A Case Of A Middle-aged Man Presented With Progressive Weakness Affecting All Limbs.

Presented By
Dr. Munira Tabassum Mumu
FCPS Part 2 Trainee
Medicine Unit 1
Kushtia Medical College & Hospital, Kushtia

PARTICULARS OF THE PATIENT:

- **Name : Rony Islam**
- **Age: 33 years**
- **Sex: Male**
- **Religion: Islam**
- **Occupation: Factory worker**
- **Address: Mirpur, Kushtia**
- **Date of admission: 15/11/2025**
- **Date of examination: 15/11/2025**

CHIEF COMPLAINTS

1) **Progressive weakness of all limbs for 6 months.**
2) **Generalised body ache for 6 month.**

HISTORY OF PRESENT ILLNESS:

According to the statement of the patient, he was reasonably well 6 month back. Then he developed progressive weakness in all 4 limbs. Initially he developed weakness in lower limbs then subsequently involved upper limbs, hampering his day-to-day activities. He felt difficulty in climbing stair, rising from sitting position, combing his hair and changing clothes.

Weakness was gradual in onset and progressive and persistent in nature. On further query he stated that Weakness is not associated with tingling and numbness in limbs, no diurnal variation, not related to any food intake or exposure to cold or exercise.

He also developed generalized body ache for the same duration, more marked in the arms and thigh, which was gradual in onset, persistent and progressive, cramping in nature, moderate in intensity, mildly relieved by rest.

He also complained of occasional low-grade fever, unintentional weight loss evidenced by loosening of clothes -without any history of excessive thirst, sweating or urination and fatigue. There is no history of tremor and palpitation.

He did not give any history of joint pain ,skin rash, oral ulcer, cough or SOB and no history of drooping of eyelid, double vision, skin tightening, dry eyes and mouth.

He visited many physician and was prescribed some medication that initially relieved his symptoms but now for last couple of weeks his symptoms reappeared and he got admitted in Kushtia Medical College & Hospital.

His bowel and bladder habit is normal.

HISTORY OF PAST ILLNESS:

No significant medical and surgical illness. No history of any endocrine disorder.

DRUG AND TREATMENT HISTORY:

No history of taking herbal and homeopathic drug or any statin or steroid.
He took pregabalin and Multi Vitamin, PPI, NSAID, Calcium.

Personal History:

He is smoker, non alcoholic, no history of IV drug abuse or extra marital sexual exposure.

Family History :

There is no positive family history of such type of illness.

Occupational History:

Factory worker (He used to polish aluminum sheets of pressure cooker)

He comes from a middle-income family and drinks arsenic free water and use sanitary latrine.

Immunization history:

He is vaccinated as per EPI schedule and vaccinated against COVID 19.

Travel History:

Not significant.

GENERAL EXAMINATION:

- Appearance: Ill-looking
- Body built: Average
- Decubitus: Lying
- Co-operation: Co-operative
- Nutritional status: Below average
- Anemia: absent
- Jaundice: Absent
- Cyanosis: Absent
- Clubbing: Absent
- Koilonychia: Absent
- Leuconychia: Absent

- Edema: Absent
- Dehydration: Absent
- Neck vein: Not engorged
- Thyroid: Not enlarged
- Skin condition: Normal
- Bony tenderness: Absent
- BP: 110/70 mm Hg
- Pulse: 80 b/min
- Respiratory rate: 16 breaths/min
- Temperature-Normal

Systemic Examination

Musculoskeletal system examination:

1. Look:

- Visible muscle wasting found over the shoulder and hip region.
- No visible deformity
- Skin condition over the bone and joint are normal

2. Feel:

- Temperature normal
- No joint crepitus
- Muscle tenderness : grade 1

3. Move:

- Limited active movement and passive movement of joint is normal
- Examination of spine: Normal
- Gower sign: Cannot be elicited.
- Grip myotonia: Absent.
- Percussion myotonia : Absent.

