



2/23/26 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: (@) Manaswini Case Discussants: Dr.Alec(@) & (@)Dr.Austin
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Siva)
CC: 56 y/o gentleman right flank and lower back pain x 2month
HPI: Pain started 2 months ago, pt woke up with R.flank & LBP (4/10), described as achy and burning, radiating to the buttocks. The pain worsens with prolonged sitting and movement and does not improve with bending forward or lying down. It is a/w numbness in the L.leg.He sees an orthopedist, has a normal X-ray, is prescribed diclofenac, and is discharged home. One month ago,pain persists & becomes constant. There is a progression of numbness and some weakness to both LE, L>R. re-ortho-the workup is unclear, and an abdominal brace is added.At the current presentation, he is brought in by the family due to progressive decline. He is wearing the brace. He reports new numbness in the groin while urinating.

ROS: Negative

PMH:
HTN, HLD

Meds:
HCTZ, ezetimibe, ,tizanidine

Fam Hx:
Not significant

Social Hx: contractor in plastics and chemical manufacturing industry

Health-Related Behaviors: social drinker,not a smoker,no drug abuse.

Allergies:

Vitals: T: 37.1 HR: 80 BP:147/86 RR: 18 Sat: 99% BMI: 21.8

Exam: Gen, HEENT, CV,Abd, Pulm: NrmI

Extremities/skin:Swollen DIP joints in the right hand.

MSK: Some tenderness in lower back .

EMG -incomplete recruitment ,but no other motor/muscle abnormalities.

Neuro: Motor-exam 5/5 UE,% LE;3+ reflexes Rt,2+ Lt.No spasticity,B/L plantar reflex - flexor Sensory- Numbness in B/I LE below L3 dermatome. Normal balance and gait

Notable Labs & Imaging:

Hematology: WBC: 10.1 Hgb: 11.2 Plt:196 MCV:47

Chemistry:
Na: 140 K:4.4 Cl: 101 HCO3: Cr: 0.82 BUN: 16
Glucose: 104 Ca:8.7 ESR: nrmI CRP: nrmI LDH: nrmI;
B12, Cu, ESR, TSH- Normal ,LDH, PT/INR- Normal
HIV, HCV, COVID, SPEP, sFLC, UPEP - Negative .U/A-NrmI

Imaging:MRI lumbar spine -Multilevel degenerative changes of the lumbar spine(no disc bulging and neural foraminal narrowing).

MRI Spine -T10 vertebral body enhancing lesion ,posterior epidural mass.
Biopsy - reactive bone with atypical cluster cells with IHC stain +ve for S100, Vimentin, SATB2 .

Surgical Rx-T10 corpectomy , T9-T11 laminectomy and posterior spinal fusion.
No metastasis seen.

NGS- IDH1 mutation+ve.



Dx: Clear cell chondrosarcoma

Problem Representation: Middle aged male with chronic myelopathic symptoms found to have clear cell chondrosarcoma of thoracic spine confirmed with biopsy.

Teaching Points (Krishna)
Back pain/ Low back pain:
 Time course:
 - Acute/Hyperacute: Vascular
 Sub-Acute: Structural, Inflammation(demyelination), Infection(HIV, Syphilis)
 - Constant/Intermittent; Static/Progressive → worsening pain/ Neurological symptoms(Numbness, Weakness, Bowel and Bladder symptoms;)
 - Think– is it local(focal); Referred type
 - Neuro-localization to the cord
 - **Level of lesion > Level of deficit**
 - Sensory: Unilateral/Bilateral, Symmetric/Asymmetric
 - Motor: Weakness
 - Reflexes: hyporeflexia (LMN); hyper(UMN)
 - Autonomic: Bladder scan; and Rectal tone(Indicative of Cord compression)
 - Multiple Bony lesions of spine (T2 hyperintense circumscribed lesion)- Is usually secondary; - Mets; Myeloma, Myelitis (TB), Mass (Benign/Malignant)
 - Multiple bony mets- Always perform Cross sectional imaging to look for primary