Meet The Experts

Clinical case presentation

Dr. Munawwar Alamgir Khan
Post Graduate Trainee
MU-I
DMCH

Particulars of the patient:

- Name: Ashraf Ali
- Age: 40 years
- Sex: Male
- Address: Tongi, Gazipur
- Religion: Islam
- Occupation: Businessman
- Marital status: married
- Ward: 3
- Bed: 14
- Date of admission: 20.1.2010
- Date of Examination: 20.1.2010
- Source of history: Both patient and attendant

Chief complaints:

- Alteration of bowel habit for 4 years
- Irregular fever for last 4 years
- Progressive weight loss with generalized weakness of the body for 4 years.

History of present illness:

- According to the statement of the patient, he was reasonably well 4 years back. Then he experienced several episodes of loose stool which was semisolid to watery in nature, occured 6-7 times in a day, no tenesmus and no per rectal fresh blood. Stool was neither voluminous nor pale. Also no history of traveling, alcohol in take, medication use or family history of such problem. Each episode of loose stool used to continue for 1 week followed by minimum bowel movement for 3-4 days. This alteration of bowel habit persisted for last 4 years. There was no history of haematemesis.
- He also complained of occasional fever which was low grade with evening rise, not associated with chills, rigor and subsided spontaneously with sweating. Fever was associated with nausea and loss of appetite but not any headache, body ache, cough, Haemoptysis, chest pain, breathlessness, abdominal pain, burning micturition, Heamaturia, loss of consciousness or convulsion. Patient didn't give any history of joint pain, mouth ulcer, rash or photophobia. There was no history of contact with TB patient.

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- He gave history of gradual weight loss during this period of illness associated with generalized weakness all limbs which is evidenced by difficulty in standing from squatting position and elevation of the arms. His attendant also stated that there are episodes of occasional incoherent speech and inappropriate behaviour over this period. On query, he also complained of occasional incontinence of urination for which he has been catheterized several times during this period of illness.
- There was also history of progressive blackening of skin of all parts of the body. He didn’t give any history of presence of arsenic suffered family member. He gave no history of trauma, extramarital sexual relationship, blood transfusion.
- With these complaints he consulted with several local physicians and took medicines but there was no significant improvement and he admitted in DMCH for better management.

Past History: He doesn’t have any significant past history

Socio Economic History: He is from lower middle class. Lives in Muddy house , Use sanitary latrine and drinks supply water.

