CASE PRESENTATION

DR.SUNITHA
DEPARTMENT OF PEDIATRICS

Name:XXXX

Age:11 YRS

Sex:MALE

Resident of nalgonda.

DOA:18/1/2015

DOD:27/1/2015

CHIEF COMPLAINTS:

2-3 episodes of deviation of angle of mouth towards right side with slurred speech and drooling of saliva – since 2 days

H/O PRESENT ILLNESS :

- Apparently asymptomatic 2days back , then he developed 3 episodes of deviation of angle of mouth towards right side with slurred speech and drooling of saliva, each episode lasting for about 10- 15 minutes.
- No loss of consciousness
- No h/o fever/headache/vomiting
- No bowel and bladder incontinence
- No h/o headache prior to the attack of seizures
- No h/o altered sensorium
- No h/o speech deficit

- No h/o diplopia
- H/o decreased vision present in the Lt eye
- No h/o any FND except deviation of angle of mouth present towards Lt side while smiling/showing his teeth
- No h/o nasal regurgitation of feeds
- No h/o head injury
- No h/o any involuntary movements

PAST H/O-

- Feb 2014: pt. had 2 episode of seizures(GCTS) for which he was started on anti epileptics (valproate and leviteracetam) by local practitioner
- May 2014: admitted in KIMS hospital for
  - 2 episode of CPS with transient weakness of Rt UL and LL and facial palsy UMN type
  - MRI brain revealed - cystic lesion in left temporal and left frontal lobes s/o NCC with perilesional edema.
  - Fundus- sub retinal cyst with dead scolex in macular area (Lt eye)
  - B- scan showed – Lt eye ocular NCC with old choreoretinitis
  - Rx : sod valproate, leviteracetam, prednisolone, albendazole-14 days, and F/U every month
  - Pt didn’t report for F/U

- **PERSONAL H/O:** Diet-mixed with normal Appetite, Sleep, and Bowel and bladder habits.
- **FAMILY HISTORY**:

  No h/o similar complaints in the family.

  No h/o contact with tuberculosis.

  No h/o asthma/DM/HTN/convulsions in the family
- **DEVELOPMENT:** Attained according to age and Now studying 6th standard with Average academic performance

GENERAL EXAMINATION:

Patient is concious,coherent and co-operative

Moderately built and nourished

No pallor/icterus/cyanosis/clubbing

No lymphadenopathy /pedal edema

VITALS:

Temp- afebrile

BP- 100/60 mm of hg

PR- 84bpm

RR- 28/min

SYSTEMIC EXAMINATION:

CNS

- Conscious, coherent, Oriented to time ,place and person
  Speech, Intelligence & memory – normal

CRANIAL NERVE EXAMINATION :

- Cranial nerve 1 – normal

•2nd CRANIAL NERVE :

Visual acuity-Rt eye - 6/6.

- Lt eye -counting finger from 1meter distance.

Fundus examination:

Rt eye - lens clear, disc-normal size, pink circular well defined margin,
Vessels - normal.
Macula-normal.

Lt eye - lens clear, disc-normal size ,pink, circular well defined
margins, peripapillary chorioretinitis +,vessels –normal.
Macula-sub retinal cyst with dead scolex

Pupils reflex : right eye: reactive to light
Left eye :sluggishly reacting to light

Impression: Lt eye-old dead cyst ,poor vision

- **CRANIAL NERVE-7- Rt. UMN PALSY**

  Decreased nasolabial fold prominence on right side

  Deviation of angle of mouth towards left side while smiling/ showing his teeth

  Closure of eye & frowning present on both sides
- Rest CNS are : intact

MOTOR SYSTEM EXAMINATION

	Upper limb		Lower limb	
	right	left	right	left
BULK	NORMAL	NORMAL	NORMAL	NORMAL
TONE	NORMAL	NORMAL	NORMAL	NORMAL
POWER	5/5	5\5	5/5	5/5
DTR	2+	2+	2+	2+
PLANTAR			FLEXOR	FLEXOR

- SENSORY system examination: all sensations intact.
- No signs of meningeal irritation, raised intra cranial tension or autonomic system dysfunction
- Cranium and spine normal.

