Case report:

Myalgia case with unique features

Dr Rajsinh Patil , Dr Satbir Malik , Dr Varsha Bhatt

Department of Medicine, P.Dr D Y Patil Medical College and Hospital , Pimpri , Pune , Maharashtra , India
Corresponding author: Dr Rajsinh Patil

Abstract:

Myalgia, or muscle pain, is a symptom of many diseases and disorders. The most common causes are the overuse or over-stretching of a muscle or group of muscles.Herewith we reported a case of 23 years old female residing at Miraj, Dist-Sangli, Student By OccupationAND unmarried came with Complaints of Bilateral Lower Limb Pain since 6 months , difficulty in sitting and getting up from squatting position since 6 months , tingling in the left hand since 2 months and nasal Regurgitation and nasal intonation of voice since 15 days before admission.

Keywords : myelgia

Background:

Myalgia, or muscle pain, is a symptom of many diseases and disorders. The most common causes are the overuse or over-stretching of a muscle or group of muscles. [1]Myalgia without a traumatic history is often due to viral infections. Longer-term myalgias may be indicative of a metabolic myopathy, some nutritional deficiencies or chronic fatigue syndrome.[2]

Case report:

A 23 years old female residing at Miraj, Dist-Sangli, Student By OccupationAND unmarried came with Complaints of Bilateral Lower Limb Pain since 6 months , difficulty in sitting and getting up from squatting position since 6 months , tingling in the left hand since 2 months and nasal Regurgitation and nasal intonation of voice since 15 days before admission. History Of Presenting Illness noted a patient was asymptomatic 6 months back when she noticed . Difficulty in sitting and getting up from squatting position while doing day to day activities like sitting on the floor while eating ,washing clothes and utensils and during defecation.Gradually since 2 months she avoided sitting, squatting and uses the chair mostly.Difficulty is the same throughout the day, there is no diurnal variation.

She also gave history of Bilateral lower limb pain confined to thigh and calf muscles since 6 months.Pain was dull aching , generalised and uniform throughout the day aggravated by movements, increased recently since 2 months. She gave history of tingling in the lateral aspect of the left hand, on extensor aspect since 2 month.

She also gave history of nasal regurgitation for liquids and difficulty in swallowing food and water since 15 days.She had developed nasal twang ,which was sudden in onset 15 days back and increased within 15 days.

No history of difficulty in eating, writing, sewing , No history slipping of Chappals , No history of twitching , No history of ptosis and diplopia, difficulty in chewing , No history of numbness, repeated burns and injuries, fall in the dark , No history of Seizure, loss of consciousness , No history of Urinary incontinence, retention , No history of

prolonged drug intake, prolonged fever , No history of photosensitivity, mood disorder, weight loss

Past History

No similar complaints in past.

Menstrual History - Normal monthly cycle, no menorrhagia or oligomennorhea.

Birth History/Developmental History

General Examination

a) Thin built, Wt:32 kg, Ht:150 cm,BMI:14.22

b)Vitals - normal limits.

c) Mild pallor.

d) Peripheral pulses normal, no thickened nerves

e) No skin rash or ulcer.

Systemic Examination:

a) Higher mental function:

1) Conscious, oriented to time, place and person.

2) Speech: dysarthria present with nasal intonation while content, fluency, comprehension normal.

Crainal nerves:

i) IX,X Examination: gag reflex poor on left side poor movement of soft palate on the left side.

ii) other cranial nerves : normal

Motor System :

a) Nutrition: left hand small muscles wasted

b) Tone: normal

c)Power: i) At hip 4 minus in all the flexors, extensors bilaterally, 4/5 at knee and 5/5 ankle.

ii) upper limb: bilateral shoulder & elbow 4/5, left interossei weakness; difficulty in adduction of fingers, weak opponens pollici

Reflexes: All deep tendon reflexes normal, plantar flexors.Sensory decrease pain and temperature sensation on the lateral 2/3 of the hand on the posterior aspect, Rest normal , All other systems: cerebellar function and autonomic system, gait were normal , CVS, Respiratory system and per abdomen : normal examination.

Clinical summary

With this clinical picture of progressive proximal weakness and asymmetric sensory signs and symptoms in left upper limb with ongoing myalgia and arthralgia for last 6 months we suspected autoimmune process affecting muscles/ nerves/ radicals.

Routine Tests:

a)HB:8.8 gm/dl, ESR: 100, PBS: microcytic hypochromic.

b)Renal and liver function : normal

c) HIV,HbsAg and VDRL: negative

d)Urine test:1+ protein rest normal

e) Blood sugar levels: 82 mg/dl(random).

f) Serum Electrolyte :normal.

g) 24 hour protein : 800 mg/day

h)Thyroid function test: normal

f)X ray chest PA view normal, USG abd pelvis: normal study.

