Massachusetts Neurologic Association

March 25, 2017

CALL FOR ABSTRACTS

Deadline for submission: January 31st, 2017

Submit to: mna@mms.org

The Poster Presentation Session at the MNA Spring Meeting aspires to allow residents and fellows in training to present their research or interesting cases in a poster session. Please follow the following abstract guidelines:

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Title: Miller Fisher Syndrome Preceded by Streptococcal Pharyngitis and Polymyalgia Successfully Treated with Plasmapheresis

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Abstract:
Miller-Fisher variant of Guillain-Barre syndrome (GBS) is a rare post-infectious, self-limited, immune mediated neuropathy that typically presents with the triad of ataxia, areflexia, and ophthalmoplegia. Its incidence is not exactly known, but it is estimated that it accounts for approximately 5% of GBS cases worldwide. This case presents a 39-year-old Hispanic male who presented to Boston Medical Center with a 24-hour history of headache, ataxia, and diplopia. The patient had been diagnosed with streptococcal pharyngitis and was started on a course of penicillin at an outside hospital 2 days prior to admission and had been evaluated for migrating polymyalgia a month prior. During the first 24 hours of admission, he developed paresthesias, pain, diminished deep tendon reflexes, dysarthria, dysphagia, rapidly progressing diffuse motor weakness, and dysautonomic features and was clinically diagnosed with Miller-Fisher variant of GBS. The next day, he subsequently developed rapidly progressive bulbar weakness, acral paresthesias, and a tenuous respiratory status and was transferred to the neurocritical care unit for monitoring of neurologic function and airway integrity. Cerebrospinal fluid analysis showed cytoalbuminologic dissociation. MRI/MRA head and neck and MRI of the cervical spine with gadolinium did not show evidence of demyelinating disease. Electromyogram and nerve conduction studies were concerning for primary demyelinating polyneuropathy. Given the history of migrating polymyalgia, extensive rheumatologic and infectious work up was done which showed no evidence of

rheumatologic or infectious disease. The rapid decline of the neurological exam prompted the initiation of 5 courses of plasmapheresis on hospital day 3. Ataxia and dysmetria were improved and he was discharged to rehabilitation. The patient's neurological exam was back to return to baseline with the exception of mild left facial nerve weakness 2 months after discharge.