5/10/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: *Gillian* **Case Discussants**: *Kuchal & Lera*

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

Scribing (Noah)

CC: 33 y/o M w/ 3 weeks of intermittent right-sided blurry vision

HPI: Describes vision as cloudy during episodes, can still see. It comes and goes, last seconds to maybe minutes. Confined to the right eye. No pain, redness, discharge.
Intermittent headaches, usual to his chronic tension headaches associated with neck pain.
Several weeks ago he had URTI.

ROS: no diplopia or jaw pain or similar episode

Saw Optho, referred urgently to the ED for evaluation.

PMH: None

Meds: None

Fam Hx: HTN, Crohn's disease

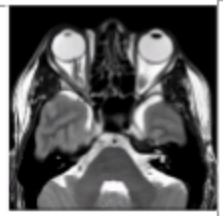
Social Hx:

Health-Related Behaviors: Recent travel to Dominican Republic

Allergies:

Vitals: T: 97 **HR**: 82 **BP**:149/72 **RR**: **Sat**: 99% RA **BMI**: 30
Exam: Gen: Comfortable
HEENT: No conjunctival injection, discharge, ocular tenderness. No jaw tenderness. Neck supple with full ROM.
Neuro: VA 20/20 BL. Visual fields intact. CN II-XII intact, no FND.

Notable Labs & Imaging:
Labs: CBC and BMP wnl.
Optho:
Normal VA, motility, confrontation, ocular pressure, macula, and periphery. Frisen Grade 4-5 in the right eye and Frisen Grade 2-3 papilledema in the left eye.



MRI Orbits: Bilateral papilledema, optic nerve tortuosity, optic nerve sheath distension, and marked enlargement of the oculomotor nerve cisterns.
MR Venogram: No evidence of venous sinus thrombosis
MRI Brain w/wo: A 5.3 x 3.8 x 4.2 cm large right lateral intraventricular solid and cystic, heterogeneously enhancing mass. Heterogenous susceptibility suggesting hemorrhage and/or calcification. Mild adjacent FLAIR hyperintensity consistent with vasogenic edema.
-Ventriculomegaly — consistent with obstructive hydrocephalus -No restricted diffusion — no acute ischemia -No acute hemorrhage or extra-axial collection -Basal cisterns patent

He was started on dexamethasone 4 mg IV q6 hours to reduce vasogenic edema around the tumor and decrease ICP. CT of the chest, abdomen, and pelvis was performed to rule out a primary malignancy with CNS metastasis. This was negative for any extracranial disease. Resection was successful. Circumscribed glial neoplasm with astrocytic morphology. Rosenthal fibers and eosinophilic granular bodies. + KIAA1549::BRAF fusion

Dx: Pilocytic astrocytoma

Problem Representation:
33 yr male with chronic headaches p/w 3 weeks of intermittent right sided blurry vision notable for B/l papilledema(R-⅘;L-⅗) and brain MRI showed an right sided intraventricular mass which was dx as pilocytic astrocytoma on H/P study.

Teaching Points (Siva)
1.Blurry vision-base rate:refractory issues
Any associated sx?hypoglycemia?TIA-r/f?
Anterior issue(scleritis,keratitis)-can be seen
Post issues/CNS-can't be seen -thorough ophthal examination.
Intermittent nature-vascular issue?
Ophthal emergencies- LVV,stroke?focal issues??
2.Intraventricular mass- choroid plexus papilloma,neurocytoma,subependymal giant cell astrocytoma colloid cyst,ependymoma.

3.Dx-Intermittent nature is classic in pilocytic astrocytoma (KIAA1549::BRAF fusion)
Pilocytic astrocytoma is commonly seen in children and common site is posterior fossa(intraventricular mass is uncommon)