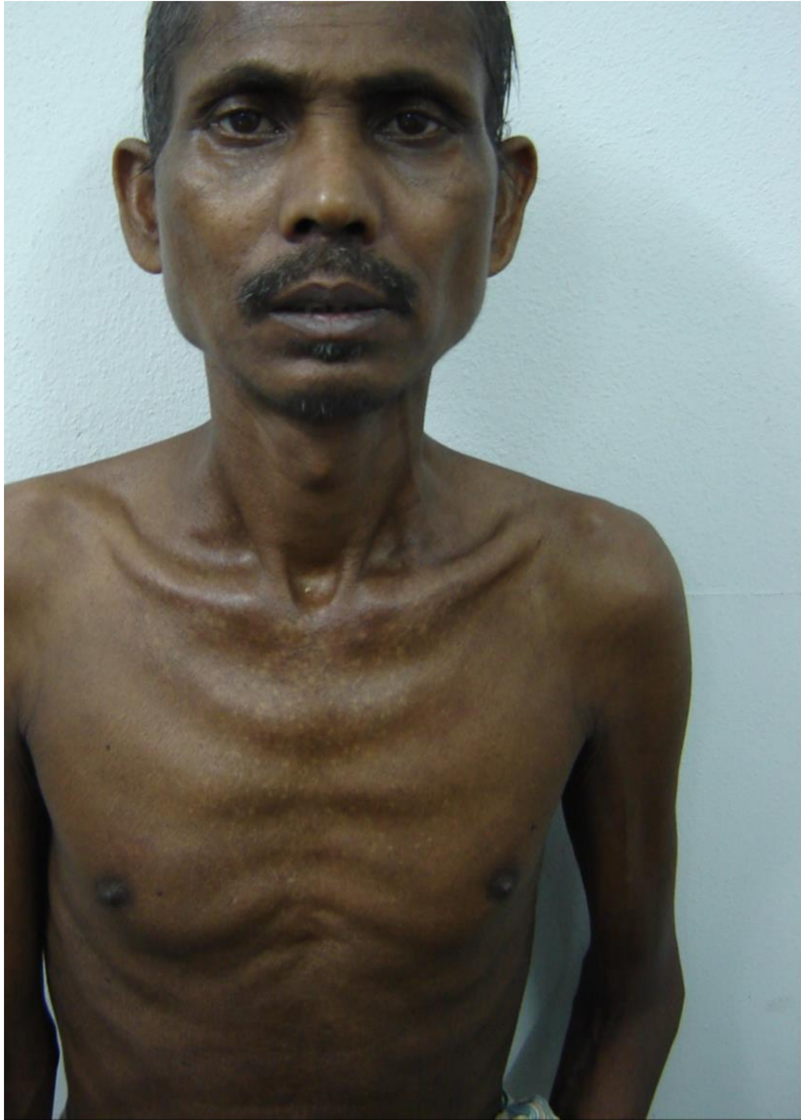
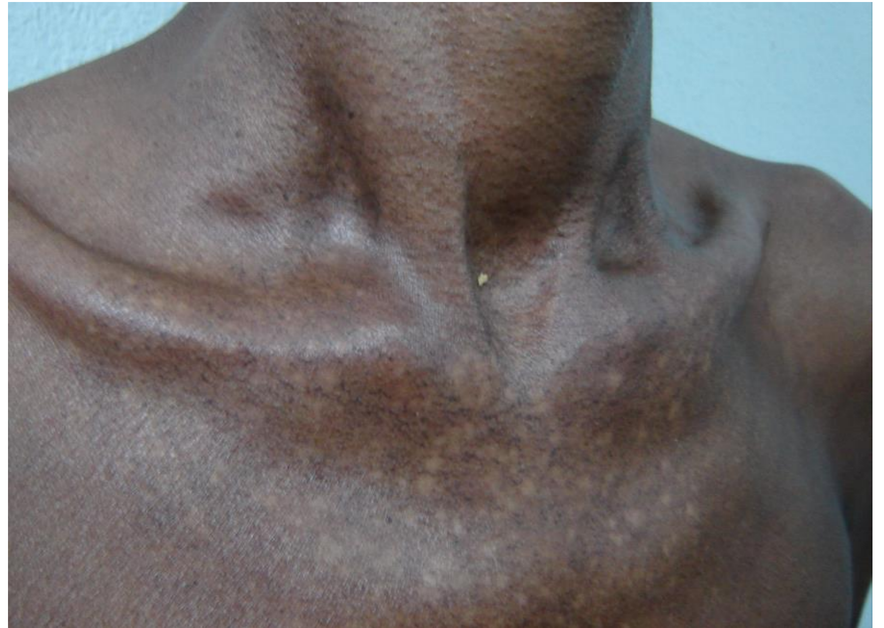
Family History: He has 1 son and 1 daughter, all are alive and good health. His parents died due to age.

Immunization history: Not completed according to EPI schedule.

Personal History: He is smoker and used to take 20 sticks per day. No history of exposure to veneral diseases.

