J Clin Case Rep 2016, 6:3(Suppl)
http://dx.doi.org/10.4172/2165-7920.C1.006

The red herring in disc herniation with severe nerve deficit and when should we not operate them

Balachandar Gopalan
American Hospital, Dubai

A 77-year-old gentleman presented with sudden onset pain in the right knee since three weeks followed by buckling of the right knee a week later while attempting to stand. He had an unremarkable medical history, led an active lifestyle and had no other joint pains elsewhere. He was a non-smoker and non-alcoholic. The motor power of right knee extensors and hip adductors was medical research council (MRC) grade 1, hip flexors and abductors grade 3 and other muscle groups were normal grade 5. There was reduced sensation over anterolateral right thigh with absent knee jerk reflex.Radiographs of thigh and spine were normal. MRI of lumbar spine showed L2-3 and 3-4 disc extrusion causing thecal compression, L4-5 disc protrusion and post contrast enhancement on right sided L2-3, 3-4 nerve roots. Discrepant clinical picture and MRI findings prompted electrophysiological studies which revealed femoral neuropathy on right side. A consult with spine specialist (who advised surgical removal of the disc urgently) and a consult with neurologist (who advised conservative management) further added to the conundrum. On initial therapy with intravenous followed by oral steroids for a month the patient recovered rapidly. At four months, he recovered power in all muscle groups to grade 5. At one year he was completely fine except for absent knee jerk. Although treated based on conjectural diagnosis of lumbosacral plexitis, then thought to be due to be incited by the extruded disc, a clear mapping of the neurological temporal improvement every month, it was deduced to be an entirely different entity called chemical radiculitis. This disease is very rare and the combination of upper lumbar disc herniation and picture of lumbosacral radiculoplexopathy only confounded the clinical scenario. This case serves as an important reminder of not to operate all disc herniations with nerve deficits.

drbala8782@gmail.com

Timely embolectomy in acute massive pulmonary embolism prevents catastrophe: An experience from two cases

Natraj Setty, D Ramesh, Kumarswamy, Sunil Kumar, Guru Prasad, Jayanth and **C N Manjunath**
Sri Jayadeva Institute of Cardiovascular Sciences and Research, India

Acute massive pulmonary embolism is a life threatening emergency that must be promptly diagnosed and managed. Over the last several years the use of Computed Tomography (CT) scanning has improved the clinician's ability to diagnose acute pulmonary embolism. We report two cases of acute massive pulmonary embolism that presented with sudden onset of dyspnoea and underwent successful open pulmonary embolectomy. First case presented with acute onset of dyspnoea of 2 days duration, in view hemodynamic deterioration and 2D Echocardiography revealed clot in RV apex and RPA, underwent cardio pulmonary Bypass and open pulmonary embolectomy with RV clot extraction. Second case presented with sudden onset of dyspnoea on 15th day of Post-operative day for traumatic rupture of urinary bladder, in view of recent surgery patient was subjected to surgical embolectomy. Following surgical intervention, both the patients made a prompt recovery.

drnatrajsetty75@gmail.com

Notes: