



6/16/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Dr Rasik Neupane Case Discussants: Dr Kentris



<p>Scribing (Dan) CC: "65M w/ HTN & HLD p/w BLE weakness progressing to BUE weakness x 3-4 hours" HPI: - No deficits at baseline. Started with left arm pain, tingling and numbness progressing to right arm. Progressed to bilateral lower extremity sensory loss. Patient not able to stand or sit. ROS: - No history of IOC, seizure, headache/fever, recent travel, bowel/bladder incontinence. - Flu-like illness 2 weeks ago a/w multiple loose stools + COVID infection 1 month prior. ED: Hypotensive, improved s/p 2L</p>	<p>Vitals: T: 99F BP: Normal HR: 74 RR: 24 Sat: 93% on 15L Exam: Gen: CV, pulm and Abd: nl Neuro: Higher mental function intact. CN II-XII intact. No movement in 4 limbs; tone mildly reduced. Light touch/pinprick intact. Absent Babinski, 1+ Achilles, 2+ in Patellar, Brachioradialis, and Biceps</p>	<p>Problem Representation: 65M with HTN and HLP who presented w acute weakness and sensory disturbances in his limbs due to an anterior spinal artery infarct, with spinal MRI showing abnormal cord signal from C3-T2</p>	
<p>PMH: Hyperlipidemia</p> <p>Meds: Amlodipine 5 Lisinopril HCTZ Rosuvastatin 5 Alprazolam Bupropion</p>	<p>Fam Hx: Diabetes in parents</p> <p>Social Hx: 7.5 pack-year smoking history (quit 23 years ago) Clerical work. 1 standard drink/week</p> <p>Health-Related Behaviors:</p> <p>Allergies:</p>	<p>Notable Labs & Imaging: Hematology: WBC: 21.5 (Neutrophil 88%) Resp panel negative. CRP: 45</p> <p>Chemistry Na: 137 K:4.3 Cr: 0.8 BUN: Ca: 9.4 Ph: 5.5 Mg: Glu: Cl: HCO3: AG: CRP: ESR: LDH: AST: 37 ALT: 27 ALP: Bili: LDL 51, A1c 5.4%</p> <p>Imaging: CTA H/N & CT Head unremarkable (9mm isodense nodule in L-frontal/parietal lobe, c/f malignancy). Seen on MRI Brain. LP: WBC 5, Protein 24, Glucose 122, No RBC. PCR -nve for any infection. Cultures -ve. Opening pressures normal. West Nile -ve. MRI Brain: 9-mm dural lesion in L-parietal lobe, likely meningioma. MRA Neck with C-Spine DWI: Increased cord signal of C3-T2, acute phase spinal cord ischemia</p> <p>Interval Updates: - Intubated after MICU transfer for weakness - Started IVIG (x2 days) - Not a candidate for TNk or Thrombectomy, started on DAPT - Persistent fevers despite antibiotics with c/f neurogenic fever</p> <p>Final Dx: Anterior spinal artery infarct</p>	<p>Teaching Points (Julia): <u>Weakness - localization and timeline</u> - Where: Lower or upper limb, bilateral or unilateral - Hyperacute (stroke), acute (neuromuscular junction disorder), chronic (myopathies), if is related to the same etiology (DM) - HTN, HLP - risk factors for stroke - Can misdiagnosis: Myopathic process, GBS, myelopathy - myelitis</p> <p><u>Upper respiratory tract infection + weakness</u> - First: Guillain Barre syndrome - Transverse myelitis' like syndromes - Associated symptoms could help to localize if the disease is localized to: muscular disorder, neuromuscular junction, peripheral nerves (small fibril involvement vs large fiber), dorsal ganglia</p> <p><u>Intact sensation + mild flaccid weakness</u> → probably bellow the brainstem - Spinal cord etiology less likely → absent babinski - Neck flexion, breath count - useful as a measure of disease progression</p> <p><u>CT head - nodule</u> - Diff: infectious vs malignancy vs myelopathy - Next step: think about life-threatening conditions (GBS, cervical spine myelopathy) and the least invasive test to diagnose them → the goal will be start treatment as soon as possible</p> <p><u>Negative LP:</u> do not rule out GBS</p> <p><u>Spinal cord infarction</u> - Rare; HTN, HLP as risk factors; could be provoked by dehydration</p> <p><u>Neurogenic fever</u> - Look for some possible causes of fever, for example ulcer, in cases of spinal cord issues</p>