

**COMPLEX INTEGRATIVE ETIOLOGICAL (POSSIBLY  
ENCEPHALOMYELITIS), CLINICAL, PARACLINICAL AND  
THERAPEUTIC ASPECTS IN A PATIENT WITH OLD, QUITE LIGHT  
SPASTIC PARAPARESIS AND SENSITIVITY DISORDERS, OBJECTED BY  
MEDULLAR MITIGATION AT VERTEBRAL T5-T7 LEVELS  
-CASE REPORT-**

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## Abstract

**Introduction:** This paper, approved by the Bioethical Committee of TEHBA (no. 911/ 11 may 2018), presents an extremely complex case of quite light spastic paraparesis, with a medical history from childhood (at 12 years), encephalomyelitis (remission?), which in adulthood (at 22 years) was diagnosed and treated as multiple sclerosis 1 year and 6 months (this diagnosis has been subsequently denied with IRM in 2017: reducing the size of the medullary cord in the vertebrae plane T5-T7 sequelae aspect) and the afferent neuro-rehabilitative actual management approach, respectively.

**Materials and methods:** 43 year old female patient admitted in our Clinic's Division for a AIS/ Frankel D motor deficiency, pain with mechanical carcass at the spine, disturbances of balance, bladder dysfunction (incontinence), bilateral dorsal plantar flexion deficit (left > right), gait with a broad base of support with external unilateral support, with hip flexural, knee flexion, and dorsal flexion deficiency while walking, attack digitigrad (left > right), and sensibility impairment from T12 level downwards. The patient was clinically and functionally evaluated, according to the standard implemented protocols of our Unit, through the following measurement evaluation scales/scores: AIS, FIM, QQL (Quality of life), Ashworth, Penn, FAC, and investigated para-clinically through IRM brain, cervical and thoracic spine, radiographic cervical spine, abdominal echography.

**Results:** Following optimal treatment including pharmacological, and complex neuro-rehabilitation program, the patient had a favorable evolution with increased values of the measurement scales (motor AIS with 4 points, FIM motor with 5 points, QQL with 6 points, and FAC with 2 points), remission of ataxic/vertiginous phenomena, quasi-remission of urinary incontinence (controlling micturition for at least 10 minutes after the urge to urinate); in addition and also very important: diminished spasticity and significantly improved gait pattern. Now she can walk without support on short/medium distances and also very important, she can rise without sitting support (in a relatively low position) to orthostatism, and also climbs and descends stairs with the support of the bar and only with the supervision of another person.

**Conclusion:** From the etiologic point of view, multiple sclerosis, uterine apoplexy as well as arteriovenous malformation has been recently refuted. The present case represents the importance of building a complete diagnosis (etiologic and of stage) and particular neuro-rehabilitative therapy approach with both clinical, psychological and scientific impact.