General Examination:

- App: Ill looking
- Body built: Below average
- Patient is cooperative
- Nutritional status: Poor
- Dehydration: Mild
- Anaemia: Moderate
- Jaundice: absent
- Cyanosis: absent
- Clubbing: Absent
- Koilonychia: absent
- Leuconychia: absent
- Lymph node: not palpable
- Thyroid gland: not enlarged
- Pulse: 78 B/M
- BP: 90/60 mm Hg on standing, 100/60 mm Hg on lying
- Temp: 99 F (Highest recorded temp was 100 F)
- Respiratory rate: 16 B/M
- Skin condition: Generalized hyper pigmentation with scattered area of hypo pigmentation over skin (Predominantly in chest and upper abdomen), Hair is sparse and lusterless

Alimentary system:

- Mouth and oral cavity: There are some hyper pigmented area over hard palate and buccal mucosa.
- Abdomen:

  Inspection: Scaphoid shape, Hyper pigmentation with some hypo pigmented area over skin particularly on upper part, no visible swelling

  Palpation: No organomegaly, Fluid thrill- Absent

  Percussion: Normal, no shifting dullness

  Auscultation: Normal
- DRE : No abnormality detected.

Nervous System:

- Higher Psychic Function – Intact
- MMSE – 30 of 30
- Cranial Nerves – All nerves are intact except

  Jaw jerk: Present

  Fundoscopy: Single hard exudate in right eye
- Motor system –

  Lower limb: Fasciculation - absent

  Bulk – Symmetrically wasted

  Tone – Symmetrically increased

  Strength – 3/5, Both proximal and distal muscles

  Reflexes - Symmetrically brisk

  Planter – Bilateral extensor

  Clonus - Absent

Upper limb: Fasciculation – absent

Bulk – Symmetrically wasted

Tone – Symmetrically increased

Strength – 3/5, Both proximal and distal muscles

Reflexes – Symmetrically brisk

Hoffman sign - Positive

- Coordination of movement – Normal
- Gait – Can walk with support
- Involuntary movements – Absent

- Sensory – All modalities of sensation including joint position and vibration sense are normal.

- Cardiovascular system – Normal
- Respiratory system – Normal
- Loco motor system – Normal
- Genitourinary system - Normal

Salient feature:

Asraf Ali, a male, muslim, married, normotensive, non Diabetic patient hailing from Tongi, Gazipur admitted with the complaints of several episodes of loose stool, semisolid to watery in nature, neither voluminous nor pale, occurred 6-7 times a day, persisted for 1 week followed by minimum bowel movement for additional 3-4 days. This alteration of bowel habit persisted for last 4 years. There was also history of low grade irregular fever with evening rise, not associated with chill, rigor and subsided with sweating. Fever was associated with nausea and loss of appetite but not any headache, body ache, cough, Haemoptysis, chest pain, breathlessness, abdominal pain, burning micturition, Heamaturia, loss of consciousness or convulsion. There was no history of contact with TB patient. These complaints was also associated with progressive weight loss and generalized weakness. There are episodes of occasional incoherent speech and inappropriate behaviour over this period. On query, he also complained of occasional incontinence of urination for which he has been catheterized several times during this period of illness.

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There was also history of progressive blackening of skin of all parts of the body. He gave no history of trauma, extramarital sexual relationship, blood transfusion. On Examination, there is generalized hyper pigmentation with scattered hypo pigmented area over skin with sparse hair , patient is cachexic, not well nourished, moderately anaemic, mild dehydrated, P-72 B/M, BP-100/60 mm Hg with no postural drop, highest recorded temp was 100 F. Abdomen is scaphoid shaped with no visible swelling and organomegaly. Nervous system examination reveals presence of jaw jerk, both upper and lower limb muscles are symmetrically wasted, hypertonic, strength-3/5 of both proximal and distal muscles, reflexes-brisk, planter-bilateral extensor and Hoffman sign-positive. Other system reveals no abnormality.