Special tests

a)serum LDH:903 IU/L (normal range:250-400)

b)C-reactive Protein: 29 mg/l(normal upto 6 mg/l).

c)Rheumatoid factor: negative

d)Creatinine Phospho Kinase : 1240 (Upto 190 U/l)

e)ANA :1.49 (positive> 1.20),

f)ANA blot negative.

g) Anti dsDNA: 27.91 U/ml (positive more than 24).

MRI Brain and Cervical spine : normal study.

Echocardiography : normal study

Nerve Conduction Study/Electromyography

Motor Nerve Conduction

www.ijbamr.com P ISSN: 2250-284X , E ISSN : 2250-2858

i) Rt. Median : Normal.

ii) Lt. Median: Severely reduced CMAP amplitude; Normal Conduction velocity.

iii) Rt. Ulnar: Normal

iv) Lt. Ulnar: Severely reduced CMAP amplitude; Normal Conduction velocity.

v) Rt. & Lt. Common Peroneal : Normal.

vi) Rt. & Lt. Tibial : Normal

Sensory Nerve Conduction

Rt. Median : Normal

Lt. Median : Reduced SNAP amplitude ; normal conduction velocity.

Rt. & Lt. Radial: Normal.

Rt. Ulnar : Normal

Lt. Ulnar : Reduced SNAP amplitude; Normal conduction velocity.

Rt. & Lt. Sural : Normal

Comments:

NCS: reduced CMAP and SNAP amplitude in left Median and Ulnar nerves with normal distal latency and conduction velocity suggestive of axonal asymmetric polyneuropathy compatible with Mononeuritis multiplex .

Muscle-Side	**Spontaneous activity**		**Volitional MUAP**			**Recruitment**
	Fib/ PW	Fascics	Amp	Dur	polyphasics	
Vastus Med Rt	nil	nil	decrease	decrease	+	Early and full
Ilio-psoas Rt	+++	nil	decrease	decrease	+	Early and full
Deltoid Rt	+++	nil	decrease	decrease	+	Early and full
Abd poll Brev Lt	+++	nil	increase	increase	Unstable polyphasics	Moderately full
FDIO Lt	+++	nil	increase	increase	Unstable polyphasics	Moderately full
Ext indicis Lt	+++	nil	decrease	decreased		Early and full

www.ijbamr.com P ISSN: 2250-284X , E ISSN : 2250-2858

Needle EMG

Diffuse fibrillation potentials with reduced duration and amplitude of MUAPs in Rt. Vastus Medialis, Rt. Iliopsoas, Rt. Deltiod and Rt. Extensor Indicis muscles with early and full recruitment.

Diffuse fibrillation potentials in Lt. Abductor Pollicis brevis and Lt. First dorsal Interroseus muscles, with unstable polyphasics and reduced recruitment pattern.

Nerve conduction study/electromyography:

Mononeuritis Multiplex in Left median and Ulnar nerves.

Additional finding suggestive of Inflammatory muscle disease are seen in the upper and lower limbs.

Muscle Biopsy: specimen-right bicep muscle shows sparse interstitial mononuclear cel infiltrate & mild degeneration of muscle fibres s/o polymyostis.

Discussion:

In this case inflammatory Myositis/myopathies with connective tissue disease. Well Characterised overlap syndrome are dermatomyositis + systemic sclerosis characterised by sclerotic thickening of skin microangiopathy, esophageal hypomotility, calcium deposits, contractures with other connective tissue disorder is rarely seen. [3]Specific antinuclear antibody anti-PM/Scl, directed against a nucleolar-protein complex is seen in dermatomyositis and SS. Polymyositis overlap with connective tissue disorder similar to dermatomyositis but not as frequent like it. Polymyositis is commonly seen in association with autoimmune diseases like Crohn's disease, vasculitis, primary biliary cirrhosis, myasthenia gravis etc.[4]

References:

1. Balon R, Segraves RT, ed. (2005). Handbook of Sexual Dysfunction. Taylor & Francis. ISBN 9780824758264.
2. Wylie KR, ed. (2015). ABC of Sexual Health. John Wiley & Sons , p. 75.ISBN 9781118665565.
3. "Postorgasmic illness syndrome". Genetic and Rare Diseases Information Center (GARD). National Institutes of Health. 2015. Retrieved 30 July 2015.
4. Glueck, Charles (August 30, 2013). North American Journal of Medical Sciences **5** (8): 494–495. DOI:10.4103/1947-2714.117325