Case presentation

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CASE:1

- Patient name: xxxx
- Age : 25yrs
- Sex : Female
- Residence : Nalgonda.
- Occupation : daily labourer.

CHIEF COMPLAINTS:

- fits----------------------since 1 day.
- headache -------------------since 1 day.

h/o present illness:

- After one day of normal vaginal delivery, patient presented with (history given by mother)
- ***fits:***
- ✓ one episode ,
- ✓ focal type,started in right fingers as involuntary tonic movements,involving whole right upper hand,associated with smacking movements of right sided face for 1 min.,followed by post ictal todds palsy for 24 hrs.
- ✓ Tongue bite - absent
- ✓ Drooling of saliva from angle of mouth – absent
- ✓ altered consciousness - absent
- ✓ bowel,bladder incontinance- absent

Contd…

- HEADACHE:sudden and severe type,

central in loction,associated with watering of eyes,nose ,and nausea,relieved by medication and rest,aggravated by sounds, light.

- ✓ No h/o trauma, fall,sleep deprivation.
- ✓ ***Past history:*** ***no*** h/o seizure disorder, earlier auras,stroke,tumor,CNS infections,systemic diseases,syncopes,TIA,migraine,acute psychosis.
- ✓ Not a known Diabetic- / CAD- / Tuberculosis- /asthma.
- ✓ Personal History: h/o GIH WITH PREECCLAMPSIA+, on treatment. Pt takes mixed diet,bowel,bladder normal and regular,no h/o smoking,alcoholism.
- ✓ DRUG H/O:no h/o ocp,heparin,tamoxiphen,epo ,B-lactams,quinolones,INH,chloroquine use.

General examination:

- Patient is moderately built and nourished
- Patient was pale
- No cyanosis-, clubbing-, lymphadenopathy-, oedema+ pitting type,icterus-.
- ***Vitals:***

✓ febrile

✓ pulse :100beats/min, rapid, normal volume, regular in rhythm.

✓ Blood Pressure : 160/100 left arm in supine position.

✓ Respiratory rate : 24cyc/min

CNS examination:

- GCS- 15/15,HMF-normal.
- No neurocutaneous markers present(ashleaf macules, NF)
- No signs of neck rigidity.
- Cranial Nerves: normal , visual fields –normal.
- Fundus: normal.
- ***Motor system :***
  B/L LL TONE,POWER,COORDINATION-normal
  Right upper limb power-3/5.
- Superficial reflexes :

	RIGHT	LEFT
Corneal reflex	+	+
plantar reflex	upgoing	upgoing

- DTR:

Biceps	++	++
Triceps	++	++
Supinator	++	++
Knee	++	++
Ankle	+	+

- SENSORY FUNCTIONS : normal
- CEREBELLAR FUNCTIONS : normal.
- Bladder and bowel: normal.
- Stance & Gait : normal
- Skull and spine: normal

Systemic examinnation:

- ***Respiratory system*** : BAE +
  No e/o adventitious sounds.
- ***Per abdomen*** : Soft; no e/o hepatomegaly- / spleenomegaly- / Ascites-
- ***cardiovascular system***:
  S_1 S_2 heard
  No murmurs are heard.
  JVP- normal.
  no carotid bruit heard.

INVESTIGATIONS:

CBP: Hb – 9.6 g%;

TLC- 6,300 /cu.mm;

Platelet – 2.1 lakhs.

CUE: proteinuria ++, NO e/o ketone bodies --

ABG: Ph: 7.38 ; pCO_2 – 38 ; PO_2 – 96 ; HCO_3 – 26.6 ; O_2 sat – 99.8%

Indicative of normal study

RBS: 166mg/dl

ECG: Normal.

HIV: Non-Reactive

HBsAg: Non-Reactive

RFT: sr.creat- 0.8mg/dl , B.urea- 33mg/dl.

Contd…

- ***LFT***: Total.Bilirubin – 1.73 mg/dl ;
  Direct Bilirubin – 0.52 mg/dl
  AST – 40 IU/L ;
  ALT – 36 IU/L;
  Total Proteins – 5.7 g/dl;
  sr.Albumin – 3 g/dl

