



# 7/22/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Ahmad Ali (@) Case Discussants: Youssef (@) and Julia (@)



<p><b>Scribing (Seeme)</b>  <b>CC:</b> 36 y old FM with weakness  <b>HPI:</b> She had been in her usual state of health until approximately three years ago, when she began experiencing <b>generalized weakness</b>. Over the following two years, she underwent multiple evaluations by local physicians and was treated symptomatically with multivitamins and analgesics for persistent bone pain. One year ago, she developed a <b>toothache accompanied by swelling in the left upper jaw</b>. She consulted a dentist, underwent a dental extraction, and was prescribed antibiotics for what was presumed to be a <b>cystic lesion in the maxillary region</b>, but did not improve. Following the extraction, <b>her and her family also felt her left eye was more prominent and "sticking out."</b> Over the last 6 months in particular, she had developed significant bilateral lower-limb weakness to the point she was no longer able to walk, requiring <b>family members to carry her</b>. Given ongoing progression of weakness, she was brought in by her family to the clinic for evaluation.  <b>ROS:</b>  She had a history of malaise and 5 kg of weight loss for the last 2 years. She also noted diffuse bone pain involving multiple areas of the body. She was unable to lie on the same side throughout the night due to the onset of pain after a short duration, but had no associated trauma, swelling, or erythema. She reported some anorexia and constipation.</p>	<p><b>Vitals:</b> T: 99 BP:100/60 HR: 72 RR: 17 Sat: 98% BMI: 20  <b>Exam:</b> <b>Gen:</b> Thin, alert but weak. Carried into the clinic by her brother.  <b>HEENT:</b> Firm swelling over the left maxilla; mild proptosis on that side. No palpable cervical lymphadenopathy, thyromegaly, or masses appreciated.  <b>CV:</b> Regular rate and rhythm, no murmurs, rubs, or gallops <b>Pulm:</b> clear  <b>Abd:</b> mild distension <b>Neuro:</b> AOX4. Intact sensation to light touch throughout; strength % in the and the shoulders, hips, and knees, otherwise 5/5. Reflexes 2+ and symmetric throughout. <b>MSK:</b> diffuse tenderness on extremities. Reflexes 2+ and symmetric throughout. Unable to stand without assistance</p>	<p><b>Problem Representation:</b>  36 y old FM presented with weakness, toothache and cystic lesion in the maxillary lesion.</p>	
<p><b>PMH:</b>  None  C-section</p> <p><b>Meds:</b>  Multivitamins (B12 and iron)</p>	<p><b>Fam Hx:</b>  non-significant  <b>Social Hx:</b>  non-significant  <b>Health-Related Behaviors:</b></p> <p><b>Allergies:</b> NKDA</p>	<p><b>Notable Labs &amp; Imaging:</b>  <b>Hematology:</b> WBC: nl Hgb: 11.6 Plt:nl MCV: nl</p> <p><b>Chemistry</b> Na:131 K:4.4 Cr: 0.7 BUN:30 Ca: 11.6 Ph: 3.5 Glu: Cl:107 CRP: nl ESR: 49 LDH: AST:40 ALT: 45 ALP:582 Bili: Total pr: 6.2 Alb: 4.2  <b>UA:</b> nl  -25 vit D: low 1,25 vit D:mildly low SPEP and SFLC:nl  UCa: 250  Biopsy: scattered giant cells unevenly distributed  <b>Serum PTH: high</b></p> <p><b>Imaging:</b>  EKG:nl CXR:nl  CT skull: 6.5*6*6.2cm solid and cystic mass in maxillary region  X-ray: subperiosteal resorption with osteopenia/ diffuse bone demineralization  US neck: extra thyroid lesion in lower lobe of thyroid measuring 1.7cm*1.4cm</p> <p><b>Dx : Parathyroid adenoma with brown tumour</b></p>	<p><b>Teaching Points (Nikola):</b>  <b>Approach to weakness:</b>  <b>1st step:</b> discern if "true" (muscle weakness -&gt; cause in the "neuro axis") vs generalized weakness (asthenia -&gt; look for the COG!), the exam is key!  <b>2nd step:</b> tempo (acute vs chronic), localisation (eg. lower limb)  In lower limb weakness: assess for issues with the autonomic innervation (incontinence)  <b>Isolated lip swelling causes:</b>  Angioedema (look for ACE-, if C4 low think of HAEI) vs Histamine related (anaphylaxis vs allergy)  <b>Facial edema:</b>  Fluid vs infiltration (GAGs in hyperthyroidism causing exophthalmos)  <b>Bone pain:</b>  Hyperparathyroidism (adenoma vs paraneoplastic -&gt;PTHrP), low vitamin D (rickets), MM, metastatic disease etc.  <b>Weight loss:</b>  Low PO intake vs consumptive disease  <b>HyperCa:</b>  Assess PTH (PTHrP), vit D levels (excessive intake vs granulomas)  An overlap between hyperCa and bone lesions are:  - hyperparathyroidism and "brown tumours" -&gt; not malignant tumor but rather lesions due to high osteoclast activity, another alternative would be  - Cancer secreting PTH-rP and causing bone lesions  - Rare head and neck cancers secreting PTH causing bone lesions</p> <p><b>High urine Ca</b> -&gt; comes either from PTH or PTHrP  <b>High PTH</b> -&gt; primary hyperparathyroidism (in young patients can be part of Men I and Men IIa, hyperparathyroidism jaw syndrome)</p>