Government of Western Australia
WA Country Health Service

A CLINICAL BUFFET

NIL RANWALA
ALBANY HEALTH CAMPUS
GENERAL MEDICINE AT

Our minds are like our stomachs; they are whetted by the change of their food, and variety supplies both with fresh appetite

-Quintilian

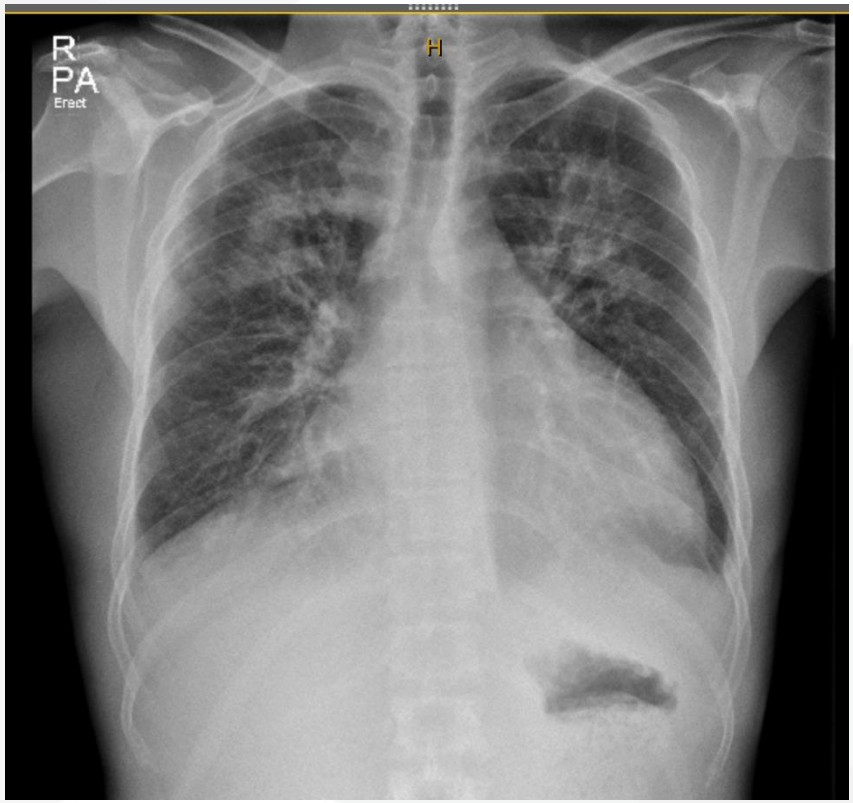

albany health campus
EMERGENCY
MAIN ENTRY

A CLINICAL BUFFET

1. 43yo with dyspnoea
2. Bilateral ptosis
3. A blown pupil

43 YO WITH DYSPNOEA

- 43 M presents with 1 month of dyspnoea and anxiety.
- Nil PMHx
- Smoked “lots”, nil EtOH.
- Uses THC, IV methamphetamine
- No fevers, HR 120 BP 128/94
- CRP 6 Troponin 21



- TTE: Moderate dilation of LV with very severe global impairment of systolic function (LVEF 10%), non dilated RV with severely impaired systolic function. Moderate TR. Moderate MR. Moderate Dilated atrium.

