CASE PRESENTATION

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NEUROLOGY RESIDENCY PROGRAM

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HISTORY OF PRESENT ILLNESS

- May 2016:
  - Case of 44 y/o right handed man who presented on May 2016 with a fall after develop left side weakness and slurred speech for which evaluation at periphery hospital was performed and found with two lesions at right thalamus and midbrain. Patient was treated with Dexamethasone. Lumbar punctures x3 performed that were negative for malignancy. Patient discharge home with Prednisone 10mg daily with improvement of left side hemiparesis. Patient persisted with left hemiparesis and dysarthria without new neurological deficits or new imaging findings during 2017.

HISTORY OF PRESENT ILLNESS

- March 2018:
  - Patient continued with left side hemiparesis, chronic headaches and developed incoherent behavior that consist of misplacing objects worsening since one month prior to evaluation. Work up for demyelinating disorder was ordered.
- June 2018:
  - Hospitalized due to suspected autoimmune encephalopathy treated with Solumedrol and IVIG for 5 days with improvement of left extremities weakness.

HISTORY OF PRESENT ILLNESS

- August 2018:
  - Follow up visit in which persist with inconsistent generalized weakness. Associated with headache, profuse sweating episodes, salivation and dysphagia, speech and cognitive impairment.
  - Patient started on high-dose Prednisone and since stable started on Imuran on subsequent visit.

PHYSICAL EXAM

- Neurologic exam:
  - GCF: Awake, Alert and oriented x3 (partial in time).
  - SCF: no aphasia, apraxia or agnosia. Dysarthria.
  - CN I-XII: Grossly intact
  - Motor: Left hemiparesis
  - Sensory: Left hypoesthesia
  - DTR: 3+ throughout except left achilles tendon 4+
  - Station and gait: cane for assistance. Slow short stepped gait with imbalance. Difficulty walking on tandem heels and toes. Dystonic-like posture of LUE upon walking, at times.

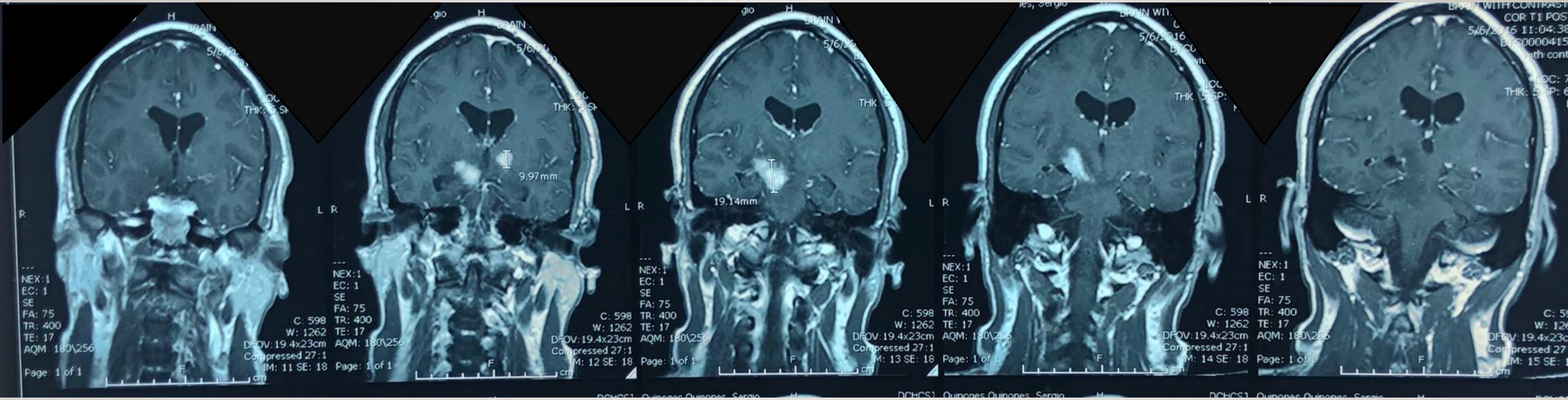
LABORATORIES

- Multiple Sclerosis Panel
  - Oligoclonal bands: no bands
  - IgG synthesis rate/index: 2.3 (normal)
  - IgG index: 0.56 (normal)
  - ACE levels: 6 (normal)
- CSF:
  - Colorless, Clear
  - RBC 0
  - WBC 1
  - Glucose 66
  - Protein 17

