CASE PRESENTATION

BY DR.CH SARISHMA

PG PEDIATRICS

- Name : XYZ
- Age : 8 years
- Sex : Male
- Address : Nalgonda
- Date of admission : 21-1-2014
- Date of discharge : 5- 2- 2014

Chief complaints :

- Abnormal movements of upper and lower limbs since 7 days .

History of present illness

- The child was apparently alright 7 days back.
- To start with he had sudden onset of involuntary movements of both upper and lower extremities.
- Later, the movements increased and he had difficulty in performing routine activities like feeding and drinking by self, buttoning and unbuttoning his clothes, inability to sit, stand and walk. The movements were subsiding during sleep.
- No h/o emotional disturbances like sudden outbursts of laughing.

- H/o sore throat 4 weeks back for which he received treatment.
- No history of

  - Head injury
  - Ear discharge,
  - Intake of drugs
  - Headache, fever, vomiting
  - Visual disturbances
  - Skin rashes
  - Convulsions
  - Jaundice
  - Breathlessness
  - Loss of weight, appetite

Past history

- No h/o similar illness in the past
- No h/o contact TB

Birth history

- 2nd by birth order, born to non-consanguineous parents. Delivered by LSCS at term (ind: prolonged labour) with B. Wt : 3 kg.
- No h/o perinatal asphyxia, jaundice or NICU admissions.

- Immunized as per the schedule
- Developmental milestones attained as per age and studying in class IV
- Family and Socio economic status
  - low SES according to modified kuppuswamy scale.
  - Joint family with 1 sibling – female child 14 yrs apparently healthy.
  - No history of similar illness in the family

General examination

- Conscious and sitting with support in the bed
- Abnormal movements are present

  -spontaneous, fast, jerky

  - non-repetitive,

  - purposeless

  - involving all the limbs and head
- Facial grimacing present.

General examination

- Temperature: 98.6^{o} F,
- Pulse Rate : 88/min, normal volume, regular, no radio- radial delay. All peripheral pulses were felt.
- Respiratory Rate : 18/min,
- Blood Pressure: 100/60 mm hg of right arm, supine position.
- Spo2 98% at room air.

General examination

- No Pallor/ Icterus/ Cyanosis/ Clubbing/ Edema/ Lymphadenopathy.
- Head, Eyes, ENT: normal , pupils : NSRL
- No evidence of neurocutaneous markers.
- Wt: 21kg (Expected-27),
- Ht: 119cm (Expected-125)

Central Nervous System

a) Higher Mental Functions

- Conscious
- Well orientated to time, place, and person
- Slurred speech
- Apparently normal intelligence
- Memory normal

b) Cranial Nerves: normal

c) Sensory System

- Touch, pain, temp, position, and vibration sense were intact.

d) Motor System

- Bulk : normal
- Power: 4/5

} both UL and LL.

- Tone decreased in upper and lower limbs
- Reflexes: Knee jerks – Pendular (b/l), all other superficial and DTRs are normal

f) Cerebellar Signs

- Tremor : absent
- Nystagmus: absent
- Finger nose test
- Romberg's sign

Could not be tested because of abnormal movements

g) Skull and Spine : Normal

h) Meningeal signs: Absent

- g) Extra-pyramidal Signs

  Milkmaid sign
  Pronator sign
  Darting tongue
  Deterioration of handwriting
  Difficulty in buttoning and unbuttoning

  } Present

  Other extra-pyramidal signs like dystonia, rigidity, athetosis and ballismus are absent

Other systems

- CVS: S1, S2 -normal, no murmurs.
- Musculoskeletal: No evidence of arthritis or myositis
- RS: B/l AE equal, NVBS.
- P/A: Soft , non tender, and no organomegaly.

Provisional Diagnosis

Sydenham Chorea

Acute Rheumatic Fever

Investigations

- Hb: 11.9 gm%
- TLC : 9,300 cells/cu.mm
- DC: N 57, L 36, E 4, M 3
- Platelet count: 4.49 lakhs
- **ESR: 65mm, CRP: -ve**
- **ASO titres: Negative**
- BUN: 15mg/dl, S Cr: 0.5mg/dl, uric acid 2.7mg/dl
- Ca: 10.1mg/dl, Na+ 145mmol/L, K+ : 4.2 mmol/L

- Throat swab c/s: Streptococcus pneumoniae isolated, sensitive to amoxicillin.
- Chest X ray , ECG, 2D Echo: Normal
- MRI brain: Normal
- CUE: WNL

Management

- Reassurance
- Rest (Protection against possible injuries)
- Tab Phenobarbitone - 5mg/kg/day
- Tab amoxicillin 250mg TID X 10days
- Inj Benzathine pencillin 1.2 million IU deep IM after skin test .

- On day 5 :
- Involuntary movements decreased
- Able to sit without support .
- Able to stand and walk with support.
- Speech improved.

- On day 15:
- Abnormal movements decreased
- Able to stand and walk without support.
- Able to eat food with hands
- Speech improved
- Improvement in hand writing.
- CVS: S1, S2- normal, no murmur

- Follow up at 1 month :

- Able to perform routine activities and attending schools.
- Very minimal abnormal movements were present.
- Tab phenobarbitone tapered to 3 mg/kg/day and advised follow up after 2 weeks.

- Advised to continue secondary prophylaxis with Inj. Benzathine penicillin 1.2 million units I.M. for every 3 weeks.