7/11/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: (Zakariyya E@thestudydoc) Case Discussants: (Rabih@) and (Reza@)

Scribing (Masah and Seeme)

Case A

CC: bilateral symmetrical proximal and distal extremity weakness

HPI:42M no PMD, presents with acute onset (10 hrs) of rapidly progressive LL weakened, with now worsening respiratory difficulty. Preceded by diarrhea, vomiting, low-grade fever following a wedding. Treated with unspecified oral meds at clinic before referral

Patient intubated in ER

Physical Exam: Marked Resp distress
SpO2 90% RA
Unremarkable systemic exam
Neuro exam: ⅘ LL, ⅘ UL, areflexic, preserved sensation, nl bladder & bowel function.
Labs: K 2.5, Mg 1.2, Na 132. Labs otherwise wnl.
Imaging: MRI & CT head: wnl
Nerve conduction studies: normal
CSF analysis: normal

Extubated within few hrs after tx with IV K & Mg.
Dx: acute hypokalemic-hypomagnesemic paralysis

Case B

CC: bilateral symmetrical proximal and distal extremity weakness

HPI: 38M presents with 5 days of progressive LL weakness that progressed to the arms with tingling in feet & falls. 10 days prior, he had flu-like illness with mild fever and cough

Patient intubated in ICU

Physical Exam: 1/5 LL ⅘ UL. Mild paresthesias in extremities, preserved sensation, CN intact. No neck stiffness.

Labs: CSF: protein 1.1 g/L (high),WBC 1

Imaging: **MRI & CT head:** wnl
NCS: slowed conduction, demyelinating pattern.

Completed 5 day IVIG → complete resolution
Dx: GBS

Case C

CC bilateral symmetrical proximal and distal extremity weakness

HPI: 45 year F with 4 days of progressive weakness in arms and legs, became non-ambulatory, constipation for 1 week, history of MDR-TB newly diagnosed with HIV CD4 79 started on bactrim 1 month ago. Admission 2 months earlier for nervous breakdown.

Became extremely confused and was intubated

Physical Exam: tachycardic and tachypneic
Neuro exam:Flaccid quadriparesis (⅘) bilateral facial palsy, areflexia
Sensory level at T4, absent proprioception and sacral sensation
Neck stiffness

Labs: Na:128 and urine Na 83
CSF: Protein 1.25g/L, 0 cells.

Imaging: **CT chest:** pulm embolism.
CT brain: wnl.
Spine MRI: wnl.
CT abdomen: mild colonic distension.
AI & inflammatory work up in serum & CSF negative. Seeked mental healthcare 2 months ago.

Urine: elevated ALA/PBG. Plasma peak high. Partial neurological recovery, demised before therapy.

Dx: Acute intermittent Porphyria

Problem Representation: Three patients who presented with bilateral symmetrical proximal and distal extremities weakness.

Teaching Points (Krithika):

Rapid onset of weakness- generally involves the brainstem and normal sensorium
Causes-Obstruction(vascular or mechanical),compression, rupture, electrolyte abnormality, sudden onset of action of an abnormal molecule, Could be an immune mediated disease(post infectious).
To do- MRI, Labs(for substance, electrolyte Abn), History of exposure
Axonal neuropathy(diabetes, alcohol)- length dependent- ascending weakness
GB- clinically ascending but involves nerves diffusely
Myelopathy vs Demyelinating
LP-to check A:C dissociation- Polyradiculopathy- inflammation of roots- spillage of protein in CSF
Tingling- indicates neuropathy, mimic- myelopathy
HIV- risk of opportunistic infections, malignancy- neuropathy could be due to demyelination associated with infections or IRIS.
Hypercarbia with normal saturation- Neuromuscular causes
Definite sensory level points to a spinal cord lesion
Subarachnoid space- likely site involved if both symptoms suggestive of spinal cord and peripheral nerves involvement- LP should be done
Hypokalemic periodic paralysis-areflexia can be explained by the inadequate muscle contraction to elicit the reflex, Hypokalemia get periodic paralysis if it is associated with thyrotoxicosis
Bactrim-could precipitate porphyria-could explain the diffuse neurological involvement, Bickerstaff encephalitis- Brainstem involvement with B/l facial paralysis
Psychiatric involvement with NM involvement-Catatonia,Acute Intermittent porphyria