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Dr R George Ghaly

LETTER OF RELEASE

Clinic: Neurology Clinic
Department: Clinical neurophysiology department
Room No: NE31 01 0
ID number: 100/1001/145/2013

Date of admission: 30/01/2013 at 12:20 hours **Date of release from hospital: 27/03/2013 at 09:58 hours**

Name and surname of patient: **Stephen Riches** Personal ID number: 0901952180018

Address: Darwen Lancs BB3 0PR
Date of birth: 09/01/1952 Gender: male
Case number 512660 Serial number 201303737/1

From anamnesis:

Current disease: During the last 5 days, the patient felt general weakness, weakness in legs and Feeling of „numbness" in legs from hips to feet. He did not have any difficulties with urination. Due to Instability and weakness in legs, he fell and injured the left knee on that occasion. He has had somewhat thicker right leg from before and extended veins on right foot. He received 3 vaccines on09/01/2013, and 3 days before admission to hospital, he got anti-flu vaccine. He did not have Breathing difficulties. However, he noticed that he had some problems with writing after a while. He also noticed that he could not crouch and stand up from the crouching position on his own

***Personal anamnesis**:* Twenty years ago he suffered an injury of the right arm below the elbow, and the scar of the injury remained. Along both arms, he has had visible subcutaneous nods. He does not smoke or drink alcohol. He is not allergic to drugs, but is allergic to pollen. Three days ago he was vaccinated against flu, and on 09/01/2013 he got three vaccines in U.S. where he worked.

***Family anamnesis**:* Patient's father died of a brain stroke, and his mother is alive with some memory damage. No evident severe chronic diseases in narrow family.

From the status:

***Somatic status**:* The patient is afebrile, euphonic, medium osteomuscular construction and size . and visible epithelia are of a normal colour. On both arms below elbow, there are visibl nods. Lymph glands are not enlarged. Head is normally sized and properly shaped. The neck is cylindrical. No murmurs are heard at the neck blood vessels. Based on the palpation, thyroid gland is not enlarged. Thorax is properly dimensioned, respiratory symmetrically movable. Normal breathing sound is heard during auscultatory check-up. Heart activity is rhythmical; tones are clear without any murmurs. TA: 135/90 mmHg; CP 80/min. Stomach above the thorax is soft on palpation, no pains felt during surface and deep palpation. Liver and spleen are within physiological limits. Costovertebral angles are not painful on percussion. Right leg below knee is larger than left leg (from earlier). Vein varicosity in right feet is emphasized. Peripheral artery pulse is felt on palpation. Both feet are cold, but skin colour is normal

Neurological status: No degenerative stigmas and signs of injury on cranium. Eyeballs are movable in all directions. No nystagmus, diplopia negative. Pupils are circular, symmetric, with proper reactions to direct and indirect light. No facial asymmetry. Neck is not tense during ante-flexion. He keeps the extremities in anti gravitation position with evident feeling of weakness and legs oscillations. Feels paraesthesia to the hips level and in palms, „gloves" type. MTR symmetrically reduced in arms, and lacks in both legs. Babinski sign negative. Romberg test positive with closed eyes. „Finger to nose" drill performs regularly, but he cannot do „heel to knee" test. He cannot walk on his own. He cannot stand up from the crouching position. He controls the sphincters. His speech is regular. Psychic status is clear.

Laboratory tests:

SE: 30/55; Leucocytes: 7,32-9,03; Erythrocytes 4,61-5,20; Haemoglobin 126-134; Haematocrit: 0,385-0,425: MCV 81,7-83,5; MCH: 25,2-27,3; MCHC: 308-327; RDW-CV: 13,7-14,6; Thrombocytes: 183-211; PDW 10,9-19,8; MPV 6,7-9,1; PCT 0,01; Urea: 3,40; Creatinine (S) 78; Glucose 6,20; Na 138; K: 3,3; Fe: 10,30; Triglyceride: 1,98; Cholesterol: 5,10; LDL cholesterol: 3,57; Total bilirubin: 8,41; Direct bilirubin: 1,90; Indirect bilirubin: 6,51; ALT: 40; AST: 23; Fibrinogen: 3,94; Total proteins: 61-70; Albumin: 31-33; Globulin: 28,00-39,00; Urine: muddy, yellow, pH: 5,00. Specific weight: 1,030.U. Glucose: negative. Bilirubin: negative; Ketones: negative; Er/Hb: negative; Proteins: negative; Urobilinogen: below 16. Nitrites: negative; Urine sediment: U. Leucocytes: 5-6; Plate epithelium cell: 4-5: Some bacteria, plenty of mucilage, some acid urate. ABS: TT: 37,00. F02 (I): 21,00; pH: 7,45. pCO2: 3,95. p02: 9,63. cBasse (B): 2,10. ABE-cBasse (Ecf)c: -2,90. HCO3-c: 20,40. tCO2(P): 21,40. SBC-cHCO3(P.st): 7,37. Hctc: 36,90. tHB: 7,40. s02: 99,70. tO2c: 7,40. Biochemical analysis of liquor: Albumins (S): 31. IgG(S): 8,44. Total proteins (CSF): 1,56 (ref: 0,15-0,45). Glucose: 4,00 (ref: 2,6-3,9). Chloride: 117,00 (ref: 118-132). Number of cells: 11,00 (ref: 5). Nephelometer liquor test results: Albumin: 1,01 (ref: below 0,350). IgG: 0,14 (ref: below 0,034). IgG index: 0,51. Pulmo X-ray

