



11/12/24 Morning Report with @CPSolvers

“One life, so many dreams” Case Presenter: (@Dr.Sheri Walls) Case Discussants: (@Dr.Youssef Saklawi) and (@Dr.Kirtan Patolia)



CC: 58 year-old male with unsteady gait

HPI: 58 year-old male presented with unsteady gait, started with right lower limb heaviness, onset 3 weeks prior and progressively worsened, denies fever, chills, chest pain, slurred speech, facial droop, vision changes, headaches, unintentional weight loss, abdominal pain, nausea, vomiting, changes in urination and bowel

Vitals: T:98 HR:90 BP:140/80 RR: SPO2 99%
Exam:
Gen: well
HEENT: normal
CV: regular rate and rhythm
Pulm: Normal
Abd: soft, no mass
Neuro: AOX4, CN II to XII normal, upbeating nystagmus +, Motor - 5/5 all limbs, reflexes - 2+
Sensory - intact
Finger-nose dysmetria +?, heel-shin test - normal
Extremities/skin: warm and dry without obvious rash/lesion

Problem Representation:

Teaching Points(khashayar)::

Approach to unsteady gait -> Localization and time course!

Anywhere along the path of the complex pathway of walking can lead to unsteady gait -> Sensory , synapse, neuromuscular junction, motor pathways, CNS

Key to start the localization -> Lower motor neuron vs upper motor neuron lesion

Localization

Dysmetria & gait -> Cerebellum -> vermis(truncal ataxia , vs hemisphere(dysmetria, dysarthria & tremor)

Weakness -> Multiple lesions (afib as risk factor) vs single lesions -> **Glioblastoma** -> the exception (primary brain neoplasm that presents as multiple lesions)

Nystagmus -> Vertical Nystagmus (very sensitive for CNS Pathology -> key localizations brain stems & cerebellum), Horizontal nystagmus (most likely a peripheral cause)

Reflexes -> time course matters -> after 3 weeks hyporeflexia is not characteristic of a lesion in the cerebellar cortex

Understanding the time course -> subacute

Vascular causes -> most intensity at the beginning of event without progression over the next few weeks -> **Stroke** as one of the most common vascular causes is key to be ruled out and be aware of as timing of the event can affect how you manage them

Infections -> lyme, syphilis, classic bacterials(usually fulminant so unlikely), mycobacteria, endemic mycoses, atypical bacteria(nocardia listeria -> base of the brain, brain stem), viral(HIV, Hep), parasites (time course mismatch, risk profile mismatch)

Other causes -> Autoimmune(demyelinating conditions, sarcoidosis,SLE),Paraneoplastic(autoantibodies causing paraneoplastic cerebellar demyelination),Deposition disorders(amyloidosis , POEMS),Tumors(lymphomatous meningitis, carcinomatous meningitis),Genetic(every disorder can present in different times), Dystrophic disorders

Heaviness -> motor deficit(weakness leading to feeling heavy) vs sensory deficit

Findings in the Patient background

Medications -> over the counters -> anticholinergic, sympathomimetic, hypercoagulable states, heavy metal toxicities

Diabetes -> diabetes neuropathy, lumbosacral neuropathy, microvascular infarcts in the brain

Afib -> key factor here is the CHA₂DS₂-VASc score -> approach can start from simple antiplatelet therapy and escalate all the way to dual pathway inhibition depending on the risk profile

Notable Labs & Imaging:

Hematology:
WBC: Hgb: Plt: normal
Chemistry:
Na: K: Cl: HCO3: BUN: Cr: glucose: Ca: Mag: all normal
AST: ALT: Alk-P: Lipase: normal
BUN: Cr: normal
UDS: neg
HIV: neg

Imaging:

CT head: parietal lobe mass with surrounding edema
MRI head: brain-enhancing lesions in left parietal lobe with involvement of temporal and posterior frontal lobes with surrounding edema
Cytology - glioblastoma grade 4

Dx: Glioblastoma grade 4

PMH: hyperlipidemia, Afib, type 2 DM

Fam Hx: nil

Meds: Atorvastatin

Soc Hx: nonsmoker, non alcoholic/drug user

Health-Related Behaviors:

Allergies: