04/30/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Yousef Saklawi(@SaklawiMD) Case Discussants: Sharmin (@Sharminzi) and Prof Rez(@)

Scribing (Johann) **The Rising Tide**
CC: headache and blurry vision

HPI: 45 yo male reports severe HA x2wks, primarily at temples & occipital region, radiating to bilat shoulders. HA assoc w/ photo/phonophobia, L-eye blurry/double vision, & intermittent nausea w/o emesis. HAs episodic, worse when supine, better when sitting/standing.
PMH: migraines, previously on valproate. Episode of imbalance.
Does not smoke or drink, lives w/ wife. Works in landscaping. From mexico, moved to the US 10 years prior.
Home meds: None

Vitals: Afebrile, HR 85, BP 110/70, SPO2 95% room air
Exam: Gen: NAD
Head: NCAT
CVS: RRR, S1/S2 normal
Resp: Clear, no wheezes/crackles
Abd: Soft, NT
CNS: A&Ox3, 5/5 strength throughout, gait impaired (stumbling, requires wall/bed/cane support)

Notable Labs & Imaging:
CBC, CMP within normal limits. HIV screening negative. Optho exam showed papilledema.

Problem Representation:

P1
Imaging:
MRI brain in ED: Homogeneously enhancing extra-axial mass abutting L cerebellar tentorial leaflet, causing mass effect on cerebellum & midbrain. Unchanged effacement of cerebral aqueduct w/ moderate supratentorial hydrocephalus.

Eval by NSGY, suspected meningioma. CT CAP w/o additional masses. Underwent VP shunt placement, followed by mass resection; path confirmed meningioma. Pt did well, discharged to subacute rehab.
Dx: Meningioma

P2 Imaging:
MRI brain: Diffuse ventriculomegaly/hydrocephalus, likely communicating, w/o transependymal edema, indeterminate chronicity/etiology. Mild focal prominence of prechiasmatic cistern. Chronic lacunar infarct in pons. MRV: No dural venous thrombosis.
Ophtho exam: Papilledema. LP performed, OP ~60 cm H_2O. CSF: Elevated protein (54 mg/dL), low glucose (44 mg/dL, serum 103 mg/dL), 64 WBCs (60% lymphs, 14% eos).
Pt reports neg TB test at US entry, HIV - , VDRL -
Cocci AB negative, Toxo Ab CSF negative, Leukemia/lymphoma CSF negative. CSF cytology negative, T solium CSF negative.

HAs improved post-LP. NSGY placed VP shunt. Cysticercosis Ab +
Dx: Extraparenchymal NCC

Teaching Points (Sawsan):
Approach to Headache and Blurry vision:
Headache
- Most often benign(primary headache disorders)
- As internists our job is to know when we should be concerned about a secondary cause
- SNOOP mnemonic for red flags: so severe brings the patient to the ED, sudden onset, positional, any neurological sx

Blurry vision :
- Blurry vision itself can cause blurry vision
- In this context we should prioritize it
- Binocular vs monocular
- No miss DX: increased ICP, when suspected consult ophthalmology

Why would intracranial pressure htn improve with standing/sitting vs lying supine ?
Gravity
Approach to optic disc swelling:
- Bilateral vs unilateral , bilateral> true vs pseudopapilledema
- Example on True: intracranial htn, intracranial mass , venous sinus thrombosis , hydrocephalus
- Example on pseudo: hyperviscosity

Approach to hydrocephalus :
- Communicating vs non communicating (obstructive)
- Communicating > increased production vs decrease reabsorption

Eosinophils in CSF:
Parasite EX angiostrongylus cantonensis, endemic mycoses, TB,eosinophilic meningitis
Neurocysticercosis :
Whenever you suspects it you should consult ophthalmology to look for cysts before treatment , because they can cause blindness .