12/13/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter***: *Elmhurst IM Residency Program (IG: @elmhurstmedicine)* ***Case Discussants***: *Jas (@JasBajwa18) & Sawsan (@sawsan_Hs)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Eyron)

CC: 41/M presenting with papilledema and worsening headache

HPI: 4 months prior, seen for headaches in the R frontal area, radiating to the temporal and occipital regions, pressure-like, 8-9/10, not improving with pain meds. Woke up most mornings with headaches. No n/v, photophobia, phonophobia, blurry vision, weakness, or numbness. CTH unremarkable and d/c home.

1 month after, p/w severe R sided headache and witnessed focal seizure, admitted had CTH, MR Brain, and LP which were unremarkable -> d/c with Keppra

Pt f/u with neurology outpatient for **persistent headache and seizure** in the setting of medication non-compliance. Pt was sent in from neuro clinic for worsening headache and **R eye papilledema.**

PMH: None

Meds: Magnesium oxide, Oxcarbazepine

Social Hx: No smoking, EtOH, drugs; works as a care salesman, used to live in area endemic to mosquitoes, from Philippines

Fam Hx: Migraines

Allergies: None

Vitals: T: 97.9F **HR**: 83 **BP**: 151/101 **RR**: 20 **Sat**: 100% RA

Exam: Gen: Uncomfortable **HEENT**: Anicteric sclerae, PERRLA, MMM

CV: RRR, normal S1/S2, no m/r/g **Pulm**: Clear **Abd**: Normoactive BS, soft, nt,nd

Extremities/skin: No LE edema

Neuro: A&Ox3, mild **right lower facial droop, hyperreflexia of LLE**, CN intact, gross strength 5/5 intact of b/l UE and LE, sensation intact throughout

Notable Labs & Imaging:

Hematology: WBC: 10.3 Hgb: 15.6 Plt: 201

Chemistry: Na: 140 K: 4 Cl: 102 HCO3: 25 Cr: 0.99 eGFR: 98 BUN: 12 Glucose: 94 Ca: 9.4 Mg: 2 AST: 26 ALT: 44 Alk-P: 74 Albumin: 3.7

CTA H/N: No intracranial arterial occlusion or significant stenosis in head and neck

CT Head: Mild hydrocephalus

MRI Brain: **Leptomeningeal enhancement** in the R temporal region and focal cortical enhancement posteriorly in the R temporal lobe

MRI Cervical/Thoracic: **Leptomeningeal enhancement** involving the visualized portion of the cerebellum, brainstem, cervical, and thoracic cord

LP: Pressure 37 (10-25), nuc cells 0, protein 38 (<40), Glucose 41 (40-70), ADA <1

CSF: HIV, crypto, toxo IgM/IgG, syphilis, lyme, mosquito, babesia, ehrlichia, ANCA, MOG, quantiferon, Sjogren, NMO, oligoclonal bands - all negative

Cytology: rare mononucleated cells and foam cells **CSF Culture**: no growth

CSF GS: no PMN, no organism **CSF Fungus/India Ink**: No growth

AFB Sputum Culture x 3 negative

CT Chest, A/P: 2.1 cm mass near the origin of the LLL concerning for neoplasm with possible liver mets.

Repeat LP: malignant cells

Transbronchial biopsy confirmed the diagnosis

Dx: Non-small cell lung cancer

Problem Representation:

41 y/o male p/w progressive headache and new R eye papilledema, with leptomeningeal enhancement in the R temporal region, cerebellum, brainstem, cervical, and thoracic cord and negative infectious workup, found to have a 2.1 cm mass near the origin of the LLL, biopsy was done revealing NSCLC

Teaching Points (Gillian)

- **Papilledema + headache→ increased ICP (hypertensive emergency, mass, impaired CSF flow, meningoencephalitis)**
- **Red flags for headaches: sudden/severe onset, waking up from sleep, neuro deficits, systemic symptoms, older age**
- **What kind of obstructive process might elude head imaging?**
    - **Venous clot**
    - **dural/arteriovenous fistula**
    - **Idiopathic intracranial hypertension**
- **Malignant hypertension leading to papilledema more likely bilateral**
- **Leptomeningeal enhancement: infection (TB, fungal, viral), autoimmune esp. sarcoid, leptomeningeal carcinomatosis**
- **Consider CSF PCR if high concern for TB**
- **Foam cells lipid laden macrophages response to general inflammation: demyelinating disease, CNS infection (HIV, PML, Tb), storage disease, neoplasm w/ necrosis**
- **Venogram to look for venous clot, arteriovenous malformation**
- **Sensitivity of MRI and LP for leptomeningeal metastasis is low especially in early disease, persistent symptoms warrant repeat imaging/CSF**