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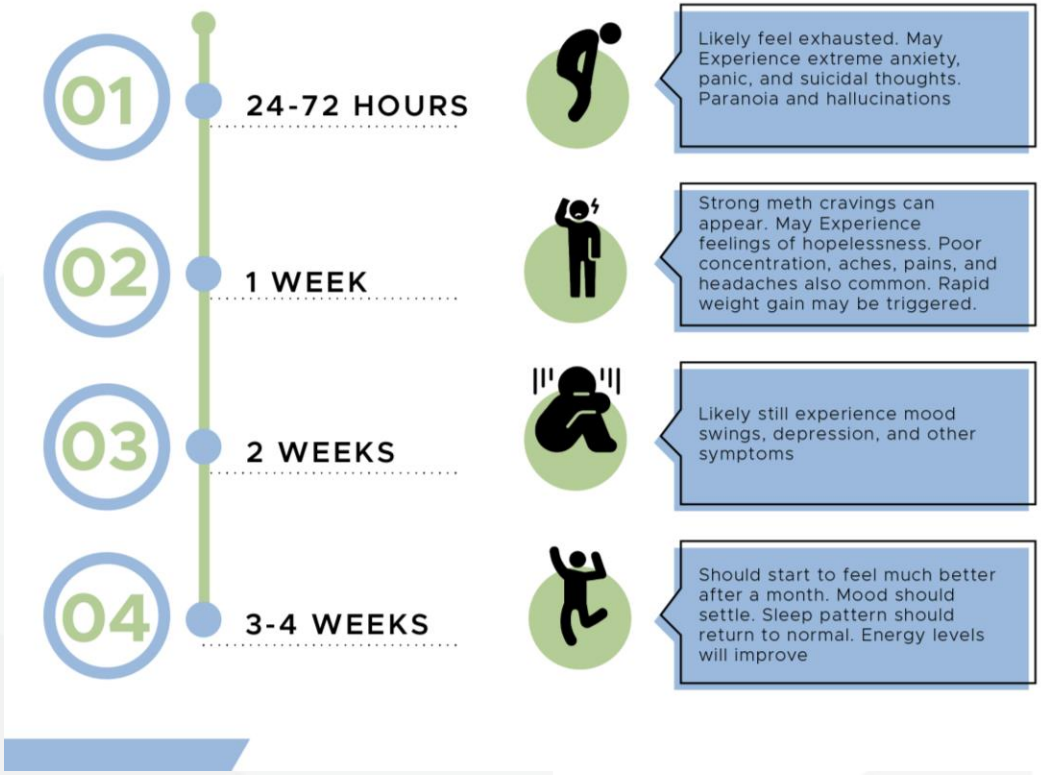
METHAMPHETAMINE INDUCED CARDIOMYOPATHY

- Diagnosis made by history and excluding Ddx
- Mechanism: Direct cell toxicity + sympathetic activation
- More common in binge use + those who use other substances
- Treat as per HFrEF
- Increased risk of LV thrombus (33%)
- Cardiac MRI useful - fibrosis + LV thrombus
- Prognosis: duration of use, **cessation**, LV size/EF, fibrosis
- Consider advanced heart therapies including ICD,CRT VAD, cardiac transplant

