



10/8/25 Morning Report with @CPSolvers



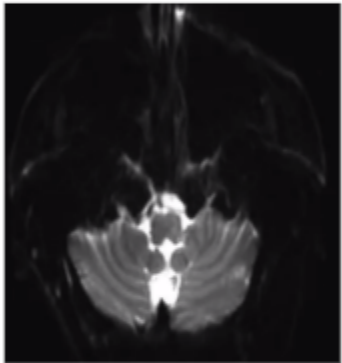
“One life, so many dreams” Case Presenter: Joshua Oommen Case Discussants: Sharmin (@Sharminzi) and Sawsan (@sawsan_Hs)
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Magnus)
CC: 45M with acute onset slurred speech and headache
HPI:
Recently admitted to OSH with intermittent headache, left-sided weakness and tingling, MRI without infarct. Discharged with aspirin mono.
Per ED, told he had a left vertebral dissection. Within same day, noticed slurred speech, with 10/10 left temporal headache. Associated dizziness and numbness/tingling on left side of face. No weakness. Denied travel hx, med changes, or prior hx of headache.

PMH:
HTN (180s-190s for yrs)
Gout
Meds:
Aspirin
Amlodipin
Colchicine

Fam Hx:
Not significant
Social Hx:
Works in IT
Health-Related Behaviors:
No alcohol.
Non-smoker.
Monogamous
Allergies:
None

Vitals: BP: 160/86, other vitals normal
Exam: Gen: NAD HEENT: PERRLA CV: RRR Pulm: CTAB Extremities: pulses nl
Neuro: AOx4. Cranial nerves intact. Speech normal, non-dysarthric. EOM normal. Face symmetric. Normal strength and sensation throughout. No dysmetria. NIHSS 0.

Notable Labs & Imaging:
Hematology:
WBC: 11 Hgb: 15 Plt: 292 MCV: 82
Chemistry:
Na: 141 K: 4.4 Cl: 105 Cr: 1 BUN: 12 Glucose: 176
AST: 17 ALT: 20 Alk-P: 64 Bili:0.4 Albumin: 4.6
Imaging:
CT-head and neck: No intracranial hemorrhage. Occlusion of left vertebral artery to the distal V4 segment. Other intracranial vasculature was patent. Left PICA also appears to have incomplete opacification along proximal segment.

CT-perfusion w/contrast: 8 cc region of Tmax>6 seconds in bilateral cerebellum without decreased rCBF. No mismatch volume noted.
Telemetry: Sinus Rhythm Echo: nl

Clinical course: Started on DAPT and migraine cocktail. At 0100 in the morning difficulties swallowing, and found to have new L facial droop, new rotary nystagmus, LUE ataxia, and reduced R hemibody sharp sensation. New CTA head and neck unchanged.

MRI of brain: left lateral medullary infarct

Dx: Left lateral medullary infarct (Wallenberg syndrome)

Problem Representation:
45M with PMH of HTN presented with acute onset and intermittent headache, slurred speech, progressing to L facial droop, rotary nystagmus and LUE ataxia, found to have vertebral artery dissection and MRI revealed left lateral medullary infarct

Teaching Points (Julia Z)
Approach to chief complaint: think about stroke first
-Stroke mimics: CNS diseases (basal ganglia, motor neuron). Look for additional symptoms would help to narrow the dx
-Important to know the pt baseline (speech). Dysarthria (problem with articulation) vs dysphagia (problem with production of the language)
-Headache: primary (migraine w neuro symptoms - hemiplegic) vs secondary (bleed)
-Vertebral dissection: can lead to bleeding of the brain as a consequence; CVA
-Aspirin: try to understand why the pt is using → Afib leading to a stroke/TIA?
Approach to PMHx: hypertension being the dangerous risk factor for stroke
-Posterior vascular diseases can initially present w dysarthria as well as vasospastic disorder of the trigeminal nerve
Approach to labs/image: young pt with vertebral dissection/thrombosis - spontaneous or not?
- Look for neck trauma - yoga, cervical spine fracture, chiropractic
- Wallenberg syndrome: stroke of the medulla
-Anticoagulation: not preferred when V4 affected since is an intracranial portion
-Transient neurologic deficit or progression of the disease? - Pt progressed with difficulties swallowing
-Nystagmus + ataxia: cerebellar problem?
Wallenberg: pt had chiropractic some months ago - late presentation