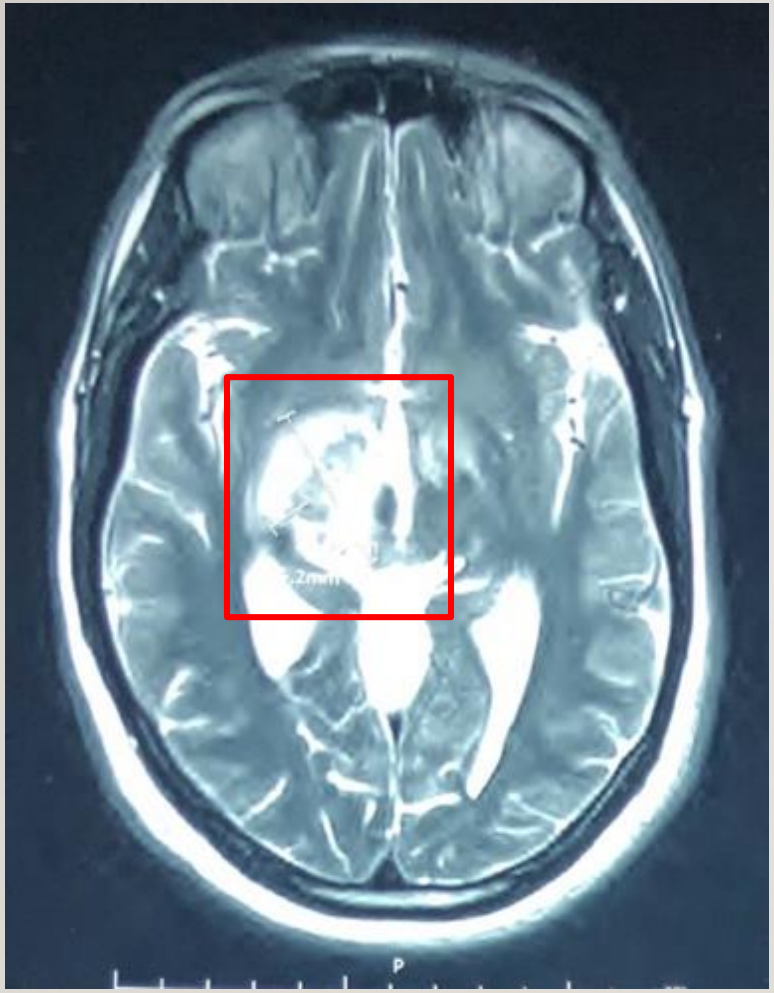
LABORATORIES

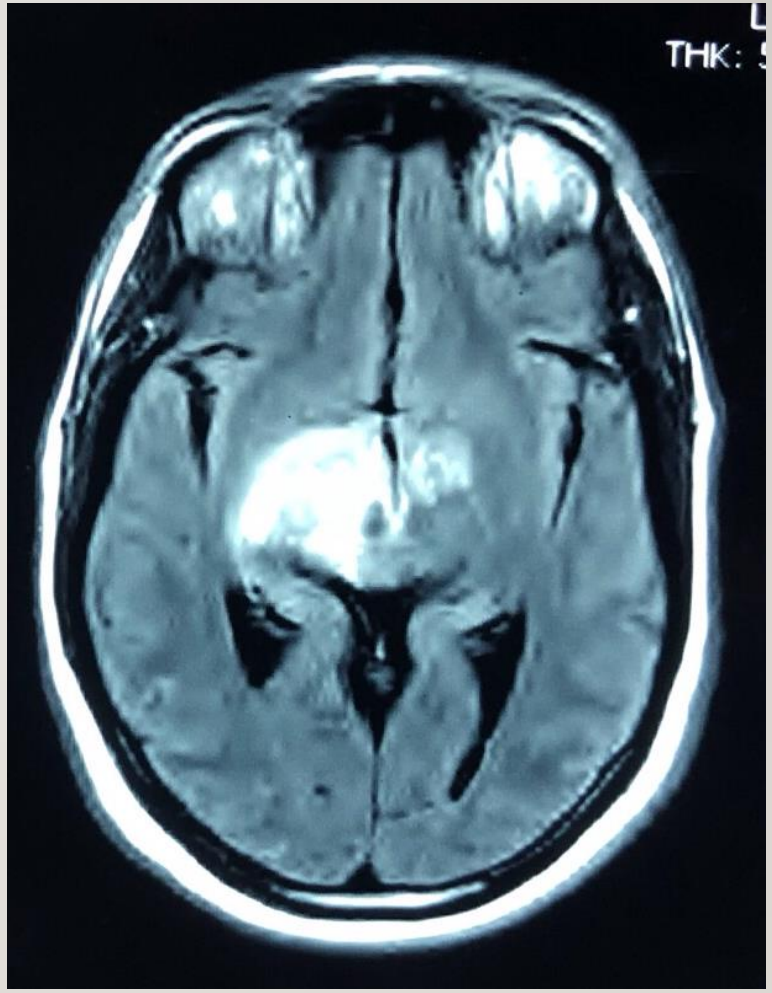
- ACE levels: 6
- VDRL: non reactive
- Serum aquaporin 4 Antibody: negative
- Gangliosides (Anti-GM1, GM2, GD1a, GD1b, GQ1b): within reference values
- MOG antibody: negative

IMAGING TESTS



Brain MRI (May 2016)





