Journal of Neuroinfectious Diseases

28th World Congress on
Neurology and Neurodisorders
September 26-27, Rome, Italy

ISSN: 2314-7326

Volume 13 | ISSUE 2

Abstract (600 word limits)

Subacute proximal myopathy - A rare presentation of Crohns disease

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Muscle diseases can constitute a large variety of both acquired and hereditary disorders. Myopathies in systemic disease results from several different disease processes including endocrine, inflammatory, paraneoplastic, infectious, drug- and toxin-induced, critical illness myopathy, metabolic, and myopathies with other systemic disorders. Patients with systemic myopathies often have an acute or subacute presentation. While dealing with myopathies associated with systemic illnesses, the focus should be on the acquired causes. Prognosis is based upon the underlying cause and most of the time, carries a good prognosis. We report this case because of the rarity of presentation, proximal myopathy as the presenting symptom of crohns disease.

Case report

Our patient, a 20 year old girl, presented to us with complaints of aches and pains of all four limbs of 18 months. 6 months later she started developing thigh cramps and progressive weakness predominantly of lower limbs. A detailed history revealed anorexia, weight loss of 15 months and a history of delayed menarche. On examination, she was malnourished and had pallor. Her general examination showed angular cheilitis and bitots spot. Neurological examination showed pure motor, symmetrical proximal muscle weakness of both lower limbs. There was no wasting or fasciculations. All deep tendon reflexes were normal. Initial differential diagnosis included chronic infection associated myopathy, nutritional myopathy – secondary to malabsorption syndrome and inflammatory myopathy. On investigating, the blood showed low Hemoglobin (7.5gm/dl) with low MCV, ferritin and peripheral smear suggestive of iron deficiency anemia, mild elevation CPK (540). Other metabolic workup showed low ionized calcium and phosphorus with a high alkaline phosphatase level of 516. Viral markers screening, chest Xray, USG abdomen and endocrinology workup for thyroid, parathyroid, pituitory were negative. Vitamin D level was very low (less than 3ng/ml). A possibility of osteomalacic myopathy due to vitamin D deficiency was considered and correction was given. With high dose vitamin D3 replacement (60000 units daily for 10 days) she started showing response and her cramps and pain got reduced and she was able to walk independently without any support by 2nd week of starting treatment. A diagnosis of osteomalacic myopathy was made and weekly vitamin D was given. Malabsorption work up including stool routine was negative. A colonoscopy done showed mildly edematous caecal mucosa and few aphthous ulcers in terminal ileum. However a biopsy was taken from the same showed non-caseating granulomatous inflammation consistent with Crohn's disease. She was planned for a muscle biopsy to look for ANCA positive immune vasculitis causing subacute myopathy, but was refused by bystanders. She was started on definitive treatment for crohns disease (budesonide and salisylate and was asymptomatic at 6 months follow up with no residual neurological deficits.

Discussion

Biography

Dr Sabu completed his MBBS from JMMC of Calicut university kerala and then did DNB from national board of examination. He is a member of the national academy of medical sciences and had done DCH from KUHS. He is currently working as a senior resident in neurology. He has got 2 publications and has presented posters in various international conferences.

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