07/23/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Sam B (@)* ***Case Discussants****: Sharmin Shekarchian (@sharminzi) and Reza Manesh (@DxRxEdu)*

Scribing (Julia)

CC: 35 M with 4 weeks of headache and 2 weeks of double vision

HPI: **Left sided headache, stabbing, behind his eye radiating down to the neck**, associated with L eye watering. Currently 3/10 but it was previously worse. Started 4 weeks ago and comes in episodes that last few hrs to all day. Partially response to ibuprofen. 2 wks ago fiancee noticed **his L eye was not moving with the R eye**. Double vision that improves when closing the L eye. Keeping eyes closed for comfort. Contacted PCP - recommended neurology evaluation

ROS: (-) photophobia, phonophobia, positional changes, fever, weight change, infectious symptoms, joint pain, significant life stressors,

PMh
ADHD, ASD

Meds:
Adderall, ibuprofen, magnesium

Fam Hx:
Maternal grandfather has a stroke

Social Hx:
Lives w mother and fiancee, not working (due to mental health), independent with ADLs
Works on projects around the house
5 cats, keep chickens

Health-Related Behaviors: rare alcohol use, no nicotine or marijuana, 2 cups of coffee daily + occasionally energy drinks

Allergies:none

Vitals: T: 98.2 **BP:** 124/63 **HR**: 68 **RR:** 18 **Sat:** **BMI:** 36
Exam: Gen: well appearing, no acute distres
HEENT: mild ptosis of the L eye and some surrounding erythema w clear discharge. No conjunctival injection, scleral icterus
Neck: nl
CV:nl; **Pulm:** nl; **Abd:** nl **Skin**: nl
Neuro: AOx4, no dysarthria, comprehension and fluency intact. Visual fields intact to confrontation. Pupils equal, round, reactive bilaterally. Normal EOM on the right, complete absence of EOM on the left with mild ptosis, otherwise intact. No pronator drift, no abnormal movement, strength 5/5 to all domains. DTRs 2+ throughout. Sensation intact throughout. No ataxia. Normal gait.

Notable Labs & Imaging:
Hematology: CBC normal
Chemistry: CMP, ESR , CRP, A1C, lipid panel, ACE all normal
ANA, RF, tick panel, syphilis all negative

CSF studies: Glucose 74; protein 40, 0 WBC, 1 RBC, culture negative. ACE 2.6 (H) HSV, VZV, WNG, enterovirus, Lyme, VDRL, Cryptococcus negative
MS profile, autoimmune, paraneoplastic panels neg
Flow cytometry: no evidence of lymphoma

Imaging:
Head CT: initially normal
Repeat CTA: no acute intracranial process, neg for hemorrhage, arterial stenosis, dissection or thrombus
MRI/MRA: neg for ischemia. Asymmetric dural thickening and enhancement of the L anteromedial middle cranial fossa involving cavernous sinus extending superiorly towards superior orbital fissure, nonspecific finding. Consider granulomatous inflammatory tissue (Tolosa-Hunt) vs plaque meningioma

Dx : Tolosa-Hunt syndrome

Problem Representation: 35 M presents with 4 weeks of left-sided headache and 2 weeks of binocular diplopia, found to have left eye ptosis & complete ophthalmoplegia. Imaging revealed inflammatory enhancement of the left cavernous sinus, consistent with Tolosa-Hunt syndrome.

Teaching Points (Anmolpreet):
I] **Diplopia:** is it blurred vision (refractory issues)/true double vision
Confirmed double vision: If it is in single eye vs both the eyes.
Confirmatory test:- by closing one eye, if the double vision:
1. disappears : BINOCULAR - EOM issue
2. persists - MONOCULAR- intrinsic eye issue (lens, retina)

No miss-causes with these symptoms: stroke
II] **Headache**: primary vs secondary [primary--a diagnosis of exclusion here]; The combination of these symptoms with non-movement of one eye makes us prioritise space-occupying lesion- needs neuroimaging
III] **Extraocular Muscles:** cranial nerve 3,4,6 → *nuclei*- in brainstem; input- contralateral motor cortex; any lesion in this pathway compressing these cranial nerves; a little odd that lesion causing isolated issue with these cranial nerves only. DDx: ?cavernous sinus; negative CT→ MRI (MRA/MRV)
IV] **Neurosarcoidosis**: a form of sarcoidosis, a long-term chronic disease of the central nervous system- granulomatous inflammation.
V] **Tolosa-Hunt syndrome:** a rare, granulomatous inflammation condition of the cavernous sinus, superior orbital fissure, or orbit. Would give steroids and imaging of cavernous sinus. It presents as painful ophthalmoplegia and causes dysfunction of the ocular motor cranial nerves. Tolosa Hunt is a diagnosis of exclusion→ r/o other causes of painful ophthalmoplegia.--> response to steroids is dramatic, recovery in 72 hours.