04/22/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Dr. Kirtan Patolia (@KirtanPatolia) Case Discussants: Dr. Gurpreet Dhaliwal (@Gurpreet2015)

"Peril in the matrix"

CC: Severe vomiting and headache

HPI: 60-year-old pleasant lady

June: right sided weakness and swaying, outside tPA window, went to rehab, unable to regain substantial strength resulting in recurrent falls, speech deficits

Oct: severe headache, nausea, vomiting, was told have bleed in brain, discharged lack of insurance.

Nov: recurrent headache, high BP 174/90, CT done in ED small acute SDH left frontal lobe, prior infarct in left frontal w/ possible superimposed acute infarct in left frontal. Aphasia, dysarthria, cognitive deficits developed following.

ROS: no dizziness, vertigo, blurry vision, diplopia, hearing changes, tinnitus, abdominal pain, chest pain, SOB, bowel or bladder disturbances.

PMH:
HTN

Meds:
Amlodipine;
ASA;
Atorvastatin.

Fam Hx:
Unremarkable

Soc Hx: No alcohol; no smoking; Cannabis.

Health-Related Behaviors:
Allergies: Denied

Vitals: T: nl **HR:** nl **BP:** nl **RR:** nl
Exam: AO person and place
HEENT: pupils round reactive and equal
Neuro: mild dysarthria, expressive aphasia, power deficits in right side RUE and RLE 1/5, plantar downgoing, cerebellar normal, gait normal, CN normal.

Notable Labs & Imaging:
Hematology: WBC: 4.6; Hgb: 10.7; MCV 84; Plt: 80k (unknown baseline)
Chemistry: HCO3: nl;BUN: nl; Cr:nl; Ca:nl; Mag: nl; AST: nl; ALT: nl; Alk-P:nl; Albumin: nl; LDH: nl
Imaging:
MRI: Bilateral hemispheric subdural collections with signal changes consistent with blood products. Encephalomalacia extending along left superior frontal gyrus and white matter gliosis. Old caudate infarct and chronic microvascular ischemia. Ventricles are normal in caliber. There is no midline shift. Diffuse patchy meningeal thickening/enhancement along the cerebral convexities bilaterally. Sagging of the brainstem and cerebellar tonsillar ectopia with the cerebellar tonsils extending approx 15 mm below the foramen magnum with pointed appearance–> suggestive of intracranial hypotension.
Myelogram: no leak noted, multiple meningeal diverticula noted thoracic and lumbar region. → bind patch placed → intermittently encephalopathic
CT chest and abdomen and pelvis: multiple thyroid nodules up to 2.6 cm, diffuse lymphadenopathy(left subpectoral, axillary, mediastinal, hilar)
Hospital course→ she developed pancytopenia WBC 1.5; Hb 7; Plt 35k ; PBS unremarkable; LDH:315 haptoglobin: normal; PT wnl; INR wnl; aPTT: 59(elevated); ESR: 140; CRP:2 ; TSH and T4: wnl. HIV syphilis negative.
BM biopsy : no evidence hemophagocytosis, unremarkable.
LN biopsy: reactive changes; IgG4 slightly elevated, not diagnostic.
Antiphospholipid cardiolipin, beta2 glycoprotein, Lupus anticoagulant: Positive
ANA>1:160; Anti Sm(+); Anti RNP(+)
UA: unremarkable

Dx: Lupus with secondary aPLS (leads to dural inflammation and leak)

Problem Representation: 60 y/o female with severe headache and vomiting, elevated BP, speech and cognitive impairment, found to have pancytopenia along with diffuse lymphadenopathy, CNS findings are encephalomalacia and pachymeningeal thickening.

Teaching Points (Kuchal):
1.Vomiting and Headache: usually don't travel together; It travels together in Migraine, other IC causes. Headache: Primary Or secondary : infections, cancers, autoimmune causes,
2.Stroke: vasculitis, vasculopathy, dissection, thrombotic, embolic, Or a change in the blood like Antiphospholipid syndrome; Thrombocytopenia might be a clue to that. AF, Sequestration (Splenomegaly)
3.Imaging For headaches: When Secondary headache is suspected, lasting for a long time, escalating, ass with focal findings, new change in character
4.Pachymeninges: autoimmune (sarcoid, EGPA,RA,and Vasculitis), Cancers; Post LP, enhancement of Meninges can occur; Inflammatory causes effects PAchy vs infectious affects the Leptomeninges, except in TB & Fungal. Headache is due to tugging of the dura.
5. Lymphadenopathy: Cancer, Infections, Autoimmune (80%)
6.Low Ret count indicates Hypoproliferative state, BM biopsy required to further assess this.
7. Increased PPT: Anti Factor 8 antibody, APPL.
8. Antiphospholipid Antibody: Persistent or transient; CRP can cause false positive too.
9. Pancytopenia, LAD, APPL: Lymphoma, SLE.
10. Lymphoma: Intravascular? BUT LDH is usually very high . - TO r/o Deep skin biopsy (B cells in the vessels); secondary to SLE? (Nephro involved usually, Hemolysis is usually present) -
11. IGG4: LN biopsy, or Storiform Fibrosis in Meninges
12: SLE: Interferon Gamma High, suppresses CRP; BUT ESR is High; Strokes +ve, ANA +ve, with secondary APLS +VE