Nervous system examination:

1. Higher psychic function:

- Consciousness level: Conscious
- Orientation: Well oriented
- Intelligence: Normal
- Memory: Intact
- Speech: Normal

2. **Cranial nerve examination :** Normal

Fundoscopy : NAD

3.MOTOR SYSTEM EXAMINATION

Upper Limb	Bulk	Tone	Power	Reflex
Right	Mildly Reduced proximally	Normal	Decreased (2/5)	All reflexes are Preserved
Left	Mildly Reduced Proximally	Normal	Decreased (2/5)	All reflexes are Preserved

3.MOTOR SYSTEM EXAMINATION

Lower Limb	Bulk	Tone	Power	Reflex
Right	Mildly Reduced proximally	Normal	Decreased(2/5)	All reflexes are Preserved
Left	Mildly Reduced proximally	Normal	Decreased(2/5)	All reflexes are Preserved

4. Sensory system examination: Normal

5.Cerebellar function examination:

- Nystagmus – absent.
- Speech Pattern – Normal
- Other examination - Cannot be elicited.

SALIENT FEATURES:

Rony Islam , 33 years of age male, smoker, non alcoholic ,normotensive, non-diabetic patient hailing from Mirpur, Kushtia got himself admitted to Kushtia Sadar hospital with the complaints of Progressive weakness of all limbs for 6 months and generalized body ache for the same duration.

The weakness initially developed in the lowers limbs and it subsequently involved the upper limbs, hampering his day-to-day activities. He felt difficulty in climbing stairs, rising from sitting position, combing his hair and changing cloths. Weakness was gradual in onset, progressive and persistent in nature.

Weakness was not associated with tingling and numbness sensation in limbs, no diurnal variation, not related to any food intake or exposure to cold or exercise.

He also developed generalized body ache that is more marked in the arms and thigh, which was gradual on onset, persistent and progressive, cramping in nature, moderate in intensity, mildly relieved by rest.

He also complained of occasional low-grade fever, weight loss and fatigue.

He did not give any history of joint pain ,skin rash, oral ulcer, cough or SOB and no history of drooping of eyelid, double vision, skin tightening, dry eyes and mouth.

He visited many physician and was prescribed some medication that initially relieved his symptoms. But now for last couple of weeks his symptoms reappear and he got admitted in our medicine unit.

His bowel and bladder habit is normal.

On general examination he is ill looking ,but cooperative, nutritional status is below average.

All the Vital signs are normal

On musculoskeletal system examination there is visible muscle wasting over the shoulder and hip joint, limitation present in active movement and passive movement of all joints were normal. There is grade 1 muscle tenderness on proximal muscles.

Examination of the spine is normal.

Gower sign cannot be elicited

Grip myotonia and percussion myotonia is absent.

On nervous system examination,

The patient is conscious, well oriented and speech is normal.

Cranial nerve examination revealed no abnormality.

On motor system examination of the upper and lower limbs, the bulk of the muscles are symmetrically proximally mildly reduced, the muscles are normal and the power is also decreased (2/5). All the reflexes are preserved in both limb.

Sensory system examination is normal and no nystagmus or speech abnormality and other cerebellar function test could not be carried out.

Other systemic examination revealed no abnormality.

WHAT CAN BE THE PROVISIONAL DIAGNOSIS?

PROVISIONAL DIAGNOSIS

Polymyositis

DIFFERENTIAL DIAGNOSIS

1. Limb girdle myopathy
2. Motor neuron disease (PMA)
3. Paraneoplastic myopathy
4. Chronic inflammatory demyelinating polyneuropathy

INVESTIGATIONS PERFORMED

COMPUTERIZED DIAGNOSTIC COMPLEX

PT. NAME : RONI ISLAM	AGE : 35 Y	SEX : Male	PT. ID : 13573
REFD. BY : DR. SUKUMAR KUNDU.,BSc. MBBS.			DATE : JUL 20, 2025

HAEMATOLOGY REPORT

Relevent Estimations were carried out by SYSMEX XN-1000 Automated 6-part Haematology Analyzer and checked manually.

