8/6/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Lourenço* ***Case Discussants****: Rabih & Austin*

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

Scribing (Eyron):

CC: 26/F comes to ED after returning from Cape Verde with 2 months of n/v, triggered by smells that she cannot specify.

HPI:

This was associated with unintentional weight loss of 10 kg. She reported poor hygiene conditions in terms of water for consumption. During her stay, she reported 3 days of fever and myalgias and arthralgia.

1 week prior to ED visit, developed intense drooling and difficulty swallowing solids and liquids

ROS:

Denies abdominal pain, back pain, headache, dyspnea, cough, urinary or skin changes. Denies contact with other people with similar symptoms or with animals.

PMH:

NC

Meds:

NC

Fam Hx:

NC

Social Hx:

Lives in Lisbon - went to Cape Verde to work as a singing instructor

Allergies:

Augmentin - severe respiratory distress

Vitals: T: afebrile **HR**: 75 **BP**: 120/80 **RR**: **Sat**: 100% RA **BMI**:

Exam: Gen: Thin, drowsy/tired with hydrated mucous membrane,

HEENT: no trismus, exudates, no neck deviation, no palpable LAD

CV/Pulm: nl |**Abd**: soft, non-tender, no masses, organomegaly

Neuro: GCS 15, awake, exhausted, pupils round, symmetric, intense vertical nystagmus, no diplopia, (+) oscillopsia, no facial asymmetry, diminished sensation to pain, left ptosis, difficulty in tongue protrusion w/o deviation, symmetric elevation of palate, abolished cough and gag reflex, dysmetria in finger to nose on left, ⅘ strength in LUE, and LLE with pronator drift on the LLE. 5/5 strength on the right and no changes in sensation on all limbs. (+) Hoffman on left. Normal reflexes and negative Babinski. Normal Romberg. Normal gait.

Notable Labs & Imaging:

Initial Labs:

WBC: 8 Hgb: 13 Plt: 180 MCV: 65

PT/INR/PTT nl | LDH 202 | LFTs nl |BUN/Cr nl | CRP 40 ESR 41

Imaging:

EKG/CXR: nl |CT Neck/Chest/A/P: nl

EGD: atrophic gastritis and erosive duodenitis

MRI Brain: FLAIR hyperintense lesions in the medulla with extension to the area postrema and left cerebellar peduncles and left diencephalon. Lesions have edematous appearance and hematic components with molding of the respective 3rd and 4th ventricles concerning for inflammatory/demyelinating lesions.

BCx neg | UCx neg | RVP neg |Normal folic/b12

Serologies

(-) for HIV, HBV, HCV, RPR, TPHA, Negative IgRA, (-) Malaria, Dengue, Chikungunya, Zika, ANA and ENA neg, APL neg, (+) IgM/IgG for lepto, (+) VCA and EA IgG for EBV, neg IgM (+) IgG for CMV

LP: 3 cells, glucose 84, protein 29, no oligoclonal bands, negative cultures, for mycobacteria, negative PCR for neurotropic viruses (HSV, EBV, VZV, HHV6), RPR and FTA-Abs negative Neg anti-ganglioside, anti-MOG, NMDA, (+) anti-aquaporin 4

Dx: Neuromyelitis optica spectrum disorder (NMOSD)

Problem Representation:

26/F presenting with gradual onset of n/v, weight loss, and dysphagia, found to have hyperintensities in the medulla, cerebellar peduncles, and left diencephalon with molding of the 3rd and 4th ventricles on brain MRI. LP and serologies revealed (+) anti-aquaporin 4 suggestive of NMOSD.

Teaching Points (Varsha)

Nausea and vomiting in isolation → rarely causes wt loss in isolation (has associated features/ systemic involvement)

- Unless acute weight loss → dehydration
- Liquid weight loss >> solid weight loss

Dysphagia → wt loss - Oropharyngeal (dental disease, cervical osteophytes, NM disease → rarely cause N&V) vs Esophageal

Drolling, dysphagia, multiple Cranial nerve involvement→ NM involvements/ bulbar lesion (botulism) Vs systemic inflammatory involvement (Viruses)

Possible differentials:

Treatment routes →

- **Immunomodulation** (infection vs suppression for autoimmune)
- **Toxic metabolic process** → Thiamine deficiency → Wernicke's encephalopathy, hyponatremia due to vomiting → osmotic demyelination (peripheral signs)
- **malignancy** (sneaky,asymmetric)

Meninges → could reflect brainstem pathology inflamed/ infected/ malignancy