7/15/25 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: *Jeffrey* **Case Discussants**: *(Vale@valeroldan23) and (Sebastian@sebfgreen)*

Scribing (Seeme)

CC: headache and painful blurry vision

HPI: 81 yo woman with 4-6 weeks of a new onset constant right sided HA with intermittent pain behind right orbit, right forehead, right temple, associated with intermittent blurred vision, eye tearing, and diplopia. Eye pain in the R is worse with rightward gaze. Some eye pain as well in the left.

ROS (+): Fatigue, joint pain (Bilateral shoulders and hands). She has sleep issues and has been waking up to every single hour each night to go pee.

ROS(-): eye discharge, new floaters, flashes of light (photopsias), or curtain descending over vision. No paresthesias, weakness, photophobia, phonophobia, or nausea. No trauma/injury, no fever, no other illness

Was started by neurology on etodolac

PMH:
-Psoriasis
-Rheumatoid arthritis
-CHF
-CAV with mitral stenosis
-A Flb
-COPD
-HLD

PSH: bioprosthetic valve

Meds: Warfarin, Diuretics, Cosentyx (secukinumab)

Fam Hx: Breast and colon cancer in multiple family members

Social Hx: 147 pack years Smoking history but quit 16 years ago

Health-Related Behaviors: no alcohol or drugs

Allergies: NKDA

Vitals: T: 100.8 **BP:** 101/62 **HR:**114 **RR:** 20 **Sat:** 96% on room air

Exam: Gen: nl HEENT:nl **CV:** nl **Pulm:** nl **Abd:** nl

Neuro: Mental status: Patient is alert, oriented to person, place, and time. Affect is normal. Memory, language and fund of knowledge within normal limit.**Cranial Nerves:** Full visual field. No ptosis and nystagmus. Extraocular movements are full and pursued saccade. Pupils are equal and reactive to the light. No facial weakness and sensory deficit. Tongue is in the midline and no atrophy. **Motor**: Normal bulk and tone. No arm drift. No tremors or fasciculations. **Strength:** 5/5 throughout. **Sensation**: Intact to light touch throughout. **Coordination**: Intact FTN. Finger taps and arm rolling intact and equal bilaterally.**Gait:** Narrow based, tandem walking without assistance. **Eye exam:** cotton wool spots

MSK: inflammatory arthritis in bilateral hands and shoulders

Notable Labs & Imaging:

Hematology:

WBC: 14 (leukocytosis) Hgb: nl Plt: nl MCV:nl

Chemistry

K: 3 Cr:1.3 CRP: 1.5 ESR: 68 , RF/CCP and ANCA: negative IgG4: nl

Blood cultures HIV, TB, hep B and C, bartonella and FTA-Abs negative

LP: 19 RBcs, 2 WBCs, protein:nl, glucose:nl, crypto Ag:negative, viral meningitis panel includes HSV: -ve ,blood AFB and fungal cx negative.

Shoulder aspiration: 29k WBCs, no crystals, bacterial culture negative

Imaging:

MRI Orbits:Stable small aneurysm of the right ICA. Stenosis of ICA at the supraclinoid segments, L>R. Enhancement of bilateral supraclinoid ICA segments.

MRA Head w/Angiogram: Moderate to severe stenosis of the bilateral cavernous and supraclinoid internal carotid arteries with vascular thickening and enhancement.

CT abdomen, chest and pelvis: no evidence of active vasculitis -plaques in aortic arch and juxtarenal aortic aneurysm

Patient was started on high dose steroids and developed AMS. Neuro exam showed preservation and aphasia

Glucose: 391, patient started on insulin

Repeat imaging results:

MRI Head: infarct in globus pallidus and stenosis on ICA and left A1 -worsening vasculitis

MRA: luminal narrowing of P2 segments, moderate to severe stenosis of cavernous segments of bilateral ICA

Temporal artery biopsy: transmural inflammation

New MRI: diffuse pachymeningeal enhancement- multiple cerebral infarctions in various territories most significant in MCA- indicative of worsening vasculitis

Dx: Giant cell arteritis

Problem Representation:

81 year old woman presented with headache and blurry vision. Temporal artery biopsy showed presence of transmural inflammation.

Teaching Points (Krithika):

Headache-

1) primary vs secondary- look for redflags

2) Anatomical approach- based on the site of origin

Secondary causes that are potential emergencies-Glaucoma, orbital Cellulitis, Optic neuritis(infiltrative, inflammatory, infective -Toxoplasmosis, syphilis,bartonella,Lyme's, viral ; metabolic), Ischemic optic neuropathy, Giant cell arteritis

Diplopia- extraocular muscle involvement(thyroid disorders, infiltrative, myasthenia, cavernous sinus involvement, midbrain, MLF involvement)

To look for- Eye movements, other cranial nerves, fundoscopy(optic disc oedema); Optic neuritis without disc edema- points to a more posterior cause then anterior.

Optic neuropathy- Visual field(central loss), Afferent pupillary defect, Disc edema, disc atrophy

To r/o meningitis-meningeal signs, photophobia, skin rashes(if bacterial inf), CSF,Blood cultures, CBC, inflammatory markers, infectious workup, Autoimmune workup

Others-ECG, thyroid workup, cytology, flow cytometry

Imaging- MRI brain with contrast, angio, orbital imaging

Vasculopathy-secondary to immune process(Rheumatoid, Sjogren's), infective, malignancy(lymphomas)

Start steroids empirically if doubt of GCA, empirical antibiotics