01/19/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Yale IM Residency Case Discussants: Rabih (@rabihmgeha) and Reza (@DxRxEdu)

CC: A 26 yo M presents with persistent right sided headache since last week.

HPI: 1 week of right sided headache and left sided weakness intermittently. Felt well prior to presentation. Headache: No prodromal symptoms, No triggers, Resolved by itself, Weakness not always associated with the headache, No numbness or tingling, No additional factors aggravating or relieving headache were noted
ROS: Otherwise negative.

Clinical course: Worsening of HA, new L sided weakness, L facial droop, slurred speech, L arm plegia & multiple stroke codes

PMH: Splenectomy @ 3yrs for unknown reasons, TB lymphadenitis, recent URTI
Meds: None for now. In the past: RIPE for TB, Augmentin

Fam Hx: None
Soc Hx: Moved from India in 2019, software engineer
Health-Related Behaviors:

Allergies: NA

Vitals: T: afeb **HR:** nl **BP:nl RR: nl**
HEENT: 2cm b/l anterior cervical lymphadenopathy
CV: nl, **Pulm:** nl, **Abd:** soft, non tender, non distended, scar from splenectomy
Neuro: 5/5 sensation, normal cranial nerve exam, 5/5 strength in UE & LE
Extremities/skin: 2 cm bl firm inguinal lymphadenopathy

Notable Labs & Imaging:
Hematology: WBC: nl with nl differential Hgb:nl Plt:703k

Chemistry: Na: nl K: nl Cl: nl HCO3: nl BUN: nl Cr: nl glucose: nl Ca: nl, LFT: nl, PT: nl, PTT: 56, CRP: 7.3

Imaging:
CT w/o contrast head: nl, CT Sinus: Acute on chronic sinusitis
CXR:abnormal-> CT Chest: Mass (4*5 cm) left lower lobe of lung with calcification CT AP: Inguinal lymphadenopathy

Imaging after worsening of course:
TTE: nl, CTA: Large right ICA thrombus
MRI brain: acute infarcts over the left cerebral hemisphere with enlarged parotid glands
AFB: Neg 3x, TB PCR:neg, HIV & Histo: neg, C3 & C4: nl, ACE level:nl, ANA: 1:320 & 1:640 homogenous, Anti SSA/B: nl, Anti Smith: nl, Anti ds DNA: nl, Anti cardiolipin: neg, Anti beta2 GP:nl
Lupus anticoagulant: Positive -> Prior records from 2 yrs ago: Lupus anticoagulant and ANA found to be +ve
Bronchoscopy: Neg for TB, **Biopsy** (lung mass): Acute inflammation & epithelioid cell

Dx: Antiphospholipid syndrome and Rosai Dorfman disease

Problem Representation: 26 yr old M patient presents with persistent right sided headache and intermittent left sided weakness was found to have progressive lymphadenopathy, a calcified lung mass and positive anticoagulant antibodies

Teaching Points (Anmolpreet):
I] Headache: associated red flag: intermittent weakness/focal neurologic deficit makes us focus on secondary headache more.: Approach: Primary headache syndrome (migraine, tension, cluster) OR Secondary headache syndrome {SNOOP(presence of red flag signs)}- causes include:
intrinsic(meninges) or **extrinsic** (eye, sinus, dental, neck) or **systemic**(inflammatory process)
Important to note is diurnal variation, headache worse in morning can indicate high ICP(concern for SOL)
II] Weakness:- Headache helps us narrow the differential and localise the cause of weakness to brain.(left sided weakness-right sided headache)
Intermittent weakness for a week: subacute CNS syndrome almost always indicates a space occupying lesions, CT imaging a priority: suspect (a) Demyelinating ds, (b) venous sinus thrombosis
III] Splenectomy indicates immunocompromised state, hence broadens our differentials to consider infection from encapsulated organisms; imp to know immunisation history;
B/L parotid swelling: unlikely to be cancer and stone
IV] Prior h/o TB: makes us think about recurrence or tuberculoma
V] Localised cervical LAD: Anterior: closer to oropharynx; 2/2 local oropharyngeal process/ infection; Posterior: most likely systemic:- eg Infectious Mononucleosis
VI] Diffuse LAD: 2 important tests: HIV and Syphilis
VII] LAD: we have to consider infection and cancer. Absence of fever and significant weight loss in this case with disproportionate LAD is something we need to evaluate.
VIII] Thrombocytosis: Reactive : to inflammation; not a primary hematologic issue; accompanying anemia of chronic ds & increased inflammatory markers are expected
IX] elevated PTT: if can be corrected with mixing study: def of one of the factors in the pathway
X] MR Venography to understand if CNS is involved, which cannot be ruled out with CT without contrast, imp because pt came with neuro sx
XI] Calcifications: indicate granulomatous diseases like TB
XII] Mass in CT Chest: could have been lung cancer which has a predilection to go to brain and Lymphoma., GPA, Sarcoidosis
XIII] In situ thrombosis: atherosclerosis, (blood vessel wall)vasculitis, dissection, hypercoagulable condition.(APLS- idiopathic, 2/2 lupus- APLS may precede any symptoms of SLE}
XIV] Rosai-Dorfman Disease: sinus histiocytosis with massive LAD