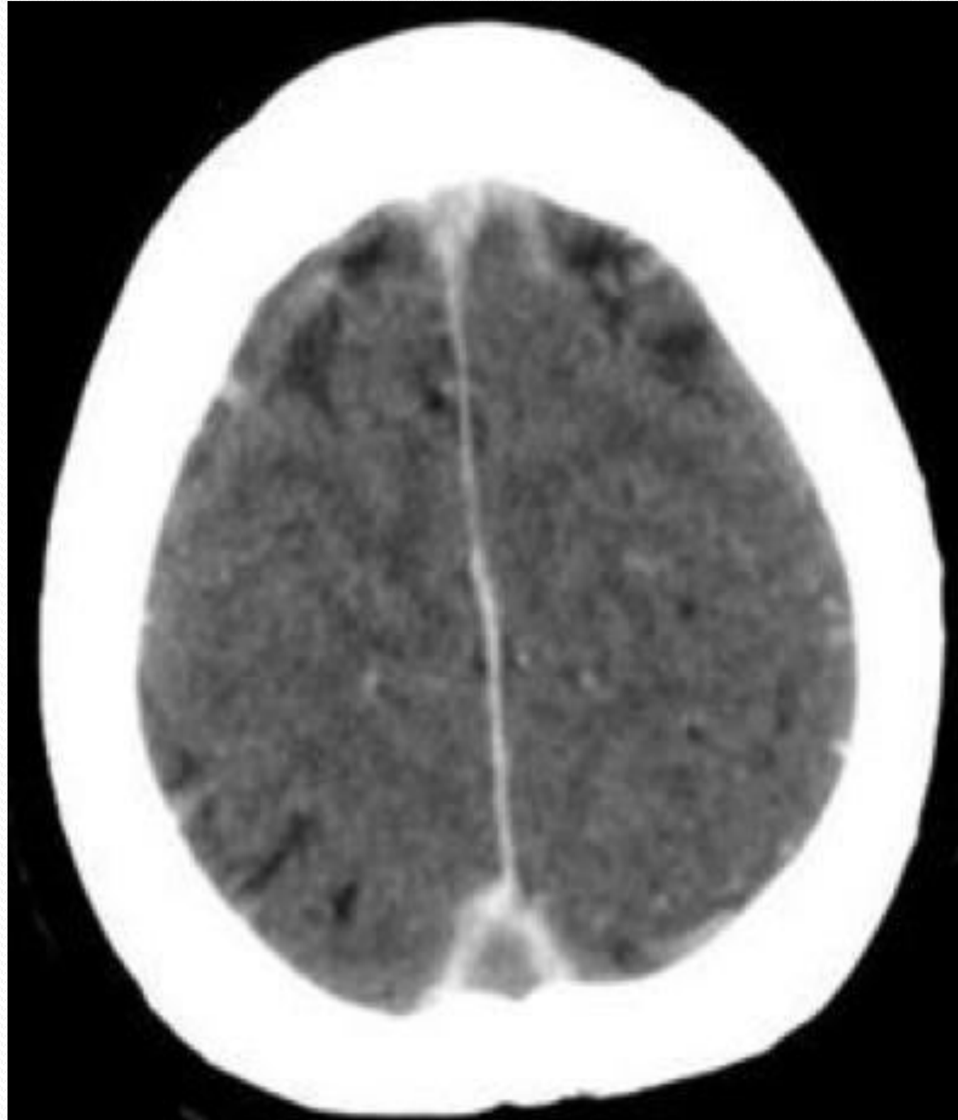
- ***S.Electrolytes***- sr.Na+- 133meq/dl;
  sr. K+ - 3.8 meq/dl;
  sr.Cl- - 99 meq/dl.
- Sr.calcium-10 mg/dl., sr.magnesium-2.5 mg/dl
- ***USG Abdomen***- Fatty change in the liver.

- ***CXR***: Normal

- ***BT,CT,PT+INR,APTT:WNL*** .
- CT SCAN BRAIN.

PROVISIONAL DIAGNOSIS:

- CORTICAL VEIN THROMBOSIS.
- REVERSIBLE ISCHEMIC ENCHEPHALOPATHY.
- STROKE IN PREGNANCY.
- HYPERTENSIVE ENCHEPHALOPATHY.



- FINAL DIAGNOSIS: CORTICAL VEIN THROMBOSIS.

- TREATMENT: LMWH 1mg/kg wt bid.
- Warfarin 5mg OD.
- T.LABETOLOL 100 mg bid.
- T.LEVITIRACETUM 500mg bid.

Case-2

- Patient name: xxxx
- Age : 27yrs
- Sex : Female
- Residence : kodad
- Occupation : daily labourer.

CHIEF COMPLAINTS:

- fits-----------------------since 1 day.
- headache -------------------since 1 day.

h/o present illness:

- After second day of normal vaginal delivery, patient presented with
- ***fits:***
- ✓ one episode ,sudden onset
- ✓ Generalised tonic ,clonic type lasts for 5 minutes.
- ✓ Tongue bite +
- ✓ Drooling of saliva from angle of mouth +
- ✓ altered consciousness +
- ✓ bowel,bladder incontinance-.

Contd…

- HEADACHE:sudden and severe type,

  occipital in loction,associated with watering of eyes,nose ,and nausea,relieved by medication and rest,aggravated by sounds, light.

