A Mysterious Squeezing Pain
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BACKGROUND
• Neuromyelitis optica (NMO) is an idiopathic, inflammatory demyelination disease of the central nervous system that causes severe optic neuritis and myelitis attacks
• Acute optic neuritis may be the first sign of multiple sclerosis (MS), but also of neuromyelitis optica
• Early diagnosis and distinction between MS and NMO is critical to facilitate correct treatment and prevention of future episodes
• There is a known association between Aquaporin 4 seropositivity and neuromyelitis optica1

CASE
• 46-yo female with a history of unilateral optic neuritis over 20 years prior without residual visual deficit presented with one week of increasing neurological symptoms
• She presented at outside hospital 1 week prior to this admission with episodic pain and band-like tightness around her chest, was diagnosed with biliary colic, and had laparoscopic cholecystectomy
• Postoperatively, she developed paresthesias from mid-chest to bilateral legs and feet, urinary retention, and increasing impairment of bilateral lower extremity coordination.
• She was initially treated with empiric antiviral and antibacterial agents as well as high-dose IV steroids
• An extended CSF infectious panel by PCR was negative and all antimicrobial medications were discontinued
• T-Spine MRI showed abnormal T2 signal in the thoracic spine with small T10 disc protrusion and diffuse thoracic myelopathy which suggested a diagnosis of neuromyelitis optica2.

RESULTS

<table>
<thead>
<tr>
<th>Cerebrospinal fluid</th>
<th>Reference</th>
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<tbody>
<tr>
<td>WBC 124 cells/mm³</td>
<td>*</td>
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<tr>
<td>Neutrophils 66%</td>
<td>*</td>
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<tr>
<td>Lymphocytes 30%</td>
<td>*</td>
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<tr>
<td>Protein 167 (H) mg/dL 15-30 mg/dL</td>
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<tr>
<td>Glucose 71 mg/dL 40-80 mg/dL</td>
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<tr>
<td>Myelin basic protein &gt;112.5 (H) ng/mL 0-1.2 ng/mL</td>
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<tr>
<td>Oligoclonal bands 8</td>
<td>*</td>
</tr>
<tr>
<td>IgG 185 (H) mg/L 10-30 mg/L</td>
<td></td>
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<tr>
<td>M/E PCR panel*</td>
<td>Negative</td>
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</tbody>
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CASE CONTINUED
• She had minimal improvement with steroids so she underwent several rounds of plasma exchange for a presumed diagnosis of NMO. She had minor improvement during her hospitalization.
• Her serum aquaporin-4 antibody was positive confirming the diagnosis of neuromyelitis optica.
• 3 years later the patient has near complete motor function and moderately improved sensory function.
• She remains on maintenance regimen of rituximab every 6 months with intermittent steroids for disease flares

KEY POINTS
• It is important to have high clinical suspicion of autoimmune neurological diseases in patients with even a remote history of optic neuritis. MRI can be used to quickly differentiate between NMO and MS, leading to expedited treatment of acute episodes.
• It is reasonable to test all patients with a history of optic neuritis for AQ4-Ab as the diagnosis of NMO leads to different maintenance and suppressive therapy than multiple sclerosis. The consequences of an acute flare can lead to significant morbidity, including permanent neurological disability.
• Aquaporin-4 antibody seropositivity in patients with a history of uncomplicated monocular optic neuritis has been shown to correlate with increased severity of optic neuritis episodes and future development of NMO. There was no increased risk of development of multiple sclerosis.1

REFERENCES

UMMS-Baystate Research & Education: Together we advance the state of caring through discovery & innovation
The Case of the Stiff Man
Ritika Walia, MD and Cortney Haynes, MD

Introduction

• Stiff Person Syndrome (SPS) is a rare neurological entity characterized by progressive muscle rigidity and painful spasms

• Epidemiology: SPS has a prevalence of 1 case per 1 million individuals, with a 2:1 female:male predominance

