A CASE OF ONCOLOGICAL EMERGENCY

UI MEDICAL UNIT

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Yogaraj

31 year old male with history of ATT intake

Presented with history of bilateral visual loss * 2 days

Was referred from Aravindh eye hospital as

? Ethambutol induced optic neuritis

HISTORY OF PRESENT ILLNESS

Patient has been having generalized itching and lymphadenopathy for past 6 months

One month back he was empirically started on anti tubercular therapy in a nearby PHC

After 20 days of ATT intake , he was referred to department of Thoracic medicine GRH Madurai as there was no improvement in symptoms

In thoracic medicine ATT was stopped as TB was not proven and they suggested FNAC of lymphnode on OP basis

7 days after stopping ATT patient developed bilateral visual loss and he consulted Aravindh eye hospital from where patient was referred to GRH as ? Ethambutol induced optic neuritis

No associated pain in the eye

No history of cough with expectoration , chest pain, breathlessness

No history suggesting any other cranial nerve involvement

No history suggesting weakness or sensory impairment of upperlimb or lowerlimb

History of low grade fever on and off for past 6 months

PAST HISTORY

No history of hypertension , diabetes mellitus , coronary artery disease

No history of pulmonary tuberculosis

No history of similar illness in the past

PERSONAL HISTORY

Normal bowel and bladder habits

Smoker and alcoholic

ON EXAMINATION

GENERAL EXAMINATION

Pallor +

Generalized lymphadenopathy +

(cervical, axillary, inguinal)

