PROVISIONAL DIAGNOSIS

- T2DM/SHT
- Non compressive myelopathy-acute transverse myelitis in spinal shock with? b/l optic neuritis
- ?NEURO MYELITIS OPTICA

Investigations

- Hb 11.2 gm/dl
- TC 9500/cu mm
- DC N 84% L12% E 2%
- ESR 21mm/hr
- HCT 31.6
- PLATELETS 2.92 L/cu mm
- RBC 3.92 million/cu mm

- FBS 110 mgs %
- PPBS 198 mgs %
- Urea 51 mgs %
- Creatinine 1.9 mgs %
- Sr.sodium 134 meq/l
- Sr.potassium 4.6 meq/l
- Sr . Calcium 10.2 mEq/l
- T.bilirubin 0.4 mg/dl

- Urine albumin +
- sugar +
- Deposits 3-4 pus cells
- ECG Normal
- HCV negative
- HBsAg negative
- VCTC non reactive
- Sr ACE Level 22 Ul/L
- ANA (BY ELISA) - Negative

- CHG : normochromic normocytic anaemia
- ECHO : EF 43%
- Moderate LU systolic dysfunction
- UDRL :Negative
- USG :medical renal disease

NEUROLOGY OPINION

- T2DM
- Paraparesis-upper dorsal level
- Bilateral blindness
- R/o Demyelination
- Sugg:
  - MRI dorsal spine with whole spine and brain (orbit) screening
  - Carotid and vertebral doppler
  - Cardiac evaluation
  - ESR/CRP,CXR,USG abdomen
  - Inj Methyl Prednisolone pulse after Visually Evoked Potential and Ophthal opinion

OPHTHAL OPINION

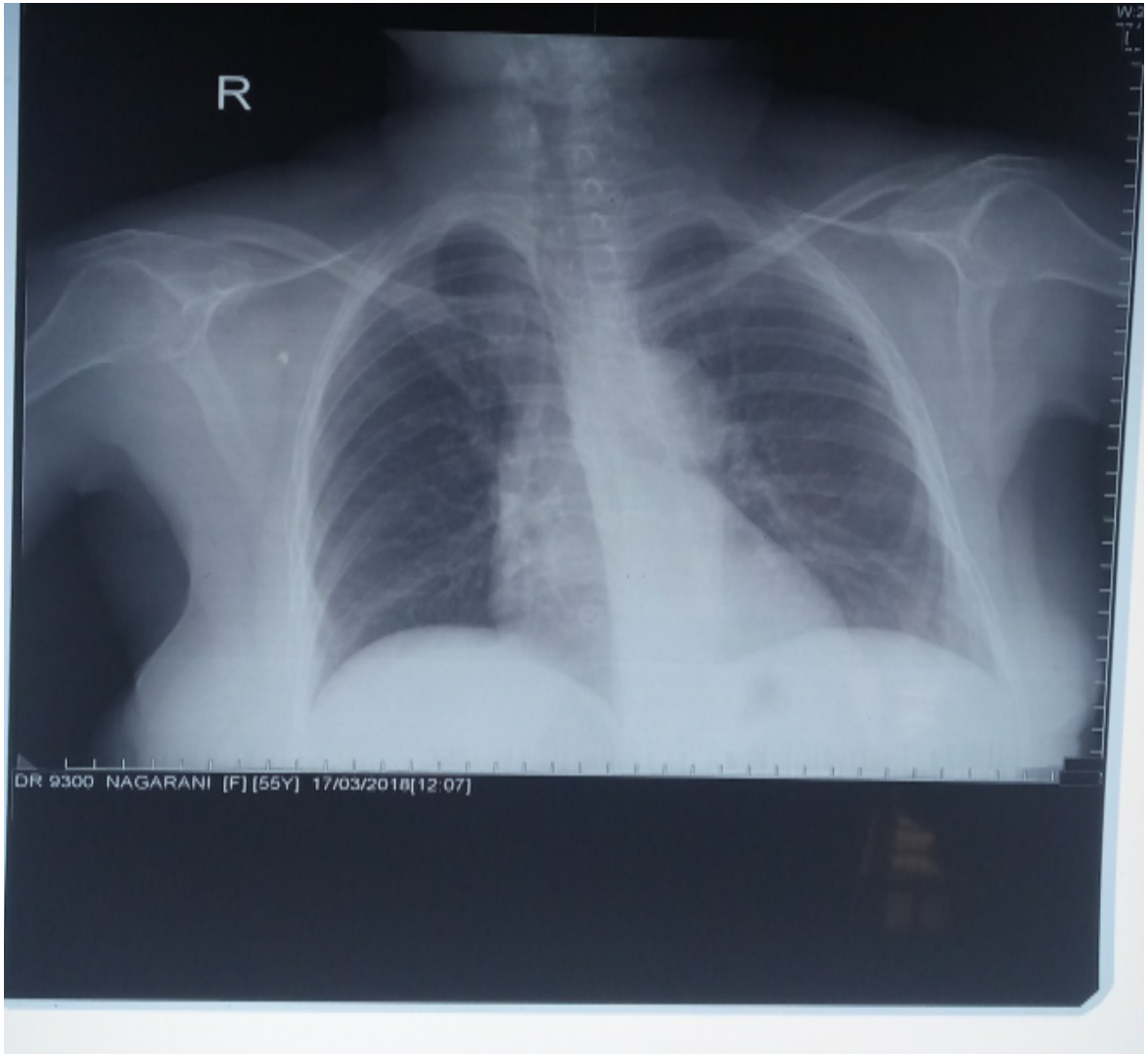
- Visual acuity b/l Perception of light negative
- Pupil b/l 5 mm not reacting to light
- b/l immature cataract
- Fundus b/l media hazy due to brown cataract.
- ?NMO

- Sugg:
- MRI Brain and orbit
- Review in every 2 days for U/A assessment.

