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Date: 22/09/2026 03:28 PM
Subject: Invitation to Join and For Circulation: AIIMS Rishikesh Tele-Education Series_Staff_CPC | 23 September 2026 | By Department of Department of Neurology, AIIMS Rishikesh

Greetings from AIIMS, Rishikesh!!

The next **Staff CPC (Clinico-Pathological Conference)** under the **AIIMS Rishikesh Tele-Education Series** is scheduled as follows:

Presenter: Dr. Mritunjai Kumar, MD, DM, Associate Professor & Head
Presenting Department: Department of Neurology, AIIMS Rishikesh
Topic: Middle aged female presenting with 6 month history of asymmetrical, sensorimotor weakness of both lower limb with facial and bulbar involvement

Date: Wednesday, 23 September 2026
Time: 7:50 AM – 8:50 AM
Mode: Hybrid
Venue: CPD, Level-2, AIIMS Rishikesh
Online Platform: Zoom
Meeting ID : 883 4635 4286
Passcode : 267216
Join the session (Zoom): <https://us06web.zoom.us/j/88346354286?pwd=6TPfgeC1zFoGkkcMIY5OM89OBdm505.1>

The clinical handout for the case to be discussed is attached for your reference.
We also request you to kindly circulate the attached flyer among your students, residents, faculty, and professional networks to encourage wider participation in the session.
Join the Whatsapp Channel for upcoming sessions



AIIMS Rishikesh Tele-Education Series

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PPT Format:
Please use the PowerPoint template for CPC CGR available at the following link: <https://www.aiimsrishikeshdigitalacademy.com/downloads>



AIIMS Rishikesh Tele-Education Series

STAFF CPC

CLINICO-PATHOLOGICAL CONFERENCE

Every Wednesday | Hybrid Mode | Venue: CPD, Level – 2 | For Online (Join @ Zoom)

Upcoming Session

Middle aged female presenting with 6 month history of asymmetrical, sensorimotor weakness of both lower limb with facial and bulbar involvement

23 SEPTEMBER 2026

7:50 AM – 8:50 AM (IST)

PRESENTER

Dr. Mritunjai Kumar MD, DM

Associate Professor & Head

Department of Neurology, AIIMS Rishikesh

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CONTACT US FOR QUERIES

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DEPARTMENT OF NEUROLOGY
CASE SUMMARY

PATIENT NAME: Ms S.	REGISTRATION NO (UHID): --
AGE/SEX: 51 YR / F	ADDRESS: UTTAR PRADESH
DATE OF ADMISSION: 07.05.2026	DATE OF DISCHARGE: 11/05/2026
CONSULTANT I/C: DR. MRITUNJAI KUMAR SINGH BED SR: DR. ANIL	

Mrs. S, 51 yr female, home maker, informant being son and pt herself (reliable) presented to this hospital with
Chief Complaint:
Numbness and tingling sensation in right leg for 6 months

Weakness in right foot since 4 and half month

Weakness in left foot and unable to walk for 45 days

HOP: she was apparently well 6 months back. To start with she started experiencing numbness and tingling sensation in lateral border of right foot along plantar aspect which was insidious onset and gradually progressed to involve the whole plantar aspect in 15 days and progressed to involve the dorsum of foot and ascending up till below knee within 2 months. In the course of this paresthesia, she started developing weakness in the right foot as evidenced by difficulty in gripping on to chappals and slippage of chappals without awareness which was insidious onset and gradually progressed to tripping on the toe while walking and feeling of foot hanging down while raising the leg since 4 months. In the course she started experiencing similar pattern of sensory involvement in her left foot 4 months back and was also accompanied by weakness in left foot for 45 days after which she was unable to walk even with support. Recently pt developed facial deviation to left with ptosis on the right eye since 10 days which was sudden onset overnight for which pt has difficulty in chewing food , mixing food in mouth and liquids coming out from angle of mouth while eating on the right side. Recently she started developing difficulty while swallowing solid food and need water often to deglute the bolus. There was

- No respiratory distress.
- No blurring of vision and diplopia.
- No tinnitus, vertigo, hearing loss.
- No difficulty on getting up from supine position, rolling from side to side.
- No buckling of knees.
- No hypoanaesthetic patch or thickened nerve.
- No neurocutaneous markers.

Past history- history of similar episode of facial weakness and deviation of angle of mouth to left and ptosis of right eye 2 yr back which was gradually improved over few months without any residual impairment.

No past history of TB or contact with TB. Not a known case of diabetes or hypertension. **Personal history-** mixed Indian diet, normal bladder bowel habit, didn't have formal education. **Family history** - no history of similar illness in any 1st degree relatives.

GENERAL EXAMINATION: on admission

Pt was conscious and responding to command

GCS - E4 V5 M6

Pulse: 94/min, regular, palpable in all 4 limbs	BP: 118/ 80mmHg	RR: 18/min
Temp: febrile	SpO2: 99% on RA	Pallor: Absent
Icterus: Absent	Cyanosis: Absent	Clubbing: present on bilateral toe
Lymphadenopathy: Absent	Edema: Absent	JVP: Not raised

CVS – Normal S1, S2 heard. No Murmur present.

RESPIRATORY- B/L VBS. No added sounds

ABDOMEN - Soft, non-tender, No organomegaly. Normal bowel sounds present.

HIGHER MENTAL FUNCTIONS:

Pt is conscious, oriented to time, place and person.

Speech - flaccid dysarthria, no nasal intonation of voice, impaired labial and guttural consonants

CRANIAL NERVES:

Olfactory: normal, no anosmia, parosmia

Optic:

Acuity of vision: finger counting is present from 6 ft Field of vision: normal

Color vision: normal. Fundoscopy: normal

Oculomotor, trochlear and abducens: eye movement normal. Both eyes.

