We present a case of lateral medullary syndrome (LMS) in which dysphagia was the only symptom. Although dysphagia is a reasonably typical symptom of LMS, it is unusual, to our knowledge, for dysphagia to be the only sign of a brainstem infarction. This kind of clinical presentation might mimic a wide range of otorhinolaryngological and upper gastrointestinal tract disorders, necessitating needless diagnostic testing. The significance of maintaining a high index of suspicion for central causes of dysphagia is highlighted by this case, especially in the absence of other localising symptoms and indications.

Keywords:
Upper gastrointestinal tract, brainstem infarctions, deglutition disorders, and lateral medullary syndrome.

Introduction

Brainstem infarctions typically have a distinct constellation of symptoms. However, in unusual circumstances, such as this one, they may sometimes show very minor clinical symptoms, which could create a diagnostic challenge to doctors at the time of initial presentation. Dysphagia as the only symptom of a localised medullary infraction might mimic several other disorders.

Case Report

A 60 year old, left-gave fat male, with hypertension, hyperlipidemia, coronary vein sickness and diabetes mellitus, gave singular protest of trouble in gulping. There was no related fever, sore throat, hack, rhinorrhea, post-nasal dribble or some other side effect reminiscent of an upper respiratory plot contamination. His dysphagia was intense in beginning, moderate in seriousness and was not related with food consumption. He denied any new debilitated contacts, emergency clinic confirmations or travel beyond his old neighborhood. He revealed a specific level of consuming sensation in his left nostril. At the hour of show, he additionally denied any related migraine, visual changes, paraesthesia, shortcoming, deadness, incontinence or some other neurologic grumblings.

On actual assessment, the patient was afebrile and hemodynamically stable. Neurologic assessment was unexceptional with the exception of left half of face being overly sensitive. Afterward, throughout medical clinic stay, he grew left-sided ptosis, somewhat debilitated fringe vision of the left side, temperature and agony sensation touchiness over the left half of face in correlation with the right side. The patient further proceeded to foster diminished agony and temperature sensation along the right half of his body, with slight dysmetria and hemiataxia on the left side.

He was upset for upper gastrointestinal plot and otorhinolaryngological reasons for hindrance as a plausible wellspring of dysphagia. His CECT neck uncovered no anomaly. Gulping concentrate on uncovered a strange gulping reflex with shortcoming of the left pharynx, special entry of barium on the right side, and pooling in the left pyriform sinus with honest goal. X-ray cerebrum showed an infarct of the left medulla. MRA affirmed impediment of distal sections of the left vertebral supply route. CT angiogram likewise affirmed the finding and showed a 50 % restricting of both inward carotid conduit starting points. EKG, cardiovascular proteins and an echocardiogram were ordinary.

His blood sugar and blood pressure were under control, and aspirin, ACE inhibitors, and statins were started. In order to treat the patient’s substantial persistent pharyngeal paralysis, a Keofeed was implanted before discharge. He had a physical therapy and rehabilitation appointment for electrical stimulation of the paralysed area. A second swallow exam performed one month later revealed a noticeable improvement in his swallowing ability. He has been seeing his primary care physician often and is doing well with the gradual weaning off of Keofeeds.

Discussion

Horizontal medullary dead tissue (LMI) or Wallenberg’s disorder is one of the better known vascular conditions of the back flow [1,2]. The standard side effects incorporate dizziness, discombobulation, nystagmus, ataxia, sickness and retching, dysphagia, raspiness, weakness of torque and warm sensation over the contralateral side, ipsilateral face and Horner’s
condition [3,4]. As clear here, many side effects cross-over with other organ frameworks of the body. Subsequently, this disorder might possibly mirror a different assortment of ailments in the event that a high list of doubt isn't kept up with for a main driver. The quandary of clinical sign towards analysis is additionally tangled on the off chance that LMI gives lone side effect of dysphagia, as in this understanding. This might possibly steer doctors off course and result in broad stir up toward precluding different reasons for dysphagia.

Albeit not the most often happening, dysphagia has been accounted for in the clinical writing as one of the more normal side effects of LMI, regularly as a feature of a star grouping of related side effects, in the scope of 23%-61% [5]. A few examinations, directed to outline the clinical-radiologic connection of medullary areas of localized necrosis, uncover that dysphagia and palatopharyngeal brokenness is the consequence of vascular split the difference to the rostral some portion of equivocal core situated in the dorsal part of the medulla oblongata. The rostro-caudal contrast in the recurrence of dysphagia is by all accounts made sense of by the anatomic portrayal and has been approved by numerous geographical examinations [6,7]. Dysphagia being the sole side effect of dead tissue is steady with the perception that the stroke seems to have developed from a much limited sore in the rostral part of medulla, as the caudal piece of medulla isn't straightforwardly connected with pharyngeal muscles [8,9].

Angiographic discoveries were predictable with vertebral vein infection, which more probable began as a little vessel dead tissue and developed to include a bigger vascular region. Risk factors in this persistent were in all likelihood his ongoing non-transferable sicknesses including diabetes, hyperlipidemia, hypertension and corpulence.

Treatment of laid out LMI incorporates suggestive administration with adjustment of neurologic status by means of against platelet treatment, control of glucose and circulatory strain and taking care of help in patients with dysphagia and chance of goal [10]. Long haul treatment essentially incorporates restoration and active recuperation [11]. A few choices are accessible for this reason, including pharyngeal activities, electrical feeling and more current rTMS (dreary Transcranial Attractive Excitement) [12]. Concerning, patients with huge, rostral injuries will more often than not have serious dysphagia, desire pneumonia and delayed affirmation. By the by, our patient had a somewhat short emergency clinic stay and genuinely mediocre progress into pharyngeal restoration.

Conclusion

Despite being the most common, “neurogenic dysphagia” as a subgroup of oropharyngeal dysphagia constitutes a clinical entity that doctors should keep in mind when treating the symptom of troubled swallowing, particularly in elderly diabetic and hypertensive patients.

References