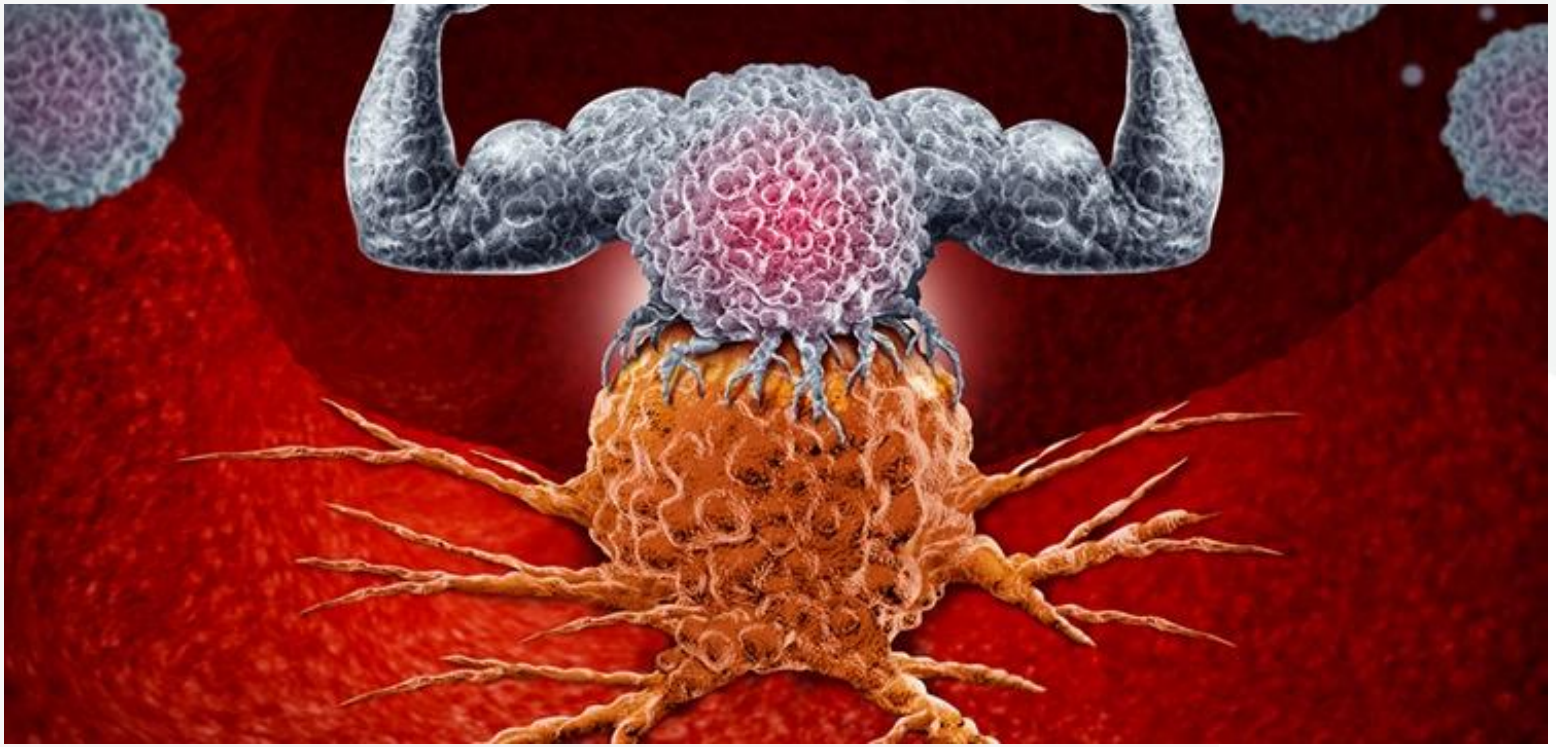
TIPS TO AID CESSATION

- Meth Helpline- 24/7
  - Phone: **1800 874 878**
  - Email: **alcoholdrugsupport@mhc.wa.gov.au**
  - Live Chat: drugaware.com.au
- Utilise family and friends
- GP and DAA services
- Treat underlying Mental Health
- No evident to support pharmacological treatments aid cessation



BILATERAL PTOSIS

- 85 M retired marine engineer
- 3 days of worsening bilateral ptosis, right worse than left
- Dysphagia to fluids and pain in thighs and with hip flexion
- PMHx – Mesothelioma Dx in May 2024
- CK 3080
- Troponin 52



1st dose of Ipilimumab and Nivolumab - 6 weeks ago

IMMUNE-CHECKPOINT INHIBITOR INDUCED MYASTHENIA GRAVIS

- Immune checkpoint inhibitor induced Myasthenia Gravis is rare with high mortality (25%)
- Onset ~4 weeks after initiation of ICI
- Progresses quickly (7 days from onset to crisis)
- Can occur with myositis and myocarditis
- Antibody negative in 33% of cases
- Monitor FVC (20mL/kg), consult oncology and neurology
- High dose steroids
- Early IVIG/Plasmapheresis
- Considered decision regarding restarting ICI

A BLOWN PUPIL

- 63 M w acute onset diplopia
- BG: BPAD, OSA, HTN (controlled), Parkinsonism, recent L cataract surgery, nil DM
- Clinically R ptosis and 3rd R pupil - down and out, b/l proptosis ?longstanding
- R Pupil dilated – no direct or consensual response to light
- Nil other neurology
- CTA - nil aneurysm, nil SAH
- MRI nil clear compressive lesion, no stroke, ?inflammatory change at R orbital apex

UNDIFFERENTIATED 3RD NERVE PALSY

- A surgical CN III palsy - If pupil is involved - look for compressive lesion
- A medical CN III palsy – if pupil spared - most commonly ischemic – will improve in 3 months, treat CV RF
- All 3rd nerve palsies should get CT Angiogram*

+ MRI/MRA

Brainstem	**Basilar segment**	**Intracavernous segment**	**Intraorbital**
Oculomotor nuclei lesion (CVA, MS)	PcoM Aneurysm Raised ICP	Cavenous sinus thrombosis/invasion Carotid aneurysm Tolosa-hunt syndrome	Tumours in orbital cavity Orbital cellulitis
(Bilateral ptosis, pupil sometimes involved)	(Pupil involved)	(CN IV,V1,V2, VI and pupil involved)	(Pupil involved, proptosis,

- Transferred to FSH
- Ophthalmology review with review of MRI images – nil biopsy of EOM feasible, ?all motion artefact
- HbA1c 5.9 TG 2
- Treated as ischemic oculomotor palsy however for repeat MRI in 6 weeks time
- ?Tolosa hunt syndrome

THANK YOU!