CSF ANALYSIS

- Protein 65mg/dl
- Sugar 74mg/dl
- Cell count 5
- 100 % lymphocytes
- Globulin negative

Chest X ray

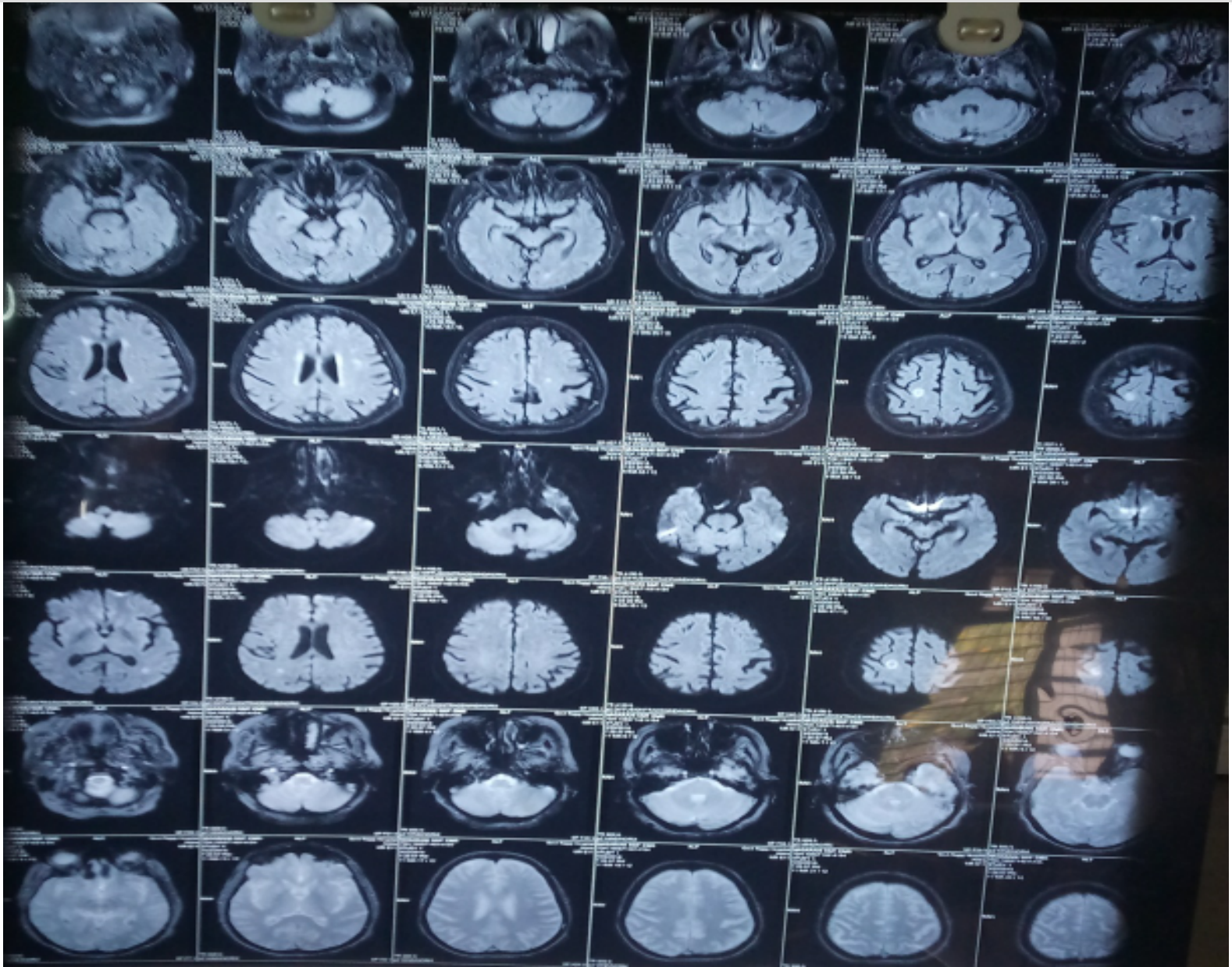