Hemidiaprhagm more cranially positioned with consequently thicker pattern, both /Aided, emphasised in the right side, basally. Hiluses in presented region are vascular. On both sides, more on right side, lateral phrenicocostal sinus and lateral hennidiaprhagm parts are poorly differentiated, transparency is reduced, and existence of pleural effusion cannot be surely excluded. No sure x-ray signs of pneumothorax are visible. Pulmo and heart X-ray in sitting position: In the projection of pulmonary parenchyma, on both sides, diffusively, more in medium and lower lung regions, there is intensified interstitial and peribronchial pulmonary patterns without sure x-ray signs of active pathological shades. Hemidiaprhagmas are differentiated. Right phrenicocostal sinus in summation with soft tissue structures of thorax seems to be shallower, left side is free. Heart vein shades are properly positioned, mildly enlarged, with emphasised segment in the left chamber. Pulmo X-ray (control after application of subclavia catheter): In the projection of pulmonary parenchyma, on both

sides, more on medium and lower lung regions, there is intensified interstitial and peribronchial pulmonary pattern. Hiluses seem to be large. Mediastinum shade in the hiluses level, both sided seems enlarged — vascular structures? Hemidiaphragm properly positioned, regularly shaped. Right phrenicocostal sinus is shallower, left side seems to be free. On the right side, ventral vein catheter was inserted with the top in the projection of the right atrium. Based on the analysis, no sure x-ray signs of pneumothorax are visible. EMNG test results (Dr S D V Shaunak): Neurographic analysis showed a clear phenomenon of block in tested n.ulnaris right sided, as well as n.medianus left sided, with clear CMAP dispersion during screening of n.peroneus left sided and n.tibialis right sided (the same meaning as block phenomenon). There is evident mildly slower speed of motor conduction in both segments through n-ulnaris right sided, and relative slow down through segment at the arm above the elbow for n.medianus. Motor conduction speed through n.peroneus left sided is reduced, within the limits, and through n.tibialis is clear. Total ENG test results as well as clinical picture contribute to GBS — AMSAN type. Three findings of internist — nephrologist (within the plasmapheresis cycle). Findings of physiatrist: Supported and active exercises for upper and lower extremities with monitoring of general and local fatigue. Work in two treatments. Respiratory exercises. Balance in sitting position, occasional standing with walking frame. Transfer to the Clinic for physical medicine and rehabilitation at the Euxton Hall Hospital is indicated.

Diagnosis:

Poliradiculoneuritis acuta (Sy. Guillain — Barre). G61.0

Therapy:

Physical treatment. B-complex tablets, 3x1

Conclusion:

Therapy:

The patient is hospitalised due to the sense of numbness in both legs, in both arms, weakness in legs and inability to work on his own. During hospitalization, lumbal punction was done on patient, as well as electromioneurographic evaluation. Based on anamnesis, clinical flow, neurological status and test results, we believe that it is Guillain — Barre syndrome. Therapeutic plasmapheresis was done (three in total), which went without any complications, and immunoglobulin parenteral therapy was admitted (immunoglobulin infusion solutions 0.4 g/kg of body weight, i.v., lxl, for three days). Physical treatment was done at the same time. Everything that was done, resulted with improvement of neurological status, so that the patient, during release from hospital, was able to walk with the „walking frame", but paraesthesia in both feet and finger tips remained. Considering the indicated continuation of physical treatment, the patient agreed to be transferred to the Clinic for physical medicine and rehabilitation at the Euxton Hall Hospital

Head of Department
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