Diagnosis

Differential Diagnosis

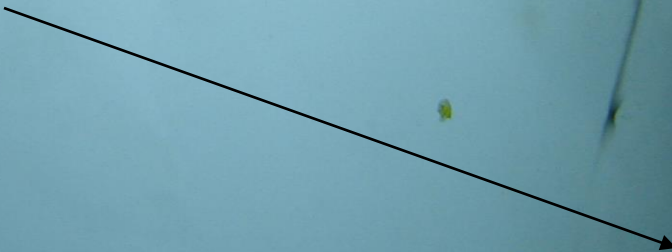
- Intestinal Tuberculosis with Motor Neuron Disease
- HIV

Investigations:

- CBC – Hb%: 7.5 gm/ dl
  WBC: 7000/ cmm (N- 86%, L- 8%, E- 4%)
  ESR: 92 mm in 1st hour
- PBF – Normocytic Normocromic Anaemia with increased Rouleaux formation
- Urine R/E – Pus cell: 5-8/HPF, RBC: 16-20/HPF, Albumin: Trace
- Fasting lipid profile:
  Cholesterol – 126 mg/dl
  HDL –29 mg/dl
  LDL – 83 mg/dl
  TG – 170 mg/dl
- S Electrolyte: Na – 132 mmol/l
  K – 2.52 mmol/l
  Cl – 100 mmol/l
  CO2 – 18 mmol/l

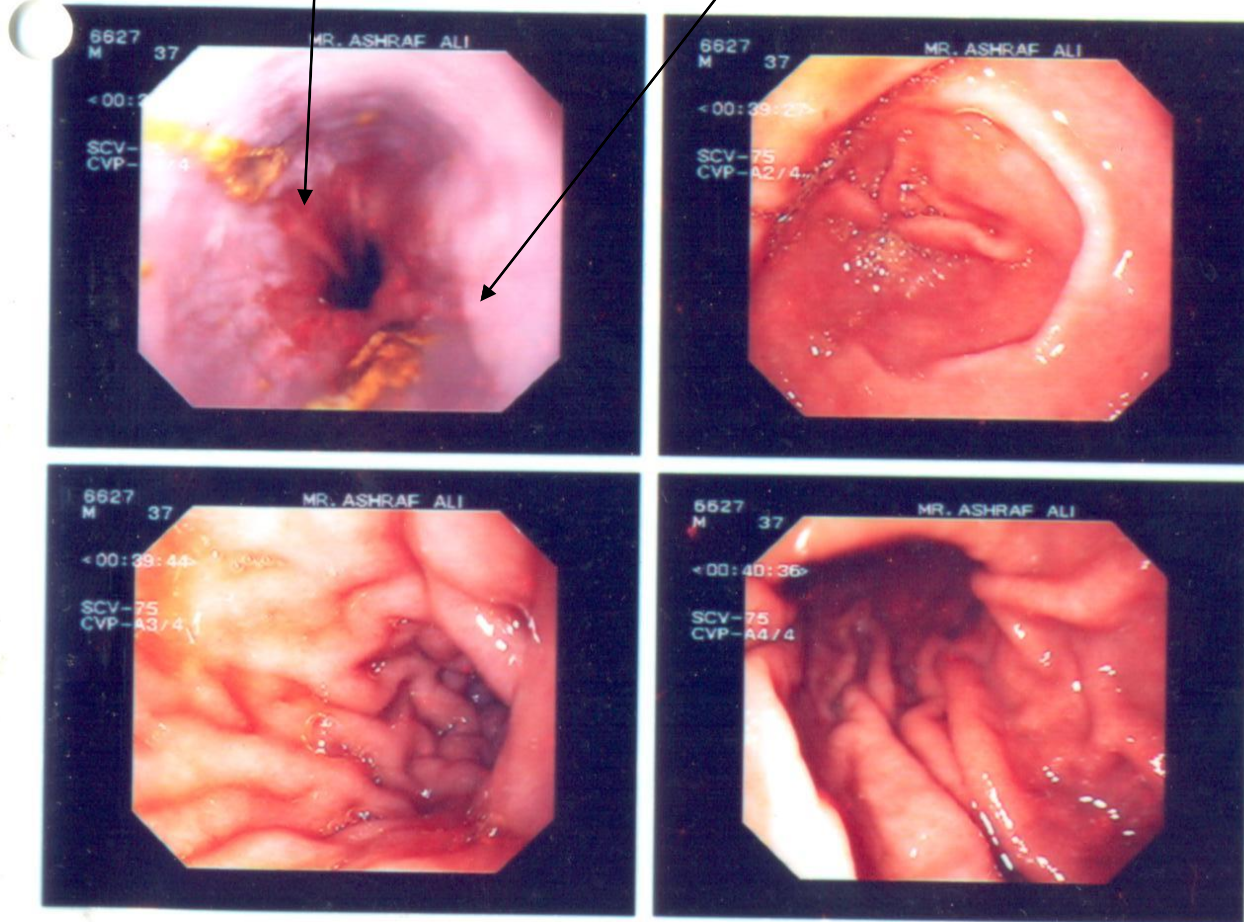
- S Creatinine – 1.1 mg/dl
- Liver Function Test: Bilirubin (Total) – 0.42 mg/dl
  SGPT – 45 mg/dl, SGOT – 41 mg/dl
  Alk. Phos – 105 mg/dl
  PT – 13.2 seconds
- FBS – 4.6 mmol/ l, 2HABF – 6.4 mmol/ l
- CXR P/A view – Normal
- Plain X ray Abdomen – Splenic calcification
- USG W/A – Splenic Calcification, diffusely echogenic liver, hypo echoic Pancreas
- MT – negative
- Sputum – Negative for AFB and C/S- no organism found
- Endoscopy of UGIT – Reflux oesophagitis, Oesophaegeal Moniliasis
- Colonoscopy – Rectal ulcer
- Biopsy of rectal tissue – Chronic non specific colitis

