9/13/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (Kaleem)* ***Case Discussants****: (Kirtan@KirtanPatolia) & (Magnus)*

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

Scribing (Seeme):

CC:68 y old M with fever, seizures and speech difficulty

HPI: 3 weeks ago developed fever and went to hospital, CBC and malaria test negative, did not respond to acetaminophen, went to hospital again improved with acetaminophen, redeveloped high grade fever with rigors and chills associated with seizure like activity, muscle twitching on R side on eyes and mouth was seizure activity recorded by family, no LOC, + tongue biting, no aura, recovered to baseline

ROS: no headache, photophobia, no sore throat, no ear or facial pain or runny nose, limited mobility at baseline

PMH:
HTN

Meds:
Amlodipine- unable to take

Fam Hx:
-

Social Hx:
Soldier by profession

Health-Related Behaviors:
No illicit drug use

Allergies:
NKDA

Vitals: T: 104F **HR**: 76 **BP**: 130/90 **Sat**: 97%

Exam: Gen: weak lethargic and ill looking, confused

HEENT: nl **Pulm**: bl basal creps

Neuro: confused, following commands. No meningismus. CN intact, dysarthric pressured speech,power ⅘ in R upper limb and ⅘ in R lower limb, tone and reflexes normal, plantar reflexes down doing—>cerebellar signs and seizure

Extremities/skin: decreased power on R side but no skin changes

Notable Labs & Imaging:

CT scan: mild changes in ventricles, no significant changes

-> started on aspirin

Hematology: WBC: 17.7 (74% N) Hgb:10.6 Plt: 246

Chemistry: Na: nl K: nl Cl:nl HCO3: nl Ca:nl Mg: nl Cr: 1.5

AST: nl ALT: nl ALP: 164 T. Bili: 2.25 CRP: 27

Procalc: 0.5 **A1c:** nl

EKG: nl

CXR: consistent with atypical PNA

MRI: left sided dural collection with thin internal septations, mild dural enhancement and foci of restricted diffusion- superimposed infection could be possible

-> started on antibiotics

Labs and symptoms improved with antibiotics

Dx: Meningoencephalitis like picture with pneumonia

Problem Representation: 68 y old M with PMH of HTN presented with fever, seizures and speech difficulty with leukocytosis and MRI showed dural collection and internal septations with evidence of pneumonia on chest X-ray.

Teaching Points (Nithya):

Fever → inflammation (autoimmune, infectious, etc.)
- **Ask time course first. Is this acute? (3 weeks → subacute)**
- **Central fevers is a diagnosis of exclusion, and recurrent high grade fevers makes a central cause unlikely**

Seizures vs Syncope
- **Convulsive movements + AMS does not necessarily mean seizures, even with incontinence or tongue biting (can occur in syncope)**
- **Localize the seizure → No sensory findings, but positive motor findings (R side motor + R face → L motor cortex)**
- **Label this Meningoencephalitis, because either meningeal or brain parenchymal inflammation can lower threshold for sz.**
- **Lack of post-ictal state makes seizure less likely (though still possible)**

Dysarthria/Aphasia vs Confusion/AMS (CNS vs outside)

Ddx (high grade fever + focal L deficit)
- **Meningoencephalitis**
- **Brain abscess or other mass lesion**
  - **Tumefactive Demyelination**
- **Vessels (AVM/hemorrhage, Infective endocarditis/septic emboli)**
- **Pressure changes (mass effect/hydrocephalus)**

Head CT ('normal' means not hemorrhage)
- **Poor gray/white matter differentiation → edema**
- **Ventricular effacement → problem is significant enough to compress**

****Focal Deficit in CNS = mass lesion, AVM, or tumefactive demyelination**

'Atypical pneumo' on Rads = diffuse infiltrates, not specifically atypical bug

Liver findings are unlikely to be cholangitis given time course. More likely reactive.

L cortical enhancement is odd- perhaps meningeal. What causes just L side meningeal involvement? Perhaps L side vascular. If it's actually epileptogenic, FLAMES (rare demyelinating disorder)

Subacute infection causing brain and lung findings: strep pneumo, toxo, klebsiella. Staph would be unlikely given time