full and intact sensation, strength, reflexes, and unremarkable focused spine, hip, or knee examinations.

Setting: Outpatient rehabilitation clinic

Results: In conjunction with the patient’s endocrinologist, she was advised to stop Forteo for a trial period and reported relief of symptoms off Forteo. She has since restarted alendronate for treatment of osteoporosis and resumed playing tennis five times a week without return of symptoms.

Discussion: While weakness and leg cramps are reported adverse effects of Forteo (<1%), the relationship between the medication and the patient’s symptoms was not recognized earlier on in her course. In the meantime, she underwent extensive testing to exclude other etiologies of bilateral leg pain.

Conclusions: Bilateral leg pain and weakness has a broad differential diagnosis. Teriparatide is an under-recognized etiology of drug-induced myositis and should be considered in patients with refractory symptoms in the absence of neurologic deficits for earlier diagnosis and to avoid unnecessary testing.

Level of Evidence: Level V

Poster 177:
Alternative Options for Anticoagulation in a Prothrombotic, Bilateral above Knee Amputee with Life-Threatening Reactions to Standard Anticoagulants

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Disclosures: Ramsay Elhindi: I Have No Relevant Financial Relationships To Disclose

Case/Program Description: A 60-year-old Caucasian woman presenting with a thoracic aortic thrombus complicated by bilateral lower extremity atheroemboli resulting in ischemia requiring bilateral above knee amputations (AKA).

Setting: Diagnostic workup revealed JAK2 gene mutation as etiology for essential thrombocythemia and resultant thrombus formation. Given patient’s ambulatory limitations following bilateral AKA, coupled with increased clotting risk in prothrombotic state, patient was initiated on warfarin with heparin bridging for treatment of hypercoagulable state. Patient subsequently developed heparin-induced thrombocytopenia as well as warfarin-induced skin necrosis, requiring discontinuation and avoidance of heparin-like products as well as warfarin. Patient was transitioned to fondaparinux to achieve anticoagulation in setting of increased risk of recurrent thrombotic episodes further worsened by immobility due to bilateral AKA. Unfortunately, patient developed significant bleeding with hematoma development, necessitating discontinuation of fondaparinux in addition to other novel oral anticoagulants due to significant bleeding risk.

Results: Ultimately, patient was initiated on hydroxyurea and aspirin for treatment of essential thrombocythemia as well as placement of SVC filter for prophylaxis against recurrent thromboembolic disease.

Discussion: Essential thrombocythemia is a rare hematologic condition characterized by overproduction of platelets resulting in platelet dysfunction. Due to platelet dysfunction, patients may be predisposed to bleeding as well as prothrombotic states resulting in thrombi formation. This is of significant importance in the rehab population, specifically amputees with ambulatory limitations. Treatment is determined by risk stratification; high risk patients for are usually treated with aspirin and hydroxyurea. Patients with thrombotic disease at high risk for embolic incidents may benefit from anticoagulation.

Conclusions: The clinical manifestations of essential thrombocythemia can be widely varied, requiring vastly different management strategies. In high risk patients with a propensity for thromboembolic disease and limited ambulatory capacity, such as amputees, it is important to manage these patients with appropriate chemoprophylactics/anticoagulants to prevent thromboembolic events.

Level of Evidence: Level V

Poster 178:
A Case of Guillain-Barre Syndrome Following Laminectomy and Epidural Abscess

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Disclosures: Tahsin Ashraf: I Have No Relevant Financial Relationships To Disclose

Case/Program Description: A 56-year-old woman with past medical history of chronic back pain presented to acute rehabilitation s/p recent laminectomy and lumbar fusion. Following surgery, she developed fever and chills and was found to have an epidural abscess. She developed acute weakness and decreased sensation in her bilateral lower extremities. Patient was diagnosed with GBS - AMSAN variant based off EMG results which showed non-length dependent sensory greater than motor polyneuropathy with mostly axonal features. She was treated with IVIG. On presentation to rehabilitation, patient had normal strength in her bilateral upper extremities. She had 3/5 strength, diminished sensation and reflexes in her bilateral lower extremities as well as decreased proprioception.

