8/26/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (@Jas)* ***Case Discussants****: (@Ravi) & (@Sharmin)*

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

Scribing (Jahanvi):

CC: 45 Y M presented with sudden onset generalised abd pain, nausea, vomiting and diaphoresis.

HPI:

Had previous ep of chest pain & nausea vomiting- treated with cath few months back, came to ED for same complaints twice after this episode.

Now also c/ o of acute back pain - radiating to b/l legs, and urinary retention needing foley's.

ROS:

No fever, chest pain, dyspnea, or chills

PMH:

Admission for Cath (NSTEMI), was given Aspirin, Enoxaparin, fluids, antiemetics

HTN, Hyperlipidemia

Type 2DM (well controlled), GERD

Morbid Obesity

Meds:

Amlodipine

lisinopril

atorvastatin

Fam Hx: NA

Social Hx:

marijuana (edible/smoke)

Health-Related Behaviors:

sexually active with 1 partner

Allergies:

NA

Vitals: T: afebrile **HR**:94 **BP**: 120/80 **RR**: 16 **Sat**:98% **BMI**: 52

Exam: Gen: alert, oriented **CV**: nl **Pulm**: nl **Abd**:

Neuro: no dysphasia, dysarthria, pupils reactive, no palsy, visual field intact, no facial asymmetry, light touch intact, tongue midline, B/l U/E showed dec strength in grip strength, tingling sensation in 5th and lateral aspect of 4th digit, unable to maintain pincer grip (difficulty > on left), B/l L/E : not able to maintain light touch, absent L/E reflexes, gait test couldn't be performed

Notable Labs & Imaging:

Hematology: WBC: 21.4—>14.7(repeat) (april- 8) Hgb: 12→10.7(repeat) (april- 16) Plt:260

Chemistry: ESR:28 CRP: 47 lactate : normal IL 2 R: low

Imaging:

EKG: minimal ST elevation

CT abd/pelvis: Normal (in ER)

CT angio: no patent aneurysms Normal, Lumbar spine MRI: chronic severe canal stenosis at L4-L5; Thoracic spine MRI: heterogeneous t2 signal from T5 -T10 (right side), patchy enhancement of lesion, intramedullary t2 signal likely edema (T4-T6), non enhancing fluid collection at T11-T12, Brain MRI: leptomeningeal enhancement, most prominent parietal lobes; MRI C spine- moderate cervical spondylosis, osteophytes, inc t2 signal in T2

ID: **cefepime, vanco, acyclovir** Blood cultures: nl, HIV: nl —> still no clinical improvement. Syphilis: neg, HTLV antibody: neg

Rheumat panel (ANA, NACA, C3, C4, anti SSA/ SSB, proteinase 3a/b, anti dsDNA): neg; Lyme panel: neg, serum encephalopathy (autoimmune and paraneoplastic panel): neg

Lumbar puncture: attempted thrice, only **clotted blood** (repeat: **Xanthochromia** and protein)

Intracath spinal angiogram, repeat MRA (suspect AVM): neg

Working Diagnosis: **Spontaneous subdural hemorrhage and epidural extension** with subarachnoid hemorrhage due to redistribution of spinal subarachnoid blood causing leptomeningeal enhancement (Undiagnosed cannabinoid hyperemesis syndrome?): from **extensive retching- Valsalva**

Problem Representation: 45 Y M with PMH of HTN, DM, GERD, hyperlipidemia- developed paraplegia, sensory loss and urinary retention after forceful vomiting, with extensive thoracic subdural hemorrhage causing severe cord compression and ischemic infarction likely exacerbated by increased cannabinoid use

Teaching Points (Preethi)

Approach to abdominal pain: time of onset, acute vs subacute vs chronic.

Itisis, obstruction, ischemia, perforation, ectopic pregnancy

Sometimes abdominal pain is not just abdominal pain- important to get an EKG and Troponin

- **CT abdomen with IV contrast does not capture intermittent symptoms like intussusception and arterial abnormalities like Acute mesenteric ischemia (which will need arterial phase contrast)**
- **Thoughts after a recent procedure like a cath → consider throwing off a plaque to set in blue toe syndrome and acute mesenteric ischemia due to an plaque emboli**

Approach to Urinary retention

Drugs like opioids, morphine

Epidural abscess (IV drug use), hematoma (ASA, enoxaparin), cauda equina syndrome

Constipation, BPH

Sympathetic stimulation

[Diabetes can mask fever, tachycardia due to immunocompromised state- pts can be afebrile, have normal rate even with infection brewing]

Approach to Neuro symptoms

Sudden back pain + urinary retention + abnormal neuro exam on the lower extremities: consider acute spinal cord infarction

Primary neurological pathology vs vascular vs demyelinating disorder

- **Get a Spinal MRI**

Meningeal enhancement in brain and multiple enhancements in the spinal cord: infection/inflammation/autoimmune.

- **LP, SPEP, IPEP, HIV, MOG, ANA, ANCA, C3, C4, AntiSSA, SSB, IgG4, proteinase 3a/b, lyme, GAD, Vitamin B12, copper, D, involvement of neurology and ID**

Ddx: infections like HIV, autoimmune: transverse myelitis, NMO, GBS, post- vaccination

- **Think about AV malformations in the dura given clotted blood in LP - consider spinal angiography. Ddx: neurosarcoid, lymphoma, leptomeningeal carcinomatosis**

Extensive valsalva maneuver iso cannabis hyperemesis syndrome -> can cause rupture of spinal venous plexus, rearrangement of blood from spine to brain can lead to leptomeningeal enhancement.