4/27/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Renzo Moreno Macedo(@)* ***Case Discussants****: Alec(@)@ABRezMed & Austin(@)@RezidentMD*

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

Scribing (Sneha)

CC: 65/F with **headache, nausea and vomiting**

HPI: 1 mo H/O persistent headache, initially holocephalic, intermittent & moderate in intensity 5/10 partially relieved with analgesics and associated with nausea and photopsia

2 week prior to presentation, headache increased in intensity 8/10, more frequent, waking her up from sleep. She also developed recurrent vomiting (2-3/day occurring every other day)

On day of admission, she reported severe, persistent throbbing headache 10/10, associated with up to 6 episodes of vomiting, new onset cervical pain radiating to jaw

ROS: No fever, upper respiratory symptoms, dysuria or GI symptoms. No seizures, focal neurological deficits or loss of consciousness

PMH: SLE (Dx 1 year back: *hemolysis?*) Rx with prednisolone 5 mg, azathioprine, and HCQS 400 mg
Type 2 Diabetes mellitus (HBA1C 12% at diagnosis, 8% at admission) Rx with metformin

Fam Hx: nil

Social Hx: Lives in Lima and works as hardware store seller. Denies tobacco, alcohol or IV drug abuse
Travels back and forth to Pulcapa

Health-Related Behaviors: 3 partners

Vitals: T: 36.8 **HR**: 79 **BP**: 110/80 **RR**: 20 **Sat**: 98% on RA **BMI**:
Exam:
Gen: alert and oriented, GCS 14/15, uncomfortable due to headache
Neuro: no CN deficits / FND
CV: N **Pulm**: N **Abd**: N **Extremities/skin**: N

Notable Labs & Imaging:

Hematology:
WBC: 8.4 Hgb: 12.3 Plt: 341 MCV:
(87% N, 6.1% L, 0.2 % E, 0.2% B and 6.1 % M)
Chemistry:
CRP: 0.3 Cr: 0.6 BUN: 34 Glucose: 114
AST: 28 ALT: 55 Alk-P: Bili: 0.7 Albumin: 4.4 Total Protein: 7.1

ID: VDRL +, FTA -, HIV -, HTLV-1 -, HBV / HCV -

CT brain - decreased cerebral volume and chronic microvascular ischemic changes in the subcortical and periventricular white matter without evidence of acute hemorrhae or mass effect

CSF analysis - Opening pressure - 60 cm H20
Appearance clear
Glucose 45 mg/dL (serum 115), protein 56 mg/dL, 3? mononuclear cells
Microbiological exam - India ink positive, cryptococcal antigen (LFA) 1:5120 , KOH positive, Ziehl- Neelsen stain : negative

Dx: Cryptococcal meningitis in a patient with systemic lupus erythematosus on immunosuppressive therapy

Problem Representation: 65/F with SLE on immunosuppressive therapy with subacute worsening headache and signs of raise ICP which was image negative with high CSF opening pressure but no pleocytosis or remarkable protein elevation in the CSF

Teaching Points (Manasa)

RED FLAGS OF HEADACHE: SNOOP
Systemic symptoms, neurological symptoms, old age, onset, pattern changes. 3 out of these are present here. Waking up from sleep to vomit is highly suspicious of raised ICP.
Subacute(infections, mass lesions, venous obstruction)
Vs acute (trauma, hematoma)
Diffuse vs localised increase in pressure in the CNS. Blocked Drainages of venous sinuses, inflammed meninges, obstruction, hemorrhagic stroke could caused high ICP
Prone to infection due to T2DM, SLE, immunosuppression.
Non-infectious(Coagulation)) Vs infectious(HIV, Syphilis, geographical susceptibility) in a subacute cause.
High suspicion of vasculitis/coagulopathy-CT angiogram would help.
Markers of inflammation are less specific in CNS diseases.
FTA is more specific and would suggest recent exposure compared to VDRL. Caribbean- also consider HTLV-1.
Consider false positives of VDRL(TB,SLE, HIV, APLS here)
Autoimmune? Infection?
Imaging more informative and done prior to non- specific serum markers in CNS disorders.
Cryptococcal meningitis?(Very specific to High opening pressure)
Crytptococcal antigen testing if accessible along with imaging would be gold standard.
Serial LPs to relieve the pressures and following up is indicated.