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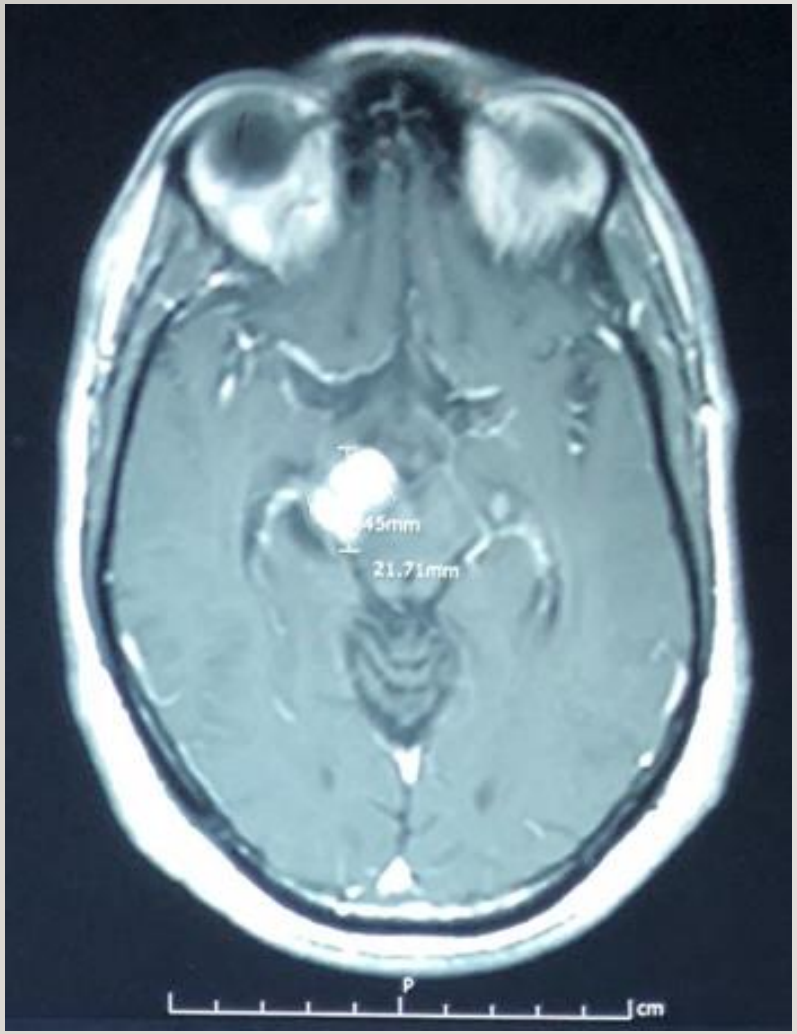