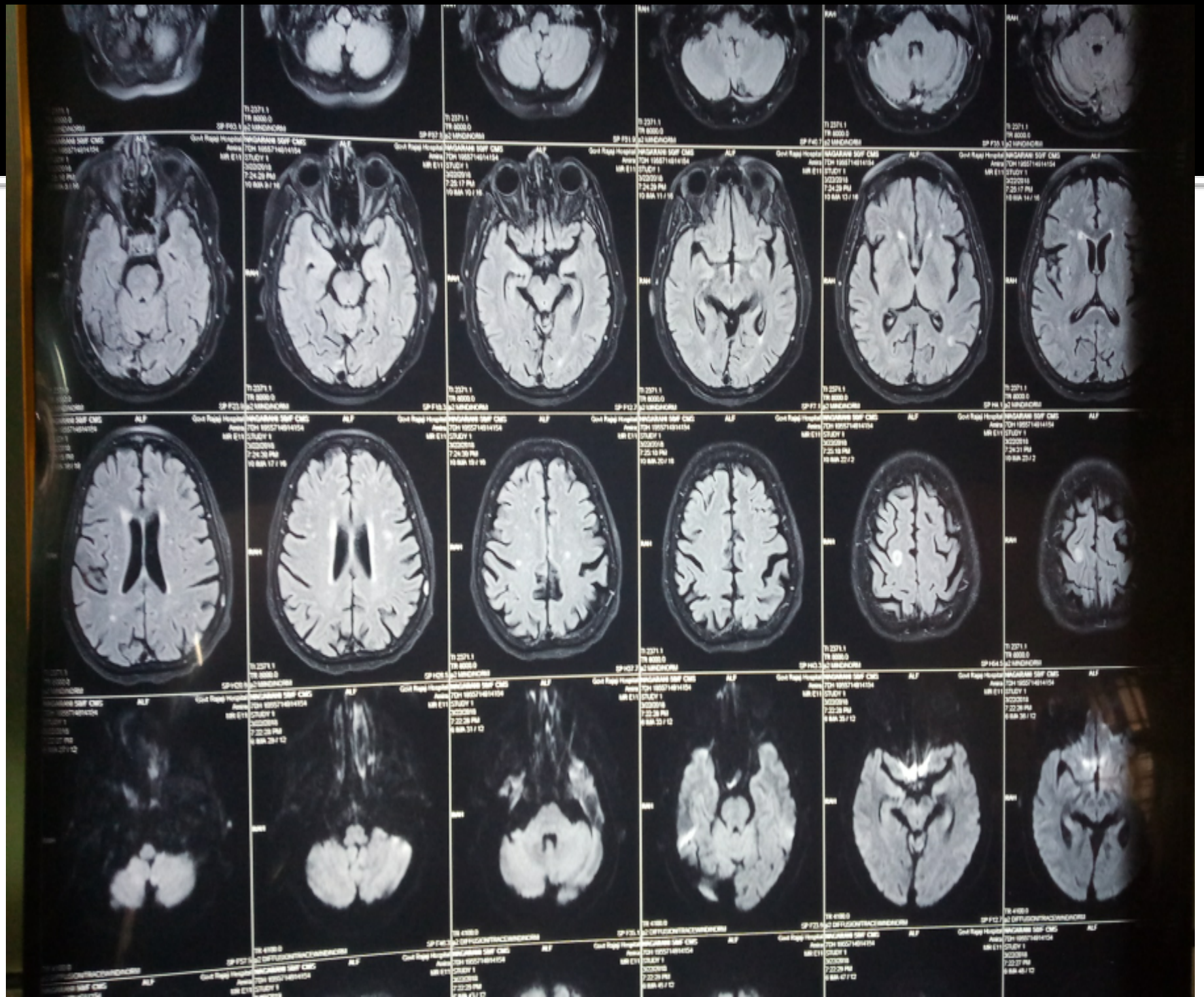
VEP

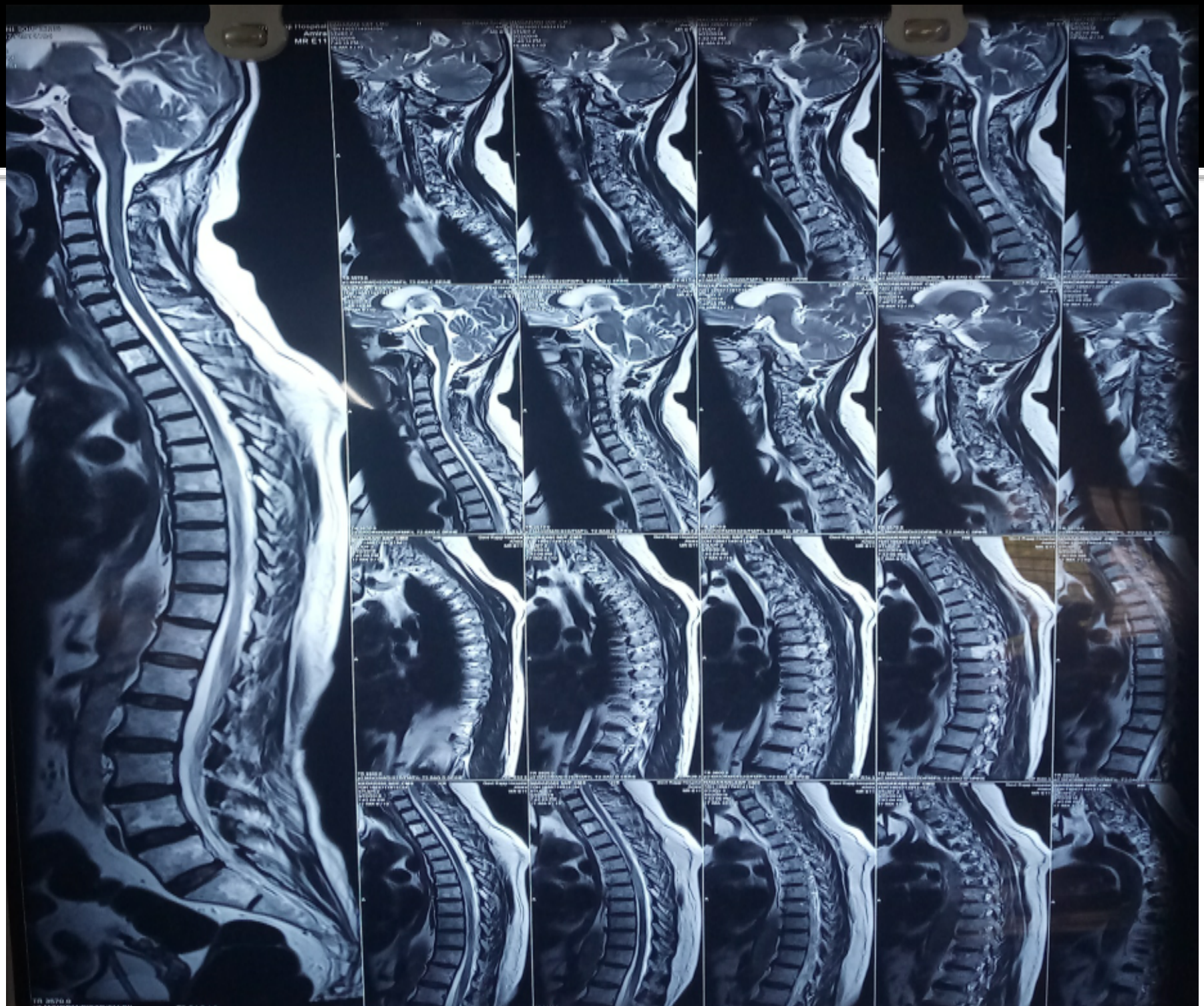
- P 100 latency prolonged on both sides.
- P 100- N 75 amplitude reduced in both sides.

