meds: Amlodipine, olmesartan, sevelamer, tramadol, flagyl → PO Vanc

Fam Hx: unremarkable
Soc Hx: see above
Health-Related Behaviors:
Former smoker (40py)
EtOH: in moderation
No recent travel/exposures
Allergies: none

Vitals: **T**: 37.4 **HR**: 115 **BP**: 85/60 **RR**: 12 **SpO_2**:98 RA BMI 18
Exam:
Gen: age-appropriate, energetic man laying still, cachectic
HEENT: dry mucous membranes
CV: mild tachy, no murmur JVP low/normal
Pulm: Normal
Abd: BS+ scaphoid, well healed incision no erythema/drainage
Neuro: CN intact. Symmetric UE weakness ⅘, LE: ⅗, reflexes: brisk ¾, + ankle clonus, light touch diminished torso + extremities
Extremities/Skin: no edema, warm, no rash. Catheter. Stage 2 decubitus ulcer on back. Mild decrease range of motion in C spine. Decreased muscle mass. No joint effusions

Notable Labs & Imaging:
Hematology:
WBC: 8 (normal diff) *Hgb: 11*, normal MCV (bl) Plt: 360
Chemistry:
Na: 132 K: 3.1 Cl: 80 CO2: 33 *BUN: 77 Cr: 7.3* glucose: 100
Ca 9.5 Mg 2.6, Phos 4.9
LCT: unremarkable Albumin: 2.7
Normal: CK, B12, TSH, ACTH stim test. RPR non-reactive

Imaging:
MRI-brain: age related changes
MRI-spine: severe cervical stenosis w/ compression. C6-C7 damage → myelopathy

Clinical update: surgical decompression. Improvement in strength, d/c to rehab

Problem Representation: Frail older man w/ mild RA & chronic/ progressive weakness presents s/p elective surgery found to have hypotension, upper extremity weakness with hyperreflexia & MRI evidence of C-spine stenosis with compression and myelopathy

Teaching Points (Anna):
Key to define the problem representation: epidemiology, clinical syndrome, duration of symptoms

Approach to a non-specific clinical syndrome: allow something vague to develop with history and workup

- FTT shouldn't be a final dx itself, think broadly about the etiology (endocrine, neurologic, psychiatric, etc)

Weakness: neurologic vs non-neurologic (asthenia)

- Asthenia: symmetric, whole body, no sensory symptoms, feel weakness at rest
- Neurologic etiology: dynamic, worsens with movement (localizing the lesion: brain, spinal cord, peripheral nerve, NMJ)
- History: weakness (gross/ fine motor), sensation, function
- Clinical exam: tone, spasticity, reflexes (***acute UMN etiology may present initially with hyporeflexia)
- Imaging pearls: need MRI spine to evaluate for myelopathy, need EMG to evaluate for nerves, NMJ

Weight loss: caloric intake < caloric output
Ddx: decreased oral intake, malabsorption, increased metabolism (endocrinopathies, inflammation)

Overlap of neurologic symptoms and hypotension: think of autonomic dysfunction

- CNS: (Parkinson's, myelopathy (usually cervical)
- PNS: amyloidosis, diabetes, alcohol, infections, AIDP