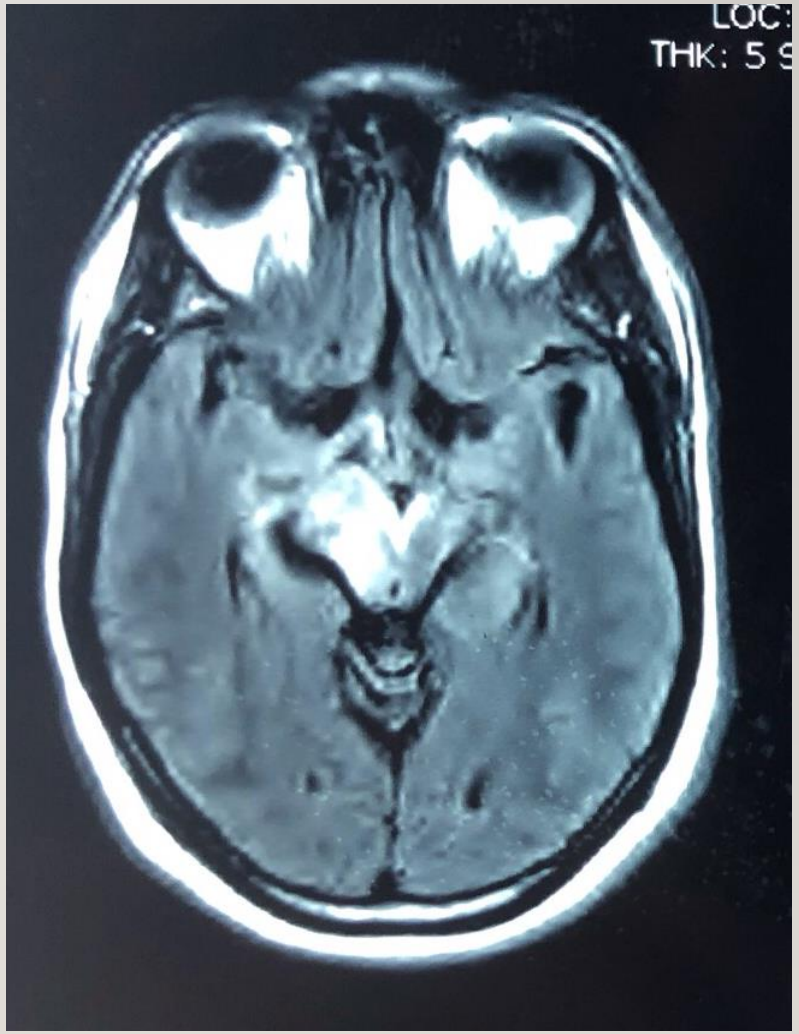

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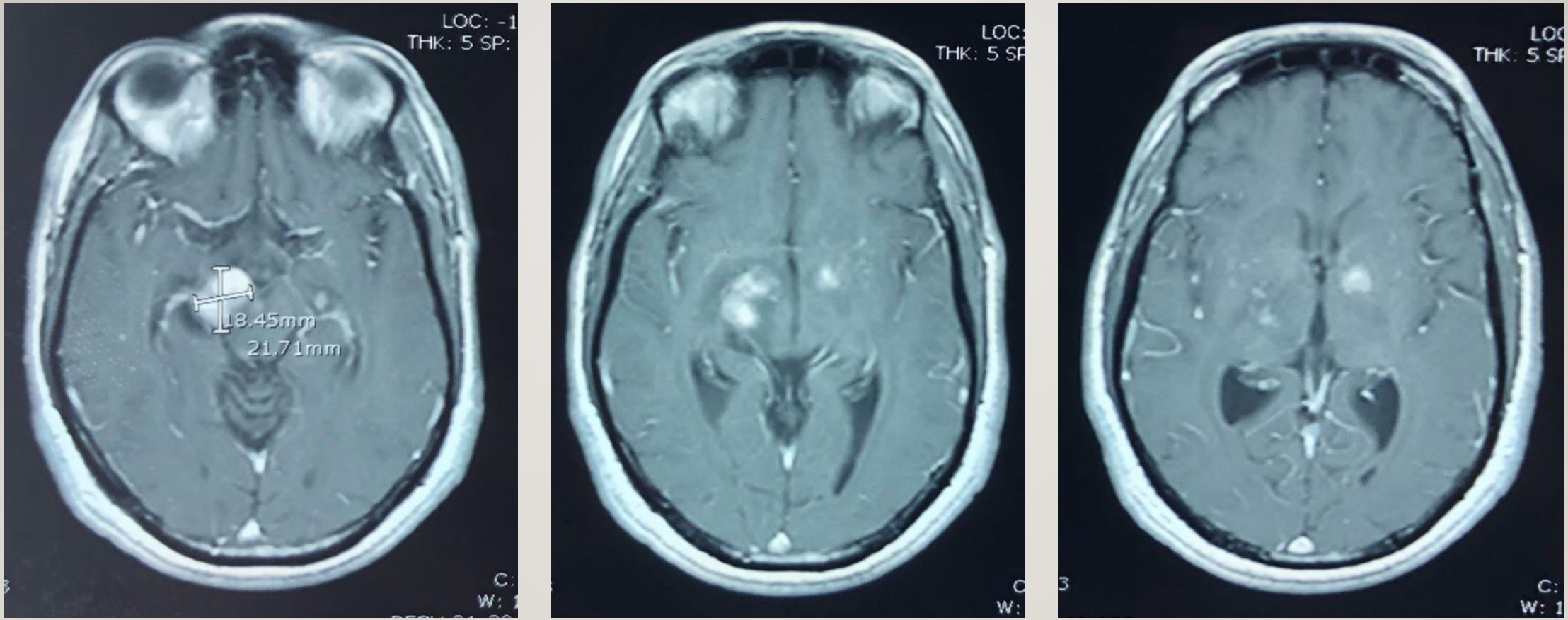

