Correspondence

Tropical Spastic Paraparesis from Northern India

Sir,

In 1964, a progressive myelopathy involving the thoracic region was termed Tropical Spastic Paraparesis (TSP). Subsequently a similar myelopathy associated with HTLV-1 antibodies in both serum and CSF patients were found and named HAM (HTLV-1 associated myelopathy).1 The epidemiological, clinical and pathological features of cases from India are similar to the description form rest of World, though attempts to link TSP and HTLV-1 have largely been unsuccessful. Most of the cases of TSP reported from India are from southern parts of the country. Although sporadic case reports have been made from various other parts, we report an interesting case having features consistent with TSP from northern India.

AK, 33- year male hailing from Motihari, Bihar presented to Medical OPD with a 13- year long duration illness. He had insidious onset, gradually progressive weakness of lower limbs beginning almost symmetrically. Lately from last 4 years he is bedridden with frequent flexor and extensor spasms. He gave history of bladder dysfunction (urinary frequency, hesitancy, urgency) beginning early in course of illness. For last 9 years the patient is having lower limb parasthesia (painless). There was no history suggestive of upper limb, cranial nerve or higher mental function abnormalities. The patient denied any history of Khesari dal intake, remission or acute exacerbation in symptoms, blood transfusion, high risk behaviour for STDs and relative or neighbour suffering from such illness. Examination revealed markedly increased tone with grade 0/5 power in both lower limbs with exaggerated deep tendon reflexes, sustained ankle clonus, bilateral extensor plantars and mildly impaired vibration sense in lower limbs. Higher mental function, cranial nerves, optic fundi, upper limbs and cerebellar functions were normal. Routine hemogram, blood biochemistry and X-ray of thoracolumbar and cervical spine were unremarkable. ELISA for HIV-1 and HIV-2 was negative. CSF analysis revealed 15 cells/mm³ all lymphocytes, normal glucose and protein with negative VDRL and absence of oligoclonal bands. MRI revealed atrophy of lower part of spinal cord. (Fig. 1).

The temporal profile of illness in the present case including typical clinical presentation, CSF and MRI findings are highly suggestive of TSP. However, HTLV-1 and HTLV-2 serology could not be carried out due to non-availability of the test, very high cost and low diagnostic yield specially in India.2 In a study from South India,2 out of 25 subjects only one case tested positive for HTLV-1 antibodies. The other differential diagnosis to be considered in such clinical syndromes include lathyrism, hereditary spastic paraplegia, spinal from of primary progressive multiple sclerosis, HIV related myelopathy and primary lateral sclerosis. Lathyrism can be differentiated from TSP by specific geographic distribution, khesari dal intake, other family members suffering from similar illness and frequent upper limb involvement. Hereditary spastic paraplegia is unlikely because it usually has a positive family history, young age of onset, marked spasticity with minimal pyramidal weakness, marked lumbar lordosis and acellular CSF. The spinal form of primary progressive multiple sclerosis may behave exactly like TSP. But absence of oligoclonal bands in CSF and characteristics MRI do not favour the diagnosis of MS. Bladder dysfunction, sensory symptoms, absence of pseudobulbar palsy and abnormal MRI are against the diagnosis of primary lateral sclerosis. HIV related myelopathy is unlikely in view of prolonged duration of illness, absence of other manifestations and negative serology.

Although the diagnosis of TSP is significantly supported by HTLV serological studies, the clinical recognition of this entity along with consideration of other differential diagnosis (as discussed above) is of...
Atypical Presentations of Sheehan’s Syndrome

Sir,

Sheehan’s syndrome, first described in 1937, is an adrenal pituitary insufficiency from hypovolemia secondary to excessive blood loss during or after delivery. It may present in post-partum period or several years after delivery. Patients of Sheehan’s syndrome present in emergency due to situations like coma, hypothyroidism, hypoglycemia or hyponatremia following a stressful event. Patients also presents with anemia, dry and light colour skin. Ozkan and Colak reviewed 20 cases of Sheehan’s Syndrome; 3(15%) presented with hypoglycemia, 3(15%) with hypothyroidism, 1(5%) with hyponatremia, 6 had empty sella and 9 had partial empty sella.1