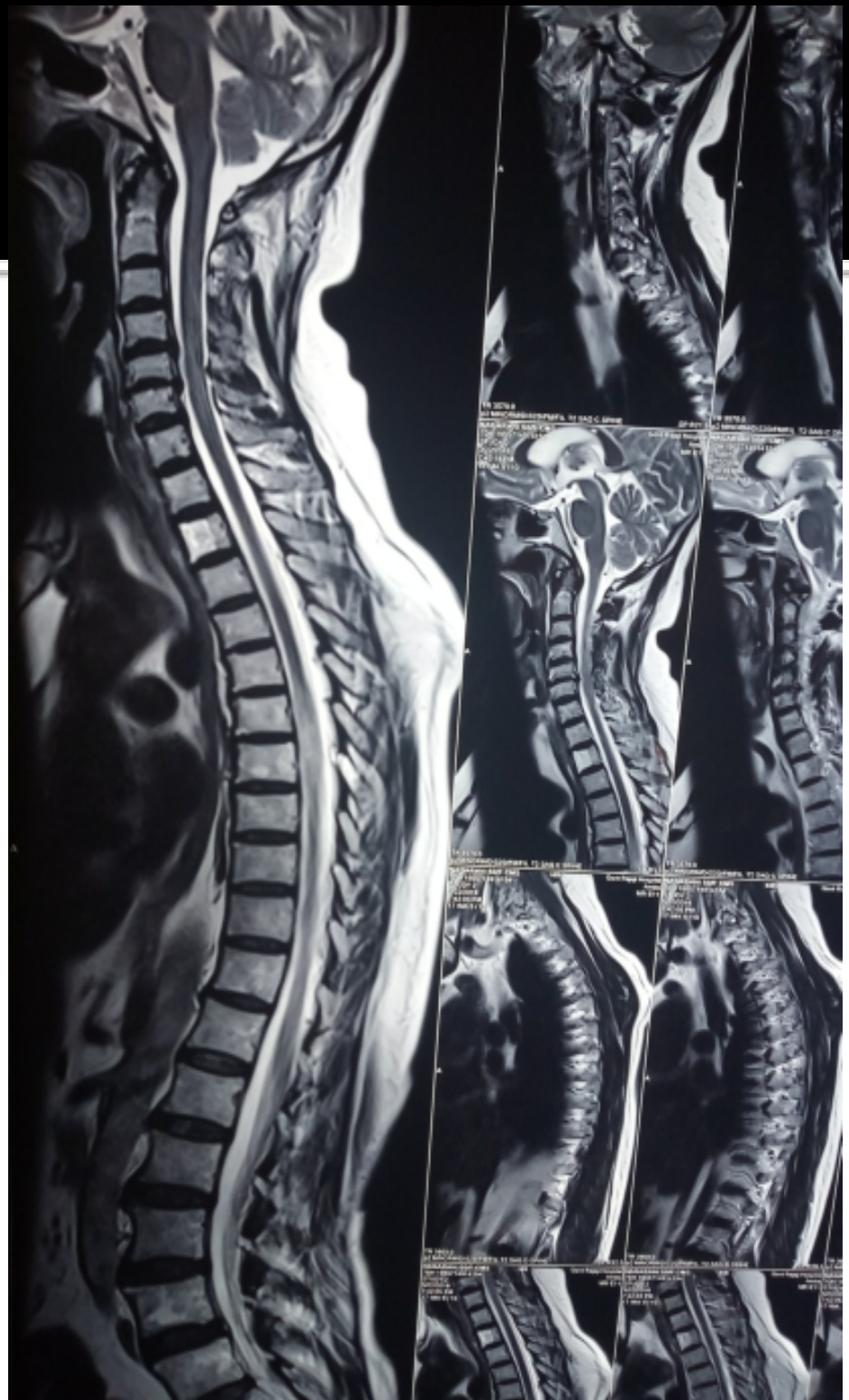
- IMP: B/L OPTIC NEUROPATHY

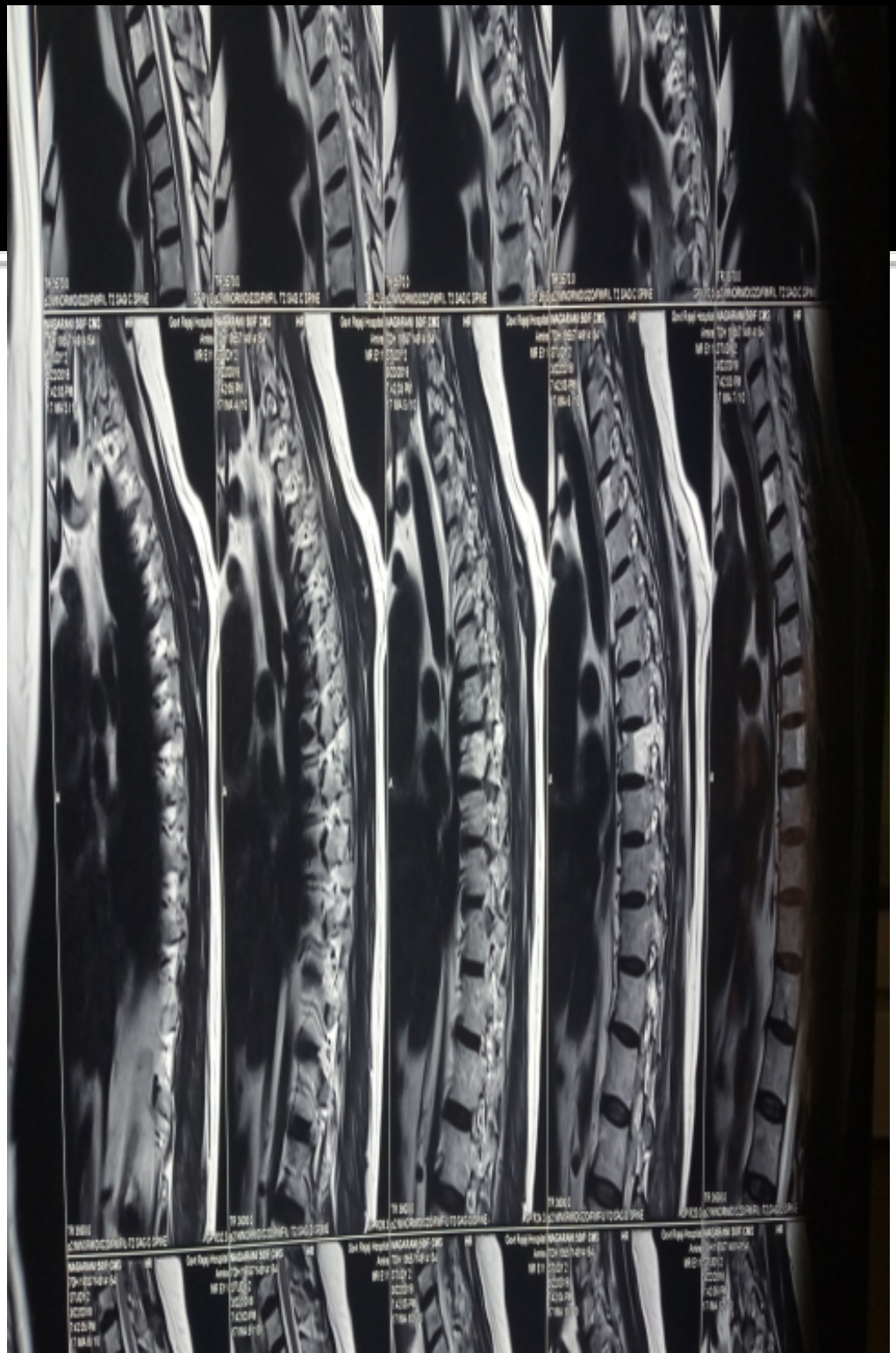
MRI

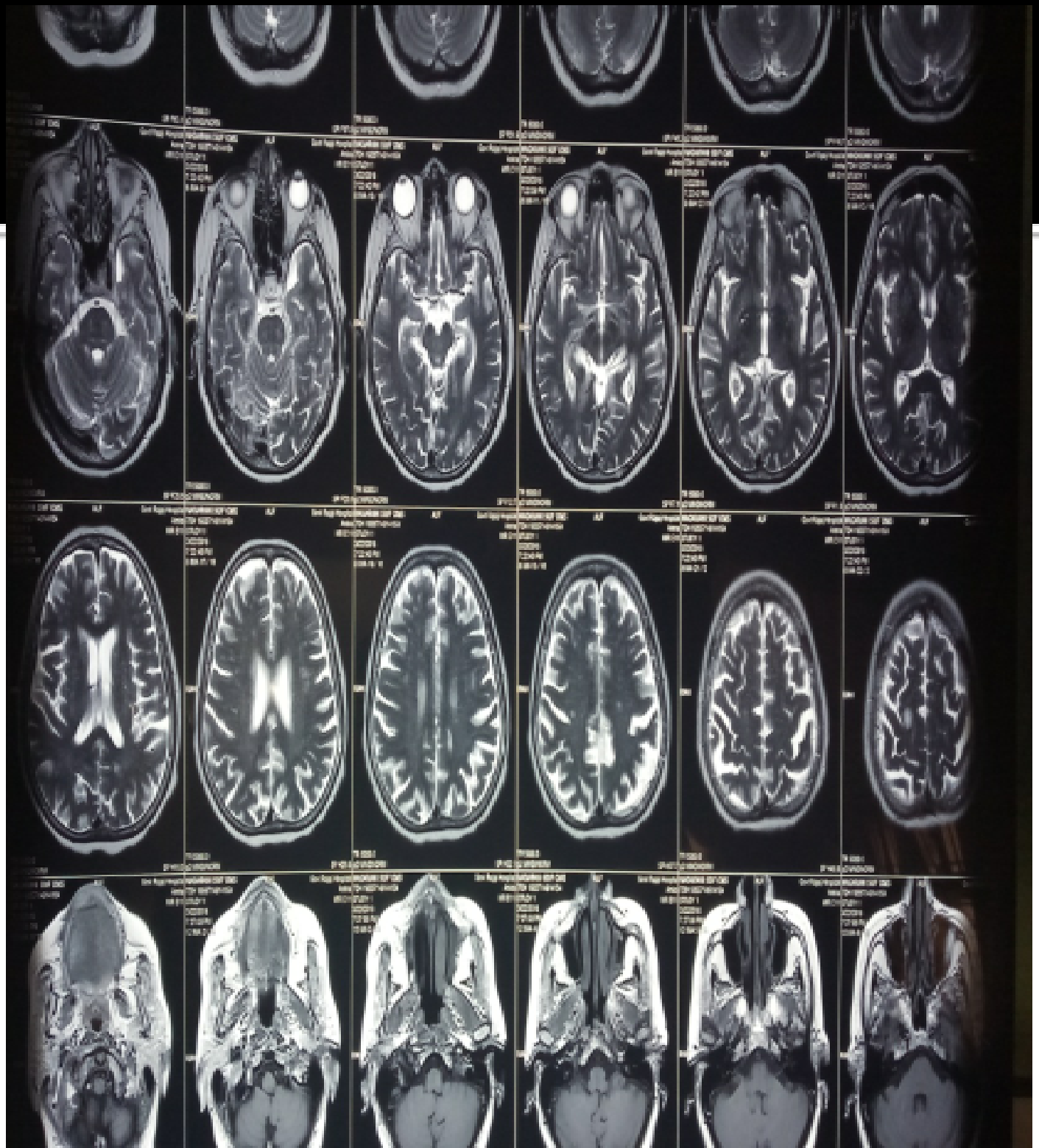


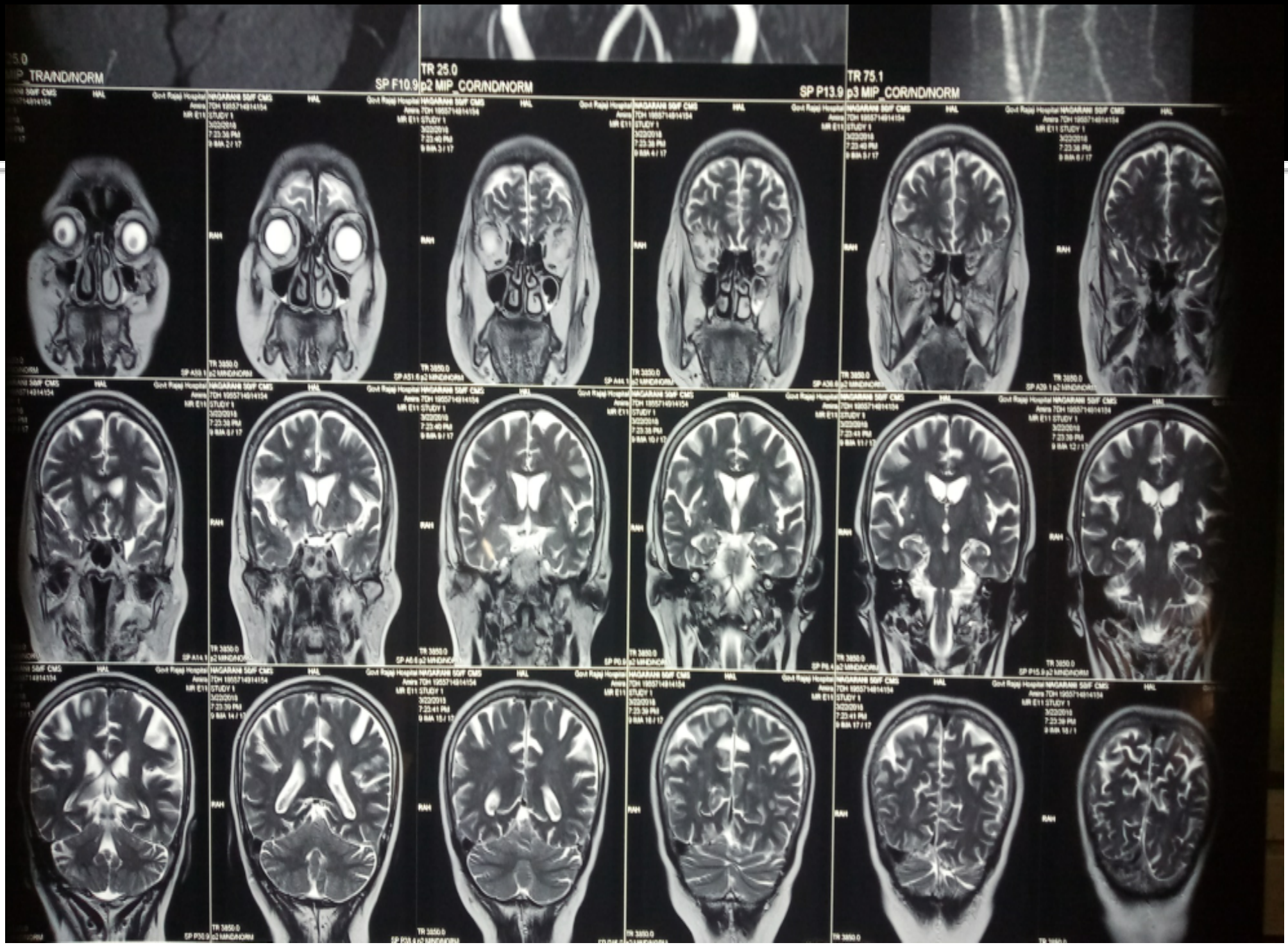











TRA/ND/NORM
TR 25.0
SP F10.9
p2 MIP_COR/ND/NORM
SP P13.9
TR 75.1
p3 MIP_COR/ND/NORM

- e/o 10*9 mm measuring T1 hypointense, T2 central hyperintense with peripheral hyperintensity,flair -central hypointensity with peripheral hyperintensity lesion showing peripheral diffusion restriction noted in right high parietal white matter.
- Multiple T2/Flair hyperintense lesion

- b/l optic nerve shows altered signal intensity.
- Ill defined T2 hyperintensities noted involving brain stem to C6-C7 and D6 -D9&D12 vertebral level in the spinal cord.

- Imp:S/O NMO

Treatment

- Inj.methyl prednisolone 1gm iv od*3 days followed by
- T.prednisolone 5 mg 12 OD
- T.Ranitidine 150 mg bd
- T.calcium bd
- Inj.HA 12 12 10
- HM 10 0 8
- T.Enalapril 2.5 mg 1 BD

