9/26/23 Neuro Morning Report with @CPSolvers

Case Presenter: *Vanessa Roque (@)* ***Case Discussants***: *Maria (@MariaMjaleman) and Sridhara (@)*

CC: Shallow breathing

HPI: 64 female p/w episodic shallow breathing that last a few minutes in multiple episodes. Acutely and persistent.Presented with right neck pain and diaphoresis. Sent to hospital denies losing consciousness and head back Hospital: Admitted to neurology intensive unit No other intervention. She developed paralysis of extremities with left gaze preference. The patient became incoherent and less responsive.

Ed: patient was given Teneoplast she presented with nih scale 2 and sent to neuro icu

PMH:

Meds:

Fam Hx:

Soc Hx:

Health-Related Behaviors:

Allergies:

Vitals: T: 96.6 **HR: BP:** 76/49 **RR:** 38 **SpO2** 80
General Exam: normal sr, equal chest expansion, respir pattern even, soft abdomen, femoral pulses normal, no hematoma
Neurology Exam
- Mental Status: awake alert, nodes yes or no follow commands. Pupils 3 mm no assimetria absent cough reflex
- Motor: 0 in all extremities. Paralyzed from the neck down
- Sensory: fells light touch

Notable Labs & Imaging:
CT: No intracerebral hemorrhage, occlusion of right vertebral arTery

MRI brain: acute infarction in posterior circulation secondary medullary junction, bilateral cerebellum
MRI spine: edema in inferior aspect of cerebral hemisphere extending to mid aspect of c2 vertebral body

Coagulation studies were unremarkable

Dx: acute ischemic stroke of posterior circulation cerebellum due to spinal shock syndrome and vertebral thrombosis

P was in vm but she was able to breathe on her own and recovered moor strength to baseline

Problem Representation: 64 yo woman p/w shallow breathing, left gaze and paralysis of extremities. CT showed RVA occlusion causing cerebellar stroke and spinal shock syndrome

Teaching Points (Debora): #EndNeurophobia
- **SOB in neurology**? Can be associated with weakness, neuromuscular disorder, diaphragm paralysis.
Ddx: ALS, myasthenia gravis, botulism, Guillain barre, myopathy. Not excluding the pulmonary and cardiac causes.
- **Acutely** → look for a trauma and lesion.
Ddx: TIA. Seizure can do anything, can cause autonomic dysfunction e.g. tachycardic, arrhythmia, the patient can present deja vu (you have been in a place). Pain is not a part of seizure!
- **Neck pain:** Dissection carotid vertebral artery, stroke, ischemic episode. Prioritized something vascular.
- Urgency neurology: stroke, seizure, toxic metabolic.
- Can be a huge stroke and now is increasing the cerebral pressure. SOB can be part of the Cushing triad)
- Stroke: Basilar artery → can move anything below the neck, not affecting the face.
- The **middle cerebral artery (MCA)** is the most common cerebral occlusion site. The **anterior cerebral artery (ACA)** it's least commonly vessel affected by strokes, so a stroke involving the ACA can easily be misdiagnosed. Classic signs of an ACA stroke are contralateral leg weakness and sensory loss.
- A stroke affecting the vertebral-basilar circulation can affect the cerebellum, brain stem, or both.
- Vertebral artery can be painful, the vertebral body infarct can be painful too.