

A Silent Creeper-Multiple Sclerosis

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Abstract: Multiple Sclerosis (MS) is an immune mediated process in which an abnormal response of the body's immune system is directed against the central nervous system (CNS). Multiple sclerosis is a very variable condition and the symptoms depend on which areas of the CNS have been affected. There is no set pattern for MS and everyone with MS has a different set of symptoms, which vary from time to time and can change in severity and duration, even in the same person. Hence diagnosing MS at the earliest is very essential. Therefore we report an unusual case of a 42-year-old man who presented with painful limp in the left leg on walking a distance of around 200 metres attributed to fracture of left leg 20 years back with history of repeated falls and trivial trauma. After thorough history taking and detailed clinical examination he was finally diagnosed to have Multiple Sclerosis. This case is being reported in view of varied clinical presentation, subtle symptoms, occurrence in male sex and delayed onset

Keywords: Multiple Sclerosis, Ataxia, Internuclear Ophthalmoplegia, Optic Atrophy, Swaying Gait.

1. Introduction

Multiple sclerosis (MS) is a chronic autoimmune disease that affects the myelinated axons in the central nervous system (CNS) [1]. This disease affects women more frequently than men. The estimated female-to-male ratio of MS incidence increased from 1.4 in 1955 to 2.3 in 2000, according to a systematic review of 28 epidemiologic studies [2]. The average age of onset of MS is 30 years, and the disease starts approximately five years earlier in women than it does in men [3]. MS symptoms at presentation vary individually and are unpredictable [4]

2. Case Report

42 year old man non alcoholic, non smoker with history of fracture of left neck of femur operated 20 years back presented with complains of vague pain in the left leg with limping on walking a distance of around 200 metres noticed for the last 5 years for which he was prescribed analgesics intermittently. On detailed history taking, it was noticed that he had history of repeated falls due to buckling of legs. Wife gave history of clumsy hand movements, easy fatigability and reduced bladder control for the past 5 years.

In the past he had a history of transient paraparesis at the height of fever spike which reversed after the fever subsided. On examination he was normally built and nourished, conscious, oriented and hemodynamically stable. Systematic Nervous system examination revealed right INO, fundus examination showed bilateral temporal optic atrophy. Power and Tone normal. Brisk reflexes, right cerebellar signs positive with Ataxic gait. Routine blood work up- CBC/ RFT/ LFT/ were normal. HIV/ VDRL/ ANA profile - Negative. Serum Vitamin B 12/ vitamin D levels were normal

MRI brain with contrast showed multiple hyperintense lesions characteristic of multiple sclerosis. (Figure 1) MRI spine was normal.. CSF analysis showed oligoclonal bands.

Visual evoked potential showed conduction block in right optic nerve. He was started on injection beta 1-a interferon, 30 micro grams, intramuscular once a week and has been advised to continue for 2 years with repeat MRI after 6 months and CBC and LFT once in 6 months. Presently, patient is carrying out his routine activities normally with no acute relapses

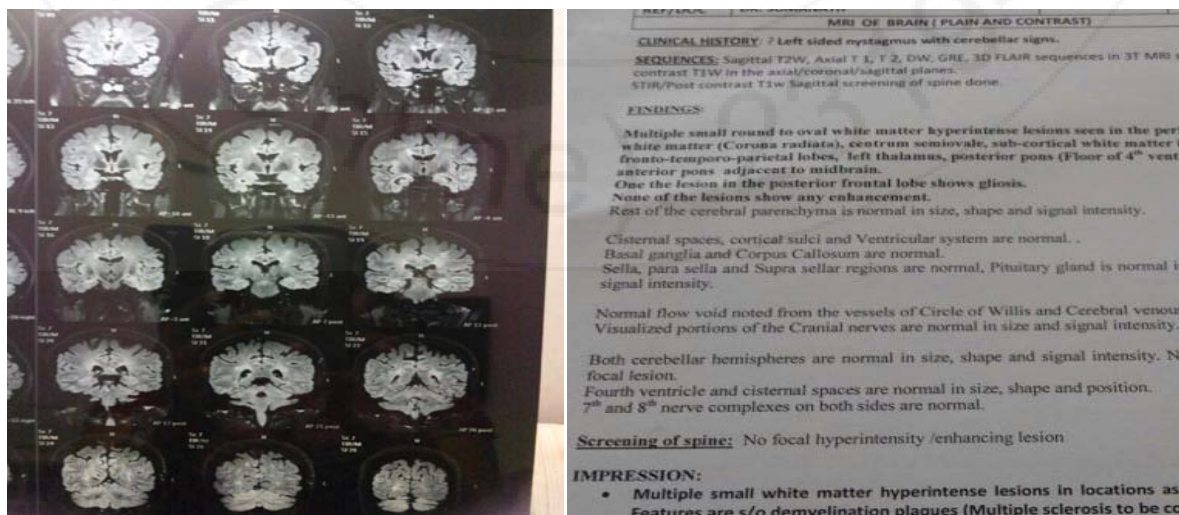


Figure 1: A- MRI Brain showing features suggestive of multiple sclerosis.

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3. Discussion

Multiple sclerosis (MS) is a chronic disease characterized by inflammation, demyelination, gliosis (scarring), and neuronal loss; the course can be relapsing-remitting or progressive. Lesions of MS typically occur at different times and in different CNS locations (i.e., disseminated in time and space). MS is approximately threefold more common in women than men. The age of onset is typically between 20 and 40 years slightly later in men than in women. (as seen in our case.- age of onset was 43 yrs)

The onset of MS may be abrupt or insidious. most common presenting complaint is sensory loss 37 %, ataxia is seen in only 11 % of patients. (our patient had ataxia at presentation.) Right Internuclear ophthalmoplegia and optic atrophy was noted in our case , however the patient did not give any history contributing to the findings. Bladder dysfunction is seen in more than 90 % of MS patients. It is also common for MS symptoms to worsen transiently, sometimes dramatically, during febrile illnesses as reported in our case. (5) He was started on interferons 30 micrograms intramuscularly once a week and is advised to continue for 2 years along with other supportive care.

4. Conclusion

Multiple sclerosis is a disease which is described as ‘Disseminated with time and space’ which holds good in our case. This patient had subtle symptoms which were gone unnoticed. However on examination he was found to have significant neurological deficits. Patient had eye signs in the absence of symptoms at present or in the past which is very peculiar to this case. Patient and the attenders were biased with the history of swaying gait to the old fracture which was misleading. However a thorough history and detailed clinical examination guided in recognition of the underlying disease and providing treatment at the earliest. This has definitely saved the patient from developing acute attacks in the form of stroke which would be debilitating. To conclude, be it any complaint a detailed history and examination remains the corner stone of medicine and will definitely reduce the mortality and morbidity. Early recognition and treatment of multiple sclerosis will help the patients to lead a better quality of life.

5. Abbreviations

MS- Multiple sclerosis.
INO- Internuclear Ophthalmoplegia
CBC- complete blood count
RFT- Renal function tests
LFT- liver function test
HIV- Human immunodeficiency virus
VDRL- Venereal disease research laboratory
ANA- Antinuclear antibody
MRI- Magnetic Resonance Imaging

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