# 8/28/20 Morning Report with @CPSolvers

***Case Presenter**: Ravi Singh (@Rav7ks)* ***Case Discussants**:Reza Manesh (@DxRxEdu) and Rabih Geha (@rabihmgeha)*

**CC**: Leg weakness

**HPI**: 27 M found down in street with shallow respirations
-Given Narcan with mild improvement
-During hospitalization, tried to stand up but could not move his legs, also with LE numbness and tingling
-ROS: increased back pain over prior few days, had been using more opiate pain medication

**PMH**:
Cellulitis
Tricuspid valve endocarditis

**Meds**:
None

**Fam Hx**:
None

**Soc Hx**:
Unhoused

**Health-Related Behaviors**:
Smokes ½ ppd
Occasional heroin use for 9 years, last use was few days ago

**Allergies**: None

**Vitals**: **T**: Normal **HR**: 108 **BP**: 149/79 **RR**: 12 **$SpO_2$**: 90

**Exam**:
**Gen**: Awake, diminished cognition
**HEENT**: Poor dentition, dry mucosa, needle track marks all over the body. Open wounds and sores. Neck without trauma
**CV**: Normal
**Pulm**: Normal
**Abd:** Normal. Rectal tone diminished
**Neuro**: Mental back to baseline II-XII: 5/5 strength, 0/5 Right lng, ⅖ left leg, tone exaggerated. Sensory normal until T10. Coordination unremarkable. He cannot stand. Reflexes: 4+, clonus, Positive Babinski
**Extremities/Skin**: Swollen upper extremities. Dilation of veins due to injection

**Notable Labs & Imaging**:

**Hematology**:
WBC: 4.7 Hgb: 9.8 MCV 88 Plt:130

**Chemistry**:
Na:134 K:4.5 Cl:99 CO2: 22 BUN:55 Cr:3.88
AST: 523 ALT:166 Alk-P: 206 Albumin: 2.8 CK:28,905
UA: Dark urine protein, few RBC, hemoglobinuria
Urine tox: Cocaine, opioids and benzodiazepines

**Imaging**:
Lumbar puncture: CSF glucose elevated 96 3WBC traumatic, nothing remarkable
CT head and spine: Normal
MRI after fluids: Abnormal T2 signal, hyperintense from T8-T9
Dx: Transverse Myelitis possibly associated with heroin use

**Problem Representation**:
27 M found down. His PMH includes cellulitis and tricuspid valve endocarditis. Patient had leg weakness, clonus and positive Babinski.
Final Dx: Transverse myelitis (etiology 2/2 heroin use)

**Teaching Points (Anna)**:
- ."Found down"
  - Management > diagnosis
  - Evaluate immediately reversible causes: hypoglycemia, opiate-induced
  - Use time course, determine focality to guide ddx
- Leg weakness
  - Frontal cortex, subcortical structure, spinal cord, peripheral nerve, NMJ, muscle pathology
  - Use UMN/LMN signs to determine what to image
- Transverse Myelitis
  - Acute: vascular, compressive
  - Chronic: inflammatory (autoimmune dz, infx) non-inflammatory (vit B12 def, Cu def)
- Opiate Use Disorder
  - A medical problem that needs medical treatment
  - Withdrawal: "flu-like" sx, n/v/d, yawning, muscle aches, anxiety
  - Trt: symptom-specific + partial/full agonist therapy
- Diagnostic approach to elevated CK
  - Meds, Toxins, Electrolyte derangement
  - Bed-bound, endocrinopathies
  - Genetic syndromes, inflammatory dz