Parameter	Result	Reference Value
Haemoglobin	14.6 g/dL	Male: 14-18, Female: 11.5-16.5, Child: 12-14
ESR (Westergren Method)	04 mm/1st Hour	Adult(Male:0-15,Female:0-20),Child(0-10) mm in 1st hr
Total Count		
Total WBC Count	12.20 X 10^3 /uL	Adult: 4-11 X 10^3/uL, Child(Birth-1 mon): 6.0-36.0 X 10^3/uL, Child(6 mon-3 yrs): 6.0-17.5 X 10^3/uL, Child(4-10 yrs): 5.5-14.5 X 10^3/uL
Differential Count		
Neutrophils	73 %	Adult (40 - 70%), Child (25 - 66%)
Lymphocytes	20 %	Adult (20 - 40%), Child (25 - 62%)
Monocytes	03 %	Adult (02 - 08%), Child (02 - 07%)
Eosinophils	04 %	Adult (00 - 06%), Child (00 - 03%)
Basophils	00 %	0 - 1%
IG%	00 %	
IG#	0.00 X 10^3/µL	
NRBC%	0.00 /100WBC	
NRBC#	0.00 X 10^3/µL	
RBC Panel		
Total RBC Count	4.91 X 10^6 /uL	3.5 - 5.5 X 10^6 /uL
HCT	47 %	37.00 - 47.00%
MCV	95.7 fL	76.00 - 96.00 fL
MCH	29.7 pg	27 - 32 pg
MCHC	31.1 g/dL	30.00 - 36.00 g/dL
RDW-SD	50.4 fL	42.5 ± 3.5 fL
RDW-CV	14.2 %	12.8 ± 1.2 %
PLT Panel		
Total Platelet Count	490 X 10^3 /uL	150 - 450 X 10^3/uL
MPV	8.6 fL	9- 13 fL
P-LCR	14.2 %	13 - 43 %
PCT	0.43 %	0.20 - 0.50 %
PDW	9.1 fL	09 - 17 fL

Note : In case of lack of correlation due to technical/typing error, the laboratory should be informed immediately for the rectification/review/re-sampling & re-testing etc..

Printed By _____

Prepared By
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Medical Technologist

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BIOCHEMICAL REPORT OF BLOOD (SERUM / PLASMA)

Estimations are carried out by HITACHI (Roche) cobas-c 311 / Dade Behring Dimension RxL Random Access Automated Multibatch Chemistry Analyzer.

Test Name	Result	Unit	Reference Values
Blood Glucose Parameter			
Random Blood Sugar(RBS)	8.14	mmol/L	Adults : Up to 7.80, Neonates (1 day) : 2.22-3.33, Neonates(>1 day) : 2.78-4.44, Child : 3.33-5.55
Renal Function Test			
Creatinine	0.55	mg/dL	Males : 0.70-1.20, Females : 0.50-0.90 Child : 0.24-0.87
Electrolytes			
Sodium	137.4	mmol/L	135-148
Potassium	4.04	mmol/L	3.50-5.30
Chloride	99.7	mmol/L	95.0-107.0
Bicarbonate(HCO3)	30.25	mmol/L	18-28
Total Carbondioxide(TCO2)	31.48	mmol/L	22-30
pH	7.35	***	7.35-7.45
Non Panel Test			
Calcium	10.55	mg/dL	Adults (Males/Females): 8.4-10.2, Infants (0-10 days) : 7.6-10.4, Child (10 days-2 yrs) : 9.0-11.0, Child (2-12 yrs) :8.8-10.8

CLINICAL PATHOLOGY REPORT

URINE PROFILE

Estimations are carried out by SYSMEX UN-2000 Automated Urine Analyzer and checked manually

Physical Examination

Quantity/Volume	:	**Sufficient**
Color	:	**Light Yellow**
Appearance	:	**Clear**
Sediment	:	**Absent**
Sp. Gravity	:	**1.036**

Chemical Examination

Reaction (pH)	:	**6.0**
Albumin	:	**Negative**
Sugar (Reducing Substance)	:	**Negative**
Ketones Body	:	**Absent**
Excess of Phosphate	:	**Nil**
Bile Salt	:	**Nil**
Bile Pigment	:	**Nil**
Bilirubin	:	**Nil**
Urobilinogen	:	**Normal**
Nitrite	:	**Nil**

Microscopic Examination

Pus Cell	:	**1-2**	/HPF
Epithelial Cells	:	**1-3**	/HPF
RBCs	:	**Not Found**	/HPF
Calcium Oxalate Crystal	:	**Not Found**	/HPF
Triple Phosphate Crystal	:	**Not Found**	/HPF
Yeast Cells	:	**Not Found**	/HPF
Sperm	:	**Not Found**	/HPF
Trichomonas Vaginalis	:	**Not Found**	/HPF
Casts /LPF :	:	**Not Found**	/LPF
Granular Cast	:	**Not Found**	/LPF
Hyaline Cast	:	**Not Found**	/LPF
RBC Cast	:	**Not Found**	/LPF
WBC Cast	:	**Not Found**	/LPF