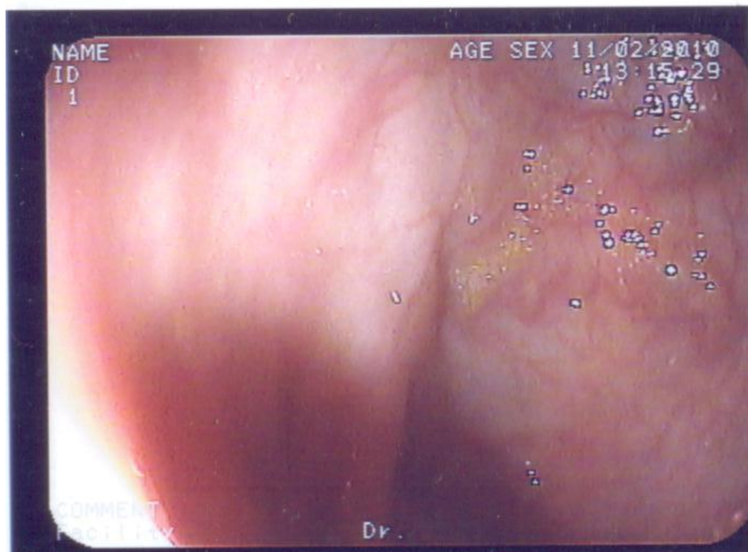
Splenic Calcification

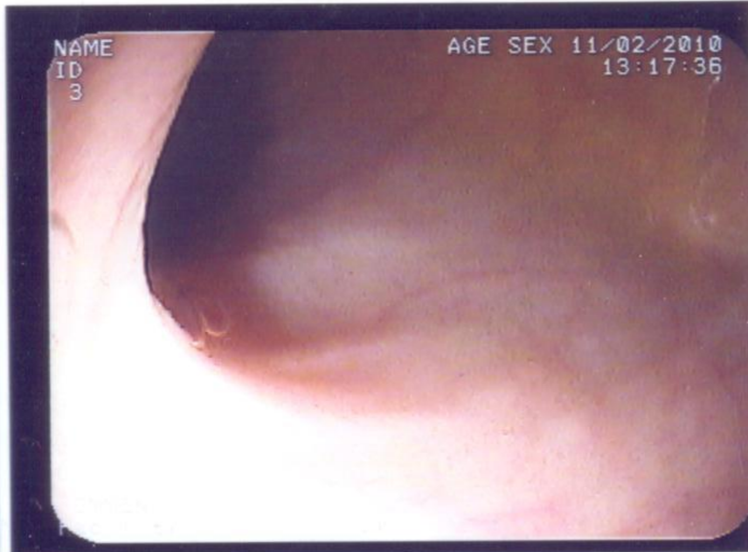


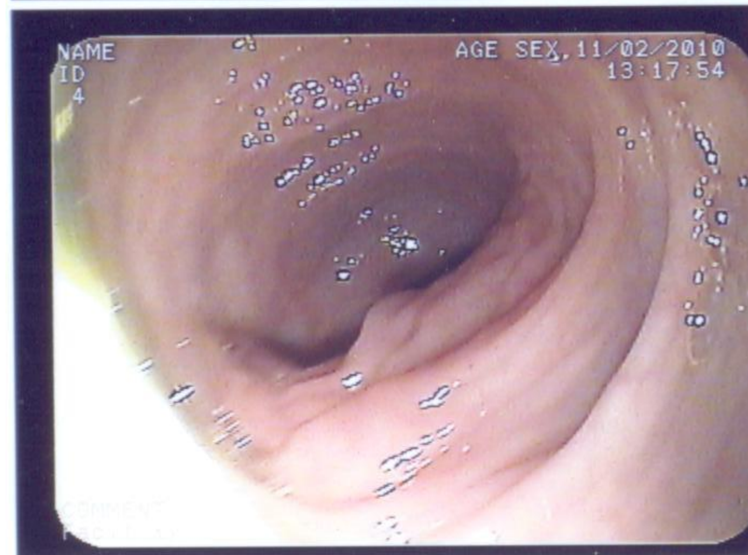
SHRAF Age: 28 year(s) ID: 20922 Sex: Male Chest PA True size

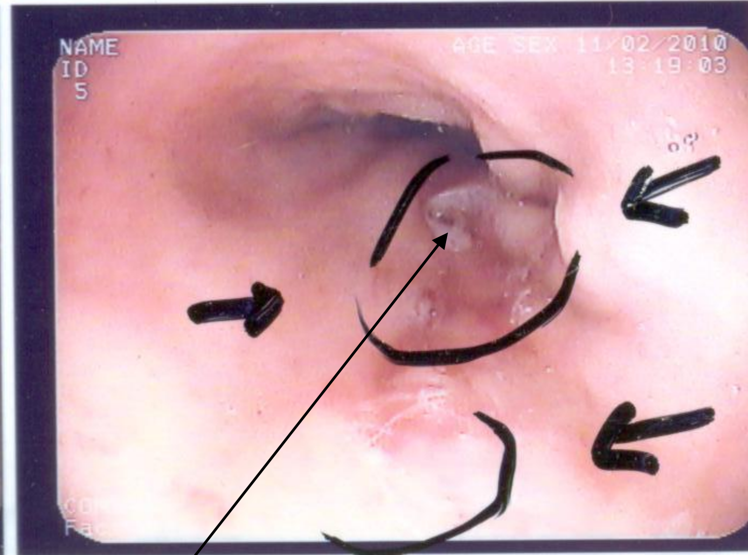
Reflux Oesophagitis with Oesophageal Moniliasis