R

Pupil— Size: left 2 mm and right 4 mm
round Reaction: b/l present no worsening in dark or light?
physiological anisocoria

Shape:

Trigeminal:

Motor function: intact Sensory function: intact
Corneal reflex—Right: present Left: present Jaw jerk absent

Facial:

Facial deviation to the left side is present Sensory function: Nad

Vestibulocochlear:

AC > BC
WEBERS Not Lateralized

Pharyngeal or gag: gag reflex is intact. Reduced movement of soft palate on right side.

Spinal accessory— Intact

Hypoglossal: No deviation of tongue on protrusion

Motor Examination:

Bulk – Normal on upper limb
Symmetrical atrophy on lower limb below knee and foot
Tone: normal in upper limb Bilateral ankle hypotonia present

Power:

POWER			
		left	right
Neck	Flexion		
	Extension	5/5	5/5
Shoulder	Flexion	5/5	5/5
	Extension	5/5	5/5
	Abduction	5/5	5/5
	Adduction	5/5	5/5
Elbow	Flexion	5/5	5/5
	Extension	5/5	5/5
Wrist	Flexion	5/5	5/5
	Extension	5/5	5/5

Hip	Flexion	5/5	5/5
	Extension	5/5	5/5
	Abduction	5/5	5/5
	Adduction	5/5	5/5
Knee	Flexion	5/5	5/5
	Extension	5/5	5/5
Ankle	Flexion	0/5	0/5
	Extension	0/5	0/5
Toe	Dorsiflexion	0/5	0/5
	plantarflexion	0/5	0/5

REFLEXES ON ADMISSION	Biceps	Triceps	Supinator	Knee	Ankle
Right	2	2	2	2	0
Left	2	2	2	2	0

Plantar - B/L mute

Meningeal signs: absent

Sensory-pain, soft touch, crude touch and vibration is lost by 80% medially below knee till medial malleolus (saphenous territory) and 50 % in below knee joint along lateral aspect of leg till lateral malleolus (common peroneal territory) and circumferential loss of sensation in both feet.

Cortical sensations: intact EXTRAPYRAMIDAL: not present CEREBELLAR: absent

GAIT- couldn't be assessed.

SPINE - No kyphosis or scoliosis, no gibbous and knuckle or any spinal tenderness.

INVESTIGATION RECORD:

	14/03/26	15/03/26	21/3/26	29/03/26	14/04/26
Hemoglobin	13.6	12.1	12.2		12.4
TLC	10.0	9.5	9.2		14.96
DLC(N/L/M/E)	56/32/7	56/33/8	66/25/5		71/24/3.9
Platelet count	384		399		454

Bilirubin(T/D)	0.66/0.07	0.2/0.07	0.7/0.1	0.4/0.05	
SGPT/sgot	18/25	17/42	13/19	11/25	16/20
ALP	66	52			
GGT					
S. Protein	6.7	6.3	5.9	6.8	
S. Albumin	4.2	4.0	3.8	3.3	
Blood Urea	28	25	40	28	30
S. Creatinine	0.8	0.7	0.9	0.9	0.70
S. Na+	140	139	133	132	141
S. K+	3.9	4.1	3.5	3.0	3.2
S. Ca ++	13	12	13.3		11
S. Phos	3.5	3.7	4.3	2.3	

NCS study - motor nerve conduction study is not recordable at bilateral peroneal and tibial nerve.

- sensory nerve conduction study is not recordable at bilateral saphenous, superficial peroneal and sural nerve suggestive of axonal pattern of sensory motor involvement bilateral lower limb.

Hbs Ag/ HIV / HCV - negative

Vitamin D - 75.92

Vitamin B 12 - >2000 pg/ml

TSH - 3.05

24-hour urine protein - 140 mg/dl

CSF analysis - acellular/ sugar - 67 mg/dl/ protein - 109 mg/dl

NCCT brain - old, calcified granuloma in right high frontal lobe, high parietal lobe, bilateral occipital lobe

CEMRI brain with CISS sequence - similar to NCCT findings s/o healed calcified granuloma

ANA profile- negative / ANCA profile - negative

Nerve biopsy - epineurium is hyalinized, epineural blood vessels shows thickened walls along with neovascularization, moderate perivascular lymphocytic inflammation around epineural vessels. Fibrinoid necrosis is not seen, there is acute axonal breakdown

, S/O - probable vasculitic neuropathy, right sural nerve.

CECT thorax - multiple bilateral pulmonary nodules few showing spiculated margins, predominantly subpleural in distribution suspicious of metastatic etiology.

Cytopathology of EBUS guided biopsy- features of non-necrotizing granulomatous pathology favoring sarcoidosis.

Histopathology - No evidence of granuloma / dysplasia/ malignancy noted in the tissue section.

Histopathology of labial salivary gland biopsy - nonsignificant.

2D-ECHO - normal. EF - 60%, grade I diastolic dysfunction

MYELOMA PANEL- LDH- 145 U/L

Calcium - 14.0 mg/dl M spike - not seen

Serum beta 2 microglobulin - 6573 ng/ml IgG/IgM/IgA- normal limits

Kappa free light chain - 42.39 Lambda free light chain - 30.18 Serum ACE - 77.70 U/L

PTH - 9.70 pg/mL

PET - CT - mild metabolically active pleura based ill-defined thickening of fibrotic / fibro- consolidatory changes involving upper lobe right lung, mild metabolically active mediastinal lymph nodes, metabolically inactive multiple predominantly pleural based fibronodular opacities involving bilateral lung field. S/O infective / inflammatory etiology.

Histopathology, remaining investigation and course of the management to be discussed.