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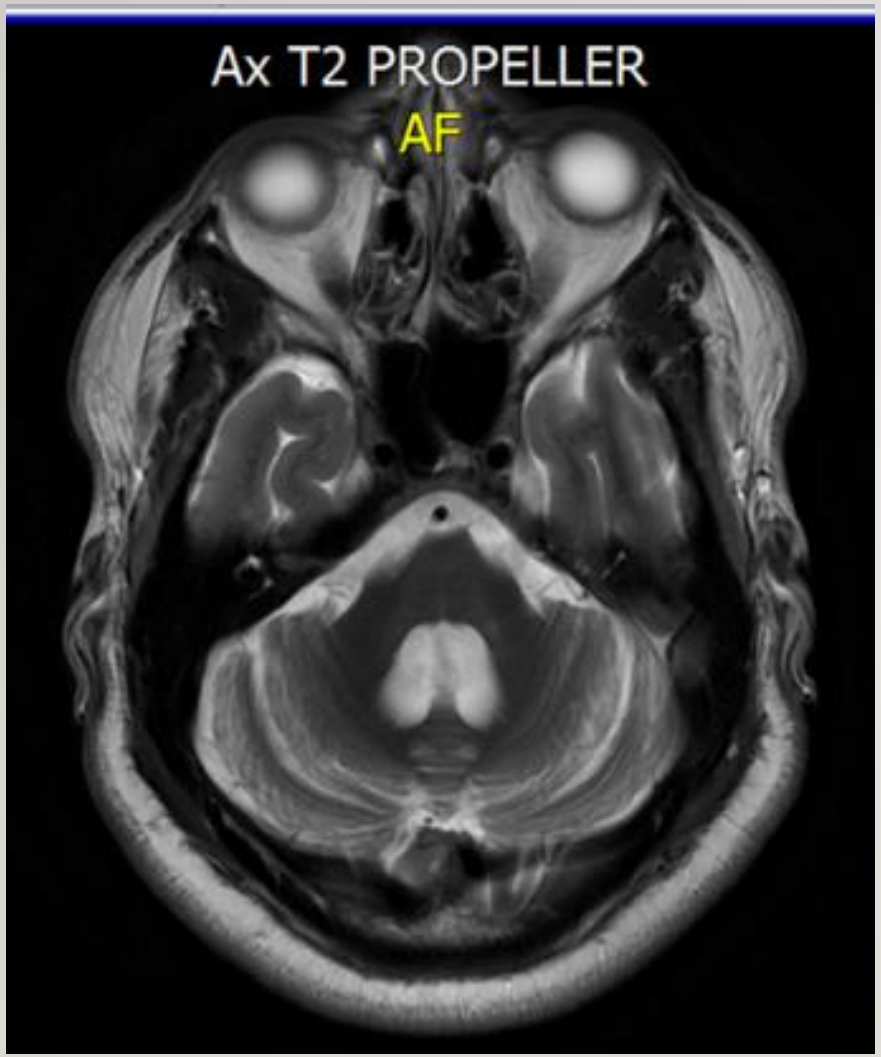
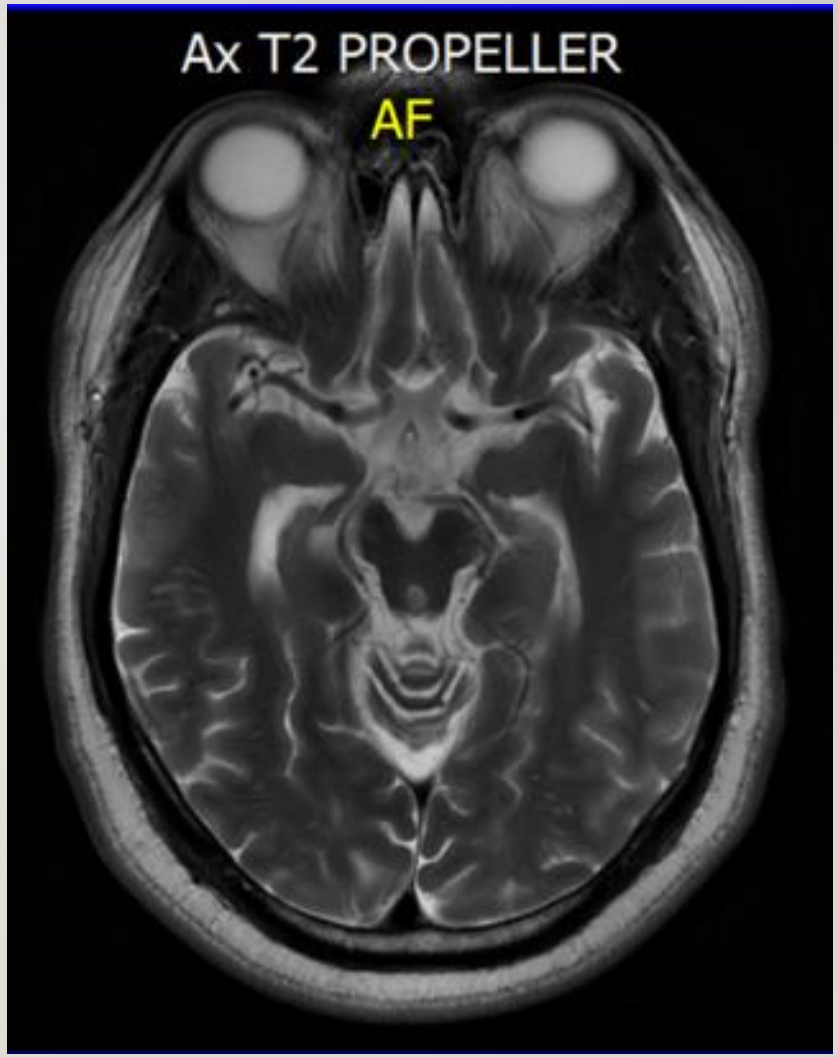
