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Case Report

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Unsual Cidp Presentation

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1. Case Report

67-year-old male with a history of CAD, HTN, ITP & total splenectomy, presented with complaints of progressive weakness over a 4 months period. In January 2022, Patient presented with a new onset of distal limb swelling & diplopia, which occurred as he woke up from sleep and progressed in an ascending pattern to bulbar weakness, facial diaphoresis & diffuse quadriparesis. Physical Exam revealed cranial neuropathies, diffuse numbness, weakness, & decreased reflexes. He was discharged after achieving partial improvement. Patient presented again in April 2022 with complaints of significant weakness extremities, inability to grip objects as well as inability to transfer independently [1].

2. Physical Examination

Patient is alert, oriented to person, place, time and situation, follows commands. Cranial Nerve exam grossly intact.

2.1. Motor

Diffusely decreased tone bilaterally in upper and lower extremities. Extremities of patient could move against gravity but not against resistance.

2.2. Sensory

Revealed normal light touch sense except symmetric decrease in temperature sense below mid-thigh, and no vibration senses below patellae.

2.3. Labs

Serologic testing including VDRL, flow cytometry, HIV, GM1 autoantibody, Cryoglobulin, B12,
folate, TSH, Immunofixation, IgG4 subclass and VEGF all were unremarkable, CSF glucose 61.

2.4. Imaging

• **Non-Contrast head CT:** No evidence of acute intracranial abnormality,
• **MRI (cervical):** Degenerative disc disease, bulging of disc and mild focal myelopathic-cord changes at C6.
• **MRI (Thoracic and lumbosacral spine) :** Normal.
• **Cardiac PET** Diffuse LAD.

3. AMB Electromyography with Nerve Conduction

Motor nerve conduction of right median nerve showed severely prolonged distal latency, severely reduced amplitude with significant dispersion. No CMAP was obtained with cubital fossa stimulation.

4. Discussion

Chronic inflammatory demyelinating polyneuropathy (CIDP) is an immune-mediated neuropathy leading to a variety of motor and sensory deficits. In CIDP motor impairment is more prominent than sensory and involves gradual and symmetric loss of distal and proximal motor function [2].

The pathophysiology of CIDP is idiopathic & involves an autoimmune process that can lead to
activation of a T-cell-mediated immune response directed against myelin sheath.

5. Assessment of the Case

Due to similarities of CIDP with other neuropathies, this case report points out importance of developing standard criteria for prompt diagnosis and treatment of this disease. History of progressive weakness and all positive findings were consistent with sensorimotor CIDP; patient was started on IVIG for 3 days monthly. Prednisone 60 mg daily was planned if deterioration occurred. Rituxan initiation was discussed with patient.

References

1. Lehmann, H. C., Burke, D., & Kuwabara, S. (2019). Chronic inflammatory demyelinating polyneuropathy: update on diagnosis, immunopathogenesis and treatment. *Journal of Neurology, Neurosurgery & Psychiatry, 90*(9), 981-987.
2. Dyck, P. J., Lais, A. C., Ohta, M., Bastron, J. A., Okazaki, H., & Groover, R. V. (1975, November). Chronic inflammatory polyradiculoneuropathy. In *Mayo Clinic Proceedings* (Vol. 50, No. 11, pp. 621-637).