07/24/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Renzo Moreno Macedo* ***Case Discussants****: Rabih Geha (@rabihmgeha) and Reza Manesh (DxRxEdu)*

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

Scribing (Lukas):

CC: *location: Peru*

22 yo woman p/w *15 days* of progressive headache and vomiting, lower extremity weakness, neuropsychiatric symptoms, urinary incontinence

HPI:

Headache: intermittent, pulsatile, occipital NSR 5-8/10

10 days before admission:

- developed nausea, vomiting up to 5x daily
- Generalized weakness
- Progressive lower extremity weakness with walking difficulty
- Initial Rx with unknown antibiotic

5 days before admission:

- Brother noticed episodes of fixed gaze, decreased responsiveness
- Repetitive hand movements
- Hallucinations and erratic behavior

Day of admission:

- Developed urinary incontinence
- Could not longer stand without assistance
- Brought to the ED

ROS: weight loss (not quantified)

PMH:

- Depression
- Pulmonary tuberculosis 2 years ago

Meds:

- Sertralin started 6 months ago
- Stopped TB-Rx after 6 weeks

Social Hx:

- Babysitter
- Student
- No recent ravel
- 3 dogs

Health-Related Behaviors:

- Smokes socially
- sexual Hx unknown

Vitals: T: 36,8°C **HR**: 68/min **BP**: 100/60 **RR**: 18/min **Sat**: 98% on RA

Exam: Gen: GCS 14/15; **Pulm**: wnl

Neuro: positive bilateral Babinski and Hoffmann sign; moved extremities spontaneously; no meningeal sign, pupils equal and reactive to light

Notable Labs & Imaging:

Hematology:

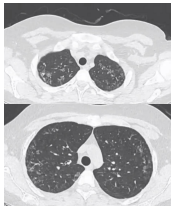
Hb: 11,1 WBC: 15k neutrophils 80,8% lymphocytes 4%, eos 0% basophils 0% monocytes 6,2% PLT: 250

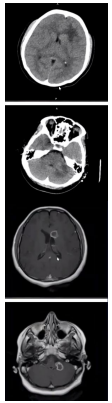
Bilirubin: wnl ALT: wnl AST: wnl HIV: negative

CT non contrast: hypodense area left frontal with mass effect lobe and left cerebellum

MRI: 2 ring enhancing lesion periventricular and in the cerebellar peduncle with perifocal edema; signs of increased ICP

CT Chest: infiltration of miliary pattern bilaterally





LP: microscopic appearance: cloudy

Leucocytes: 350

PMN: 35% **LMN**: 65% **RBC**: 30%

Gram stain: neg **Glucose**: 20

Proteins: 282 **HGT (blood)**: 102

Opening pressure: 40 cm H20

Culture: negative

VDRL in CSF: neg **ADA**: neg

Crypto antigen/latexn in CSF: negative

India ink: negative

Genexpert CSF: positive for susceptible MTB

KOH: negative

Fungi culture: pending

Dx: TB with Tuberculomas

Problem Representation: 22 yo woman from Peru p/w 2 weeks of rapid progressive pan-neurologic syndrome with a history of previously incomplete treated TB and now ring enhancing lesions in the MRI and CT chest findings consistent with TB

Teaching Points (Anmolpreet)

I] Severe headache and vomiting: if acute:- we are concerned for increased intracranial pressure. With multiple symptoms, always ask what is bothering the patient the most.

Acute-to-subacute progressive neurologic syndrome

II] Headache: ***primary*** (migraine, cluster, tension) vs ***secondary*** (brain or outside brain - systemic illness/glaucoma/sinusitis, etc); Need to know the immune status. **Progressive headache syndrome** with **neuropsychiatric symptoms** is intriguing in this case. Our schema of:

STRUCTURE vs **SUBSTANCE** (99% times psychosis is a substance ?or both)

-With the new uncovering PMH of mood disorder, we are inclined to think of severe depression with psychotic features or a bipolar disorder.

III] History of tuberculosis: tuberculoma increases the risk of psychiatric symptoms; and can block CSF drainage leading to hydrocephalus - just another differential. (inflammation/inflammatory exudate)

Inflammatory CNS issue without systemic signature

IV] Ring-enhancing lesions: Diffusion-weighted imaging can help. (Malignancy/Infection/Autoimmune);A complete ring enhancement means an autoimmune pathology is less likely; autoimmune and demyelinating conditions characteristically present with an incomplete or open ring sign.

V] Lung and a brain syndrome in a immunocompetent host: a strong possibility of having Nocardia.With PMH of untreated TB, a risk of multi-drug resistant TB looms large; but question lies how was TB diagnosed? Even Nocardia is partially acid-fast. Nocardia does not cause meningeal involvement, but parenchymal involvement; Cryptococcus-more meningeal than parenchymal; TB can cause both parenchymal+meningeal involvement horrifically.

VI] Hypoglycorrhachia: bacterial/fungal/tuberculosis