Scratch marks +

VITALS

BP - 120/ 80 mmHg

PR - 80 per min , regular normal volume and character

SYSTEM EXAMINATION

CUS sl s2 +, no murmur

Respiratory system - b/l air entry +, NUBS+

P/A soft , no hepatospleenomegaly

Central nervous system

HMF - normal

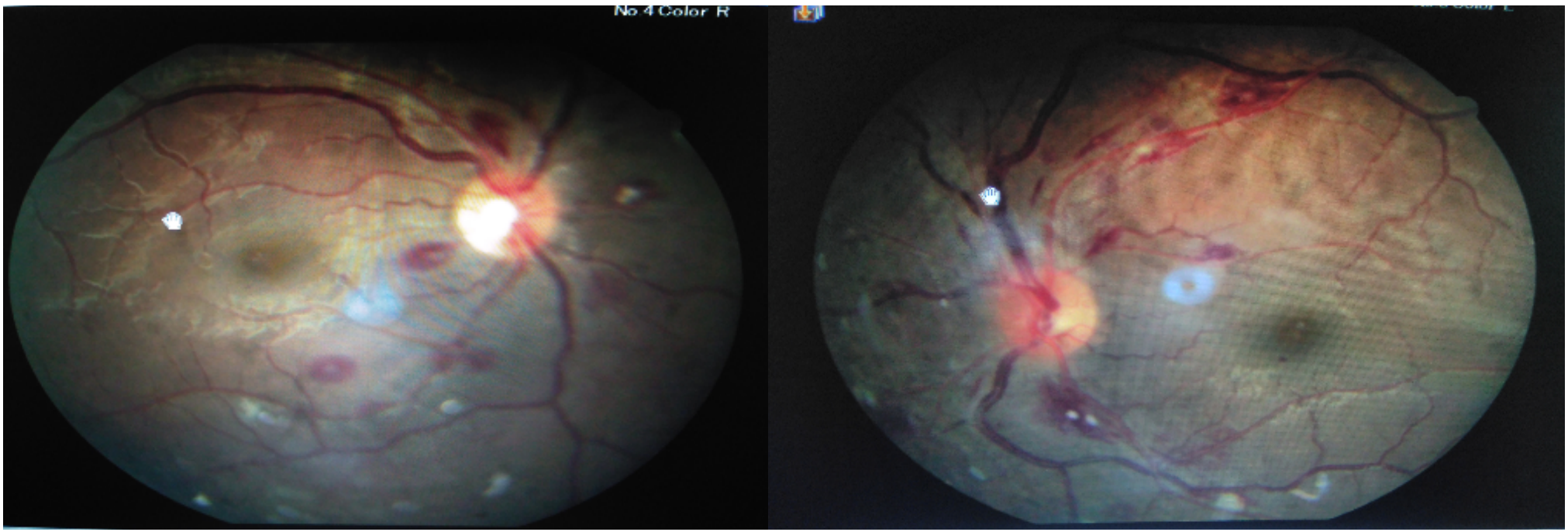
Cranial nerves - optic nerve

Visual acquity - b/l absent light perception

Direct and consensual light reflex absent

Fundus examination - Roth spots , Flame haemorrages

FUNDUS



other cranial nerves

Motor system, sensory } NORMAL

Cordination

PROVISIONAL DIAGNOSIS

Retrobulbar neuritis - ? Ethambutol induced

Generalized lymphadenopathy

? Tuberculosis ? Lymphoma

INVESTIGATIONS

COMPLETE BLOOD COUNT

Hb - 6.7

Total count 15000 - 38 % eosnophils, 26 % neutrophils,

37 % lymphocytes

PCU - 20 %

Platelet count - 2.4 lakhs

ESR- 140 mmHg

Pereheral smear - Hypochromic microcytic anaemia with severe Eosnophilia

RBS - 130

Urea - 42 mg/dl

Creatinine - 1.1 mg/dl

LFT - S.Bil-0.6 (.4/.2) OT/PT 38/42

Albumin/Globulin - 3.5/2.5

UDRL AND HIV NON REACTIVE

BONE MARROW EXAMINATION

Hypochromic microcytic anaemia with severe eosinophilia

No blast cells , No atypical cells

CHEST X RAY - normal

ECG - normal

ULTRASOUND ABDOMEN - mild hepatosplenomegaly with mesenteric and para aortic lymphadenopathy

Rule out lymphoproliferative disorder

Suggested excision biopsy of node

MRI BRAIN

There is evidence of thickening edema and intra neural bright signal involving both optic nerves – Retrobulbar neuritis ? Toxic

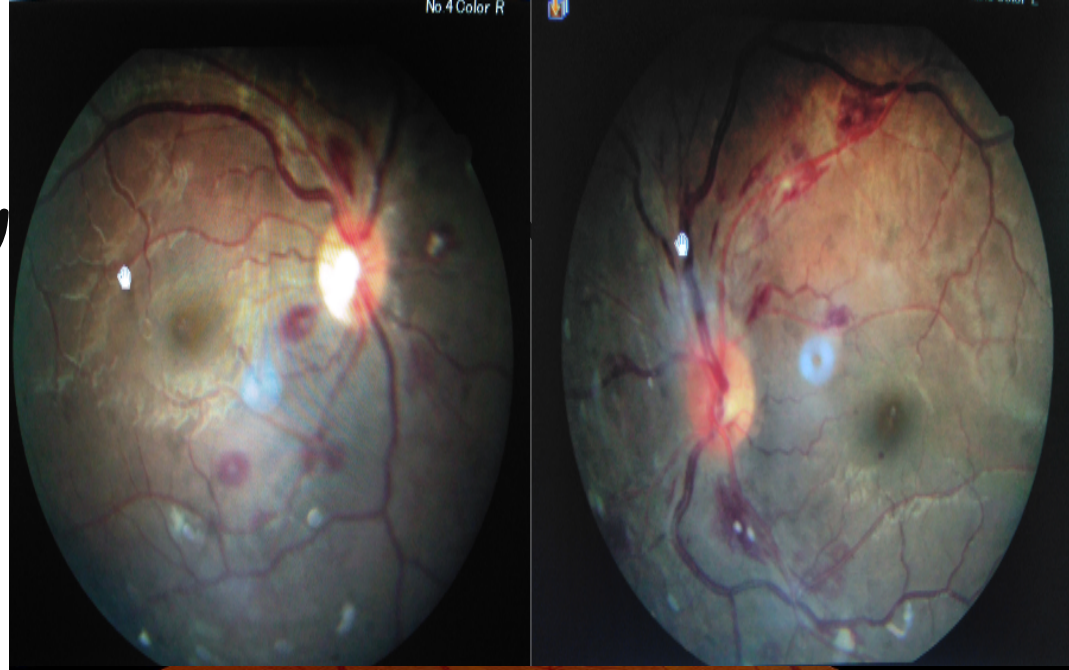
No obvious demonstrable infarct , haemorrhage , SOL in Brain

