

A Rare Case Report On Miller Fisher Syndrome Emphasizing Clinical Feathers And Focused Diagnosis

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Abstract: *Miller Fisher syndrome(MFS) is a likely variant of Guillain-Barre syndrome(GBS). Here, we present a case with peculiar demonstration of MFS as per the patient was found to have areflexia, ptosis left right distal with absent positional, vibration sense and positive Romberg's signs. There was history of pricking sensation in both Upper limb/Lower limb and swaying while walking, more towards the right. It was concluded as MFS from the clinical reports and the history taken. The infirm was started on methylprednisolone 1gm was given for 5 days followed by tapering dose of oral steroids along with Physiotherapy. Patient improved during the course in hospital and became stable. This event, point out the facts of a atypical disorder, which able us to limit the discrepancies to work out rapidly and properly handle such infirm. The anti GQ1b immunoglobulinG antibody is a definite marker of Miller Fisher syndrome, thus helps in the diagnosis of MFS. This moreover shows the importance of taking the history and medical assessment.*

Keywords: *Areflexia; Ataxia; Guillain-barré; Miller fisher syndrome; Ophthalmoplegia; Parasthesia; Ptosis; syndrome.*

INTRODUCTION

Miller Fisher syndrome is a variable, atypical neurological syndrome that is considered to be an another version of Guillain-Barré syndrome(GBS).It was named after Dr.C.Miller Fisher in 1956 as a limited variant of ascending paralysis. It's described by means of irregular muscle coordination, numbness of the eye muscles, and lack of the tendon reflexes. Patients who progress Miller Fisher syndrome commonly have a sudden onset of ataxia, lack of reflex and ophthalmoplegia,which is generally headed by a viral illness. .Other symptoms include general muscle faintness and dyspnea(Bukhari et al.,2017).

CASE REPORT

56year old lady with no known co-morbidities came with history of fever 2 weeks back which subsided after 4 days following which she developed paresthesia of both upper limb over palms and lower limbs over the foot associated with pain since the past 2 weeks. The pain ascended to involve both upperlimb/Lowerlimb. No history of decreased sensation. History of pricking sensation in both Upper Limb and Lower Limb and swaying while walking, more towards the right. The swaying is more at night. She also has a cottonwool

sensation on walking. Patient also gives history of drooping of left eyelid since last 2 weeks. On examination, patient was found to have areflexia, ptosis left right distal with absent positional, vibration sense and positive Romberg's signs. Patient was admitted for further evaluation. Based on the above reports and clinical examination, it was diagnosed as Miller Fisher Syndrome. An Nerve conduction Velocity (NCV) was done which showed absent H reflex with right S1 radiculopathy. RNS was negative. An MRI brain was done in view of ophthalmoparesis which was found to be normal. Patient was started on MethylPrednisolone 1 gm was given for 5 days followed by tapering dose of oral steroids. Patient improved during the course in hospital. Physiotherapy was initiated and the same was continued. At the time of discharge, patient became stable, numbness persist and can walk by herself without support.

DISCUSSION

MFS is a self-limiting disorder and steady progress points its renewal phase as well as the strength of indications shown. MFS usually begins with acute neurological signs for about 8–10 days (range of 1–30), subsequent to the precursor ailment. Then the complaint develops till a clinical base is accomplished within a period of around 2–21 days, next to the primary neurological indications (Chang Cj et al., 2016). Hardly, severe difficulties such as irregular heartbeat or dyspnoea have been announced. Ataxia and ophthalmoplegia usually diminishes in one to three months after the initiation of illness, and almost the overall rehabilitation is probable in six months. Although areflexia may possibly stay, it won't affect the functional ability (Gopinath S et al., 2017).

It has been found that numerous MFS patients keep on getting the protuberant, extensive faintness of GBS. Neurological debit of MFS patient usually start with external ophthalmodynia triggering visual impairment eventually leading to double vision.

The main indicative symptom of MFS is bilateral ophthalmoplegia (Boycer et al., 2007), which is also seen in this patient, where the patient shows a history of drooping of left eyelid together with paresthesia.

About one to five percent of all GBS cases in Western countries are reported as MFS, but only 19% and 25% in eastern countries like Taiwan and Japan respectively (Bukhari et al., 2017). Women get leastly affected than men. It affects people of all ages, with a mean age of 43.6 years. Diplopia (78%), ataxia (48%) or both (34%) are the main features usually seen in them. Rarely seen signs include limb dysesthesia, low-lying upper eyelid margin, bulbar, and pupillary palsies; motor weakness; and disturbance while micturition. Along with these clinical signs, about 56–76% of the patients shows upper respiratory tract infection.

By taking correct clinical history, basic symptoms, typical results on CT or MRI, along with manifestation of albuminocytologic dissociation in the CSF, MFS can be diagnosed. One of the definite marker of Miller Fisher syndrome is antiGQ1b immunoglobulinG antibody (Kusunoki S et al., 2003). Immunomodulatory therapies involving intravenous immune globulin and plasmapheresis have been carried out to treat the patients even though MFS is a self-limiting disorder (Rajendran S et al., 2015).

CONCLUSION

The Miller Fisher syndrome is an idiopathic disease presenting the symptoms of motor ataxia, absence of reflex and drooping of eyelids, which is typically headed by a viral infection. It occurs most frequently in the fifth decade of life and affects men twice as often as women. The diagnosis of Miller Fisher syndrome ought to be limited to patients with ataxia, areflexia and ophthalmoplegia and no other neurological signs. Besides, cerebrospinal fluid analysis, magnetic resonance imaging appears to be the mandatory test to confirm diagnosis. This case highlights the atypical exhibition of MFS as patient was found to have areflexia, ptosis left right distal with absent positional, vibration sense and positive Romberg's signs. It also

shows the significance of knowing the past history and medical investigation in order to reduce the discrepancies to perform rapidly and properly handle the patients.

DECLARATION OF CONFLICT OF INTERESTS

The authors declare that there is no conflict of interests

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