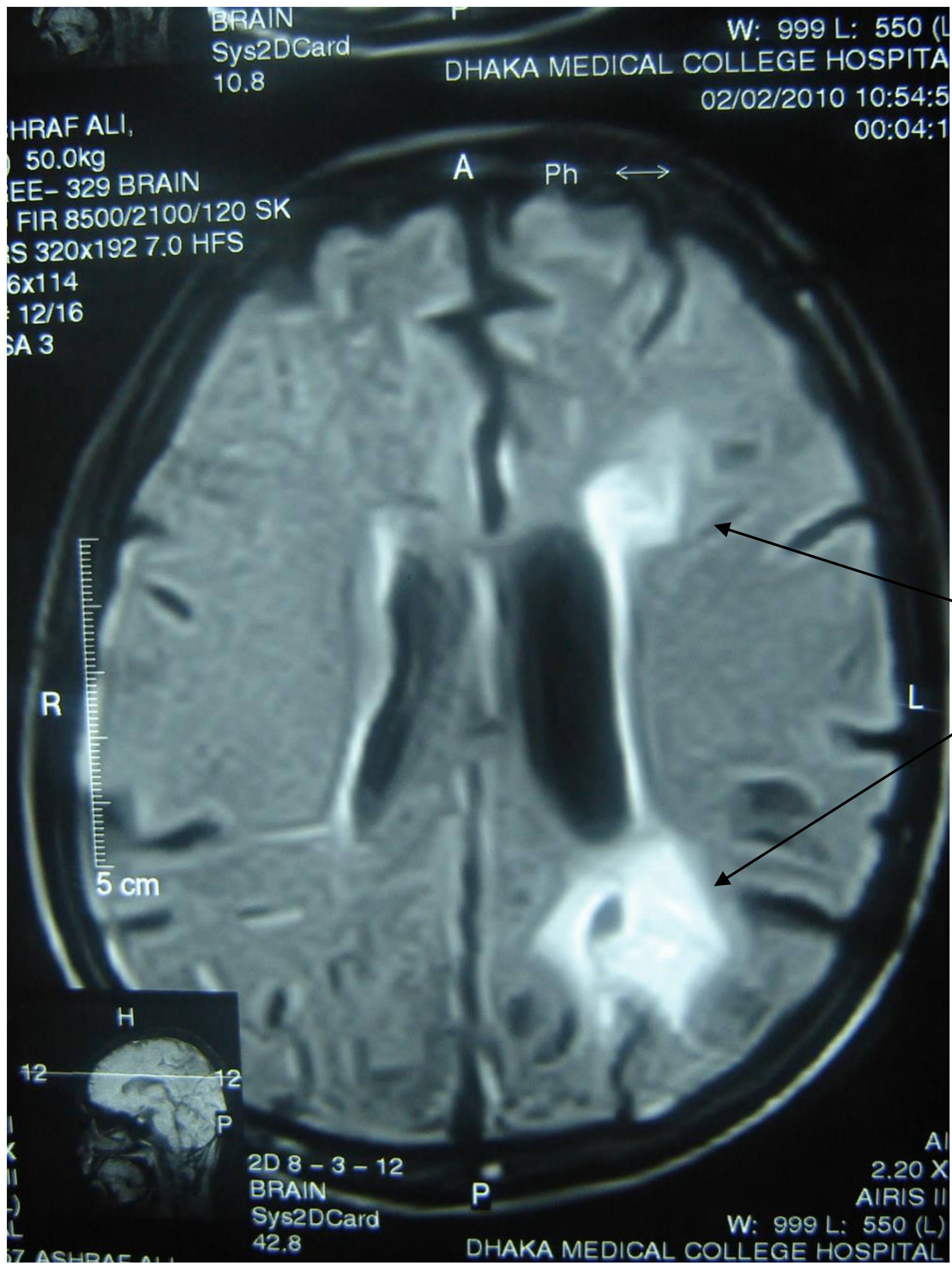
Rectal Ulcer

- Bone marrow - Normal
- MRI brain – left cerebral infarct, right cerebellar infarct, white matter ischaemic change, generalized cortical atrophy