Setting: Acute inpatient rehabilitation

Results: Through weeks of therapy, patient improved upon her seated balance. She was able to achieve transfers with a sliding board. Patient was unable to ambulate for greater than a few feet due to ataxic and unsteady gait. For patients with AMSAN-GBS approaches focus on trunk control, increasing upper body strength, and proprioception training.

Discussion: AMSAN is a variant of GBS which affects sensory nerve conduction and typically occurs in adults with an abrupt onset and rapid progression. Patients usually present with ascending weakness/paralysis and paresthesias preceded by infection. The workup includes ruling out other causes, CSF analysis, and electrodiagnostic testing. Management methods include immunotherapy, plasmapheresis, and physical therapy. The prognosis is poor with about 20% ambulating at 1 year.

Conclusions: This is an atypical presentation of AMSAN following lumbar laminectomy and fusion complicated by epidural abscess. A high level of awareness is needed to diagnose this rapidly progressive and treatable condition that should not be confused with paraplegia from epidural abscess.

Level of Evidence: Level V

Poster 179:
Temporomandibular Joint Heterotropic Ossification and Myositis Ossificans of Facial Musculature Following Traumatic Brain Injury: A Rare Case

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Disclosures: Nathaniel Montag: I Have No Relevant Financial Relationships To Disclose

Case/Program Description: This patient was treated at our inpatient rehabilitation facility for his impairments from resultant TBI and traumatic injuries following a motor vehicle accident, including left radial fracture and bilateral mandibular fractures s/p ORIF and interdental wiring, with subsequent removal. He had complained of pain at the left elbow, and imaging at that time showed heterotopic bone at the lateral elbow joint. Toward the end of his rehab stay, he complained of insidious onset left facial pain and swelling and, considering prior instrumentation, was sent for CT Maxillofacial with contrast to rule-out abscess formation.

Setting: Inpatient Rehabilitation Hospital

Results: CT Maxillofacial revealed heterotopic bone in the region of the TMJs, with questionable bony ankylosis on the left. There was also right masseter and medial pterygoid myositis indicative of early myositis ossificans.
Discussion: While heterotopic ossification of the TMJ has been documented in orthopedic literature, this is the first case, to our knowledge, in the TBI population.

Conclusions: While rare, heterotopic ossification is possible in any area of immobility and trauma and should be considered as a possible diagnosis with TBI patients and joint pain. Careful consideration should be applied to patients considered high risk and determining in prophylaxis is indicated.

Level of Evidence: Level V

Poster 180:
Improvement of Refractory Lower Extremity Edema with Multilayered Compression Bandaging: A Case Report

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Disclosures: Jegy Tennison: I Have No Relevant Financial Relationships To Disclose

Case/Program Description: A 64-year-old man with multiple myeloma treated with chemotherapy, autologous stem cell transplant, and radiation therapy to the T9-L1 vertebrae was admitted to the hospital for neutropenic fever, right lower extremity (RLE) cellulitis, bilateral lower extremity (BLE) weakness, and BLE edema. He was treated with cefepime and vancomycin for his RLE cellulitis and pneumonia. His physical examination was significant for 3+ pitting BLE edema, decreased light touch sensation to distal RLE, 3/5 strength to BLE, and 4/5 strength to BLE. For his BLE edema, he received furosemide (40 mg daily) and was prescribed compression stockings. Magnetic resonance imaging demonstrated stable thoracic compression. Electrodiagnostics showed active and chronic lumbosacral radiculopathy affecting multiple nerve roots along with mild axonal sensory and, to a lesser extent, motor symmetric peripheral neuropathy in the lower extremities. BLE venous Doppler ultrasonography revealed no deep vein thrombosis, and the patient’s ankle brachial index and toe brachial index were within normal range. RLE cellulitis improved. Due to persistent edema, it was decided to place a referral to a lymphedema-certified therapist to apply lower extremity multilayered compression bandaging and document serial limb circumference measurements.

Setting: Quaternary cancer center

Results: The patient’s weight decreased from 94.5 kg on day 1 of compression bandaging to 86.3 kg on day 7. The circumferences of BLE also decreased significantly (details will be discussed).

Discussion: Compression bandaging is the standard of care for lymphedema and venous edema, while the standard treatment for refractory peripheral edema is diuretics. This case demonstrates the utility of multilayered compression bandaging, typically used in the management of lymphedema, in the control of peripheral edema, refractory to diuretics and compression stockings. Documenting serial limb circumference measurements and weight are essential outcome measurement tools for compression bandaging.

