



# 10/27/25 Morning Report with @CPSolvers

“One life, so many dreams” Case Presenter: Vale (@valeroldan23) Case Discussants: Alec (@ABRezMed) and Austin (@RezidentMD)  
<https://clinicalproblemsolving.com/present-a-case/>



Scribing (Bahae & Magnus)

### Patient 1

**CC:** 35 year old woman presents to the clinic with 1 day history of **facial drooping**  
**HPI:** Noticed difficulty closing her left eye, and fluid dripping from mouth. Denies weakness, numbness, double vision, hearing changes, dizziness or headache.

### Patient 2

**CC:** 68 year old male presents with a sudden onset of **right sided facial drooping and slurred speech** for the past 3 hours.

### HPI:

He also reports **dizziness, nausea, and unsteadiness** for some minutes after the onset of facial weakness.

### Patient 1

**PMH:**  
Asthma

### Fam Hx:

**MS** recently  
Diagnosed - sister

### Health-Related Behaviors:

No alcohol or smoking

**Allergies**  
none

### Patient 2

**PMH:**  
HTN, Dyslipidemia,

### Meds:

Amlodipine 10 mg daily, Metformin 500 mg twice daily, Simvastatin 20 mg nightly

**Fam Hx:**  
None

### Patient 1

**Vitals:** normal, HR 76, BP 100/80

**Exam:** **Gen:** no acute distress

**Neuro:** **left facial drooping involving upper and lower face forehead and mouth, she cannot raise her left eyebrow or close eye tightly.**

Intact sensation.

Tongue picks up bland taste.

### Notable Labs & Imaging:

Discharged on steroids.

**Dx:** Bell's palsy

### Patient 2

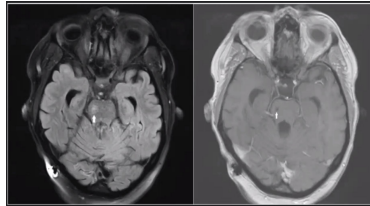
**Vitals:** **BP:** 160/90, otherwise nl

**Exam:** **Gen:** stable

**Neuro:** **right facial weakness affecting smile and also closing his eye. Also horizontal nystagmus was noted. No dysarthria or aphasia, normal sensation and motor exam in limbs.**

### Notable Labs & Imaging:

**MRI:** Pinpoint diffusion restriction on the right dorsolateral pons.



Work-up showed A-fib.

**Dx:** Stroke

**Problem Representation:** 1) A 35 year-old female with no past medical history presented with acute left facial weakness and on exam was found to have a lower motor neuron pattern of weakness and isolated CN VII palsy i.e. Bell's palsy. 2) 68 year-old male with metabolic syndrome presented with hyperacute right facial weakness and vertigo and was found to have right facial droop and nystagmus and MRI with a right lacunar infarct consistent with acute ischemic stroke.

### Teaching Points (Sarah B)

1. In patient 1, the features of both face and eye involvement made the localization to the whole CN VII more likely. The base rate of vascular illness is lower in younger patients. Patient 2 had additional features that localized to CNS locations. The age of patient 2 and hyperacute timeline, increased likelihood of a vascular event or seizure.
2. Inheritance of autoimmune conditions is complex, so a first degree relative with AI is not a certain sign. A family member with a condition may cause someone with symptoms to seek out care or influence how they interact with the healthcare system.
3. In patient 2, the background of metabolic syndrome decreases the threshold to order imaging and rule out vascular events. If the involvement of multiple nerves is confirmed on exam, the move to rule in or out vascular events should be fast.
4. For case 1, trying to differentiate between CNS and PNS localization was be high yield in diagnosis. For patient 1, paying attention to sensory symptoms was important to differentiate between an isolated CN VII lesion vs. CNS/additional lesions. Don't miss diagnoses in this patient include infectious causes of CN VII palsy e.g. HIV.
5. Smile may be normal even in CN VII palsy if you elicit a true laugh from the patient. Testing corneal reflex (eye sensation V -> blink VII) and taste are helpful in CN VII testing (taste: VII, IX, X).
6. Patient 1 localized to a LMN pattern of CN VII weakness, and was low risk. While ruling out don't miss diagnoses (e.g. HIV) it would be safe to send home with return precautions.
7. Direction of nystagmus can be helpful for precise localization of a CNS lesion.
8. HINTS exam should be performed in patient 2 because it has high sensitivity for central causes of nystagmus/vertigo. Additionally, it is accurate even if the patient only has nystagmus and no vertigo and is accurate before MRI findings.
9. Sometimes brainstem imaging is necessary to increase sensitivity for small lesions that can cause vertigo/nystagmus/facial droop.
10. Lesions present <4 hours are generally not visible on T2 but may be visualized on DWI/ADC. For patient 2, ADC/DWI correlation are important for identifying acute ischemia.