7/17/26 Morning Report with @CPSolvers

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

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

Scribing (Javier)

CC: 58 year-old-man presented with blurry vision in right eye

HPI: 58 ys old man, symptoms started 4 weeks ago, progressed over the last 2 weeks. It started in the central visual field and expanded. Blurriness became constant. One week prior to presentation, he developed dull retro-orbital discomfort in right eye. He reported difficulty concentrating at work.
No trauma or associated symptoms

ROS: No other symptoms

PMH:
HTN
syphilis Rx with intramuscular penicillin

Meds: Penicillin

Fam Hx: History of non- melanoma skin cancer in his mom
Multiple sclerosis in one of his relative

Social Hx:

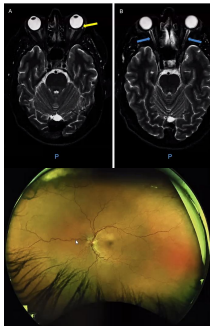
Health-Related Behaviors: Former smoker , ten pack years history
Social alcohol use
Allergies: Non mentioned

Vitals: T: nl **HR**: 70 **BP**: 110/70 **RR**: 18 **Sat**: 96 **BMI**:
Exam: HEENT: nl LAD, poor dentition
CV: nl **Pulm**: CTAB **Abd**: nl **Extremities/skin**: NL
No periorbital edema, no redness
Ophthalmologic exam: Afferent pupillary defect, decreased visual acuity, right panuveitis, Bilateral retinitis with optic disc edema & retinal vascular tortuosity

Notable Labs & Imaging:
Hematology: WBC: 10.7 Hgb: 11 Plt: 160
Syphilis testing: RPR: Positive
Treponemal antibodies positive
First lumbar puncture, 6 wbc, elevated total protein
Imaging MRI: bilateral symmetric optic nerve sheath with proteinaceous material in the posterior chamber left > right, posterior scleritis
Clinical Course:
Rx w/ 14d of IV penicillin, symptoms recurred, now with symptoms migration to the left eye
Bilateral optic disc edema, with uveitis
Repeat MRI showed unchanged findings
Second LP: 8 wbc, VDRL negative, Rest normal,
Autoimmune panel: negative
ACE negative
Bartonella, Lyme , herpetic PCR, CMV negative
CBC: increased leukocyte count with lymphocyte predominance

CSF flow cytometry: Abnormal B-cell population

Dx: CLL with optic nerve and ocular inflammation



Problem Representation: 59 ys old man with a recent history of treated syphilis now with a subacute presentation of right blurry vision with physical exam findings compatible with compromise of optic nerve and retina with rapid progressing migration to left side and new isolated lymphocytosis and pleocytosis in CSF.

Teaching Points (Lukas)

I. **Neuro problems always: timecourse and localization**
II. **CC Blurry vision**→ Identify the exact patient problemvision distorsion vs double vision vs visual loss Blurry vision approaches: monocular vs binocular Visualize neuropathways - anatomic approach Address associated symptoms
III. **CC Distorsion:** Blurriness → suggests pathology affecting the visual pathway before image procession; most often representing problems of the globe itself so **Intraocular vs orbital**
IV. Always verify treatment adherence. Check for complete course of treatment
V. Ocular syphilis can occur at any stage in syphilis with multilocular affection: uveitis, retinitis, papilledema, tortuous vessels; pan-ocular + systemic highly suggestive for syphilis
VI. RAPD = asymmetric dysfunction in afferent light conduction; check with swinging flashlight testing , indicates damage to retina or optic nerve itself before the chiasma
VII. In ocular syphilis CSF-VDRL can be negative, and does not exclude (Neuro-)syphilis
VIII. Every ocular syphilis is per definition neurosyphilis and requires i.v. treatment 14 days Penicillin G; so always check if initial Rx was adequate (i.m. not sufficiently crossed blood-brain barrier in therapeutic concentration)
IX. Be aware of Syphilis Rx reactions: Jarish-Herxheimer, paradoxical up regulation
X. Always consider Mimics when Rx gets fails: wrong bug, wrong drug, wrong diagnosis DDx NMOSD, MS, MOGAD, Lymphoma
XI. IgM seronegativity under treatment does not rule out active infection