We report two cases of Sheehan’s syndrome with uncommon presentations - paralytic ileus and acute psychosis. The first patient was a 32 years female; presented with loose motions, vomiting and giddiness. On examination, she had fever, pallor, dry coarse skin, hoarse voice and madarosis, BP of 80/60 mm Hg; peristaltic sounds were absent. Serum Na+ 127 mEq/L, K+ 3.9 mEq/L, BSL® was 61mg%. X-ray abdomen erect showed multiple air fluid levels. Provisional diagnosis of acute gastroenteritis with paralytic ileus was made and treated accordingly. Peristalsis returned and air fluid levels on X-ray disappeared after 2 days. Repeat serum Na+ and K+ were 137mEq/L and 4.5mEq/L. Serum T3, T4, TSH levels were done, all of which were low. Obstetric history was reviewed; she had history of post partum hemorrhage 13 years ago followed by lactation failure, amenorrhea and loss of secondary sexual characteristics. She also gave history of increased lassitude, giddiness, vague indigestion and fatigue. Serum cortisol levels were low. Due to financial constraints, other hormonal levels could not be done. A diagnosis of Sheehan’s syndrome was made and she was put on oral steroids, followed by L-thyroxine and estrogen supplements.

The second patient was a 25 years female presenting with acute psychosis. She had multiple episodes of altered sensorium with frequent loss of consciousness since past one year. There was history of postpartum hemorrhage five years ago followed by amenorrhea. Her investigations one year ago showed subnormal levels of serum FSH, LH, HPRL, cortisol, T3, T4 and TSH. She was receiving oral L-thyroxine for hypothyroidism since then. One week ago she had been put on 60mg of oral prednisolone daily. On examination she was intermittently rowdy; had retrograde amnesia. A diagnosis of Sheehan’s Syndrome with acute psychosis was made. She was treated with antipsychotic drugs; dose of prednisolone was tapered slowly over a week and maintained at 7.5 mg/day. Thyroxine and estrogen supplements were given. In both the patients, USG abdomen-pelvis showed small atrophic uterus with shrunken ovaries and CT scan brain showed partially empty sella. The psychosis recovered within a week and after 10 days of presentation, she was off antipsychotic medications.

In the first patient, paralytic ileus despite normal serum K+ levels was due to hypothyroidism with acute gastroenteritis. Pseudo-obstruction of the intestine can occur in conditions like scleroderma, myxedema, diabetic autonomic neuropathy and amyloidosis. However, after extensive review of literature we have not come across any report of paralytic ileus as the presenting feature in Sheehan’s syndrome. We would like to highlight how we investigated the patient with high index of suspicion and arrived at the diagnosis and also emphasize the importance of a detailed past and obstetric history which sometimes takes a back seat in acute emergencies. In the second case, while the patient was on treatment outside, low TSH and cortisol levels were overlooked. Ideally, steroid replacement should precede thyroxine replacement. Also the recommended dose of steroids in a hemodynamically stable patient is 5 mg A.M and 2.5 mg P.M. Behavioral disorders can occur with high dose of steroids which probably happened in our case.

REFERENCES

Sabharwal reported a case of Sheehan’s syndrome that developed acute psychosis following a single tablet of 5 mg of prednisolone. Patients with adrenal insufficiency are extremely sensitive to steroids. Acute psychotic reactions are rare and occur during initial days of therapy. Reduction in the dose of steroids helps recovery which is usually rapid.

Sheehan’s syndrome is rare in developed countries, but is a significant cause of maternal morbidity and mortality in developing countries like ours. Timely and efficient management of the condition requires high index of suspicion and awareness among the general practitioners, obstetricians and physicians.

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REFERENCES

API Expert Consensus Document on Management of Ischemic Heart Disease

Sirs,

There are two issues which need additional clarification

1. Routine CAG after thrombolysis -

   Can data from CAPITAL AMI,1 GRACIA 12 and SIAM III3 be extrapolated to Indian settings? In all these trials a fibrin specific agents were used for fibrinolysis, i.e. either TNK, RPA or tPA. In India streptokinase remains the most commonly used agent, which has systemic lytic action, also no trial with SK and immediate angioplasty has shown benefit. (SWIFT and TIMI IIb trials and SIAM4)

   Why should a stable patient with small infarct with stable LV function should undergo CAG (coronary angiography)? Patient can always undergo noninvasive testing prior to CAG. These patients if catheterized routinely may show borderline lesions, leading unnecessary interventions without documented objective ischemia.

   Also the apparent coronary stenosis a few days after MI is well documented to reduce in severity and stabilise at the end of 3 months. So early CAG will again lead to unnecessary intervention.

2. 80 mg dose of Atorvastatin

   Dyslipidemia in Indian patients is different from western population with low HDL, high TG with relatively normal LDL also high Lp(a). High dose of statins is not been studied in this subset, additionally worry about side effects with such a high dose always remains. Even with smaller doses many patients complain of myalgia without rise in enzymes, which subside with stoppage of drug. Lastly cost of 80mg dose will burden patient economically to already burdened patient. It is our impression that the vast majority of physicians and cardiologists use much smaller doses (even as low as 5 mg) in view of above factors. In fact, it would interesting to know how many members of this expert committee use 80 mg dose.

