LANDESKLINIK FUR NEUROLOGIE
VORSTAND:
HR PRIM. UNIV.-PROF. DR. GUNTHER LADURNER

Landeskliniken
Salzburg

Christian-Doppler-Klinik

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Kobalia Georg Anzor
5. Maiokorski Street
384730 Tsalenjicka
Georgian

Preliminary report

Salzburg, 19.09.2002

PATIENT
Kobalia Georg Anzor, geb. 22.12.1989
5. Maiokorski Street, 384730 Tsalenjicka, Georgien
AZ:020349548302
Station: NE Station f. Neurorehab. (2007)
Aufnahmedatum: 11.07.2002

To whom it may concerns,

Anamnesis:
On March 18th 2002 the patient was vaccinated the first time against hepatitis B.
The next day March 19th he felt pain and weakness of the right leg. The following day March 20th he had a sore throat, felt apathic complained about general muscular weakness und vomited. The parents of the boy noticed a change of the voice. He was admitted in hospital and stayed in intensive care treatment until June 25th . At that time artificial ventilation could be stopped and the boy was breathing spontaneusly through *a* trachea! cannule. Neurologically he showed a bulbar palsy and was tetraplegic except fur minor movements in both hands.
He was treated with corticoids, immunoglobulines and antbiotics.
His arrival and admission in the hospital was on the 11th July 2002.

Neurological findings:
I: normal.
II: visual field normal.
Ill, IV, VI: pupilles round, reacting well on light and accomoclation, no double vision, nystagmus in endposition.
V: mot. and sens, normal.
VII: normal.
VIII: no hypaccusis.
IX-X: palsy of the left N. hypoglossus, atrophy of the left half of the tongue, fibrilllations.

Upper extremities:
Power, tonus, motility with spastic severe paresis both hands, left more than right, generalized atrophy.
Reflexes brisk, some on both sides.
Neck:
The patient ist not able to hold his neck in position, weakness of all cervical muscels especially sternocleido-mastoid muscle.

The patient has a trachea! cannule without the possibility to speak.
Lower extremities:
Power paraplegic without increased tone as spasticity, cramps. Pyramidal tigues positive. Reflexes exaggerated both sides. Sens, normal.

General investigation:
No abnormality found.

Investigations:
Cranial CT normal.
Chest X-ray normal.
Cervicalspine X-ray normal.
Neurosonology normal.
EEC normal.
Evoked potentials: visual, acoustic pathways normal, sensomotor. EP Laesion of the central pathways.
Videocinematography of deglutition normal.
Spect of the brain (rCBF): small areas of lower perfusion in both hemispheres.
Knee X-ray: no significant alteration.
ONT of remouval of the tracheal tuke failed. At two control investigations a remouval was impossible.
MRI (in copy).

Laboratory examinations (in copy).

On the day of arrival the young patient showed signs of bulbar palsy (hypoglossuspalsy left and tongue atrophy with fibrillation) with a severe weakness of both upper limbs and a spastic plegia of lower limbs with clonic spasms and positiv pyramidal signs. He had a severe weakness of cervical and truncus muscles.
Due to the weakness of the auxiliar muscles for breathing the attempt to remove the tracheal cannule was not successful. We had to reaply a new one.
For further diagnostics we did another MRI with Gadolinium, which showed a little improvement of the known lesions in the medulla oblcngata and the cervical spinal corde, a Videocinematography with a normal deglutitation, neurophysiological testings and blood controls.
Under treatment with physio, ergo therapy and speech therapy the paresis and the spasticity improved. Very positive results were obtained with botox therapy against the spacity of the legs. The control of the head improved considerably; the patient is now able to hold his head in position over a period of 10 minutes and more and is able to sit and travel in a wheel chair.
In addition we prescribed thymoleptics, some antispastics and analgetics per oral.

Diagnosis:
Transversal myelitis.

Since other causes are missing and reports are available showing similar neurological features in patients with hepatitis B. The vaccination has to be seen as the most likely reason for the myelitis.

We would advise further physiotherapy, probably a repetition of the Botox-therapy and medical treatment with:
Mezlozillin 2 g/2 g/1 g i.v. until 23.09.2002
Fluoxetin Sirup 10 mg
Tizanidin 1/1/1/2 mg
Tramadol 50 mg
Oxazepam 25 mg 0/0/0/1
Pentoxifyllin 200 mg 1/0/1
With kind regards

Hofrat Prim.Univ.Prof.Dr. G. Ladurn