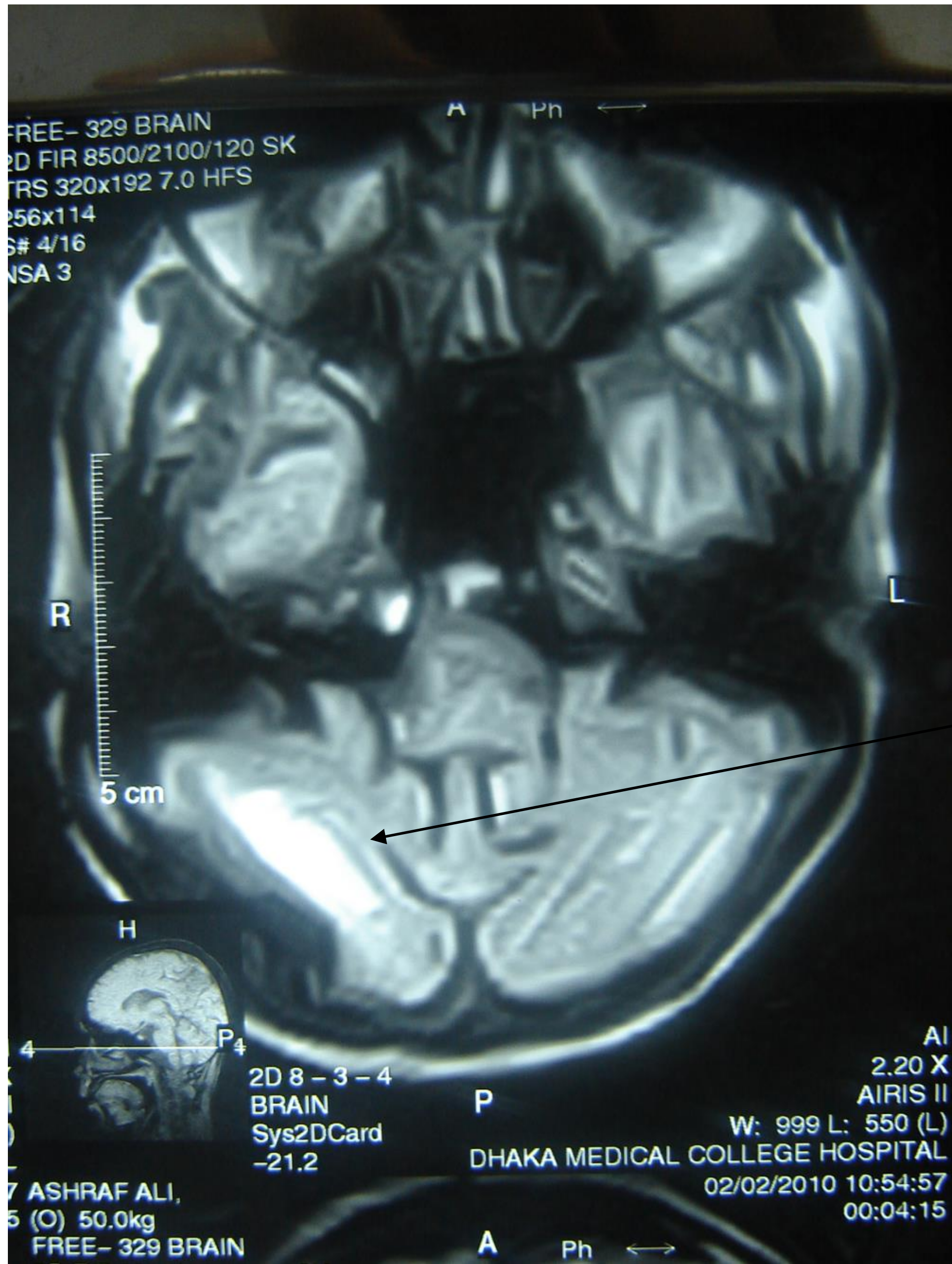
- NCV/EMG – Mild demyelination of both peroneal nerves

Supplementary Investigation:

- S Vit B12 – 227 pg/ml (Normal: 243-894)
- S Cortisol – 28.70 micro gram/dl (Normal: 4.2-38.4)
- HIV screening test – Non reactive
- VDRL – Non reactive
- TPHA – Negative
- Thyroid Function Test – Normal
- Nail and skin sample – sent to Atomic Energy commission, report pending



Left Cerebral Infarct



Right Cerebellar Infarct

Definitive Diagnosis

Thanks to All