HPI: A 71 year old woman presents with complaints of recent abdominal pain, a new right foot drop, and progressive right sided weakness.

The patient was in her usual state of health until six months prior to presentation when she was admitted to the hospital for nausea, vomiting and left lower quadrant abdominal pain. She was diagnosed with diverticulitis. During that admission, she also reported a headache and was noted to have a right cranial sixth nerve palsy. She underwent a temporal artery biopsy (negative per report), was diagnosed with giant cell arteritis, and was started on high dose prednisone. Over the next four months, the cranial nerve palsy and abdominal pain improved, though she required one additional hospitalization for pain. Two months prior to presentation at our facility, the patient stopped her prednisone. One week later she was hospitalized with severe depression and ‘failure to thrive’. At the time she reported profound weakness and fatigue. She was seen by rheumatology and restarted on prednisone 60mg daily for a flare of her giant cell arteritis. Her weakness reportedly improved.

One month prior to this presentation, the patient reported profound weakness in the right upper and lower extremity. Examination by her primary care doctor revealed right foot drop.

The patient now reports weight loss of 20 lbs over the past 6 months, 8/10 pain in both legs, and 6/10 pain in both hands. She describes tingling in both hands and feet. She cannot walk at home. She also reports an intermittent rash and abdominal pain. She denies fever, chills, arthralgias, pulmonary symptoms, diarrhea, urinary symptoms.

Medications:
- Citalopram 20mg daily
- Prednisone 20mg daily (stopped 2 weeks prior)
- Aspirin 81 mg daily

Allergies:
- Demerol

Past Medical History:
- Steroid induced diabetes
- Osteoporosis
- HTN
- Hyperlipidemia
- Depression

Past Surgical History:
- Appendectomy
- Parathyroidectomy
- Cholecystectomy
- Abdominal hysterectomy
- Total left hip and knee replacement

Social History:
- Lives with her husband and grandson
- Denies tobacco, alcohol or illicit drugs; denies recent travel
- Retired nurses aid
- Ambulates with cane or walker

Physical Exam

Vital Signs: BP 135/76mmHg; HR 84bpm; RR 16; Temp 36.4 Wt 54.9 kg

General: Alert and oriented. Thin, frail looking woman in wheelchair

HEENT: No jaw tenderness or temporomandibular joint clicking. No firm or palpable temporal artery. Conjunctivae pink, sclera anicteric, no fundoscopic abnormalities noted, no oral lesions, no lymphadenopathy. Full range of motion of neck

CV: Regular rhythm, normal S1/S2; no S3/S4, murmur, rub; PMI nondisplaced. No carotid bruits.

Lungs: Clear to auscultation

Abdomen: Normoactive bowel sounds, soft, non-tender, non-distended; liver span 8 cm, no splenomegaly

Skin: Petechial lesions on arms, abdomen and bilateral lower extremities.

Extremities: Pitting edema in both legs at the ankles.

Neuro: Hearing is diminished bilaterally. CN II-XII intact. Sensory testing reveals severe stocking/glove pattern (up to knees and forearms bilaterally) - loss to vibration and temperature

Strength in upper extremities: 4+/5 bilaterally – proximal and distal

Strength in lower extremities:
- Right: Tone is flaccid in the distal right lower extremity. There is loss of bulk in the thighs. 4/5 strength with hip flexion and 4+5 with knee flexion and extension bilaterally. 1/5 strength with dorsiflexion and 2/5 with plantar flexion
- Left: 3/5 with plantar flexion and dorsiflexion

Deep tendon reflexes 2+ in upper extremities and absent in knees and ankles. No Hoffman reflexes elicited. Downgoing Babinski

Mild tremor when arms extended. Few myoclonic jerks. No dysmetria with finger to nose. Unable to do heel-to-shin. Unable to stand without assistance.

Psych: Mood depressed with appropriate affect and judgment

Joints: No swelling, warmth, erythema. Full range motion all joints

Laboratory and Imaging Studies

Sodium 133 mmol/L Potassium 3.1 mmol/L Chloride 99 mmol/L Bicarbonate 30 mmol/L BUN 6 mg/dL Cr 0.47 mg/dL Glucose 159 mg/dL Calcium 7.7 mg/dL

AST 17 units/L ALT 12 units/L ALP 95 units/L Total bilirubin 0.5 mg/dL Albumin 3.3 gm/dL
WBC 8.4 x10^9/L, Hemoglobin 11.1 g/dL, Mean Corpuscular Volume 91.2 fl, Platelets 211 x 10^9/L

Serum
- CK 18 units/L
- CRP 16.7 mg/dL
- ESR 100 mm in 1 hr
- ANA negative
- Cryoglobulins negative
- C3 84 mg/dL
- C4 23 mg/dL
- C-ANCA <1:20
- P-ANCA <1:20
- Atypical ANCA <1:20
- CH50 51 U/ml
- SPEP negative for monoclonal gammopathy
- TSH 7.10 uIU/L
- Free T4 0.9 ng/dL
- Hepatitis B surface antigen positive
- Hepatitis B surface antibody positive
- Hepatitis B e antigen positive
- Hepatitis B e antibody negative
- Hepatitis B c antibody IgM negative
- Hepatitis B c antibody total positive
- HIV negative

CSF
- Tube #1 clear
- colorless
- RBC 593 /mm3
- WBC 1 /mm3
- Lyme IgG negative
- IgG 7.1 mg/dL (0 - 8.6 mg/dL)

MRI abdomen
- Patent abdominal vasculature (MRA not done). No evidence of bowel dilation, thickening or abnormal enhancement. Trace mesenteric edema associated with subcutaneous anasarca.
- The liver and spleen are within normal limits. Pancreas atrophic but demonstrates normal signal intensity.
- Multiple fluid signals within kidneys suspicious for renal cysts.

MRI/MRA brain
- No mass or midline shift. No intracranial hemorrhage. Small vessel ischemic disease but no evidence of acute ischemia. Mild narrowing of proximal right ACA. Mild narrowing of the MCA at the origin of the anterior trunk. Otherwise unremarkable MRA of the head.

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A 71 year old woman with abdominal pain, weight loss and neurologic findings