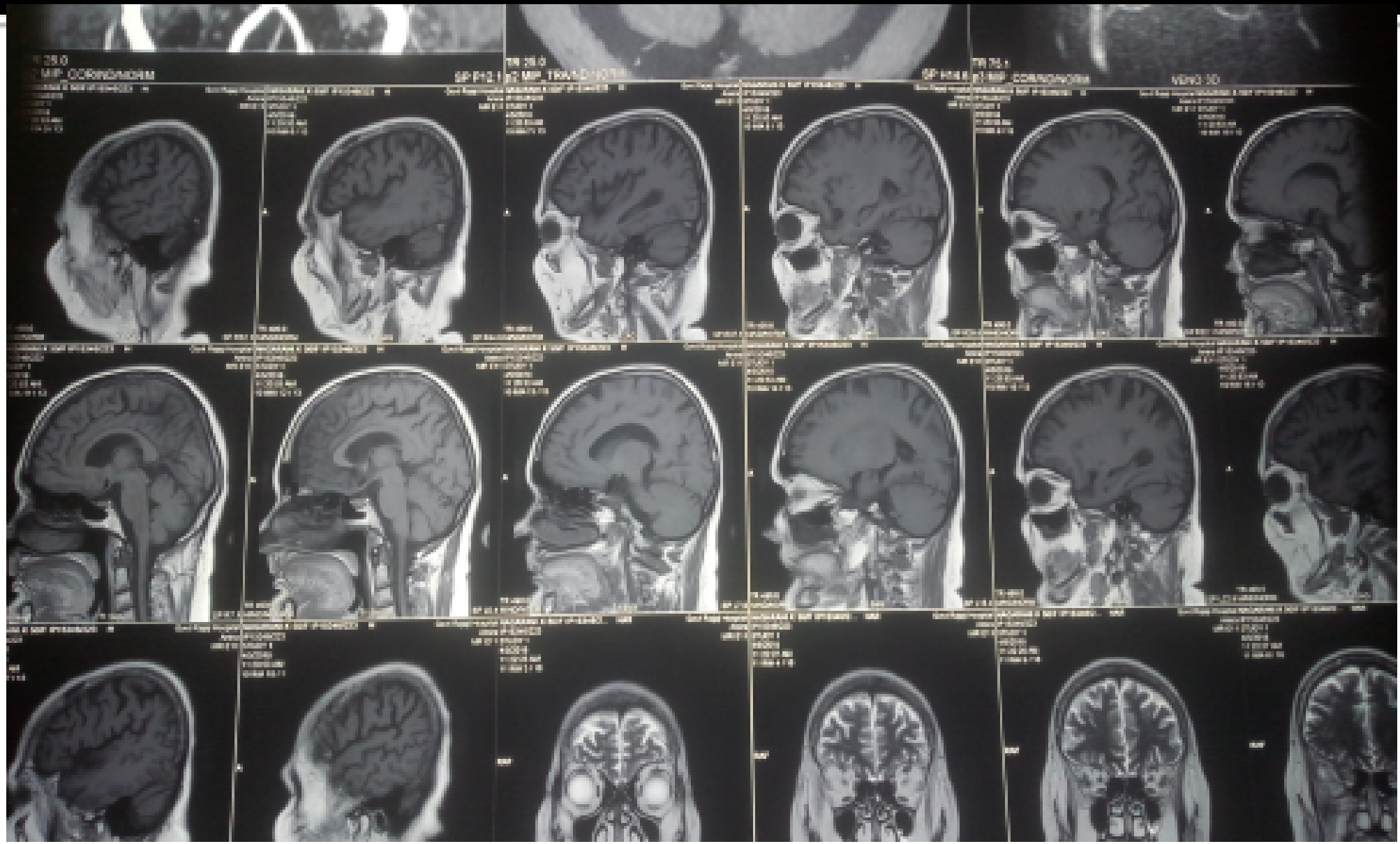
NEUROLOGY REVIEW

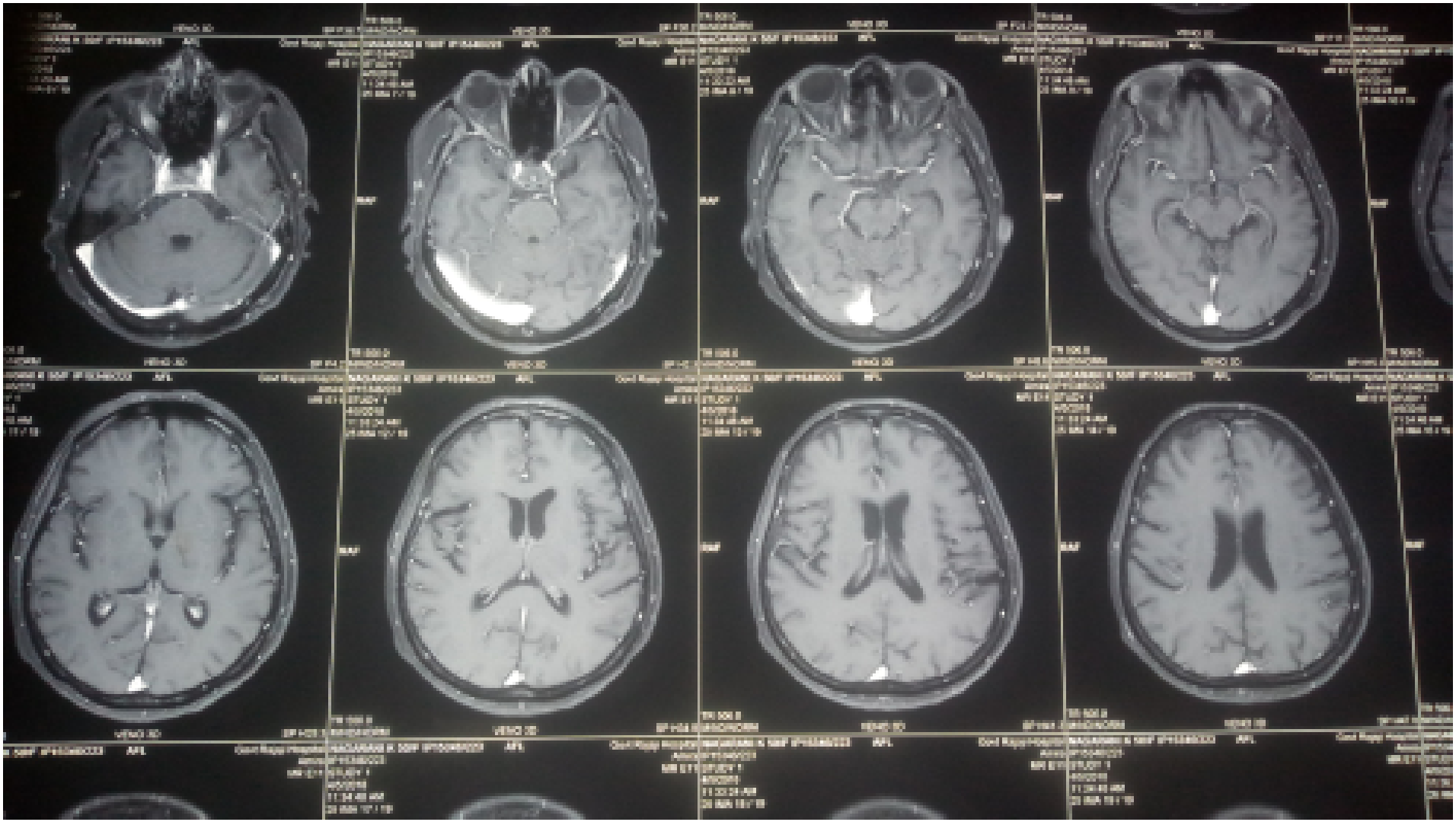
- ?NMO
- Sugg:
- MRI contrast brain &spinal cord
- Serum NMO Antibody