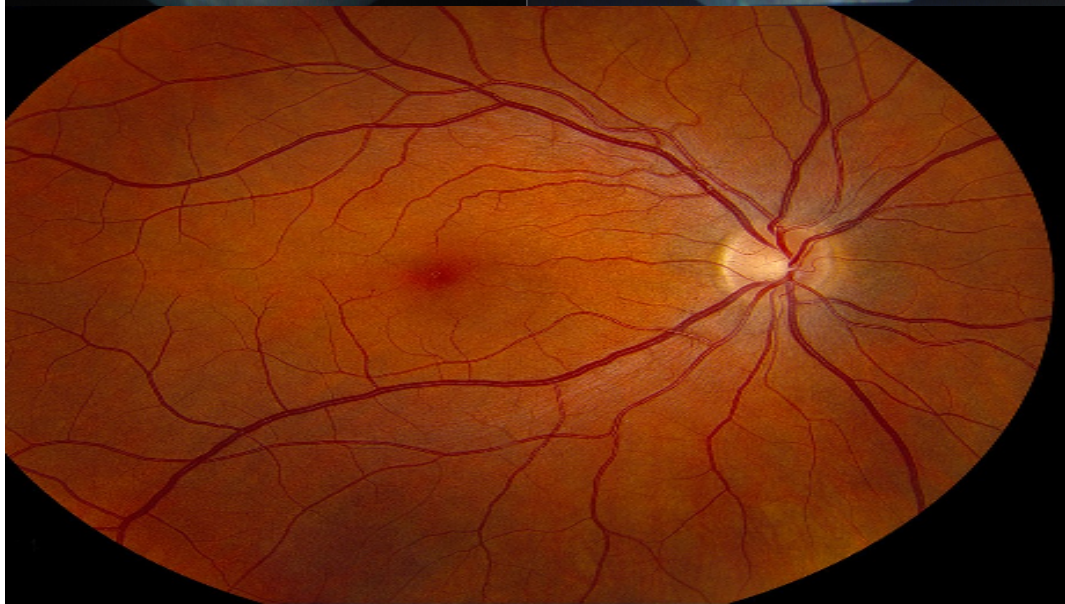
OPTHALMOLOGY

Roth spots , Flame haemorrages

Plan - Fundus fluorescent Angiography

To obtain fitness for FFA





On day 3 of admission - patient developed weakness of both lowerlimbs, difficulty in rolling over, weakness of left hand

Difficulty in breathing, dry cough

H/o tripping of toes and heaviness of both lowerlimbs

H/o difficulty in holding objects in left hand

He was able to use his right upperlimb as before

H/o numbness upto upper chest

Band like sensation in upper chest

Urinary hesitancy

No history suggesting other cranial nerve involvement

O/E

Tachypnoeic

Respiratory rate - 28/min

SpO2 - 98%

Single breath count - 15

CENTRAL NERVOUS SYSTEM EXAMINATION

Higher mental functions - normal

Cranial nerves - normal except optic nerve

MOTOR SYSTEM EXAMINATION

Bulk of muscle - normal in all 4 limbs

TONE OF MUSCLES		
	RIGHT	LEFT
UPPER LIMB	NORMAL	NORMAL
LOWER LIMB	INCREASED	INCREASED

POWER OF MUSCLES			
		RIGHT	LEFT
UPPER LIMB	SHOULDER	5/5	5/5
	ELBOW	5/5	5/5
	WRIST	5/5	4/5
	HAND GRIP	NORMAL	WEAK
LOWER LIMB		2/5	2/5