IMMUNO-SEROLOGICAL TEST REPORT

Specimen : Blood

Test Name	Result	Unit	Reference Values	Comment
CRP- Latex	**< 6.0**	mg/L	<6.0	Negative

HBS Ag→

TPHA→

VDRL→ Non-Reactive

CRP→

Mucuscells.....

Veg: Cells.....

Pus-cells.....

R.B.C

★HCV→

★HIV→ Negative

Blood Group : Rh :

M.T. Lab./Pathologist

250 Bed General Hospital Kush

BIOCHEMISTRY

Test Name	Result	Unit	Reference Ranges	Methodology
Aldolase	28	U/L	Up to 7.60	

BIOCHEMISTRY

Test Name	Result	Unit	Reference Ranges	Methodology
CPK	4771	U/L	Male: 55-170 Female: 30-135	

e : BLOOD LAB. No : 12512620845

: TSH

me: 23/12/25 01.48 pm Receive Time : 23/12/25 02 07 pm

aminations Are Carried Out By Automated Immunology Analyzer Machine (YHLO-iFlash 3000)

Test	Result	Unit	Reference Value
TSH	1.63	µIU/mL	Adult: 0.25 - 5.00 Children: 0.5 - 6.7 Infants: 0.6 - 10.2 Newborn : 1.0 - 25.0

e of lack of correlation due to technical / typing error please inform immediately for the rectification / review / re-sampling & re-g etc.

IMMUNOLOGY TEST REPORT.

Instrumentation : Cobas e 411 / Maglumi 2000 Plus/ Immulite-1000
Method : Electrochemiluminescent Immunoassay (ECLIA) / Chemiluminescent Immunoassay (CLIA).

Specimen : Blood

Test Name	Result	Unit	Reference Values	Comment
ANA (Anti Nuclear Antibody)	**< 0.50**	AU/mL	<40.0 AU/mL	

IMMUNO-SEROLOGICAL TEST REPORT

Estimation is Carried Out By AGAPPE MISPA-i2 Automated Specific Protein Analyzer.

Specimen : Blood

Test Name	Result	Unit	Reference Values	Comment
Rheumatoid Factor (RF)	**< 10.0**	IU/mL	Up to 18.0 IU/mL	

LABORATORY SERVICES

Patient Name	**Rony**	Lab No	**17670174**
UHID	**170464724**	Sample Collection Date	**09/09/2025 2:22PM**
Age/Gender	**33 Yrs/Male**	Receiving Dates	**09/09/2025 3:35PM**
Referred By	**DR. MD. SHAMIM MAHMUD. MBBS,BCS (HEALTH), AR (CARDIOLOGY). BMDC REG NO: 79117**	Report Date	**12/09/2025 8:11AM**
		Report Status	**Final**

Test Name	Result	Unit	Reference Range

IMMUNOLOGY REPORT

Sample: Serum

Anti-RNP Antibody (IgG)	0.60	U/mL	Normal:<15.00 Borderline: 15.00-25.00 Elevated: >25.00

LABORATORY SERVICES

Patient Name	**Rony**	Lab No	**17670174**
UHID	**170464724**	Sample Collection Date	**09/09/2025 2:22PM**
Age/Gender	**33 Yrs/Male**	Receiving Dates	**09/09/2025 3:35PM**
Referred By	**DR. MD. SHAMIM MAHMUD. MBBS,BCS (HEALTH), AR (CARDIOLOGY). BMDC REG NO: 79117**	Report Date	**12/09/2025 8:11AM**
		Report Status	**Final**