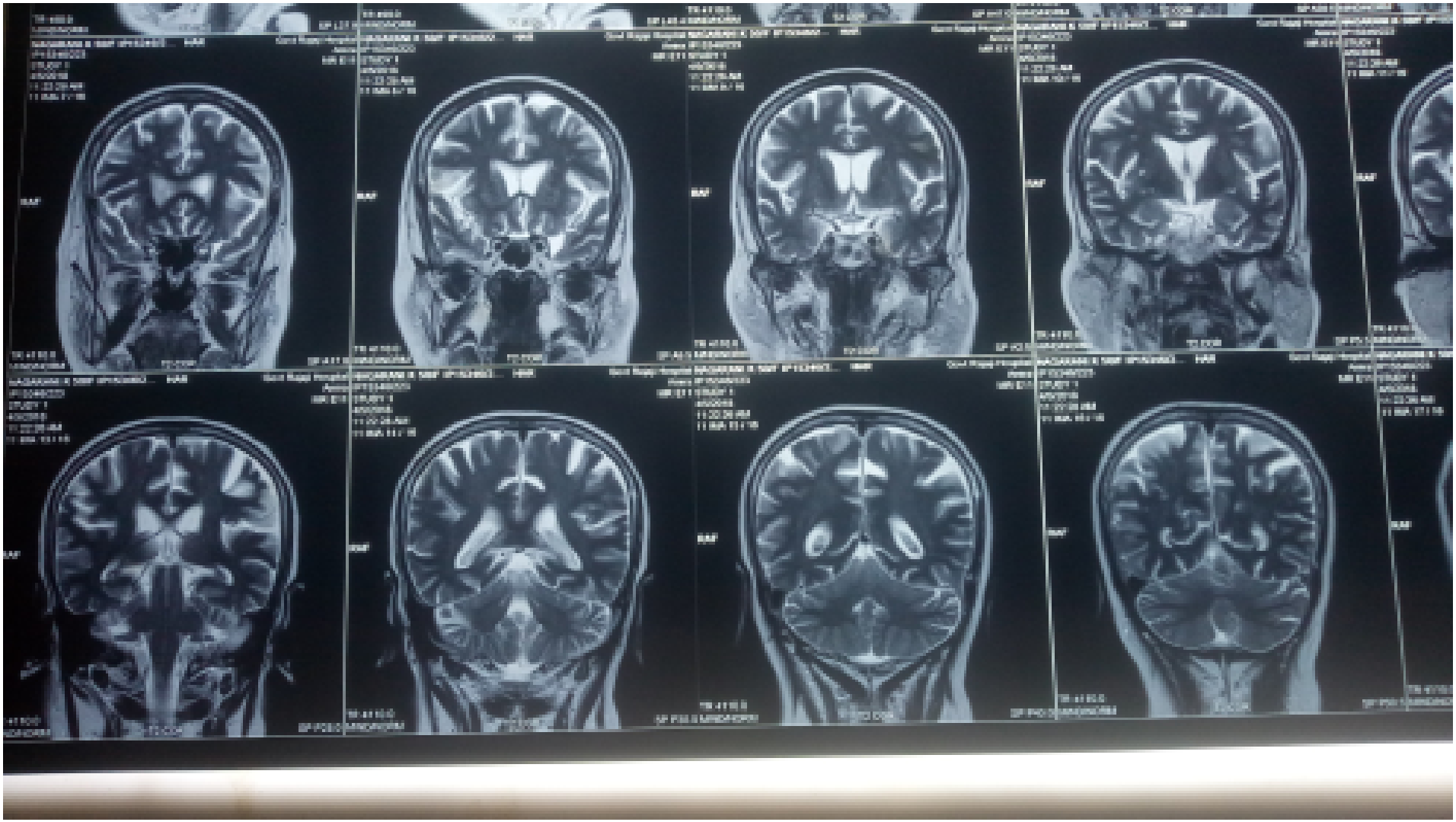
Ophthal review

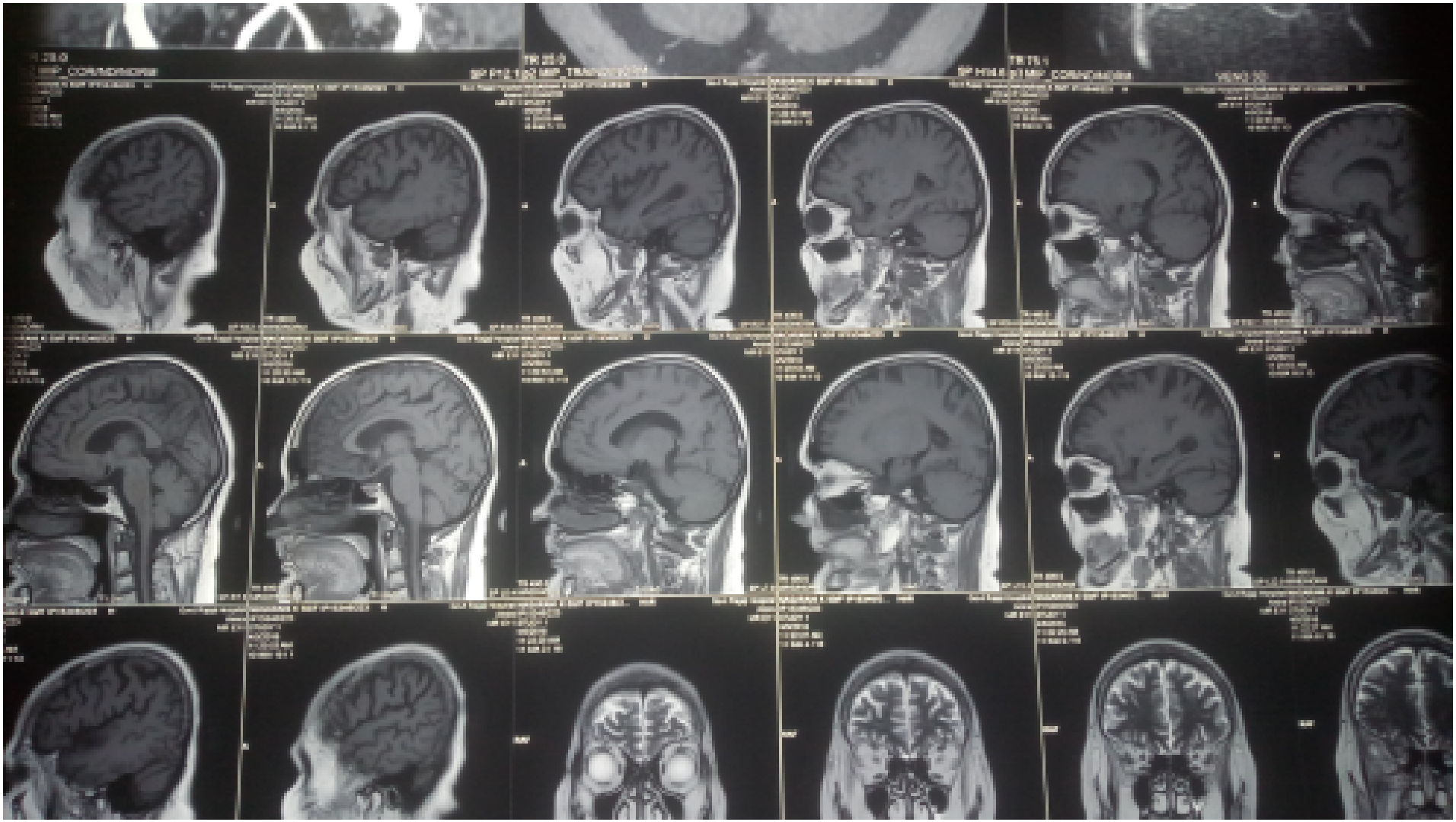
- T.prednisolone 60mg od*11 days
- Review for vision assessment

MRI CONTRAST









MRI CONTRAST

- e/o multiple small hyperintensities noted in b/l corona radiata,b/l capsuloganglionic region.
- s/o small vessel ischemic changes
- No abnomal contrast uptake noted.

- Serum NMO antibody-anti aquaporin IU
  NEGATIVE

Final diagnosis

- NMO SPECTRUM DISORDER

- After 3 days of pulse Methyl Prednisolone and oral Prednisolone , upper limb power improved to 5/5 5/5 and
- lower limb power to 4/5 4/5 .
- Vision improved to b/l counting finger close to face.

On Discharge

- Pt was discharged with
  - T.Prednisolone 5mg 8-0-0 (to taper to half dose each week and stop)
  - T.Ranitidine 150 mg 1-0-1
  - T.Calcium 300mg 1-0-1
  - Human Mixtard (30/70) 25-0-15
  - T . Enalapril 2.5mg 1-0-1
  - T. bct 1-0-0

Thank you