Unique Case of Bilateral Foot Drop

Dr. Muhammad Mohsin Isar

Consultant Acute Medicine, United Lincolnshire Hospitals NHS Trust, United Kingdom

Abstract:

Vasculitis, as multisystem disease, presents significant diagnostic challenges for physicians; however, it often responds well to treatment once accurately diagnosed.

We present a case of 65-year-old male farmer with a medical history of bronchial asthma, bronchiectasis, hiatus hernia, depression, and degenerative disc disease presented with progressive bilateral ankle drop. The onset occurred eight weeks prior following a fall due to transient right leg weakness and inability to dorsiflex the big toe. Over subsequent weeks, he developed paraesthesia over the dorsum and sole of the right foot, leading to right foot drop, and later experienced a similar episode in the left leg, resulting in left foot drop. His condition progressed, ultimately confining him to a wheelchair two weeks before admission. Medications included carbocisteine, fluoxetine, diazepam, montelukast, pregabalin, and inhalers.

Physical examination revealed scattered petechial and purpuric rashes on the medial thighs and dorsum of the right foot. Neurological examination showed intact cranial nerves, absent ankle dorsiflexion, and big toe extension bilaterally, with right plantar flexion strength of 0/5 and left side 1-2/5. Knee reflexes were brisk; however, ankle and plantar reflexes were absent. Sensory loss to fine touch was noted in the L5 and S1 dermatomes bilaterally.

Investigations demonstrated marked eosinophilia (13.74), and MRI brain suggested an acute lacunar infarct of embolic aetiology. MRI spine revealed multilevel degenerative changes. Extensive testing, including; Thyroid function test, CSF viral PCR, autoimmune and vasculitis profiles, hepatitis and HIV serology, and paraneoplastic markers (Purkinje cell antibodies (anti Hu, anti Yo) and anti-MAG antibodies), compliments C4 and Cryoglobulin level were negative. Chest CT showed bibasilar consolidation and mild pleural effusion.

Electromyography and nerve conduction studies were consistent with mononeuritis multiplex. Skin biopsy confirmed hyper-eosinophilic syndrome.

The patient responded well to a three-day high-dose intravenous methylprednisolone course followed by cyclophosphamide. He was also treated with antibiotics for possible bilateral pneumonia.

Diagnosis: Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss Syndrome).