

Case History

A 68 year-old male with a past medical history of CLL is brought to the hospital due to progressive weakness and confusion. The patient was in his usual state of health until 5 months ago when his family noted the gradual onset of mild but constant confusion which has slightly worsened in the month prior to presentation. He has remained very communicative, but over the course of several months has stopped shaving, bathing, and feeding himself. Three weeks ago, the patient first noted the onset of progressive weakness. The weakness was generalized and not associated with sensory changes. Three days prior to admission, the patient was no longer able to ambulate. Care of the patient became difficult, prompting his wife's insistence on evaluation.

Upon further review of systems, the patient reported anorexia and unintentional weight loss of 20 lbs in 5 months. He reports increased right-sided neck swelling for "about 1 year". Also complaints of mild cough productive of purulent sputum without hemoptysis for two weeks. Denies shortness of breath, chest pain, fever, chills, night sweats. Denies dysphagia or odynophagia. Denies back pain or myalgia. Denies constipation or fecal incontinence. Denies urinary complaints. Denies headache, nausea, vomiting, or diarrhea. His wife reports that his speech has been mildly slurred on occasion. Denies history of seizure activity.

Past Medical History:

- ❖ Chronic lymphocytic leukemia: Dx 1993, B-cell, Rai stage I. Recurrent. Treated with chlorambucil in 1997 and 2002 and with fludarabine in 1999 and 2005 (9 months prior to current presentation), all due to worsening leukocytosis and lymphadenopathy. No known complications of chemotherapy. Last CBC (3 months ago) WBC $32.2 \times 10^9/L$ Hgb 13.1 g/dL Plt $172 \times 10^9/L$
- ❖ COPD - FEV1 29% of predicted in 2003
- ❖ Hypertension
- ❖ Paroxysmal atrial fibrillation
- ❖ Coronary artery disease - s/p PTCA to mid-RCA in 2000

Medications:

- ❖ Quit taking all medications 3 months ago.
- ❖ Previously taking digoxin, enalapril, verapamil, salmeterol inhaler, and fluticasone inhaler.
- ❖ No known drug allergies

Family History:

- ❖ Parents deceased due to "old age".

Social History:

- ❖ Lives in Goochland, VA with his wife. Retired sheriff. 100 pack-year smoking history, currently smoking 1-2 packs per day. History of heavy alcohol use, quit 6 months ago. No history of illicit drug use. No pets or recent exposure to animals. No history of blood product transfusion. No history of travel or incarceration

Physical Exam

- General: Disheveled and unkept appearing elderly white man in no distress. Weight 152 lb Height 5'11".
- Vital signs: Temperature 98.9°F, heart rate 102/minute, respiratory rate 20/minute, blood pressure 130/85 mmHg in right arm, pulse oximetry 96% on room air.
- HEENT: Atraumatic. Dry mucous membranes. No oropharyngeal erythema or lesions. No scleral icterus or conjunctival pallor
- Neck: Supple, 2 x 2cm firm and mobile right submandibular node. No carotid bruits.
- Heart: Rate 100, regular rhythm. Normal S1, physiologic split S2. No murmurs, rubs, or gallops. PMI 1cm and non-displaced. No edema. Peripheral pulses 2+ on all extremities.
- Chest: Normal respiratory effort. Decreased breath sounds throughout. No adventitious sounds.
- Abdomen: Mildly distended. Hypoactive bowel sounds. Soft, non-tender. No palpable masses or organomegaly. No fluid wave. Rectal - normal sphincter tone with an nodular prostate of normal size.
- Extremities: No cyanosis, clubbing, or edema.
- Dermatologic: Multiple old tattoos. No rashes. No cyanosis. +mild bilateral gynecomastia
- Neurologic: Alert, oriented to person and place. Not oriented to day, date, or time. Cranial nerves I-XII intact. No dysarthria. No nystagmus. LE: 4/5 strength plantar flexion bilaterally and 5/5 strength w/ dorsiflexion and proximal muscles. UE: 4/5 strength on right hand grip. LUE strength 5/5. No abnormal movements or tremor. Sensation: normal to light touch, pin prick, vibration and proprioception. DTRs: 2+ throughout. Babinski absent. Mild past-pointing RUE > LUE. Gait: not tested (per patient request)

Department of Internal Medicine
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Laboratory Studies

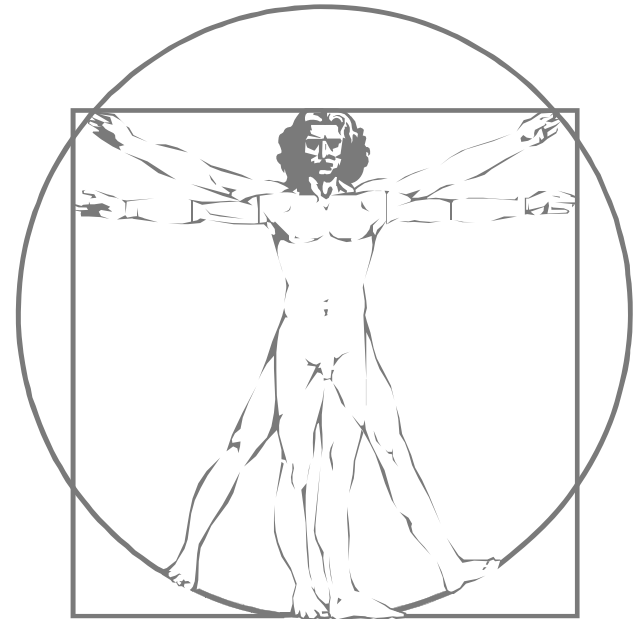
- ❖ Sodium 136 mEq/L, potassium 4.4 mEq/L, chloride 97 mEq/L, bicarbonate 33 mEq/L, blood urea nitrogen 16 mg/dL, creatinine 0.9 mg/dL, glucose 76 mg/dL, calcium 8.9 mg/dL
- ❖ Albumin 3.8 g/dL, AST 36 U/L, ALT 28 U/L, total bilirubin 1.3 mg/dL, alkaline phosphatase 88 U/L, Total protein 5.8 U/L
- ❖ WBC 41.1 x 10⁹/L, hemoglobin 12.1 g/dL, platelets 168 x 10⁹/L
Differential: 15 x 10³/μl Neu, 68x10³/μl Lymphs, 1x10³/μl Mono, bands present
- ❖ Ammonia 14 μmol/L
- ❖ TSH 1.4 μIU/ml
- ❖ Urinalysis – negative protein, negative leukocyte esterase, negative nitrites, 2 WBC/HPF, 0 RBC/HPF
- ❖ **Lumbar Puncture:** WBC 1/mm³, RBC 7/mm³, protein 29 mg/dL, glucose 84 mg/dL. Gram stain, India ink stain and AFB stain negative. IgG 2.1 mg/dL (normal). Oligoclonal bands absent. VRDL negative. HSV PCR negative
- ❖ **Chest radiograph:** mild hyperinflation with no air-space disease, nodules, or masses
- ❖ **MRI Brain:** Several new left cerebellar and bilateral frontal white matter hypointense lesions (T1). The lesions are hyperintense with T2 imaging. These lesions range from 0.2 cm – 2.5 cm in diameter. There is no surrounding edema, mass effect, ring-enhancement, or cortical atrophy.

Hospital Course

The patient was admitted to the Internal Medicine ward service.

A test was performed and a diagnosis made...

A 68-year-old Man with Confusion and Weakness



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