DIFFICULTIES IN DIAGNOSING MULTIPLE SCLEROSIS.

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The basis of the disease is the formation of foci of destruction of the nerve sheath (myelin) in the brain and spinal cord. Several different parts of the nervous system are affected, which leads to the appearance of various neurological symptoms in patients. Another feature of the disease is its remitting course. This means alternating periods of deterioration (exacerbation) and improvement (remission). These foci are called plaques of multiple sclerosis. Plaque sizes are usually, They are small, from a few millimeters to several centimeters, but with the progression of the disease, the formation of large drainage plaques is possible.

A clinical example: A 38-year-old man was admitted to the hospital. Complaints at admission of weakness in the left extremities, difficulty walking, frequent urge to urinate. It is known from the medical history that the patient had acute respiratory viral infections about 1.5 weeks ago, after which the above-mentioned complaints arose. Objective examination: Condition: relatively satisfactory. Skin: normal color. Visible mucous membranes: pink. Hell 120/80 mmHg. Pulse 73 in 1 minute. Body temperature: normothermia. Heart tones: muted, rhythmic. Breathing: hard. Wheezing: No. Abdomen: soft on palpation, painless. Chair: decorated. Urination: free, frequent urge to urinate.

Neurological status: Consciousness: clear. Cognitive impairment: none. Speech disorders: none. Eye slits: D=S. Pupils: D=S. Pupil photoreaction: D=S, live from 2 sides. Eye movements: in full volume. Nystagmus: No. Accommodation, convergence: weakened from 2 sides. Face: asymmetrical, due to the smoothness of the left nasolabial fold. Language: in the middle line. Pharyngeal reflex: preserved. Bulbar violations: none. Symptoms of oral automatism: negative. Muscle strength: reduced in the left extremities to compliance. Muscle tone: diffusely decreased. Deep reflexes: D<S, average liveliness. Pathological reflexes: positive on the left. Sensitive disorders: left-sided hemihyperesthesia. Coordination tests: with a slight drop on the left. In the Romberg pose: staggering. Meningeal symptoms are negative.

During the study: A clinical blood test – without features. Biochemical blood test: total bilirubin 17.1 mmol/L, triglycerides 2.15 mmol/L, cholesterol 5.8 mmol/L. Urinalysis without pathology. Performed: ECG: Sinus bradycardia with a heart rate of 55 beats/min. An MRI scan of the head and cervical spine revealed a large number of foci of abnormally rounded demyelination, with uneven indistinct contours from 1 to 4.5 mm in diameter. Received treatment: medication: (omez, sodium chloride, solumedrol, pentoxifylline, milgamma, medopred); physical therapy, physiotherapy: (massage of the left extremities, oxygen therapy)

Diagnosis: Multiple sclerosis, remitting course, acute phase. Since there are no specific symptoms of disseminated sclerosis, instrumental examination is an important diagnostic criterion. The diagnosis is confirmed when demyelination plaques are detected by contrast–enhanced magnetic resonance imaging