

PATIENT: Jana Narendra Nirmal

BD: 27/10/1984

AGE: 32

Male, 32 years old, who attends at 19/09/17 to medical consultation because of history of acute pain 9/10, low back and left thoracic limb, associated to numbness and paraesthesia in the same distribution. It conditions difficulty for walking and sitting discomfort, with only tolerance of laying position.

Clinical History:

1. Multiple sclerosis, controlled pharmacologically whit Methylprednisolone

Vital Signs:

Respiratory rate: 20 x' Cardiac rate: 82x' Pulse: 82x' Blood pressure: 120/78 50kgs 1.60mt

Physical exploration:

Patient with pain face, with normal mental status, cranial nerves normal, hidrataded and adecute skin and teguments color. Cardiovascular with normal exploration. Abdomen: Pain in lower quadrant, the rest normal. Upper extremities: Normal muscle strength, tone and bulk. Normal reflexes. Coordination, sensory function without alteration. Lower extremities: Straight leg raising test positive, normal muscle strength, tone and bulk. Normal reflexes. Lasegue +, Coordination, sensory function without alteration. Capillary refill 2 seconds.

Intrahospitalary management: Bed rest. Infusion of saline solution 0.9% 1000cc + 1g Methylprednisolone + Outside treatment:

1. Methylprednisolone 1 gr IV every 24 hours per 5 days (They are applied on an outpatient basis in the emergency room)

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