



7/28/26 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: [Sudharshan \(@sudharshan_rk\)](#) Case Discussants: [John Black \(@calicocapybara\)](#) & [Noah \(@Noah_Nakajima\)](#)
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Lukas/ Seeme): CC: 51 yo FM presents to the ER with LOC & unresponsiveness HPI: on arrival of EMS, the patient was unable to speak, or move the left side of her body. Transport to local ED for suspected stroke. Initial examination by the EMS demonstrated left sided facial droop, right gaze deviation, left sided weakness, hemisensory loss and aphasia with NIHSS score of 18.		Vitals: T: HR: 82 BP: 131/74 RR: 18 Sat: 98% on ventilator Exam: Gen: intubated and ill ; POC glucose: 118 HEENT: nl CV: nl Pulm: nl Abd: nl Neuro: R gaze preference, L hemianopia and paralysis, weakness in L upper and lower extremity, aphasia, L facial weakness, bilateral L extremity weakness, anarthria	Problem Representation: 51 yo FM p/w left sided hemisyn-drome and LOC to the ER with MCA-ACA-stroke in imaging with worsening clinical course. Even with ESR/CRP discordance and heterozygous Factor V the diagnosis auf Neurosyphilis was made due to positive CSF FTA/ABS testing, csf pleocytosis and clinical criteria.
PMH: depression Fam Hx: Social Hx: Meds: Health-Related Behaviors: Allergies:		Notable Labs & Imaging: Hematology: WBC: 8.8 Hgb: 10.8 HK: 32 Plt: 300 Chemistry: Na: 133 K: 4.4 Cr: 1.7 AST: 17 ALT: 16 T. protein: 7.2 Alb: 3.3 ESR: 117 CRP:0.7 Hba1c: 5.9 ANA: 1:640 M spike: 0.8 Free kappa/lambda ratio: 9 RF: positive, lupus anticoagulant: neg Hep B sAb: positive, HIV: neg, FtA/Abs: positive, serum RPR: neg, quantiferon: neg Heterogeneity/Heterozygous Factor V mutation positive Imaging: EKG: sinus rhythm cCT: no hemorrhage Angio: occlusion of right m1 segment mca Course: Transferred for mechanical thrombectomy Transferred to tertiary care center, neuro examination worsened, NIHSS score 24 TEE: no thrombus, no intracardiac mass, no valvular vegetations, no shunting MRI 24 h post admission: Infarction in R MCA and ACA territories Duplex lower extremity venous US: wnl Malignancy workup: no evidence of any occult malignancy LP: CSF leukocytes 10, 78% lymphocytes, protein 76, glucose 65, ID Serology workup: all neg Rocky mountain spotted fever, Ehrlichiosis, Anaplasmosis, Borreliosis ID CSF PCR/RNA workup: E. coli, H. influenzae, listeria, N. meningitidis, Group B , STrep, Strep pneumo, CMV, enterovirus, HSV-1, HSV-2, HHV-6, Human parechovirus, VZV, cryptococcus, VDRL, arbovirus, HSV-½ CSF FTA ABS: positive Dx: Meningovascular syphilis	Teaching Points (Lourenço) 1. LOC and unresponsiveness - think of the "S's" (Syncope, Sugar, Substance, Stroke, pSy-chiatric, Sleep). In a patient with suspected stroke, the first thing to rule out is hemorrhagic stroke (non-con head CT). If there's no hemorrhage and the patient presents < 4.5h from symptom onset, thrombolysis is safe. If not, only mechanical thrombectomy applies. 2. Clinical / imaging disconnect - if the lesion doesn't match the clinical presentation, think of other etiologies or complications of the initial disease process (e.g., hemorrhagic transformation of ischemic stroke post-thrombolysis or thrombectomy). If needed, get better imaging, such as MRI. 3. SCAN mnemonic - think in a patient with acute AMS (Sugar, CT scan, ABG / VBG, Narcan). 4. Causes of strokes - remember the TOAST classification (large-artery atherosclerosis, cardioembolism, small-vessel occlusion, stroke of other determined etiology, stroke of undetermined etiology). Usually, stroke occurs in the presence of cardiovascular risk factors. In this case, since there are none, we have to think of more esoteric causes of stroke. 5. Stroke in young patients - use the Virchow triad (or the pump-pipes-plasma schema) to guide the work-up: hypercoagulable states (e.g., acquired thrombophilias such as APLS, or congenital ones such as factor V Leiden), vessel damage (e.g., vasculitis like GCA) or stasis (e.g., AF with cardioembolism, or DVT with PFO). 6. Syphilis - very tricky disease to diagnose. Even if VDRL / RPR is negative, disease can still be present (remember prozone effect). It can cause meningovascular disease with large vessel vasculitis (Heubner arteritis) or small vessel vasculitis (Nissl-Alzheimer arteritis). FTA-Abs is very sensitive in the CSF. 7. Lymphocytic pleocytosis - think infections (bacteria, viral, fungi, parasites, ameba), cancers (liquid or solid), autoimmune diseases (demyelinating, vasculitis, NMDA, systemic diseases such as SLE), and some drugs.