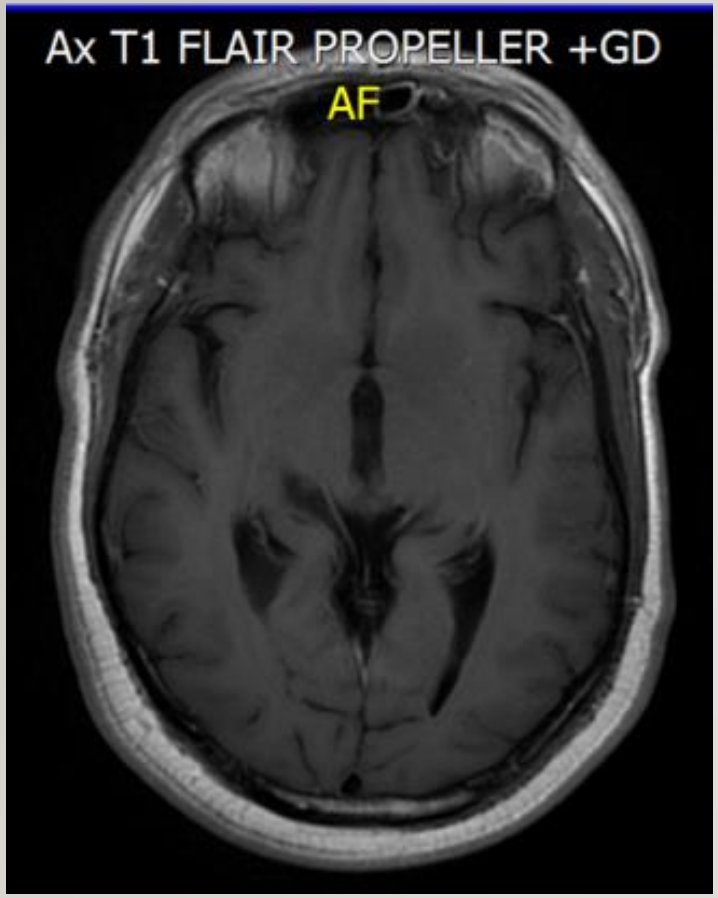
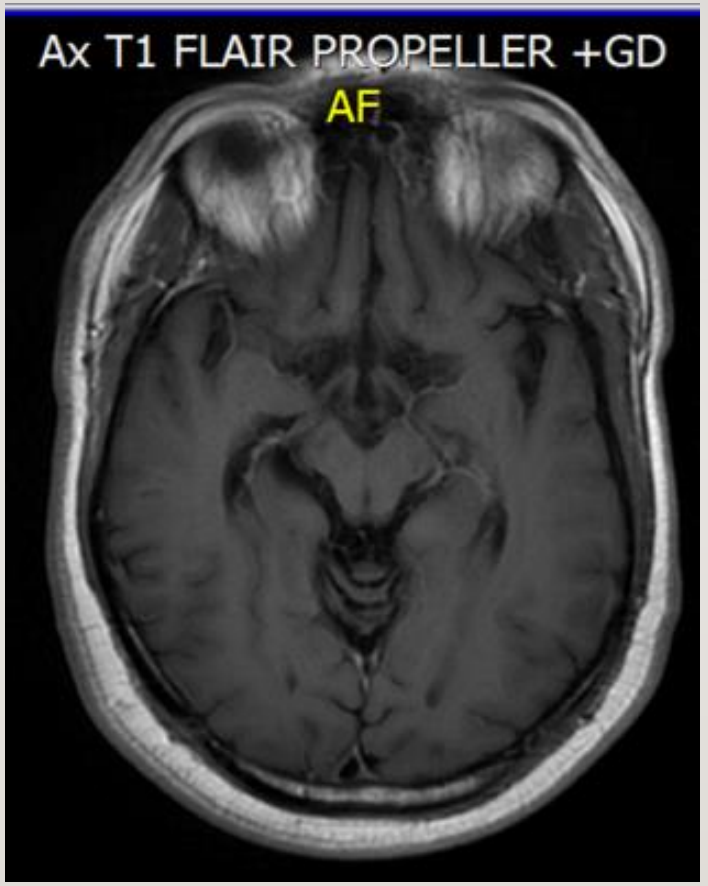
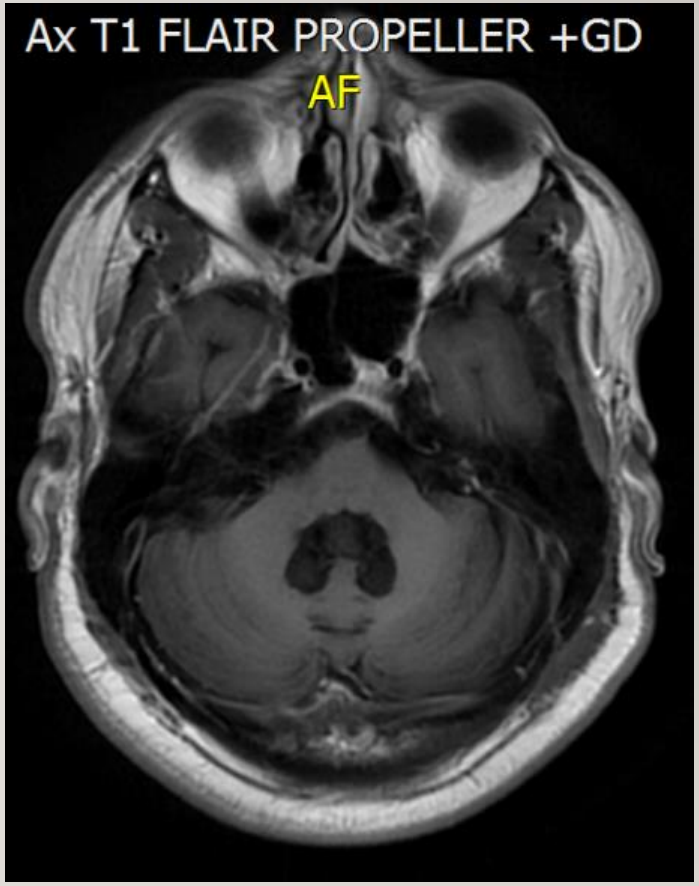