DEEP TENDON REFLEXES

		RIGHT	LEFT
UPPERLIMB	BICEPS JERK	NORMAL	NORMAL
	TRICEPS JERK	NORMAL	NORMAL
	SUPINATOR JERK	NORMAL	NORMAL
	FINGER FLEXION	NORMAL	NORMAL
LOWERLIMB	KNEE JERK	BRISK	BRISK
	ANKLE JERK	BRISK	BRISK

SUPERFICIAL REFLEXES

CONJUNCTIVAL	NORMAL	NORMAL
CORNEAL	NORMAL	NORMAL
ABDOMINAL	ABSENT	ABSENT
CREMASTERIC	ABSENT	ABSENT
PLANTAR	EXTENSOR	EXTENSOR

SENSORY SYSTEM

All modalities of sensations are lost upto nipple

Sensory loss over medial aspect of hand and forearm

Spinal vibration lost upto C7

CEREBELLAR EXAMINATION

Upperlimb coordination normal

No nystagmus

No neck stiffness ,No spinal tenderness

ACUTE SPASTIC QUADRIPARESIS WITH BILATERAL RETROBULBAR NEURITIS

MOTOR LEVEL – ABOVE C6 SENSORY LEVEL – BELOW C8

REFLEX LEVEL – BELOW T6 VERTEBRAL LEVEL– C5

? NEUROMYELITIS OPTICA SPECTRUM DISORDER ? SECONDARY DEMYELINATION

GENERALISED LYMPHADENOPATHY WITH EOSINOPHILIA

TO RULE OUT LYMPHOPROLIFERATIVE DISORDER

NEUROLOGIST OPINION OBTAINED

LONGITUDINALY EXTENDING TRANSUERESE MYELITIS WITH OPTIC NEURITIS

NEUROMYELITIS OPTICA SPECTRUM DISORDER

?SECONDARY DEMYELINATION DUE TO LYMPHOMA

Advised

Inj . Methyl Prednisolone Igm in 500 ml NS over 3 hours for 5 days

Inj. Ceftriaxone Igm IU BD

To Do

MRI SPINE WITH BRAIN SCREENING

Lymphnode biopsy/ FNAC

ANA

LUMBAR PUNCTURE AFTER 5 DAYS

LYMPHNODE BIOPSY DONE

Impression

1. Tissue eosinophilia

2. Lymphoproliferative disorder – probably Hodgkins lymphoma

Typical Reedsternberg cells could not be demonstrated.

Suggested immunohistochemistry

IMMUNOHISTOCHEMISTRY

CLINICAL DETAILS : Generalised Lymphadenopathy with muscle weakness.

SITE : Cervical Lymph node.

MORPHOLOGY:

Sections from lymph node show effacement of architecture with few surviving follicles. Nodes show involvement with Classical Hodgkin lymphoma with mononuclear RS Cells.

IHC MARKERS : RESULT

CD 45 - Negative in RS cells

CD 3 - Stains background lymphocytes

CD 20 - Negative in RS cells

CD 15 - Negative

CD 30 - Positive in RS cells

IMPRESSION:

Classical Hodgkin Lymphoma

Regd. Dt:	29/12/2017	Acc. ID: 241757754		Client Details:	Vijaya Diagnostics
Coll Dt. Tm:	29/12/2017 11:17:21				85A, North Gate, S.S. Colony,Opp. Dewaki Scan
Recd Dt. Tm:	29/12/2017 11:17:21			Refd. By:	GRN
Age:	31 Yrs	Sex:	Male	Report Dt. Tm:	01/01/2018 15:45:07
Name:	Mr. YOGARAJ				

IHC Final Diagnosis Panel

Immunohistochemistry

LAB. NO. : OLLB H 3792 / 17

CLINICAL DETAILS : Generalised Lymphadenopathy with muscle weakness.