Conclusions: This case demonstrates that refractory peripheral edema can be successfully managed with multilayered compression bandaging.

Level of Evidence: Level V

Poster 181:
Use of Myoelectric Arms in Quadrimembral Amputee: A Case Report

Gregory R. Franklin, MD (University of North Carolina Hospitals P, Chapel Hill, NC, United States), Britny Tsui, MD

Disclosures: Gregory Franklin: I Have No Relevant Financial Relationships To Disclose

Case/Program Description: Patient: 48-year-old man with Type 2 diabetes mellitus. Patient was admitted into the ICU with DKA (diabetic ketoacidosis) and septic shock. He was maintained on vasopressors for a prolonged period of time and had resultant limb ischemia, dry gangrene and necrosis of his bilateral upper & lower extremities. On day 66 of his hospitalization, he underwent bilateral trans-tibial amputations and on day 69, he had trans-radial amputations. He did well post-operatively and was admitted to inpatient rehabilitation for about 3.5 months where he learned to be functional as a quadrimembral amputee. During that time, he was evaluated by prosthetists and provided with stump shrinkers. Eight days after discharge from rehab, he followed up in amputee clinic where he was determined to be a K3 level user. He was provided with bilateral lower extremity prostheses utilizing a pin-locking suspension system. He was undergoing physical therapy, learning balance and gait training for his new “legs.” At his next follow-up visit in amputee clinic about 4 weeks later, he was interested in receiving upper extremity prostheses and wondered what type of prosthesis would help him be most functional.

Setting: Tertiary Care Hospital, Acute Inpatient Rehabilitation & Outpatient Amputee Clinic

Results: Patient was fit for both body powered and myoelectric devices. He was more efficient with activities of daily living including brushing his teeth, shaving and eating with myoelectric arms.

Discussion: Quadrimembral amputees are very uncommon and there is a paucity of literature addressing the lifestyle, functionality and treatment options regarding appropriate prosthetic devices.

Conclusions: Myoelectric arms may be useful restoring functional independence in patients who are quadrimembral amputees.

Level of Evidence: Level V

Poster 182:
Botulinum Toxin Therapy for the Management of Spontaneous Orofacial Dyskinesia Refractory to Standard Therapy: A Case Report

Lisa M. Koplik-Nieves, MD (Bayamón, PR, Puerto Rico), Keryl Motta-Valencia, MD

Disclosures: Lisa Koplik-Nieves: I Have No Relevant Financial Relationships To Disclose

Case/Program Description: A 71-year-old man with hypertension and diabetes mellitus type 2, presenting with 2-year onset of repetitive involuntary orofacial movements (at face, tongue, jaw and neck muscles), vocal tics and coughing. Given the lack of hereditary risk factors or exposure to antipsychotic use, the clinical diagnosis was orofacial dyskinesia, idiopathic and of late-onset. Initial medication trial with amantadine, clonazepam and risperidone provided significant improvements. Eventually, due to adverse reactions, he warranted a tapering of risperidone but failed alternate treatment with tetrabenazine. Since patient was tolerating only limited use of risperidone, an off-label incobotulinum toxin A trial was performed to mitigate involuntary movements and attempt a reduction in risperidone dose.

Setting: Outpatient clinics of a tertiary care hospital.

Results: Initial neurotoxin infiltration rendered excellent response and was optimized by stepwise re-infiltrations which allowed extension of treatment sites, improved function and quality of life. Initial neurotoxin trial at lower face rendered decreased involuntary oral and jaw movements. A second trial with infiltration sites expanded to neurotoxin trial at lower face rendered decreased involuntary oral and jaw movements. A second trial with infiltration sites expanded to mandibular muscles provided improvement of vocal tics. A final trial including neck and respiratory accessory muscles reduced fatigue and pain symptoms.

Discussion: Idiopathic orofacial dyskinesia is a challenging movement disorder in terms of diagnosis and treatment. For this patient, available standard pharmacotherapy was helpful but with limited tolerability. Neurotoxin infiltrations to address symptoms and abnormal functioning provided satisfactory outcomes for patient with advantage of reducing doses and adverse effects from oral medication. Additional secondary benefits were reduced anxiety, improved sleep and less distress during social interactions.