10/7/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Renzo **Case Discussants**: Zaven & Dan

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

Scribing (Meghna):

CC: 61 y/o female complains of a 4 week history of intermittent fevers, LL paresthesias

HPI: A 61 y/o female presents with a 3 week history of a persistent, fluctuating febrile illness, home temperatures peaking at 101F. During the last 2 weeks, she complains of R LL numbness. She sought medical attention for bladder fullness and unable to void urine. Nephrology was consulted for hyponatremia.

During a previous hospitalization, an MRI lumbar spins and LP was obtained (below). She was treated with acyclovir, ampicillin, vancomycin and steroids. Repeat MRI showed improvement of leptomeningeal enhancement. Patient was discharged.

ROS: Denies cough, diarrhea, wt loss, constipation

PMH: Osteoporosis,
multiple spine/back surgeries

Meds: NA

Vitals: **T**: **HR**: **BP**: **RR**: **Sat**: **BMI**:
Exam: **Neuro**: R LL weakness, near complete plegia; LL - reduced strength (⅘ hip flexors, ⅘ knee flexors). Reflexes diminished in B/L LL; Sensory loss in B/L LL

Notable Labs & Imaging:
Hematology: WBC: 3.5 Hgb: 9.8 Plt: 120 MCV: 95
Chemistry: Na: 123 K: 4 Cl: 92 HCO3: 27 Ca: 8.4 Mg:- BUN: 21 Cr:0.8 Glu: 99
AST: N ALT: N ALP: 100 T. Bili: T. protein: 7.2 Alb: 3.2 Anion gap: 4
Urine Analysis: Osm: 326 Urine Na: 34 Specific gravity: 1.009 UPCR: 2

MRI lumbar spine (prior hospitalization):
Leptomeningeal enhancement -> responsive to treatment
Post-operative changes of instrumented fusion of L4-L5 without evidence of complication
No evidence of spondylodiscitis

MRI Angio: N; **MRI Spine:** N

LP (Prior hospitalization):
Colourless, clear, 79 RBCs, 3 nucleated cells
Glucose - 53 mg/dl; protein 45 mg/dl; cryptococcal antigen -ve
LP (repeat): Glucose: 59 TP: 43 T Nucleated cells: 3 RBC: 31 PCR: -ve
Bone marrow biopsy: Normocellular (60%) w trilineage hematopoiesis, no increase in blasts

CT Abdomen + Pelvis:
Kidneys: 13x12 cm; splenomegaly, nephromegaly
Kidney Biopsy: B-cell lymphoma

Dx: Intravascular B cell lymphoma with renal involvement

Problem Representation: A 61 y/o female with intermittent fevers and lower limb paresthesias, presented with pancytopenia, elevated UPCR, nephromegaly on CT, and biopsy proven B-cell lymphoma

Teaching Points (Kwame)
Acute fevers look more infectious and protracted fevers are more autoimmune or systemic disease.Paresthesia very non specific and could be nerves being affected by toxins, infections,metabolites etc.
Findings of leptomeningeal enhancement, caused by viral fungal meningitis. Also seen in cancer metastasis and doing an Mri after a lumbar tap.
Albuminocytologic dissociation hallmark of Guillain Barre,AIDP.
Guillain Barre classically causes SIADH and subsequently hyponatremia.
Sensory symptoms are very common in Guillain Barre.GBS triggers include colitis infection, STI.

Pancytopenia and macrocytosis disseminated marrow infiltration Bone marrow process vit b12 deficiency. Vit b12 deficiency usually manifests as hyperreflexic and has a subacute process. Copper deficiency mimics vit b12 deficiency. Differentials include vasculitic mononeuropathy

High urine protein rule out immunoglobulins which we could miss on a bone marrow biopsy.

Causes of Renomegaly Amyloidosis, lymphomatous infiltration,Intravascular lymphoma (which is clinched by a random skin biopsy).
POEMS syndrome
Polyneuropathy,organomegaly,endocrinopathy,monoclonal plasma cell disorder, skin changes.
Kidney Biopsy Intravascular B cell lymphoma with renal involvement.