Removing the Anchor — Physiatry Consult Prevents Unsafe Discharge Through Identification of Rare Neuromuscular Disorder

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INTRODUCTION

- Anchoring bias—relying too heavily on initial impressions or information—is a common pitfall in medical decision-making
- Physiatrists often serve as the decisive point of evaluation before discharge, making it critical to approach each case with fresh clinical judgment

------- PRIMARY AIM -------

This case report underscores the value of physiatry in detecting subtle, significant findings and ensuring patients receive comprehensive support beyond their initial diagnosis.

CASE DESCRIPTION

Initial Presentation

- 56-year-old female
- Experiencing chronic multi-joint pain
- Presented to emergency department
- 3- month history of progressive whole-body weakness
- 2-week history of slurred speech

Functional Status

- Previously modified independent with assistance from a walker
- Now required maximal assistance for stand-pivot transfers (3-4 months)
- Began experiencing decline in mobility with frequent falls
- Unable to attend medical appointments due to immobility and lack of appropriate equipment

------- PHYSICAL EXAM -------

TABLE 1. NEUROLOGIC EXAM

Test	Findings
Speech	-Dysarthric but fluent
Reflexes	-Diminished
Hoffmans / Clonus	-Negative
Sensation	-Abnormal to light touch -Hands & feet in stocking glove distribution

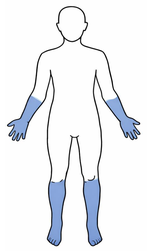


TABLE 2. STRENGTH EXAM

Upper Extremity Muscle Position	Grade	Lower Extremity Muscle Position	Grade
Shoulder abduction*	3 / 5	Hip flexion*	2-/ 5
Elbow flexion*	4 / 5	Hip abduction*	3 / 5
Elbow extension*	4 / 5	Hip adduction*	3 / 5
Finger abduction*	4 / 5	Knee extension*	3-/ 5
Finger flexion*	4 / 5	Dorsi/plantarflexion*	3 / 5

**Footnote: grossly the same bilaterally*

------- CLINICAL TIMELINE -------

11/28/23 Presentation to the ED with bilateral hip and leg pain, with ongoing weakness attributed to UTI. Home discharge planned for 11/30

11/30/23 Physiatry consulted and cancelled discharge after history & physical exam in order to pursue additional workup

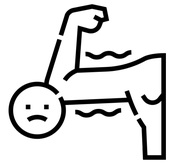
12/05/23 EMG/NCS revealed axonal sensory neuropathy and evidence of myopathy. Patient underwent five sessions of plasma exchange (PLEX), followed by nerve and muscle biopsy. Findings were consistent with lipid storage myopathy

12/05/23 Concern arose regarding patient protecting airway, transferred to ICU and intubated. Patient later required tracheostomy and PEG placement

02/06/24 Patient discharged to subacute rehabilitation, eventually weaned off ventilator

RESULTS / OUTCOMES

- Patient deficiencies were thought to contribute to lipid storage myopathies
- Targeted treatment was employed using levocarnitine, riboflavin, and pyridoxine accordingly[1]
- Patient underwent a 3-week ICU course for respiratory distress, including a tracheostomy and PEG placement
- Patient minimally improved in upper and lower extremity function

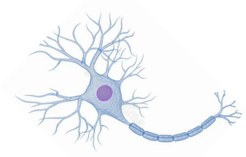


------- PRIMARY TAKEAWAY -------

This case underscores the physiatrist's vital role in catching missed or evolving diagnoses, as early involvement can reveal subtle functional decline, shift diagnostic direction, and prevent unsafe discharge.

DISCUSSION

- Through a thorough physical exam, the physiatrist identified neurological deficits that had been missed during previous medical evaluations
- The physiatrist's comprehensive assessment of the patient's functional status and discharge needs helped prevent an unsafe discharge and prompted continued inpatient care
- By avoiding anchoring and performing a thorough independent assessment, physiatrists can help prevent missed or delayed diagnoses and ensure safe transition of care



References