OTHER SYSTEMS EXAMINATION

- CVS: s1 s2 + no murmur
- Respiratory system: B/L air entry+ NVBS heard
- Gastro intestinal system examination: soft, no organomegaly
- Musculoskeletal system: normal

INVESTIGATIONS

- CBP
  - HB - 10.6 gm%
  - TLC-11,4OO/cu.mm
  - N-46%
  - L-50%
  - E-2%
  - M-2%
  - B-0%
  - PLT-3.8 lak/cu.mm
- CRP- Positive 4.8g/dl
- Blood c/s - no growth

RFT

- Urea-21mg/dl
- Creatinine-0.5mg/dl
- Uricacid-2.7mg/dl
- Calcium-10mg/dl
- Phosphorous-6.1mg/dl
- Sodium-139mmol/l
- potassium-4.1mmol/l
- Chloride-101mmol/l

LFT

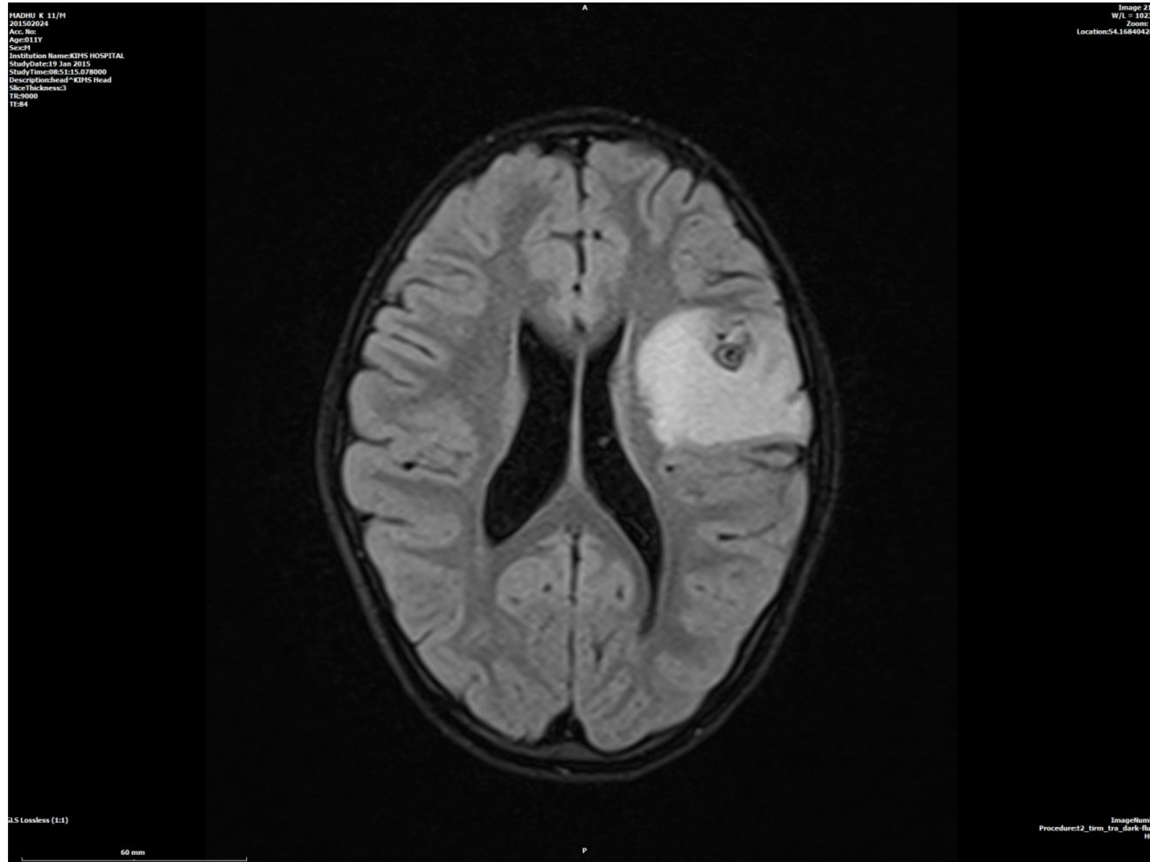
- TSB-1.23 mg/dl
- DB-0.39 mg/dl
- SGOT(AST) -31 IU/L
- SGPT(ALT) -13 IU/L
- ALKALINE PHOSPHATE-255 IU/L
- TOTAL PROTIENS-6.5 gm/dl
- ALBUMIN-3.5 gm/dl
- A/G RATIO-1.17