- ✓ No h/o trauma, fall,sleep deprivation.
- ✓ ***Past history:*** ***<u>no</u>*** h/o seizure disorder, earlier auras,stroke,tumor,CNS infections,systemic diseases,syncopes,TIA,migraine,acute psychosis.
- ✓ Not a known Diabetic- / CAD- / Tuberculosis- /asthma.
- ✓ Personal History: h/o GIH WITH PREECCLAMPSIA+, on treatment. Pt takes mixed diet,bowel,bladder normal and regular,no h/o smoking,alcoholism.
- ✓ DRUG H/O:no h/o ocp,heparin,tamoxiphen,epo ,B-lactams,quinolones,INH,chloroquine use.

General examination:

- Patient is moderately built and nourished

- No cyanosis-, clubbing-, lymphadenopathy-, oedema-,icterus-,pallor-.

- ***Vitals:***

✓ Afebrile

✓ pulse :86beats/min, rapid, normal volume, regular in rhythm.

✓ Blood Pressure : 150/100 left arm in supine position.

✓ Respiratory rate : 26cyc/min

CNS examination:

- GCS- 15/15,HMF-normal.
- Cranium & spine – Normal.
- No signs of neck rigidity.
- Cranial Nerves: normal .
- Fundus study and visual fields normal.
- NO neurocutaneous markers present.
- ***Motor system :***

  B/L UL,LL TONE,POWER,COORDINATION-normal

- Superficial reflexes :

	RIGHT	LEFT
Corneal reflex	+	+
plantar reflex	upgoing	upgoing

- DTR:

Biceps	+ +	+ +
Triceps	++	++
Supinator	++	++
Knee	++	++
Ankle	+ +	++

- SENSORY FUNCTIONS : normal
- CEREBELLAR FUNCTIONS : normal.
- Bladder and bowel: normal.
- Stance & Gait : normal
- Skull and spine: normal

Systemic examinnation:

- ***Respiratory system*** : BAE +
  No e/o adventitious sounds.
- ***Per abdomen*** : Soft; no e/o hepatomegaly- / spleenomegaly- / Ascites-
- ***cardiovascular system***:
  S_1 S_2 heard
  No murmurs are heard.
  JVP- normal.
  no carotid bruit heard.

INVESTIGATIONS:

CBP: Hb – 10.6 g%;

TLC- 7,300 /cu.mm;

Platelet – 2 lakhs.

CUE: proteinuria 3+, NO e/o ketone bodies --

ABG: Ph: 7.33 ; pCo2 – 32 ; Po2 – 93 ; HCo3 – 22.6 ; o2 sat – 99%

Indicative of normal study

RBS: 125mg/dl

ECG: Normal.

HIV: Non-Reactive

HBsAg: Non-Reactive

RFT: sr.creat- 0.5mg/dl , B.urea- 23mg/dl.

Contd…

- ***LFT***: Total.Bilirubin – 1.13 mg/dl ;
  Direct Bilirubin – 0.22 mg/dl
  AST – 30 IU/L ;
  ALT – 46 IU/L;
  Total Proteins – 8.7 g/dl;
  sr.Albumin – 3.8 g/dl

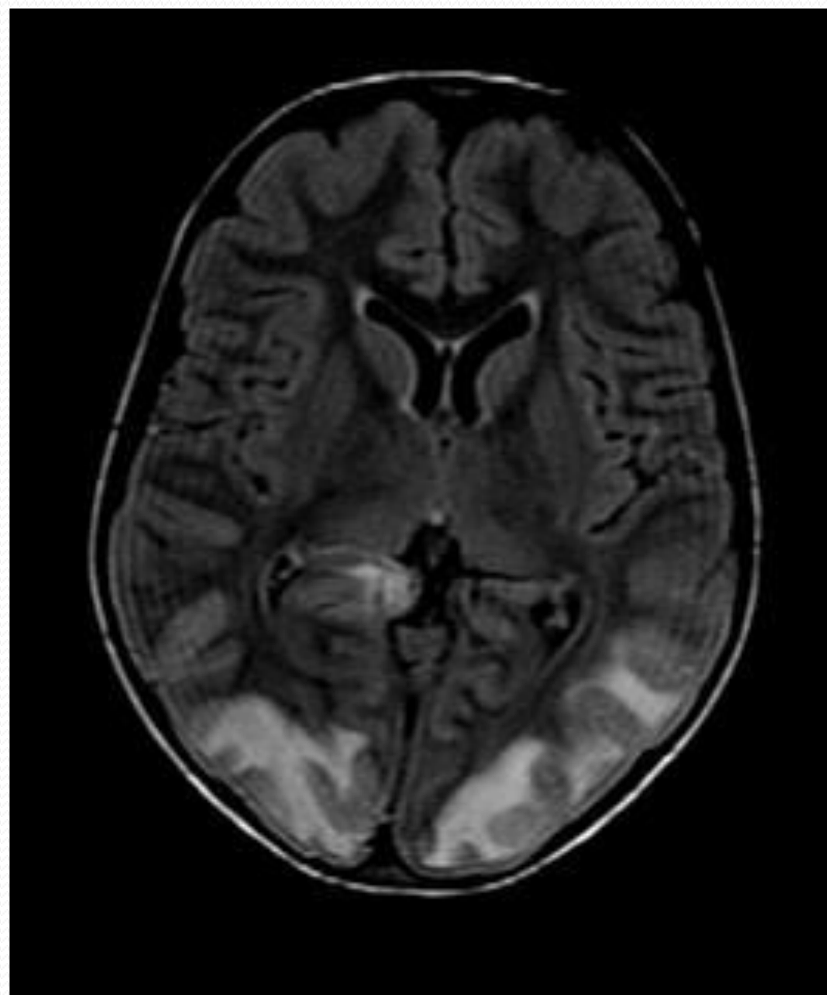
- ***S.Electrolytes***- sr.Na+- 143meq/dl;
  sr. K+ - 3.3 meq/dl;
  sr.Cl- - 96 meq/dl.
- ***USG Abdomen***- Fatty change in the liver.
- Sr.clcium -9.5 mg/dl;sr.magnesium-2.9 mg/dl.

