

Clinical Pearls: Neurology

- Time Is Brain: Always Know “Last Known Well”
 - It dictates eligibility for thrombolysis and thrombectomy.
 - Ask, “When was the patient last seen at their baseline?”—not just when symptoms were noticed.
- Facial Droop: Upper vs. Lower Motor Neuron Matters
 - Upper motor neuron lesions (e.g., stroke) spare the forehead—patient can raise both eyebrows.
 - Lower motor neuron lesions (e.g., Bell’s palsy) affect the whole face on one side—including inability to raise eyebrow or close the eye.
- Headache + Papilledema = Imaging Before Lumbar Puncture
 - If a patient has signs of increased intracranial pressure (e.g., papilledema, focal deficits, altered mental status), always get a head CT or MRI before LP to avoid risk of herniation.
- Worsening Neurologic Symptoms with Heat? Think MS
 - Patients with multiple sclerosis (MS) often have Uhthoff’s phenomenon—transient worsening of neurologic symptoms (e.g., vision loss, weakness) with heat or exertion.
- "Rule of the Hand" in Sensory Loss
 - Sensory symptoms that stop objectively exactly at an anatomic region (whole hand sensory loss or whole foot) often suggest a non-neurologic (functional or psychogenic) cause.
 - True neurologic lesions usually do not respect precise anatomic boundaries.
 - The patient may describe the whole hand or foot sensory loss but in neurological lesions only a portion of the limb is affected on sensory testing