Patient #121

Chief Complaint: This 32 year old black male presented with diplopia and difficulty swallowing.

History of Present Illness: He was well until 2 weeks prior to admission, when he developed headache and diplopia. Four days prior to admission, he developed a sore throat. He experienced difficulty in swallowing, with regurgitation of liquids into his nose and mouth. He also experienced some jaw fatigue on chewing solid foods. He noted some mild dyspnea on exertion. He denied fever, chills, or cough. He also denied weakness, numbness, or paresthesias in his extremities.

Past Medical History: He had chondromalacia patellae, and fractured his wrist 6 years prior.

Medications/Allergies: none.

Family History: His mother had migraine headaches. Otherwise unremarkable.

Social History: He works as a manager in a plastics plant. He does not use tobacco. He drank alcohol heavily in the past, but quit 5 years ago.

Physical Examination: Well developed, well nourished black male in no acute distress. BP 134/78; pulse 60; respirations 16; temperature 98.2^{o}F (36.7^{o}C).

The head was normocephalic and atraumatic. The conjunctivae were pink. The sclerae were anicteric. The pupils were equal, round, and reactive to light and accommodation. The oropharynx was mildly injected, without exudates. The neck was supple. The thyroid gland was normal in size. There was no lymphadenopathy. The lungs were clear. Cardiac examination revealed normal sounds, without gallops or murmurs. The abdomen was soft. There was no tenderness, hepatosplenomegaly, or masses. Rectal examination was normal; the stool was guaiac negative. Genital examination was unremarkable. The extremities showed no cyanosis, clubbing, or edema. On neurologic examination, he was alert and oriented. There was ptosis of the both eyes, right greater than left, and mild VI nerve palsies bilaterally. Motor strength was 3/5 on neck flexion, 4/5 in the proximal and 5/5 in the distal upper extremities, and 3/5 in the proximal and 5/5 in the distal lower extremities. Sensory examination was normal. The deep tendon reflexes were 2+ and symmetric. The plantar reflexes were flexor.

Laboratory Data:

			Normal
CBC	Hgb	15.7	*14.0-18.0g/dl.*
	Hct	46.7	*42-52%*
	WBC	5.6	*4.8-10.8 X $10^{9/L}$*
	differential	normal	
	platelet count	320	*150-400 X 10^{9}/l*
Chemistries	sodium	143	*135-149 mmol/l*
	potassium	4.2	*3.5-5.3 mmol/l*
	chloride	100	*98-108 mmol/l*
	CO2	24.6	*24-32 mmol/l*
	BUN	12	*6-20 mg/dl*
	creatinine	0.6	*0.5-1.5 mg/dl*
	glucose	84	*70-110 mg/dl*
	AST (SGOT)	30	*0-50 U/L*
	CPK	70	*21-232 U/L*
	T_4	7.8	*4.5-12.0 ug/dl*
	TSH	1.2	*0.6-4.6 ug/dl*
	ESR	20	*0-10 mm/hr*

Chest X-ray :an anterior mediastinal mass; the lungs were normal.

EKG: within normal limits.

ANA: positive at 1:80, with a speckled pattern.