11/4/21 ⚡ Morning Report with @CPSolvers

***Case Presenter**: Travis (@) **Case Discussants**: Sharmin (@) and Rabih(@)*

CC: Focal deficit and HA.

HPI: 71yF w/ R sided weakness + HA. Patient was undergoing spinal stimulator trial at another facility; during procedure she developed an acute HA and R sided weakness. SBP 260. She had been giving propofol and fentanyl.

Prior to ER arrival was given labetalol.

In the ER her R sided weakness had improved but was also noted to have slurred speech.

PMH: HTN, RA, chronic back pain. Prior CVE w/residual speech deficit.

No prior surgery procedure

Meds: losartan, ASA, MTX.

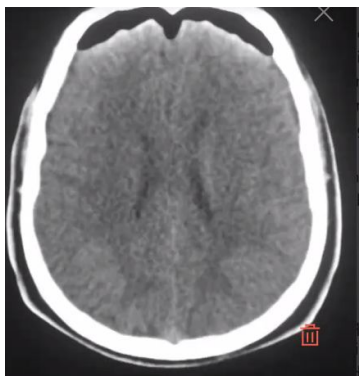
Fam Hx, **Soc Hx**, **Health-Related Behaviors**, **Allergies**: not relevant.

Vitals: **T**: 98.6 F **HR**:90 **BP**:186/95 **RR**: **SpO_2**: 98% RA
Exam:
Gen: AxO, mildly anxious.
HEENT: Pupils equal, visual and eye movements normal.
CV: Normal, no murmurs rubs or gallops.
Pulm: Clear
Abd: Normal
Neuro: CN - intact. Strength: 5/5 L, 4/5 RUE and RLE. Reflexes normal and symmetric. Speech was slurred according to son. Decreased sensation in R leg compared to L leg.
Extremities/Skin:

Notable Labs & Imaging:
Hematology: WBC:11.9 Hgb:11 MCV 82 Plt:240

Chemistry: Na: 140 K:4.8 Cl:102 CO2:24 BUN:10 Cr:0.84 glucose:98 Ca:9.6
LFT + Bilirubin: normal. Albumin and TP normal.
PT and PTT: normal

Imaging:
EKG: sinus rhythm w/out ST changes.
CT: *likely* tension pneumocephalus
(CT can see as little as 1cm air)



Placed on antihypertensives and 100% O2, 24h later CT scan and patient had improved and she was discharged..

Final Dx: Iatrogenic Pneumocephalus

Problem Representation: 71yF w/ PMHx of HTN and CVE p/w acute onset focal deficits, HA and a HTN emergency during a spinal stimulator procedure.

Teaching Points (Rafa):

- **R-SIDED WEAKNESS AND HEADACHE**
  - Focal neurologic deficit and asymmetry - rule out brain causes - eg, TIA, stroke
  - Remember to differentiate primary (cluster, migraine, and tension) vs secondary headache
  - Focus on SNOOP- systemic symptoms / neurologic symptoms/ onset/other associated conditions/previous headache story
  - If present, imaging is necessary.
- **HYPERTENSION + FOCAL NEUROLOGIC DEFICITS**
  - Think about hemorrhagic stroke
  - Most commonly caused by hypertension but also amyloid angiopathy, vasculitis, and neoplasm.
  - Could be affecting the anterior cerebral a. - affects the legs - contralateral paralysis and sensory loss - may also see urinary incontinence
  - MCA - face and arms + Wernicke and Broca aphasia (if affects dominant hemisphere).
  - Pearl: most patients with stroke have normal labs
- **PNEUMOCEPHALUS**
  - Air in the intracranial space
  - Can occur following trauma (most common cause), cranial surgeries, or spontaneously.
  - Can be simple or tension / acute (<72h) or delayed
  - PE can show CSF leak from nose, ear, or surgical site, ersistent headache after cranial or spinal surgery. seizures following surgery, postoperative meningitis