SITE : Lymph node.

SPECIMEN DETAILS :

Received two paraffin blocks No : 7932 / 17 A, B from G K Biopsy Centre Madurai for IHC.

IHC performed on formalin fixed paraffin embedded block number A.

MORPHOLOGY:

Sections from lymph node show effacement of architecture with few surriving follicles. Nodes show involvement with classical Hodgkin lymphoma with mononuclear RS Cells.

IHC MARKERS :	RESULT
CD 45	Negative in RS cells
CD 3	Stains background lymphocytes
CD 20	Negative in RS cells
CD 15	Negative
CD 30	Positive in RS cells

IMPRESSION:

Classical Hodgkin Lymphoma - Lymph node. Site ?

CSF ANALYSIS -

cell count - 2 lymphocytes

protein - 15mg/dl

sugar- 45mg/dl

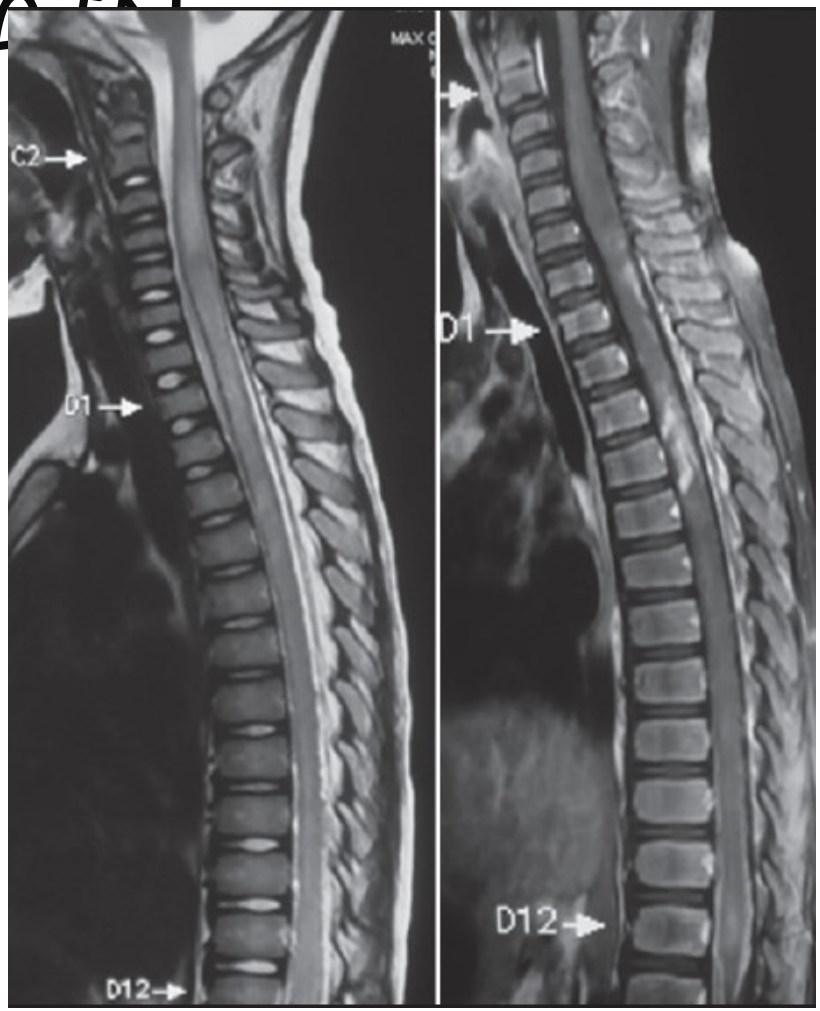
ANA AND ANA PROFILE NEGATIVE

MRI SPINE WITH BRAIN SCREENING

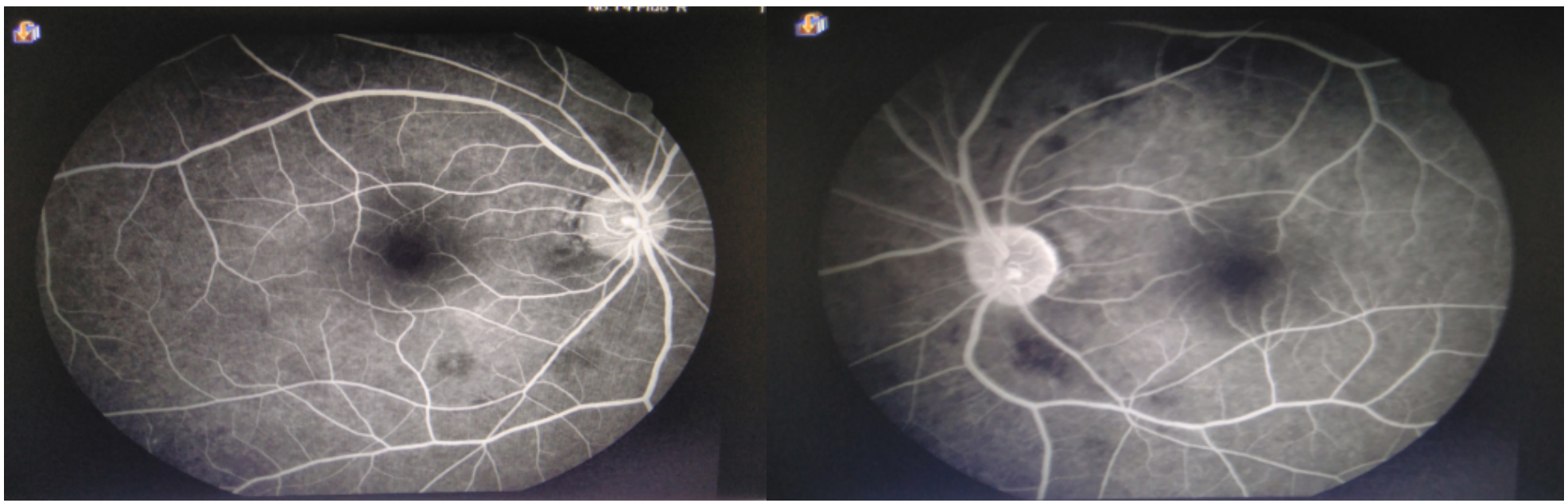
T2 hyperintense lesion noted from C 4 to T 7 level -

s/o ? Demyelination

MRA and MRU NORMAL



FUNDUS FLUORESCENT ANGIOGRAPHY



ECHOCARDIOGRAM

Normal chambers

Normal valves

No regional valve motion abnormality

No LU systolic dysfunction

No LU clot

LU EF 55%

HODGKINS LYMPHOMA

ACUTE SPASTIC QUADRIPARESIS

BILATERAL RETROBULBAR NEURITIS

SECONDARY NEUROMYELITIS OPTICA SPECTRUM DISORDER

PARANEOPLASTIC DEMYELINATION

TREATMENT GIVEN

Back rest

Nasal oxygen (sos)

Inj . Methyl prednisolone 1g in 500 mi NS over 3 hours

Inj. Ceftriaxone 1 g iv BD

Inj. Ranitidine 50 mg IU BD

ONCOLOGY REVIEW DONE

Patient was transferred to medical oncology

Started on ABVD regimen

Patient regained vision

Is able to walk with out support

On oncology treatment and follow up

THANK YOU