CC:, Headache and diplopia.,HX:, This 39 y/o African American female began experiencing severe constant pressure pain type headaches beginning the last week of 8/95. The pain localized to bifronto-temporal regions of the head and did not radiate. There was no associated nausea, vomiting, photophobia or phonophobia. The HA's occurred daily; and throughout daylight hours. They diminished at bedtime, but occasionally awakened her in the morning.,Several days following the onset of her HA's, she began experiencing numbness and tingling about the right side of her face. These symptoms improved, but did not completely resolved.,Several days after the onset of facial paresthesias, she began to experience binocular horizontal diplopia. The diplopia resolved when covering either eye, and worsened upon looking toward the right. Coincidentally, she began veering toward the right when walking. She denied any weakness. She had had chronic unsteadiness for many years since developing juvenile rheumatoid arthritis. She was unsure whether her unsteadiness was due to poor depth perception in light of her diplopia.,The patient was admitted locally 9/2/95. HCT, 9/2/95 and Brain MRI with gadolinium, 9/3/95, were ""unremarkable."" Lumbar puncture (done locally),9/3/95: Opening pressure 27cm H20, CSF analysis ( protein 14.0, glucose 66, O WBC, 3 RBC, VDRL non-reactive, Lyme titer unremarkable, Myelin basic protein 1.0 (normal <4.0), and there was no evidence of oligoclonal bands. ESR=76. On 9/11/95 ESR=110. Acetylcholine receptor binding and blocking antibodies were negative. 9/4/95, ANA

and RF were negative. 7/94, ANA and RF were negative, and ESR=60.,MEDS: ,Tylenol 500mg q5-6hrs. No known Allergies.,PMH:, 1)Juvenile Rheumatoid Arthritis diagnosed at age 10 years; now in remission. 2)Right #5 finger reattachment as child due to traumatic amputation.,FHX: ,Mother died age 42 of unknown type cancer. Father died age 62 of unknown type cancer. 4 sisters, one brother and 2 half-brothers. One of the half-brothers has asthma.,SHX: ,Single, lives with sister, and denies Tobacco/ETOH/illicit drug use.,EXAM:, BP141/84, HR99, RR14, 36.8C, Wt. 82kg Ht. 152.,MS: A&O; to person, place, time. Speech fluent; without dysarthria. Mood euthymic with appropriate affect.,CN: Decreased abduction, OD. In neutral gaze, the right eye deviated slightly lateral of midline. In addition, she had mild proptosis, OD. The right eye was nontender to palpation during extraocular movement. Visual fields were full to confrontation. Optic disks appeared flat. Face was symmetric with full movement and sensation. Gag, shoulder shrug and corneal responses were intact, bilaterally. Tongue was midline with full ROM.,MOTOR: 5/5 strength throughout with normal muscle bulk and tone.,SENSORY: Unremarkable.,COORD: Unremarkable FNF/HKS/RAM.,STATION: Unremarkable. NO Romberg's sign or drift.,GAIT: Narrow based gait. Able to TT and HW without difficulty. Mild difficulty with TW.,REFLEXES: 2+/2+ Throughout all 4 extremities. Flexor plantar responses, bilaterally.,Musculoskeletal: Swan neck deformities of the #2 and #3 digits of both hands.,GEN EXAM: unremarkable, except for obvious sign of right finger reattachment

(mentioned above).,COURSE: ,Repeat lumbar puncture yielded: Opening pressure 20.25cm H20, protein 22, glucose 62, 2RBC, 1WBC. CSF cytology, ACE, cultures (bacterial, fungal, AFB), gram stain, cryptococcal antigen, and VDRL were negative. Serum ACE, TSH, FT4 were unremarkable.,Neuroophthalmology confirmed her right CN6 palsy and proptosis (OD); and noted her complaint of paresthesias in the V1 and V2 distribution. They saw no evidence of papilledema. Visual field testing was unremarkable. MRI Brain/orbit/neck with gadolinium, 10/20/95, revealed abnormal enhancing signal in the right cavernous sinus and sinus mucosal thickening in both maxillary sinuses/ethmoid sinuses/frontal sinuses. CXR, 10/20/95, showed a lobulated mass arising from the right hilum. The mass appeared to obstruct the right middle lobe, causing partial collapse of this lobe. Chest CT with contrast, 10/23/95, revealed a 3.2x4.5x4.0cm mass in the right hilar region with impingement on the right lower bronchus. There appeared to be calcification as well as low attenuation regions within the mass. No lymphadenopathy was noted. She underwent bronchoscopy with bronchial brushing and transbronchial aspirate of the right lung on 10/24/95: no tumor cells were identified, GMS stains were negative and there was no evidence of viral changes, fungus or PCP by culture or molecular assay. She underwent right maxillary sinus biopsy and right middle lobe wedge resection and lymph node biopsy on 11/2/95: Caseating granulomatous inflammation with associated inflammatory pseudotumor was found in both

sinus and lung biopsy specimens. No sign of cancer was found. Tissue cultures (bacterial, fungal, AFB) were negative times 3. The patients case was discussed at Head and Neck Oncology Tumor Board and a differential diagnosis of Sarcoidosis, Histoplasmosis, Wegener's Granulomatosis, were considered. Urine Histoplasmosis Antigen testing on 11/8/95 was 0.9units (normal<1.0): repeat testing on 12/13/95 was 0.8units. ANCA serum titers on 11/8/95 were <1:40 (normal). PPD testing was negative 11/95 (with positive candida and mumps controls).,The etiology of this patient's illness was not discovered. She was last seen 4/96 and her diplopia and right CN6 palsy had moderately improved.