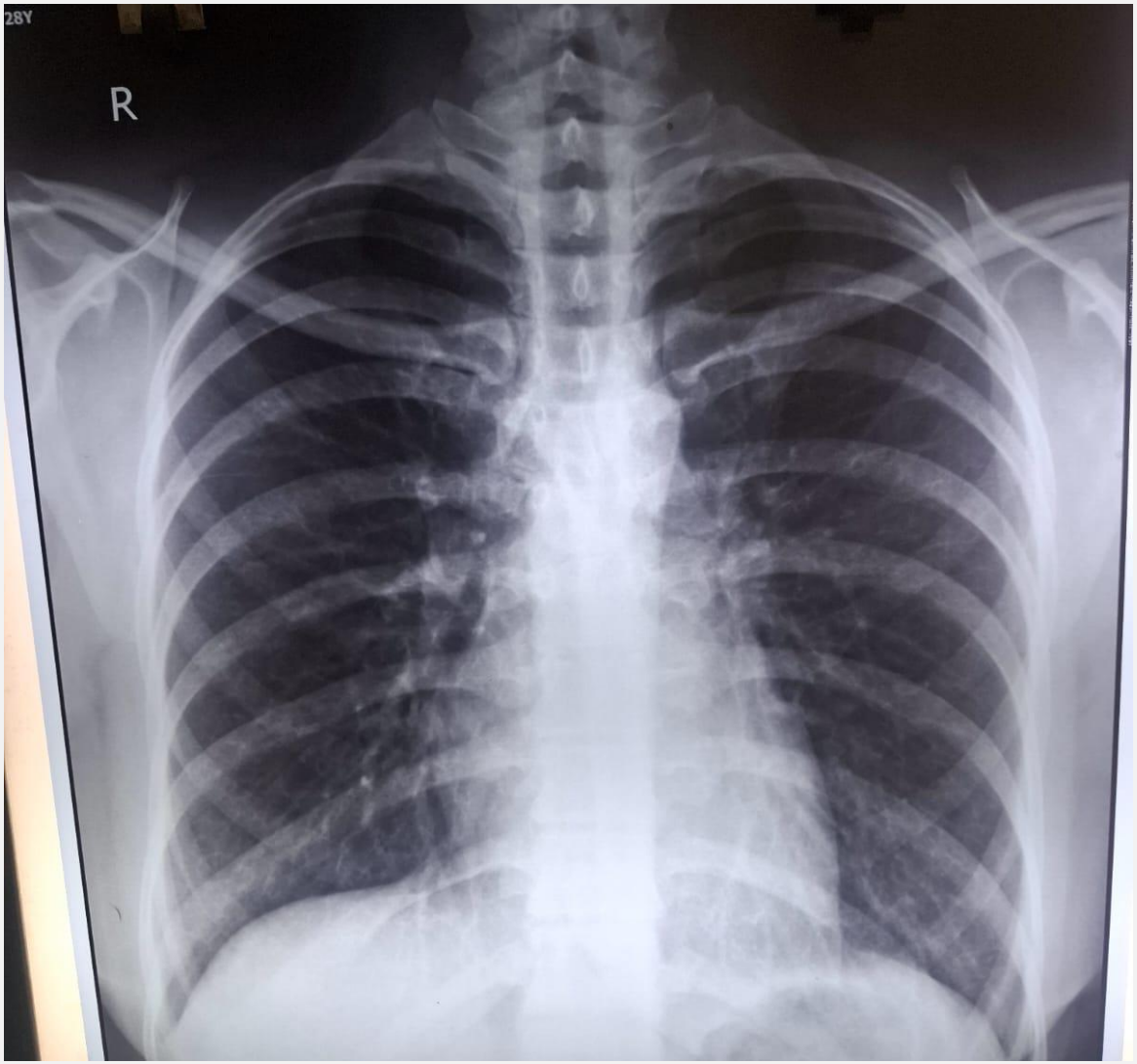
Test Name	Result	Unit	Reference Range

IMMUNOLOGY REPORT

Sample: Serum

Anti-Jo-1 Antibody (IgG)	1.30	U/mL	Normal:<15.00 Borderline: 15.00-25.00 Elevated: >25.00

CHEST X-RAY



Impression

NCS and EMG of crossed limbs done.

FINDINGS: CMAP amplitudes of all studied nerves are within normal limit.
All SNAPs are also within normal limit.
EMG reveals Short duration polyphasic MUAPs in most of the sampled muscles without features of denervation.

IMPRESSION: These electrophysiological findings are consistent with Non Inflammatory Myopathy.

Please correlate clinically and other investigations.

