8/5/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (@Gillian)* ***Case Discussants****: (@Dr. Helen Shi) & (@Valerian)*

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

Scribing (Jahanvi):

CC: A 56 Y M is brought to the ER by EMS after being found wandering, naked, in a grocery store.

HPI:

EMS assessment: Lethargic, minimally verbal, cachectic, disheveled. He receives 1 L LR in the ED, and is started empirically on vancomycin, cefepime.

Collateral history obtained from friends, roomate, Over preceding several weeks, he became progressively withdrawn and stopped caring for himself. Roommate reports increasing disorganisation, poor oral intake and declining hygiene

ROS:

PMH: Remote traumatic brain injury requiring craniotomy (1990s) , distal radius fracture requiring surgery (5 mo prior)

Meds: NA

Fam Hx: One brother described as "odd", otherwise NS

Social Hx: Lost his job of 15+ yrs because coworkers were talking negatively about him 4 months ago, suicidal ideation(1 mo ago)

No known alcohol or substance use

Health-Related Behaviors: 25lb weight loss in past 2 mo

Allergies:

Vitals: (EMS) T: 35 HR: 81 BP:75/41 **Sat: 98**% **BMI**: 19; **Repeat (after fluids) T**: 36.5 **BP** 104/58 **HR** 70 **RR** 13 **Sat:** 96%

Exam:

Gen: somnolent, no acute distress

HEENT: supple, no JVD, moist mucous memb, PERRLA bilaterally

CV/ pulm/ Abd: NS

Extremities/skin: symmetric, no edema

Neuro: **Mental status**: Initially nonverbal, eventually A&Ox3 (whispered name, hospital, month, year). **Language/Speech:** Intact when audible, but frequently mumbled, incomprehensible, or nonsensical; followed 1-step commands generally **Cranial nerves**: Normal **Motor**: Moving all extremities antigravity. **Reflexes**: Brisk in the legs, crossed adductor response, toes mute (equivocal plantar response). Bilateral palmomental reflex positive. **Sensory**: Symmetric withdrawal to stimulation, all limbs. **Coordination**: Normal **Gait**: Deferred. No asterixis.

Notable Labs & Imaging:

Hematology:

WBC:10.4 Hgb:13.5 Plt:290 MCV: 88.3

Chemistry:

Na: 139 K: 3.6 Cl: 97 Ca: 8.9 BUN:21 Cr: 0.96 Glu: 100 AST: 145 ALT: 51 ALP: 47 T. Bili: 2 lipase: 45; Urine tox: Neg ; VBG: ph 7.41, Pco2 51 Hco3 32; B12/TSH/NH3: normal; HIV/ RPR : Normal (pt empirically given B12/B1)

Imaging:

CT Head: Right frontoparietal craniotomy with 1 mm leftward midline shift, No acute hemorrhage/ mass effect or acute infarct, asymmetric hyperdensity in right cavernous sinus

CTA : Asymmetric prominence of right cavernous sinus

RUQ USG: Liver heterogeneous otherwise non specific

MRI Brain: No acute infarction/ hemorrhage/ pathological enhancement, 2mm leftward midline shift

LP: Colorless, 0 RBCs, 0 nucleated cells • Glucose 86 (mildly high), protein 40.1 (upper limit of normal • Full meningoencephalitis panel- negative

Continuous EEG: Background mildly asymmetric but organized, reactive 10 Hz PDR • Breach rhythm over the right frontoparietal craniotomy site (expected post-surgical finding) • Abundant focal right temporal-parietal polymorphic delta slowing • No epileptiform discharges/ clinical seizures

{Over the next several days, the AST normalizes to 35, ALT to 26, Bili to 0.8, WBC to 6.0, CO2 to 21. However, the patient remained minimally verbal, internally preoccupied, severely psychomotorly slowed with poor PO intake}

Transferred to Psychiatry:

Prolonged staring, slowing, poor oral intake, mutism,, waxy flexibility/ posturing, Bush Francis Catatonia Rating scale : 9 , Lorazepam Challenge showed partial but unsustained response, has episodes of urinary incontinence (after lorazepam). For concurrent psychosis/ depression- started on Sertraline (150mg) and risperidone(1mg BID), mood improved but patient still had: **Persistent Hypophone, gait disturbance, Intermittent hypotension and orthostasis.** Risperidone discontinued (concerning hypokinetic features)

Repeat Neuro Consult: awake/alert, marked blepharospasm, masked facies, decreased vertical gzaze)up>down), no resting tremor, B/l upper extremity cogwheeling, gait stooped, retropulsion testing, takes one step back and nearly fell during test Neurofilament Light chain : 4.53 (normal)

Autoimmune/paraneoplastic encephalitis panel(peripheral): negative

ENT evaluation for hypophoniaL no structural abnormality

Further history- pt reports voice feeling "tight" 3 months before admission, predating antipsychotic exposure and multiple pre medication nursing notes independently→ A carbidopa- levodopa trial initiated and titrated: Partial improvement in speech output, emergence of psychotic symptoms at higher doses (dose reduced), with quetiapine and sinemet doses, psychosis resolves and motor gains maintained

Final Formulation: Atypical Parkinsonism : PSP (Progressive supranuclear palsy) with a preceding psychiatric prodrome.

Problem Representation: 56 Y cachectic male with subacute behavioural decline, paranoia, self neglect, wt loss, mutism, hypophonia and progressive parkinsonism (with vertical gaze palsy) and unrevealing infectious/ metabolic/ structural workup and partial levodopa response, ultimately consistent with PSP.

Teaching Points (Daniel Lim)

When presenting with ams and decreased awareness:

Important to clarify baseline, tempo, last known normal, collateral, and focality

When taking hx, identify if symptoms preceded or followed precipitating event might help clarify tempo

Ask, does this localize the help identify structural symptoms:

Whispering, mumbling - speech motor control deficits

Nonsensical, incomprehensible - structures involving comprehension

Objective findings

Abnormal findings in CT ie midline shift and asymmetric prominence might warrant MRI. Important to correlate with presenting symptoms.

Cavernous Sinus Syndrome - CN 3,4 V1, V2, 6

Unilateral ophthalmoplegia with sympathetic denervation, pain, and facial numbness

Delta slowing - possible signs of hx structural or electrical (post seizure) abnormalities

Considering negative results, we might need time to determine if this is primary neurological issue vs toxic/metabolic/autoimmune etc.

Initial dx: catatonia and depression with psychotic features

Possible extrapyramidal symptoms: persistent Hypophone, gait disturbance, Autonomic features: Intermittent hypotension and orthostasis

Clarifying time course will help distinguish between encephalitis vs neurodegenerative

Final dx - Atypical parkinsonian syndrome psp vs msa