1/23/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: OG Zakariyya (@pouroverguy) **Case Discussants**: Rabih (@rabihmgeha) & Seeme (@)

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

Scribing (Dadmehr)

CC: **Unable to use arms and legs**

HPI: 20 yo F unable to use arms and legs. Well until 4 weeks prior. Developed progressive difficulty. Course was difficult to characterize though started in legs and soon after involved the arms

ROS: No preceding illness, CP, dyspnea, constitutional symptoms, headaches, abd pain, vision issues, eating issues, bowel / bladder issues

PMH: Unremarkable

Meds: None

Fam Hx: Unremarkable

Social Hx: No substance use

Allergies: NKDA

Vitals: **Normal** **Exam**: **Gen**: well appearing **CV**, **Pulm**, **Abd**, **Skin exam**: Normal
Neuro: alert oriented, CN normal
Motor: Markedly weak, no muscle atrophy/fasciculations. **Upper limbs:** Distal > proximal weakness. **Lower limbs:** Proximal > distal
Sensory: Largely unremarkable, Reduced proprioception in the R leg compared to the L
Reflexes: Globally reduced

Additional hx: 4 years prior, the exact same syndrome occurred which self-resolved over several months.

Notable Labs & Imaging:
Hematology: WBC: 9 (diff nl) Hgb: 10 Plt: 170 MCV: 103

Chemistry: CMP: nl CRP: nl CK: nl
Ferritin: 450 Transferrin sat%: 22 Transferrin: slightly low
Glucose persistently: nl TSH: nl
ANA: negative ACh receptor antibody: negative
Lumbar puncture: CSF culture positive for Enterobacter cloacae
Cell count: 0 ; Gluc nl; protein nl (both initial and second LP)
Neuronal autoimmune antibody workup: negative

B12: Persistently elevated above 1400
Anti-parietal cell antibody positive
Imaging:
CT spine: nl
EMG: Conduction block with prolonged distal motor latencies, F-wave abnormalities
MMA: normal
Anti-intrinsic factor antibody (IF): negative
IVIG started, no improvement; added pulse dose IV prednisone => symptoms improved

Dx: Motor predominant CIDP (Chronic inflammatory Demyelinating Polyneuropathy)

Problem Representation:
20 yo F with repeated subacute diffuse motor-predominant neuronal dysfunction (Limb weakness), highly elevated B12 w/ negative IF Ab and normal MMA, showing conduction block with long motor latencies on EMG, responding to IVIG + pulse IV prednisone was found to have Motor-predominant CIDP.

Teaching Points (Glen)

-B/L LIMB WEAKNESS: discomfort vs weakness? substance use? autoimmune? Stroke? NMJ?
-HISTORY severity? Able to urinate/defecate?
-SUBACUTE: infections & travel history.
-EXAM FINDINGS: nmj? Gbs? Spinal cord/brain abn less likely(LMN findings).

-EMG: help with classifying (muscle vs nmj vs nerve). Muscle unlikely(mostly distal & low reflexes). NMJ unlikely(no eye symptoms).
-NERVE: subarachnoid dx(headache,incontinence) plexus? diffuse>focal. Axonal due to substances(toxin workup of B12/copper). Demyelinating due to immune abn e.g vasculitis, GBS.

-MACROCYTIC ANEMIA: VIT B12 def?
-CSF CULTURE: real vs contaminant. Confirm with other csf labs.

-PERNICIOUS ANAEMIA: macrocytic anaemia, pos anti-parietal cell ab. Other one is anti-intrinsic factor ab. But B12 levels high. Ab to intrinsic factor can lead to false pos elevated vit B12. Confirm with symptoms and methylmalonic acid levels.

-WHY SUBACUTE: changed diet? uses substances?
-EMG: Demyelinating process, immune. Paraprotein vs paranodal vs paraneoplastic. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).
-Tx with IVIG and steroids.