CASE PRESENTATION

Dr.ANUSHA
GENERAL MEDICINE
FIRST YEAR

- NAME:XXX
- AGE:50
- SEX:Male
- OCCUPATION:Agricultural labour
- ADDRESS:Nalgonda
- INFORMANT:Patient wife
- CHIEF COMPLAINTS:
- 1.Difficulty in walking since 6 months
- 2.Difficulty in passing urine since 1 month

HISTORY OF PRESENT ILLNESS:

- Patient was apparently asymptomatic 6 months ago then he developed difficulty in initiating walking since 6 months,gradual in onset,not associated with pain.
- H/o difficulty in remembering events including past and recent things.
- H/o difficulty in passing urine associated with urgency,increased frequency of micturition since 1 month

- No H/o trauma
- No H/o difficulty in mixing food
- No H/o difficulty in combing hair
- No H/o difficulty in wearing chappals
- No H/o difficulty in getting up from squatting position
- No H/o involuntary movements
- No H/o bowel incontinence
- No H/o double vision,blurring of vision
- No H/o S/o smell disturbances

No H/o deviation of mouth

No H/o drooling of saliva

- No H/o decreased hearing
- No H/o difficulty in swallowing
- No H/o nasal regurgitation,nasal twan.
- No H/o difficulty in shrugging shoulders
- No H/o tingling and numbness
- No H/o fever
- No H/o recent vaccination
- No H/o seizures,syncopal attacks,giddiness

- No H/o chest pain,difficulty in breathing ,palpitations
- No H/o headache
- No H/o diarrhoea,vomitings

- PAST HISTORY:
- H/O hypertension since 10 years on tab amlodipine 5mg
- No H/o diabetes mellitus,asthma,tuberculosis,seizures,coronary artery disease.
- No H/o similar complaints in the past.
- DRUG HISTORY :
- He is on tablet syndopa 110mg half tablet thrice a day since 3 months.(Patient diagnosed as Parkinson's Disease in other hospital)

- FAMILY HISTORY:
- No history of similar complaints in the family.
- PERSONAL HISTORY:
- 1.Diet:Mixed
- 2.Bowel :Regular
- 3.Sleep:Adequate
- 4.Addictions:He is a known occasional alcoholic since 20 years,Non smoker.

GENERAL EXAMINATION

- Patient is moderately built,well nourished.
- BMI:28 Kg/m2
- No pallor,no icterus,no clubbing,no cyanosis,no koilonychia,no generalised lymphadenopathy.
- No muscle wasting

VITAL DATA

- PULSE RATE:82 bpm,regular,normal in volume,normal in character,no radio radial delay,no radio femoral delay.
- BLOOD PRESSURE:140/90 mm of Hg in right upper limb,supine position and sitting position.
- TEMPERATURE:99 degree F

SYSTEMIC EXAMINATION

- 1.On examination patient is conscious,co-operative,alert.
- 2.HIGHER FUNCTIONS:

a)Level of consciousness:Glasgow coma scale:15/15

b)Appearance and behaviour:Normal

c)Emotional state: depressed,not hostile

d)Orientation to time,place,person:Present

e)No illusions,delusions,hallucinations

- f)Memory:
- 1.Short term memory:Intact
- 2.Recent memory:Intact
- 3.Past memory:Impaired
- g)Speech:Normal
- h)Handedness:Right handed.
- MMSE:24/30
- 3.CRANIUM AND SPINE:NORMAL
- 4.No signs of meningeal irritation
- 5.CRANIAL NERVES:NORMAL

- 6.MOTOR FUNCTIONS:
- a)Nutrition: Normal

- b)TONE: RIGHT LEFT
- i)Upper limb: Normal Normal
- ii)Lower limb: Increased Increased

- c)POWER: RIGHT LEFT
- i)Upper limb: Normal Normal
- Ii)Lower limb: Normal Normal
- d)COORDINATION:
- i)Finger nose test: Normal
- Ii)Knee heel test: Normal

- 7.SENSORY SYSTEM:
- a)Superficial or exteroceptive:
- i)Pain:Normal
- ii)Touch:Normal
- iii)Temperature:Normal

- b)Deep or proprioceptive:
- i)Vibration sense:Normal
- ii)Joint sense:Normal
- Iii)Position sense:Normal

- c)CORTICAL:
- i)Two point discrimination:Normal
- ii)Stereognosis:Normal
- iii)Graphaesthesia:Normal

- 8.REFLEXES:
- a)SUPERFICIAL: RIGHT LEFT
- i)Abdominal + +
- Ii)Plantars: No Response

- B)DEEP: RIGHT LEFT
- i)Biceps jerk + +
- ii)Triceps jerk: + +
- iii)Supinator: - -
- iv)Knee jerk: ++ ++
- v)Ankle jerk: - -

- 9.CEREBELLAR FUNCTIONS:
- NORMAL
- 10.AUTONOMIC FUNCTIONS:
- No postural hypotension,no abnormal sweating,no atrophic changes.
- 11.GAIT:
- Magnetic gait,shuffling gait.
- Other systems examination:
- CVS:S1,S2 heard,no murmurs
- RS:BAE+,Normal vesicular breath sounds heard
- P/A:Soft,no organomegaly

- PROVISIONAL DIAGNOSIS:

  Normal pressure hydrocephalus

- DIFFERENTIAL DIAGNOSIS:

  1. Parkinson’s Disease
  2. Multi-infarct dementia

INVESTIGATIONS

- CBP:Hb:13.8gm/dl,TLC:6000/cubic mm,platelets:2.4 lakhs/cubic mm
- CUE:Normal
- RBS:80 mg/dl
- RFT:Normal
- LFT:Normal
- ECG:Normal
- CXR:Normal
- USG ABDOMEN:Normal
- HIV-Non reactive,HBsAg-Negative.

- MRI BRAIN:
- a)Ventricular enlargement out of proportion to sulcal atrophy
- TREATMENT: About 50 ml of CSF was drained by lumbar puncture under aseptic precautions.
- Patient’s gait improved in 2 days
- He was referred to Higher Centre for further shunting procedures.

THANK YOU