- CUE: normal

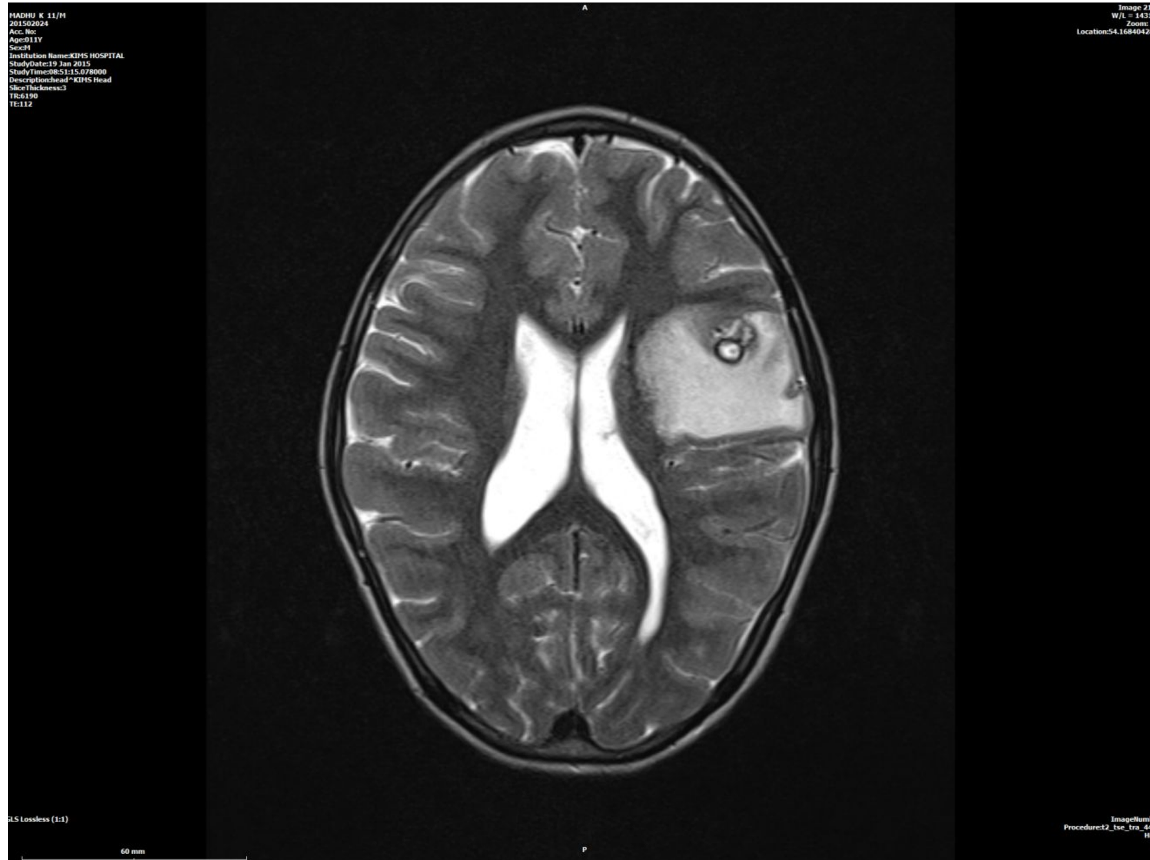
DIFFERENTIAL DIAGNOSIS

- NCC RELAPSE/RECURRENCE
- TUBERCULOMA
- PYOGENIC CEREBRAL ABSCESS
- BRAIN TUMOR

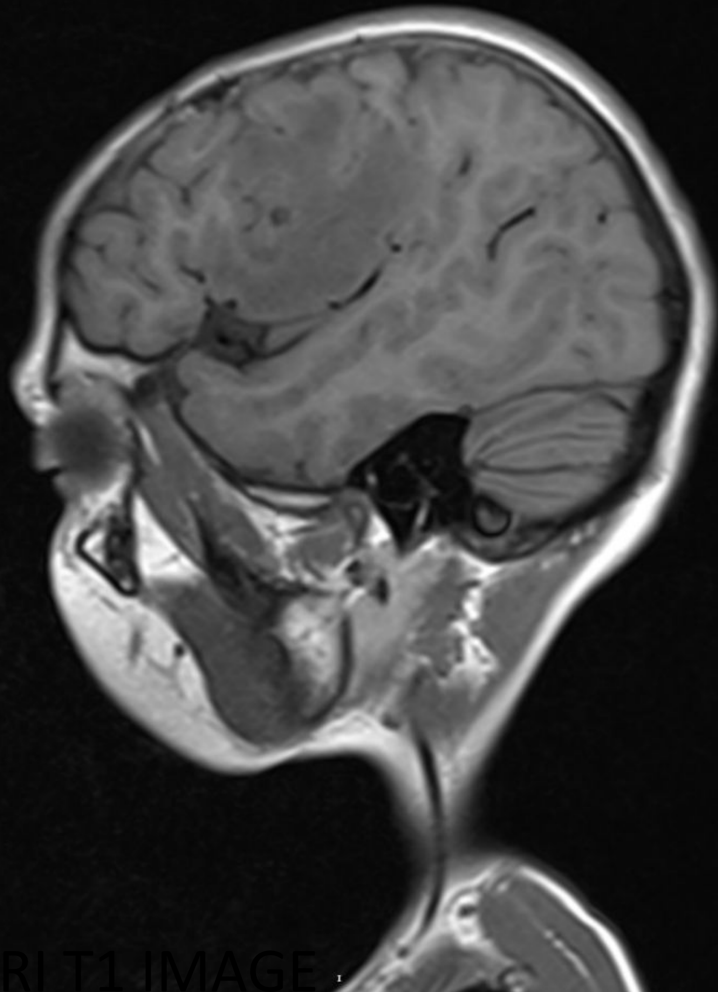
MRI PICTURES



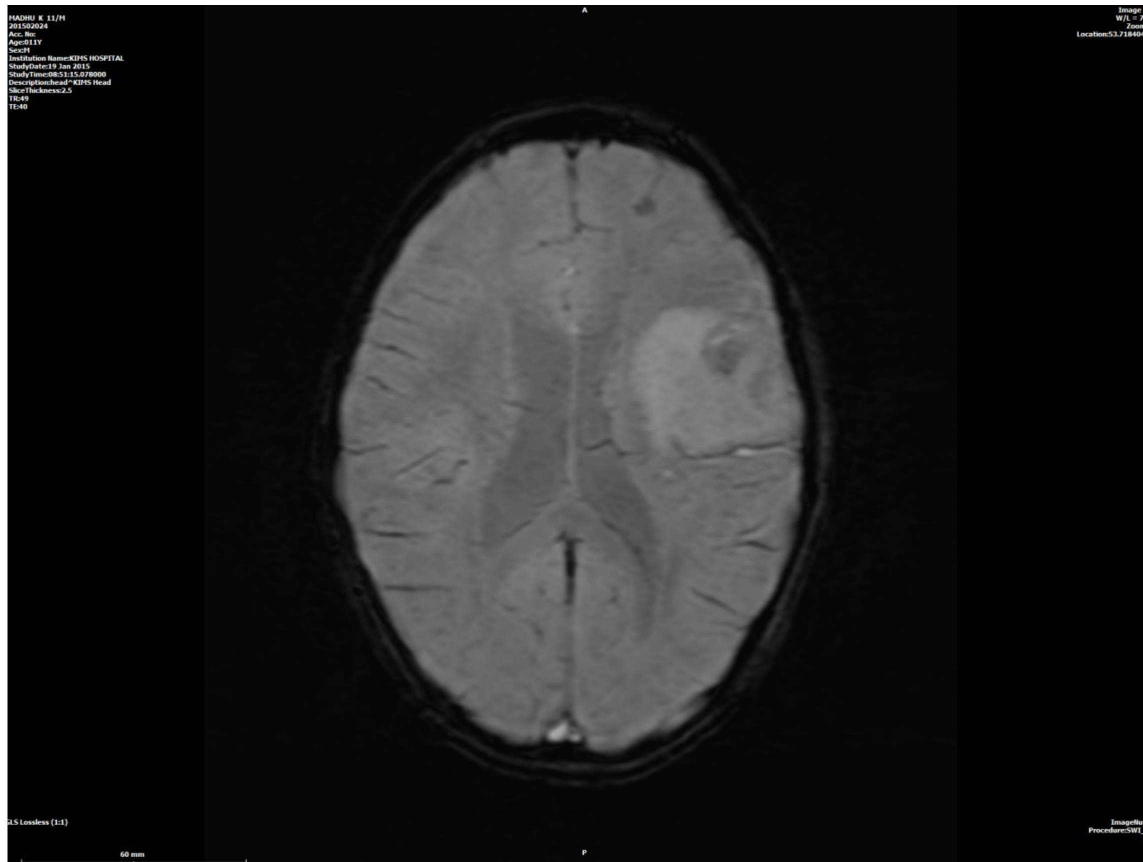
MRI FLAIR IMAGE



MRI T2 IMAGE



MRI T1 IMAGE



MRI DWI IMAGE

MRI BRAIN

- IMPRESSION: Granuloma with significant perilesional edema in left frontal lobe – NCC.
- Another granuloma in anterior aspect of left frontal lobe with no perilesional edema

DIAGNOSIS

- Neurocysticicercosis
- Active granuloma in left frontal lobe
- left eye- choreoretinitis

TREATMENT GIVEN

- Tab.Sodium valproate(20mg/kg/day)and
- Tab.Levipil(10mg/kg/day)
- Tab.Prednisolone(0.2mg/kg/day) for 5 days
- Tab.Albendazole(15mg/kg/day) for 28 days started 3 days after initiation of prednisolone