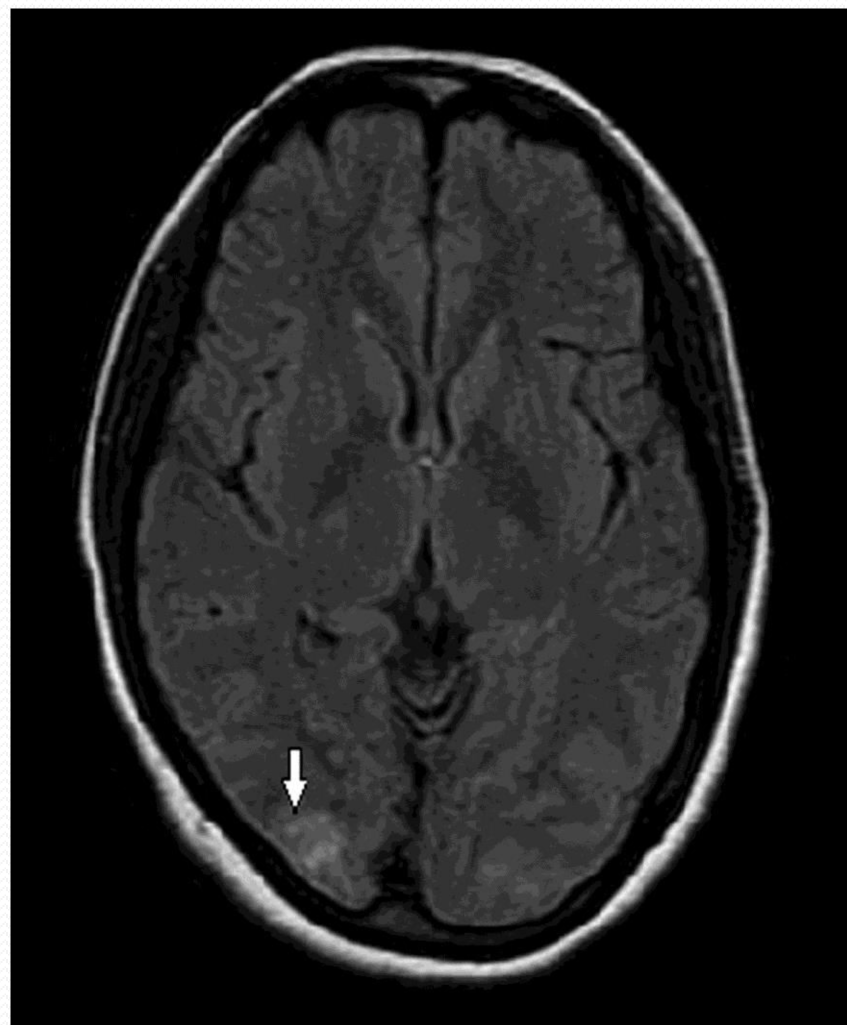
- ***CXR***: Normal

- ***MRI.***

PROVISIONAL DIAGNOSIS:

- *POSTERIOR REVERSIBLE ENCHEPHALOPATHY SYNDROME.*
- *CORTICAL VEIN THROMBOSIS.*
- *ANTON SYNDROME.*
- *HYPERTENSIVE ENCHEPHALOPATHY.*





- FINAL DIAGNOSIS: POSTERIOR REVERSIBLE ENCHEPHALOPATHY SYNDROME.

MANAGEMENT

- T.NIFEDIPINE 30mg od.
- T.LAMOTRIGINE 150 mg bid.