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REFERENCES

Reply from the Authors

Sirs,

We thank Dr. Y Lokhandwala and Dr. S Deshpande for interest in “API Expert Consensus Document on Management of Ischemic Heart Disease”, published in JAPI, 54, 469–480, June 2006.1 Drs. Lokhandwala and Deshpande raise two issues and our answers to the same are as follows :  
1) The first issue is regarding Routine Coronary Angiography (CAG) after thrombolysis.

The management of ST-elevation myocardial infarction (STEMI) after thrombolysis has undergone a major change. We have recommended routine coronary angiography after thrombolysis in every case on the basis
of global practice patterns and the recently published guidelines of European Society of Cardiology (ESC) (Reference 5 in the article). The ESC guidelines recommend routine post thrombolysis coronary angiography and percutaneous coronary intervention (PCI) if applicable as Class IA recommendation (page 817, Table 7 of Reference 2).

The global practice patterns have indicated that a more conservative pattern of care with regards to early revascularization had a detrimental effect on short and long-term prognosis. We quote a few of the major reports. A multilevel analysis of patients in ASSENT-2 showed a lower mortality in the countries with the highest rates of PCI after thrombolytic treatment. A meta-analysis of 20,101 patients from the TIMI 4, 9 and 10B and InTIME – II trials revealed that PCI during hospitalization was associated with a lower rate of inhospital recurrent MI (4.5 vs 1.6%, p < 0.001) and a lower 2-year mortality (11.6 vs. 5.6%, p < 0.001). In GUSTO – I, the rates of cardiac catheterization and revascularization during the index hospitalization among US patients were more than twice those among Canadian patients. The 5-year mortality was 19.6% among US patients and 21.4% among Canadian patients (p = 0.02). Another interesting report published from Europe in year 2000 is regarding the difference in use of coronary angiography and outcome of AMI in Toulouse (France) and Gerona (Spain). Angiography was utilized in 93% patients in Toulouse, France whereas it was used only in 6% patients in Gerona, Spain. The 28 day case fatality was 4.3% in Toulouse and 9.4% in Gerona. These reports along with CAPITAL – AMI, SIAM III, GRACIA-II and the European Society of Guidelines form the basis of our recommendations in the article.

Drs. Lokhandwala and Deshpande raise the objection of extrapolating this data in Indian settings where streptokinase is utilized. They also quote a reference of year 1990 to show ineffectiveness of immediate angioplasty with streptokinase. In absence of Indian data, we have no choice but to utilize the available global data. As we mentioned in the article the individual physician can choose what he wishes to do with his patient. However, we reiterate the European Society Guidelines and the vast amount of global data and global practice which recommends routine use of coronary angiography after thrombolysis if there is no specific contraindication.

2) The second issue is 80 mg dose of atorvastatin:

There are multiple questions which have been inserted in this issue and we wish to respond in this way. A) Dyslipidemia in a given patient should be treated as necessary. In the consensus document on page 471, para 1, it has been suggested that the necessary lipid lowering agent should be used to achieve the goals. B) There is ample data in the literature which speaks of safety of 80 mg atorvastatin and there should not be unnecessary fears on this account. The initial dose of statin which is recommended in acute coronary syndrome (ACS) is 80 mg atorvastatin based on data from MIRACL and PROVE IT-TIMI 22. As we know, the pleiotropic effects of statins are important in ACS and have been demonstrated with 80 mg atorvastatin dose. The TNT trial has emphasized the role of aggressive lipid lowering even in stable CAD. What we wish to emphasize is that the LDL cholesterol should be effectively lowered in the range of 70–100 mg. We are aware of the fact that many consultants in India use a lower dose of statin than what is prescribed in the Western literature. In formulating this consensus document, an attempt has been made to present the available evidence based data. The clinician in Indian certainly has a choice to choose the dose which he thinks appropriate for his patient. D) The 40-80 mg dose have been utilized by many members of the expert consensus writing group.

References

10. C}


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**Announcement**

4th National Conference of Cardiology, Diabetology, Electrocardiology and Echocardiography to be held on 18th and 19th Nov. 2006 at Hotel Jehan Numa Palace, Bhopal (M.P.).

**Registration Fees**

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*Accommodation will be provided on twin sharing basis.

Draft drawn in favour of ICC-CON should be sent to address mentioned below:

Conference Secretariat: **Dr. PC Manoria**, E-5/103, Arera Colony, Bhopal M.P. - 462016
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