9/10/20 Morning Report with @CPSolvers

***Case Presenter**: Ann Marie Kumfer(@AnnKumfer) **Case Discussants**: Lindsay Haselden (@hazelnutmed) and Mohamed Elashwal (@m7mdwezza)*

CC: diplopia and right facial droop

HPI: 67 F benign chronic leukocytosis (neutrophilia) and HTA, symptoms started 2 days earlier, difficult to walk appeared after diplopia. Fall 2 weeks earlier, she hitted R side of head and increased urinary frequency
ROS: No headache, no jaw claud, no neuro focal weakness, no rigidity, no symptoms prior. Symptoms better at exam
Symptoms disappeared and went to normality in days

PMH:
Benign chronic leukocytosis (neutrophilia) and HTA

Meds:
None

Fam Hx:
Sister HTA

Soc Hx:
Lived alone and walked wirth walker

Health-Related Behaviors:
Never smoker
Occasional drinker. No drugs

Allergies: None

Vitals: **T**: 38.2 **HR**: 108 **BP**:140/73 **RR**: 16 **SpO_2**:98%
Exam:
Gen: Well appearing, not acute distress
HEENT: PERLAA Right eye with surrounding equimosis, cannot adduct eye past midline, vertical nystagmus of R eye, Vision 20/50 with glasses, clear conjunctiva, normal sclera, mucous membranes moist, no masses, no rigidity
CV: Tachycardia, no murmur
Pulm: CTBA
Abd: Normal
Neuro: Normal
Extremities/Skin: Normal

Notable Labs & Imaging:
Hematology:
WBC: 22.3 (81% neut) Hgb: 13.3 Plt: 450
Chemistry:
Na:136 K: 4.1 Cl:100 CO2: 26 BUN:14 Cr: 1 glucose:170
Ca:9.4 Mag: 1.9 Hg A1C: 5.9%
AST, ALT: N, Alk-P: 45 T. Bili:1.6 Albumin:3.7 TP:7.3
Urinalysis: Specific gravity: 1.01 RBC 5-10, bacteria
HIV, Syphilis: negative

Imaging:
Head CT: No acute abnormality, chronic white matter changes
Orbital and head MRI: No acute abnormalities

Ophthalmologist: no acute abnormality
Temporal artery biopsy: Inflammatory small vessel and adventitia
FINAL DX: GIant cell arteritis

Problem Representation: 67F p/w diplopia, increased urinary frequency, and right facial droop. She has fever, tachycardia. Right eye with surrounding equimosis. Head CT and MRI were normal. Symptoms resolved in few days.
FINAL DX: GIant cell arteritis

Teaching Points (Sukriti):
How do we begin to analyse a history with multiple symptoms?
Break it down into small components to build a narrative (1 process vs 1 process + sequelae vs multiple processes)
Let's start with a Sx of "falls" -- Thinking about everything that the body needs to walk and what might be missing!
(Input-- Visual, proprioception; Output -- coordination via cerebellum, neuromuscular)
Diplopia -- Is it monocular or binocular diplopia?
a. Monocular --Lens, globe
b. Binocular -- Systemic (Coordination of gaze, Cerebral cortex all the way down to the muscle)
Get imaging and do not miss a stroke in real life!
Chronic leukocytosis -- Could a hyperviscosity syndrome tie this all together?
Building a hypothesis: Did the fall lead to the neurological Sx or did a systemic process lead to the fall?
Fever + tachycardia = inflammatory CNS syndrome (systemic reactive process iMADE vs central CNS fever -- bleed vs complication of a central CNS process)
Right eye ecchymosis (focal structural pathology) + Vertical nystagmus (central)+ facial droop (forehead sparing UMN vs LMN)
Pearl: SE HINTS exam > Brain MRI for posterior stroke (except in trauma!)
Testing the hypothesis:
Absence of acute abnormalities on brain and orbital imaging makes a central process less likely (Imaging has its limitation!)
Reframing our problem representation: What can cause episodic neurological Sx with inflammation?
Autoimmune, TIA, migraines, MS flares Giant cell arteritis