Brain MRI (June 2017)







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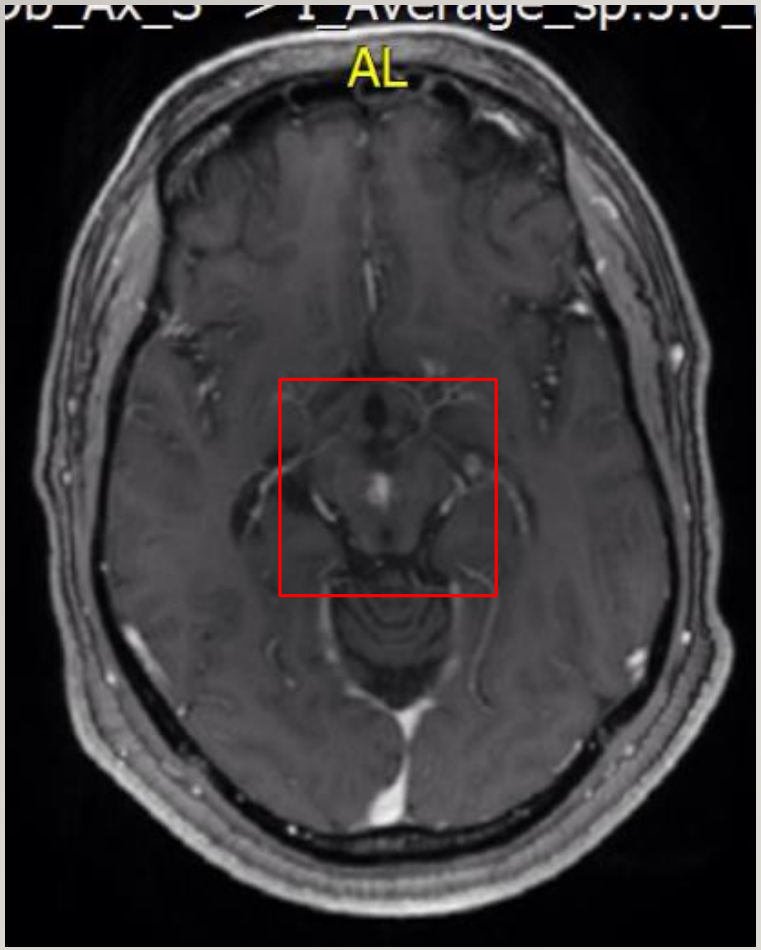