Dr Md Merazul Islam Shaikh
FCPS (Medicine) FCPS (Neurology)
Assistant Professor
National Institute of Neurosciences and Hospital,Dhaka.

Patient Name	RONY	RIS No	622221751
UHID	RAJ199334	Registration Date	4/23/2025 5:11:57 PM
Age/Gender	33 Y / M	Report Date	23-Apr-25 9:23:56 PM
Referred By	Assoc. Prof. Dr. Md. Monzurul Haque (Pintu), FCPS (Neurosurgery), MS (Neurosurgery)		
Report Status	Final		

MRI of Lumbo-Sacral Spine

Clinical History: **H/O Low backache.**

Multiplanar multiecho MRI Scan of the Lumbar Spine has been performed.

"REPORT DETAILS"

- Normal alignment and curvature of the lumbar vertebrae is maintained.
- **Mild disc bulge is noted at the level of L4-L5 causing mild indentation of thecal sac not producing significant neural compression.**
- **Marginal osteophytes are noted at L3-L5 vertebrae. Disc dessication is noted at the level of L3-L4 and L4-L5.**
- Visualised vertebrae show normal marrow signal. The posterior elements and facet joints are normal. There is no abnormal pre or paraspinal soft tissue.
- The distal cord & conus is normal.
- There is no evidence of spinal canal stenosis.

IMPRESSION:

Mild disc bulge at the level of L4-L5 causing mild indentation of thecal sac not producing significant neural compression.
Lumbar degenerative changes.

Screening part:

Degenerative changes at D11 vertebra.
Cervical spine and spinal cord is unremarkable.

Prof. Dr Md Hafizur Rahman
MBBS, M. Phil (Radiology)
Fellow MRI (Mumbai, India)
Professor & Head,
Department of Radiology & Imaging
Rajshahi Medical College, Rajshahi
BMDC: A-20925

HISTOPATHOLOGY REPORT

Patient ID	: H12509447005	Report No : 12510612115	Report Status : FINALIZED
Invoice No	: AD2509446857	Invoice Date : 27/09/2025 03:08 PM	Delivery Date : 03/10/2025
Patient Name	: RONY MONDOL		
Age	: 33Y 4D	Gender : M	
Ref. Doctor	: GENERAL HOSPITAL KUSHTIA ,		

Lab No.	: 12509567398	Collection Date : 27/09/2025 03:12 PM	
Test Name	: Histo 2		

Lab ID: H 1246/25

Specimen:
Tissue from quadriceps femoris.

Gross Examination:
Specimen consists of a 1x0.6x0.4 cm tissue. Submitted whole in 4 blocks.

Microscopic Examination:
Sections show skeletal muscle. Endomysial spaces are moderately infiltrated with chronic inflammatory cells.

No granuloma or malignancy is seen.

Comment:
Tissue from quadriceps femoris (biopsy): Compatible with 'Inflammatory myopathy'.

DR. IMTIAZ AHMED
MBBS, M. Phil (Pathology)
Associate Professor (c.c)
Department of Pathology
Kushtia Medical College, Kushtia.

FINAL DIAGNOSIS



Polymyositis

TREATMENT OPTIONS

1. First-line treatment

- Oral glucocorticoids are the main initial therapy
  Prednisolone 1 mg/kg/day
- In severe cases (respiratory or swallowing muscle weakness):
  IV methylprednisolone 1 g/day for 3 days

- Steroid should be tapered If the patient responds well:
  - Steroid should be reduced by ~25% per month
  - Target maintenance dose: 5–7.5 mg/day

2. Steroid-sparing immunosuppressive agents

Can be used when

- Steroids are insufficient
- To reduce long-term steroid side effects

Common options:

- **Methotrexate (MTX)**
- **Azathioprine**
- **Mycophenolate mofetil (MMF)**
- **Ciclosporin**

3. Refractory disease

- Rituximab
- Intravenous Immunoglobulin (IVIg)

TREATMENT GIVEN

1. Patient is counseled and educated regarding the course and management of the disease.
2. Immunosuppressant:
   - Oral Glucocorticoid. (Prednisolone 60 mg daily)
   - Azathioprine. (50 mg daily)
3. Calcium Supplement
4. Physiotherapy
5. Follow up


Thank
You!