Department Of Neurology
National Institute of Mental Health and Neuro Sciences,Hosur Road, Bengaluru,560029

DISCHARGE SUMMARY

UHID :	20220091214	**MRD No:**	N998169
Name:	Mr. MD TAWHID HASSAN	**Department:**	Neurology
Age/Sex:	5 years 20 days / Male	**Unit:**	N III
Ward Name:	Peadiatric Neurology Ward - NEUROCENTER	**Name Of the Doctors:**	Dr. Sanjib Sinha - Professor and Unit Head Dr. Madhu N - Additional Professor Dr. Seshagiri D V - Assistant Professor Dr. Viswanathan L G - Assistant Professor
Admission Id:	202212768		
Date of Admission:	16/08/2022 12:03:00 PM		
Discharge Summary Preparation Date:	30/08/2022 06:03:46 PM		
Discharge Date:			
Discharge Type :	Regular Discharge		

Diagnosis	**ICD Code**
Multifocal motor neuropathy with conduction block	Description-

History

This 5-year-old boy from Bangladesh presented with the chief complaints of
1) Weakness of right hand- 2.5 years
2) Weakness of right leg- 1.5f years
3) Weakness of left hand- 1 year

This patient was apparently alright till 2.5 years back when he developed weakness of the right hand in the form of difficulty in gripping objects and mixing food. The food used to slip in between the fingers while eating. However, there was no history suggestive of proximal muscle weakness of the right upper limb. Subsequently, since 1.5 years, he developed weakness of the right foot and difficulty in gripping footwear. For the last one year, he was noted to have mild weakness of the left hand in the form of inability to extend the fingers. For last few months he required support to get up from floor and climbing up and down stairs. All these symptoms were progressive in nature.
There was no history suggestive of craniobulbar symptoms, positive or negative sensory symptoms, bowel-bladder dysfunction, behavioural changes or seizures. There were no systemic comorbidities.
He was born to non-consanguineous parents and developmental milestones were normal.

Past history: Nil significant.
Treatment history: He was prescribed oral deflazacort (12 mg, per day) at another centre since 2 months. There was no improvement noted.

Perinatal history and devlopmenatal history were normal.

Examination

The patient was conscious and cooperative. He was thin built. Vitals were stable. General physical examination did not reveal any neurocutaneous markers.
Anthropometry: head circumference = 48 cm, height = 112 cm and weight = 15 kg
Neurological examination: Cranial nerve examination was normal. There was mild atrophy of right thenar and hypothenar eminence. Hypotonia of all four limbs was noted. There was asymmetrical weakness of distal limbs. Muscle stretch reflexes were absent except for triceps jerk bilaterally and left ankle jerk which were normal. Sensory system examination was normal. There were no cerebellar signs. Plantar was bilaterally flexor. Skull and spine were normal.

Investigations