• Here, we present a male patient in whom symptoms began in a single extremity and rapidly generalized

Case Presentation

HPI

59 yo M presented to his physician complaining of right ankle pain and stiffness

Over the next 8 months, symptoms spread to involve both legs and the lower back

Associated symptoms included dyspnea and unintentional weight loss; ROS otherwise negative

PMH

Vitiligo, benign prostatic hypertrophy, hypertension

Up to date on all age-appropriate cancer screenings

Exam

Marked stiffness in the ankle, thighs, and lower back joints

Severe pain with movement

Diminished strength in the bilateral lower extremities

Positive Hoffman’s sign on the left foot

MRI

Mild degenerative changes

GAD65 antibodies present in high titers

Started on high dose diazepam and referred to a movement disorders specialist

Discussion

• SPS is characterized by excessive firing of motor neurons and simultaneous sustained contraction of agonist and antagonist muscles

• The classic subtype manifests in the axial and proximal limb muscles, whereas distal-limb predominant symptoms are seen in the partial subtype. Less than 2% of SPS cases are paraneoplastic

• Antibodies against glutamic acid decarboxylase (GAD65) are found in 80% of patients with classic SPS; lead to disinhibition of the GABA pathway

• Typically treated with high dose benzodiazepines and IV Ig

• Depression, anxiety, and agoraphobia are common

Conclusions

• While rare, SPS is important to consider in the differential for muscle stiffness and frequent spasms

• This patient displayed characteristics of both classic and partial SPS, along with history concerning for the paraneoplastic variant

• The psychological manifestations of rapid functional decline reflect a significant component of the burden of this disorder

References


INTRODUCTION

1. Gallstones is a common cause of abdominal pain in adults but uncommonly seen in pediatrics
2. There are specific conditions that can precipitate gallstone formation in children
3. Management depends on underlying pathology

CASE PRESENTATION

• 4-year-old girl with a one-year history of constipation and failure to thrive followed by gastroenterology, presented to the ED with sudden onset abdominal pain.
• Initial workup ruled out intussusception, ovarian torsion and appendicitis and patient was discharged.
• Returned three days later with unresolved worsening sharp abdominal pain and new onset non-bloody non-bilious vomiting, scleral icterus and pale stools.
• Review of systems was negative for fevers, upper respiratory infection symptoms, diarrhea, myalgias, cough and recent weight loss.
• Stable vital signs without fever. Physical exam revealed an ill appearing child who was uncomfortable. Pertinent findings included a soft non-distended abdomen, active bowel sounds, and generalized abdominal pain on superficial and deep palpation without rebound.
• Right upper quadrant ultrasound revealed diffuse fatty infiltration of the liver, common bile duct at 6mm with trace nonspecific peripheatic ascites.
• Lab values were significant for ALT/AST of 201/76, lipase of 34, alkaline phosphatase of 309, total bilirubin of 3.8 with direct bilirubin of 2.7, and GGTP of 121. PT, CBC and electrolytes were all within normal range.
• Patient admitted for further management.
• MRCP showed dilated common bile duct at 11mm, biliary sludge and two stones.
• Then underwent stone removal via ERCP without sphincterotomy. After removal of biliary sludge and 2 stones, her clinical symptoms improved, she was pain free with no jaundice or acholic stools and she was discharged home with GI follow up.

CONCLUSIONS

Gallstones are an uncommon cause of abdominal pain in pediatric patients. Risk factors for gallstone in children include family history, obesity, type 2 diabetes, female gender, and underlying disease. ERCP, though uncommon in pediatrics, may be successfully used to manage gallstones in children with an experienced operator.

REFERENCES

• Gurauskis, S. Choledolithiasis and Choledocholithiasis. Pediatrics in Review. Sep 2009, 30 (9) 368-369; doi: 10.1542/pir.30-9-368

Figure 1: ERCP showing common bile duct dilation
Figure 2: ERCP after papillotomy showing reduced common bile duct dilation