Patient #122

Chief Complaints: This 30 year old white male recently diagnosed with hyperthyroidism, now was admitted for progressive bilateral lower extremity weakness and pain.

History of Present Illness: The patient has a remote history of a motorcycle accident resulting in an open left tibial fracture which was treated with open reduction internal fixation. Over the last several months prior to his admission, he developed fevers and erythema over his previous surgical site. He was seen by his local physician and clinically was felt to have a wound infection. However, additional history at that time disclosed that he had been having palpitations, anxiety, depression, extreme heat intolerance, and frequent bowel movements for over the past year. In fact at one point he had been started on Prozac for the anxiety and depression without much relief. Thyroid function studies were sent and he was referred to the Orthopedics Service for management of his wound.

He was admitted and was scheduled for antibiotics and surgical removal of the lower extremity hardware. Just prior to the anticipated surgery, the results of the thyroid function tests were obtained--TSH <0.003 and Free T4>6 (nl= 0.73-1.79). An Endocrine consult was called, Atenolol was instituted, and a thyroidal radioiodine uptake was obtained and showed 61.4% uptake at 24 hours. He was treated with 20 mCI of I-131 and was discharged to home on Atenolol.

Over the several weeks since his discharge, he noted shrinkage of his neck swelling and improvement in his dysphagia which in retrospect had also been present for many months. The tremulousness had also improved markedly and his anxiety resolved. He continued to have up to 6 loose stools daily and had persistent palpitations. On the morning prior to admission he awoke with pain and weakness in his bilateral lower extremities, back, chest, and upper extremities. He initially had difficulty standing and was unable to climb stairs because of weakness. Over 24 hours he noted progressive weakness and pain, described as being "all seized up." He presented back for further management.

Previous Medical History: was significant for depression.

Previous Surgical History: significant for a tonsillectomy and an open reduction internal

fixation of the left lower extremity.

Medications: Atenolol and Prozac. The patient had no known drug allergies.

Family History: the patient is from West Virginia originally and is of Norwegian descent.

Physical Examination: Thin young adult white male who appeared very fidgety and tremulous. Vital signs were: temperature of 97.5^{o} F (36.5^{o} C), blood pressure of 135/85, heart rate of 82, and respiratory rate of 18. An examination of the skin revealed no rashes or hyperpigmentation. HEENT: pupils equal, round, reactive to light; no oral or nasal lesions. The neck was supple. The thyroid diffusely enlarged about 2.5 times normal; no bruit. The lungs were clear to auscultation without rales or wheezes. A cardiac exam revealed regular rate and rhythm without murmurs or gallops. The abdomen was soft; no tenderness or distention, no abnormal bowel sounds, no hepatosplenomegaly or masses. Examination of the extremities revealed no edema and a healing left lower extremity surgical scar without erythema or tenderness. The neurological exam revealed visible tremor. Initially decreased strength symmetrically in bilateral hip flexors/extensors, knee flexors/extensors, and shoulder. Reflexes were present. Sensation was completely intact.

Laboratory Data:

			Normal
CBC	Hct	37.0	*42-52%*
	Hgb	12.2	*14.0-18.0g/dl.*
	WBC	5.1	*4-10 X $10^{9/L}$*
	Neut	76	*50-75 %*
	lymph's	14	*20-50 %*
	mono	10	*3-10 %*

			Normal
Chemistries	sodium	144	*136-146 mmol/l*
	potassium	2.0	*3.5-5.0 mmol/l*
	chloride	105	*99-111 mmol/l*
	CO2	30	*24-34 mmol/l*
	creatinine	0.5	*.9-1.3 mg/dl*
	BUN	18	*8-20 mg/dl*
	glucose	138	*73-115 mg/dl*

Urinalysis: negative