1/13/26 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Andrew (@ASanchez_PS) Case Discussants: Aaron(@AaronLBerkowitz), Sarah (@sarahkblaine), Vale (@valeroldan23)
https://clinicalproblemsolving.com/present-a-case/

Scribing (Gillian)

CC: Man in 70s presents with bilateral leg weakness

HPI: Couldn't stand up from a chair, even with walker couldn't get to bathroom (use a commode)
BL resting hand tremor (maybe med induced perphenazine, stopped due to tremor)
Describes frequent nocturnal coughing

ROS: 10 lb weight loss, stiffness in both arms, loose stools, one episode of urinary incontinence. No memory loss, joint pains, rash, changes to sensation, fever, chills

PMH: Bipolar disorder
GIST tumor (status post whipple)
DM (A1C <8% for at least 5 yrs)
HTN
CKD
HLD

Meds: quetiapine
Statin

Health-Related Behaviors:
No smoking

Fam Hx:
No early cancer or autoimmune disease

Vitals: T: nl **HR**: nl **BP**: 130s/90 **RR**: **Sat**: nl on ra **BMI**: 23

Exam:
CV: no JVD or crackles, 2+ peripheral edema
Neuro: mental status nl; cranial nerves nl except right lower facial droop (chronic per patient)
moderate to severe atrophy diffusely
cogwheel rigidity, irregular and slow finger tapping
4+/5 strength of upper extremities, 4- strength in lower extremities (ip, quads, hams, dorsal, plantar flexors)
sensory distal length dependent loss of pinprick
negative pec reflex on right, positive left, hoffman negative bilaterally

Notable Labs & Imaging:

Hematology:
WBC: 11 Hgb: 10.6 Plt: 324

Chemistry:
AST: nl ALT: nl Alk-P: 1100 Bili: Albumin: 1.9 Total Protein: 4.5 vit D: 12 CK: nl

Imaging:
CXR: hazy lower lobe opacities
CT Abd w/o contrast: no splenomegaly, no hydronephrosis, large stool burden in colon & rectum, left greater than right mild pleural effusion, anasarca
MRI Brain: subtle hyperenhancement of right facial nerve; MRI Spine: enhancement of cauda equina & sacral nerve roots
LP: protein 85, glucose 76, 1 nucleated cell
EMG: myopathic motor units
MRI thigh: muscle edema & interstitial contrast enhancement bilaterally, atrophy

Course: ICU x3 separate occasion for stercoral colitis causing septic shock Requires tube feeding due to dysphagia

Further Tests:
SPEP: no monoclonals, VEGF: normal; vitamins nl, rheumatoid nl
Mayo Myositis: anti NXP2 low antibody titer, inclusion body myositis: neg
Muscle biopsy: scattered atrophic fibers with no substantial inflammatory
PET CT: physiologic uptake scm muscle, right>left strap muscle, no abnormal FDG in muscles or lymph
Heavy metal: neg; neurofilament light chain: positive at 365 pg/mL (ul normal 35), ganglioside antibody: positive IgG GM1, IgM: Mag, IgM histone M3
Demyelinating panel: neg; paraneoplastic panel: neg

Dx: Immune mediated neuropathy

Problem Representation: 70's man with multiple PMHx presentes w subacute progressive b/l lower > upper extremity weakness, diffuse muscle atrophy, and bulbar symptoms as well as minimal sensory loss, autonomic features and systemics signs, was found to have hypoalbuminemia and elevated Alk-P, suggesting a systemic peripheral neuromuscular process.

Teaching Points (Julia)

B/L Lower Extremity Weakness: spine vs brain
-B/l = spine or bellow → nerves, neuromuscular junction, cauda equina, muscle
-Bowel and bladder problem goes toward spinal condition (upper vs lower motor neuron disease) and cauda equina
Nocturnal coughing + upper extremities → Brain involvement vs diaphragmatic weakness (union of symptoms = higher lesion on the spinal cord or multifocal disease)
- Possible causes for upper + lower symptoms: Parkinsonism; spasticity; search for mets from the previous cancer (could have multiple mets); cervical spine stenosis
Diffuse muscle atrophy: localize to the lower motor neuron disease (for example neuromuscular junction disease). Additionally, the presence of sensory loss goes towards peripheral neuropathy (vitamin deficiencies). Motor neuron disease could present as diffuse atrophy + weakness without significant sensory loss.
-Muscle, NMJ: weakness > atrophy // Nerve (LMN, peripheral neuropathy): atrophy > weakness
-↑Alk-P: biliary tract vs bones → in this case, bone more likely affected
Peripheral edema + neuropathy over months: CIDP; paraprotein associated neuropathy (malnutrition, POEMS)
Weakness + bulbar symptoms + dysautonomia → severe nerve disease
EMG/MRI: muscle disease? → Associated with ICU stay (critical illness myopathy) vs statin use? Separate for the nerve disease?
-Myositis: autoimmune vs cancer
Immune-mediated neuropathy: treatment-refractory; look clean on pathology