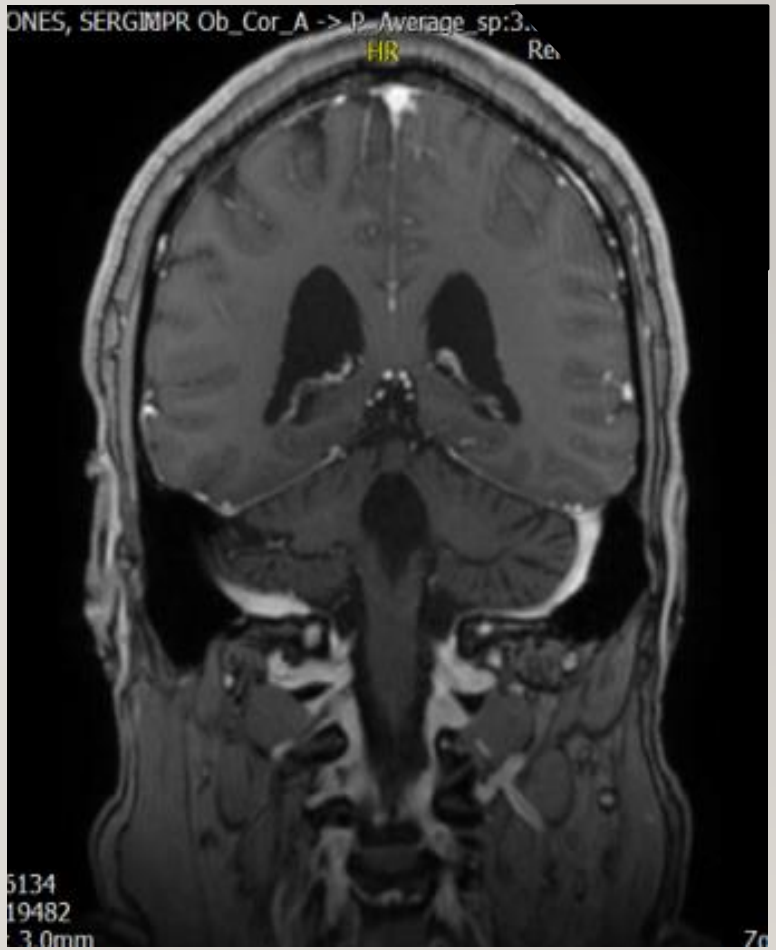
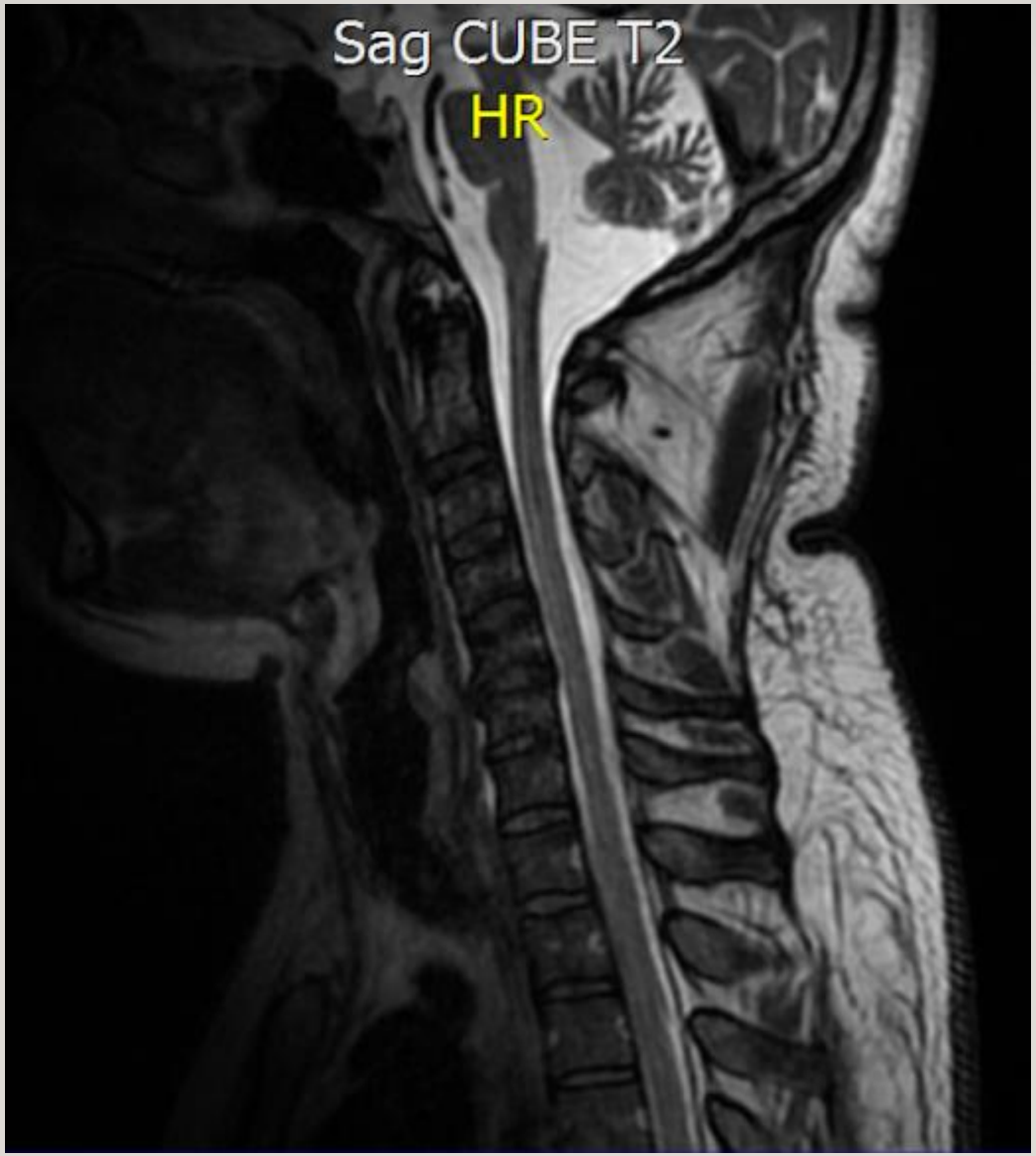




Brain MRI (Feb 2018)

Cervical MRI
(April 2018)



Thanks!