



**LIVE VIRTUAL SYMPOSIUM  
JULY 8-12, 2020**

**P1 – Q&A The Neurological Exam: From Theory to Practice - Bruce Morgenstern**

Q – What is your opinion of loss of smell and taste in covid19 patient and what is the expectancy for resolution of the problem.

A – *I briefly reviewed the literature on loss of smell (anosmia) in COVID-19 patients - it does occur frequently between one third and two thirds of patients, mostly women. Because smell is a large component of taste, patients may also experience this cozy (loss of taste). The exact mechanism remains unclear, but it is thought the virus may bind to olfactory rootlets within the nasal cavity. I could not find much information on prognosis.*

Q – Also would you recommend some sort of scans to those patient with prolonged anosmia etc?

A – *Time course and associated symptoms would be the factors that influence my deciding whether such patients require intracranial imaging. Certainly the acute onset of smell disturbance, particular if associated with other viral symptoms which strongly suggest a viral induced etiology. Alternatively, a patient without viral symptoms who presents with slowly progressive loss of smell might be a little more suspicious (the loss of smell may also be seen in neurodegenerative disorders such as premotor Parkinson's disease). Again time course of onset would govern my decision-sudden onset would suggest inflammation or infectious, slowly progressive could potentially suggest a growing mass lesion (though neurodegenerative or age-related would be more likely.)*

Q – I work in Corrections and I haven't gotten to exam this inmate yet, but history is that he has "chronic Guillain-Barré". I am not yet sure how long ago, but it must have been complete to Head, because now has intermittent hyper activity of both upper and lower extremities. I have heard he has extended periods of calm, can walk I'm told but maybe not long distances. I have diagnosed in ped's patients high suspicion of GB . Tell me a little more when a person becomes chronic GB. I have been told with stress this hyper flex movement becomes worse. Initially, the first who witnessed thought was having seizure. I'm doing a physical on this person this next week. What might I find on the exam.

A – *“Chronic Guillain-Barré” otherwise known as chronic inflammatory demyelinating polyradiculopathy is a chronic demyelinating neuropathy. Unlike acute Guillain-Barré, the motor symptoms are not strictly length dependent so such patients may have proximal weakness as well as distal weakness, as well as sensory loss and loss of reflexes, typically progressive though sometimes relapsing. As is characteristic eral neuropathy, there should be loss of reflexes, and sensory loss, usually in the lower extremities, typically “large fiber” affecting joint position and vibration more than pinprick. Your description includes “hyperactivity.” I would expect reflexes to be suppressed. I am unaware of abnormal movements mimicking seizures as*

*part of the syndrome., If any significant doubt, nerve conduction/EMG is considered diagnostic.*

*You may want to read:*

*An Update on the Management of Chronic Inflammatory Demyelinating Polyneuropathy*

*Kenneth C. Gorson*

<https://journals.sagepub.com/doi/10.1177/1756285612457215>