3/31/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter**: Ram(@Dr_RamaswamyS)* ***Case Discussants**: John(@) & Maddy(@MadellenaC)*

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

Scribing (Sam B)

CC: 27 yo F with weakness in her legs x7 days

HPI:

Primarily in legs associated with numbness and tingling, spread to all 4 extremities

Painful, not relieved with ibuprofen

Firefighter, cannot climb down ladder, affecting grocery shopping and carrying her toddler

Sleeping more than usual

Went to PCP, obvious weakness predominantly in thighs, started workup

3 days later weakness worsened, profound in lower extremities + upper extremities, went to ED

No history of trauma or recent illness

ROS: + low appetite, fatigue, nausea, myalgia, weakness

Negative for fever, chills, weight loss, vision changes, chest pain, dizziness, headache

PMH: vaginal delivery 1 year ago

Meds: none

Fam Hx:
N/a

Social Hx:
Firefighter

Health-Related Behaviors:
No alcohol, tobacco, marijua, sexually active only with husband

Allergies: none

Vitals: T: afebrile **HR**: 99 **BP**: 138/87 **RR**: 18 **Sat**: 99% **BMI**:

Exam: Gen: alert, anxious, no distress

HEENT: moist membranes, no icterus

CV: normal **Pulm**: normal **Abd**: normal

Neuro: AOx3, CN intact. + pronator drift on L. Normal tone in BUE, increased tone in BLE R>L. Mild weakness R>L and proximal > distal. DTR reduced, 1+ brachioradialis and biceps, 2+ in triceps, 3+ in BLE. Downgoing babinski. Sensation intact.

Extremities/skin: no edema, no rash or lesion

Notable Labs & Imaging:

Hematology:
CBC, electrolytes normal

Chemistry:
Metabolic panel normal
ESR, CRP normal
Tick panel, T pallidum negative
Pregnancy test negative
B12, folate, TSH normal
HIV, COVID, flu negative
ANA, anti Smith, Sjogren SSA, SSB negative
MS profile negative (NMOFS, NMO, aquaporin 4, MOGFS)
Autoimmune encephalitis panel, NMDA ab negative
Serial NIF testing was normal

Imaging:
Lumbar x-ray: normal
MRI brain and spine w w/o contrast: no demyelinating lesion, myelitis, compression, tumor, or nerve root enhancement; normal study

CSF: glucose 67, protein 30, cell count 2, 96% lymph
PCR negative for HSV, VZV, Lyme, VDRL, West Nile

Course: developed new back pain, headache, and neck stiffness during hospitalization
CSF PCR for enterovirus positive

Dx: Enteroviral meningitis

Patient recovered well with supportive care

Problem Representation: Healthy 27yo F with acute onset of ascending weakness, negative laboratory workup, negative MRI, no autoimmune process identified, grossly normal CSF, with PCR eventually revealing enteroviral meningitis.

Teaching Points (Daniel Lim)

Approach to weakness.

- Evaluate for loss of function and associated symptoms, then localize - muscle, nerves, brain, spinal cord.
- Asthenia vs neuromuscular weakness

If true weakness - localize the lesion:

Cortex -> muscles

Sensory and motor deficit localized to the leg may increase probability of nerve issue vs muscle issue

Both UMN and LMN signs with absence of demyelination on imaging

UMN signs - Pronator drift, brisk reflexes, increased tone

LMN signs - hypotonia and reduced/aflexia

Possible options when discordance between symptoms/findings and tests:

- repeat tests
- wait to see how symptoms evolve

Important to reconsider test result when high pretest probability!