Dr Prue Howson
Dr Omar Faruque
Dr Lloyd Nash
Dr Andriana Stathakis

PERIPHERAL BLOOD EOSINOPHILS OF 6

- 83 F from RACF with 3 weeks of worsening dyspnoea
- PMHx: Alzheimer's dementia, acoustic neuroma, osteoporosis
- 18kg weight loss in last 4 months
- RR 22 O2 94% on 3L
- Respiratory PCR – negative
- Hb 141 WCC 21.21 plts 679 – neutrophils 11 eosinophils 6 (12x ULN)

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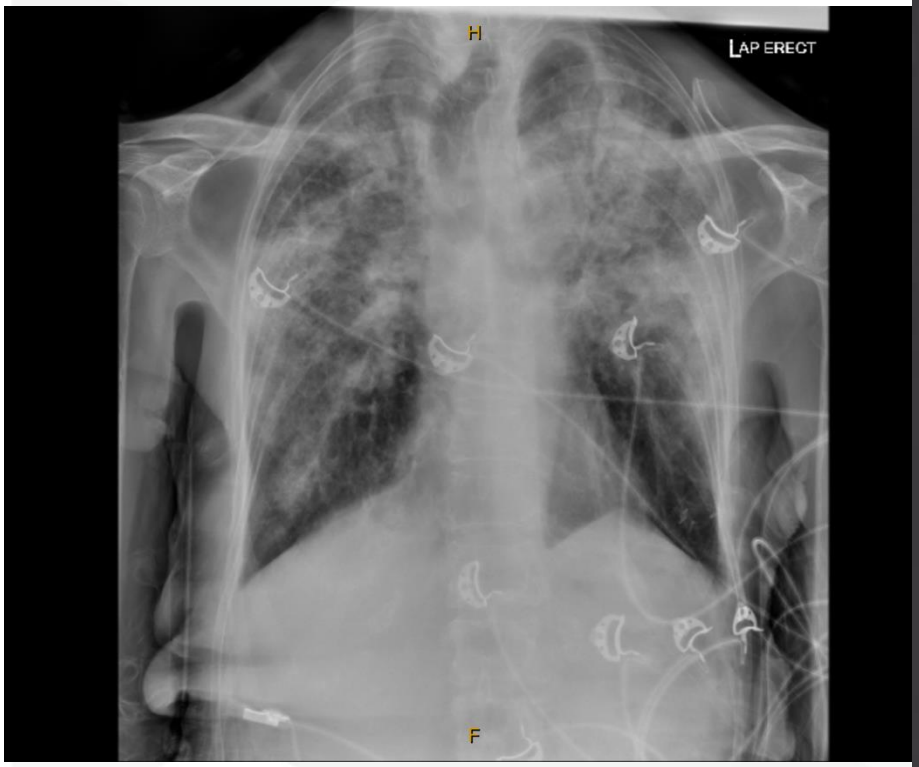

CT CHEST W/OUT CONTRAST
LUNG C- COR, IDOSE (2)
21 days, 10 hrs ago
Se: Oct 18, 2024 10:45 AM
CT #204
Thk: 3mm
1
92

- Became increasingly delirious and agitated. Difficult to maintain O2 delivery with frequent desaturation
- Decision made to transition to comfort care in-line with her AHD and discussions with her EPG

EOSINOPHILIC PNEUMONIA

Acute eosinophilic pneumonia

- Men 20-40s
- Smokers
- No Hx of atopy
- Mimics CAP and ARDS
- Symptoms < 1month
- BAL > 25% eosinophils/biopsy consistent
- Blood eosinophilia usually absent
- CT - ground glass opacities, interlobular septal thickening, pleural effusions, thickened bronchovascular bundles, centro-lobular nodules

Chronic eosinophilic pneumonia

- Women 20-40s
- Non-smokers
- Hx of atopy
- Subtle and progressive
- Constitutional Sx
- Symptoms 2-4 weeks
- BAL > 40% eosinophils
- Blood eosinophilia present
- CT – dense, patchy consolidation and ground glass changes affecting outer aspects of mid, upper lung

ALSO CONSIDER

- Eosinophilic granulomatosis with polyangiitis
- Drug induced eosinophilic pneumonia
- Hypereosinophilic syndrome
- Allergic broncho-pulmonary aspergillosis
- Loeffler syndrome
- Cryptogenic organizing pneumonia
- Idiopathic pulmonary fibrosis and sarcoidosis
- ARDS