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CASE SCENARIO

A 65 years male presented with sudden onset of weakness of left upper and lower limb at 5 am in the morning. His wife noticed slurring of speech. She reported that he had coughing while drinking water.

There was no loss of consciousness/convulsions/preceding fall/headache.

He was a hypertensive for 10 years on Tab. Amlodepine 5mg OD.

He was a chronic smoker since 30 years.

ON EXAMINATION:

Conscious,cooperative

PULSE: 80/min, regular.

BP: 160/100mm Hg, Right arm,supine.

Xanthelesma+

CNS:

Conscious, co operative

Higher mental functions : normal

Cranial nerve:

Angle of mouth deviated to right.

Loss of nasolabial fold on left side of face.

Motor:

Hypotonia of left upper and lower limb.

Power grade 0 on left upper and lower limb.

Deep tendon reflexes exaggerated on left side.

Plantar extensor on left side.

Sensory: Reduced sensations on left half of the body.

CVS:

S1,S2 normal.

Ejection systolic murmur in aortic area not conducted to carotids.