Pearls & Oy-sters: Symmetric Numbness and Paresthesia Due to Stroke-like Episode in an Adolescent Male With MELAS

Author(s):
Rachel Vassar, MD1; Nehali Mehta, MD1

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Corresponding Author:
Rachel Vassar
rachel.vassar@ucsf.edu

Affiliation Information for All Authors: 1. Child Neurology Residency Program, Department of Neurology, University of California San Francisco, San Francisco, CA

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Rachel Vassar: Drafting/revision of the manuscript for content, including medical writing for content; Major role in the acquisition of data; Study concept or design; Analysis or interpretation of data
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Pearls

- Stroke-like episodes in MELAS can present with virtually any new neurologic symptom
- L-arginine is thought to decrease severity and risk of recurrence of stroke-like episodes in MELAS but does not necessarily prevent them
- Patients with MELAS or other metabolic disorders can present with bilateral symptoms or imaging findings

Oy-sters

- Any new neurologic symptom in a patient with MELAS must be considered to be a possible stroke-like episode until an alternative explanation is identified
- Stroke-like episodes in MELAS can present in patterns that defy vascular territories

Abstract

Mitochondrial Encephalopathy, Lactic Acidosis, and Stroke-like episodes (MELAS) syndrome is a mitochondrial condition with a wide range of neurologic complications including migraines, seizures, and stroke-like episodes. This case report highlights a rare presentation of bilateral sensory changes related to MELAS and offers an opportunity to consider how a differential diagnosis may need to be modified in patients with underlying mitochondrial disorders. Neurologic symptoms in MELAS may defy classic localization patterns, and early neuroimaging is warranted.

Case report

A 19-year-old male with Mitochondrial Encephalopathy, Lactic Acidosis, and Stroke-like episodes (MELAS) syndrome was admitted to our institution for refractory nausea and vomiting. His neurologic exam was notable for a new left homonymous hemianopsia but was otherwise unchanged from prior examinations. Brain MRI demonstrated new diffusion restriction in the right occipital lobe, consistent with an acute stroke-like episode. His laboratory evaluation was notable for lactic acidemia. He was initiated on intravenous arginine to reduce the severity of the stroke-like episode.

Over the next two days, the patient demonstrated improvement in his nausea, vomiting and lactic acidosis. On the third day of his admission, however, he developed new paresthesia and numbness starting in his left chest and arm, which then evolved over 24 hours to involve his face, including his mouth and tongue, and his right arm. The following day, his sensory symptoms had worsened and involved his entire body except for his scalp and groin. He noted difficulty with swallowing pills and speaking due to decreased sensation in his mouth. He denied headache, nausea, or vomiting, and had no bowel or bladder symptoms.

His neurologic exam revealed an intact mental status. Cranial nerves were notable for preserved sensation in V1, but diminished sensation in V2 and in V3 bilaterally. His strength exam was normal to confrontational testing. He had diminished sensation to light touch, pinprick, and temperature in his bilateral upper and lower extremities. Specifically, he reported decreased sensation to light touch in his chest, abdomen, bilateral arms and legs circumferentially, more
severe distally than proximally. Overall, his sensory deficits in the torso were more severe below T9 on his abdomen, but he had patchy, decreased sensation over his back without a clear spinal level, in a non-dermatomal distribution and sparing his groin. Joint position sense was intact. Coordination testing revealed mild dysmetria.

Reflexes were chronically absent. Based on his exam, no clear localization within the neuroaxis could be identified. He received scheduled intravenous fluids, ketorolac, and metoclopramide for presumed migraine, but noted no improvement. An electroencephalogram was performed given history of subclinical seizures but showed no epileptiform discharges. Ultimately, a repeat MRI brain as well as an MRI total spine were performed two days after onset of sensory changes.

As seen in Figure 1, repeat brain MRI revealed new diffusion restriction in the bilateral post-central gyri consistent with a new stroke-like episode likely explaining his sensory symptoms. See Video for additional sequences of the brain MRI. He was given additional IV fluids and his course of IV arginine was extended. Follow-up brain MRI four days later demonstrated interval development of new diffusion restriction in bilateral cerebellar hemispheres along with evolution of injury in the bilateral post-central gyri. Three months later, brain MRI demonstrated resolution of most areas with previous injury with exception of persistent FLAIR hyperintensity in the bilateral occipital lobes. Clinically, he continues to suffer from whole body neuropathic pain requiring multimodal therapies including acetaminophen, gabapentin, amantadine, memantine, morphine, clonidine patch, capsaicin cream, TENS unit, massage, and acupuncture. Four months since initial presentation, he remains hospitalized for inpatient rehabilitation.

Discussion
We are often taught that isolated bilateral sensory symptoms involving the face and body cannot localize to a structural brain lesion as this would require very restricted injury across multiple vascular territories and sparing most of the cortex. Migraine is frequently invoked in these patients who experience positive and negative full body sensory phenomena that include the mouth and do not map to a dermatomal distribution. This case demonstrates a rare case of stroke-like episodes involving the bilateral somatosensory cortices.

Patients with MELAS often develop lesions involving the occipital, parietal, and posterior temporal cortices. Particularly, distribution tends to favor posterior cortical regions, most commonly pericalcarine visual cortex but also the primary somatosensory cortex and tends to be asymmetric. However, symmetric lesions, such as this case, are becoming increasingly recognized in this syndrome and may occur in at least one third of stroke-like episodes. The adjacent subcortical white matter can also be involved, but deep white matter is typically spared. Other less common regions affected include lacunar territories, basal ganglia, and cerebellum.

Evidence for acute management of stroke like episodes in patients with MELAS remains limited due to lack of randomized controlled trials. The most commonly studied treatment is L-arginine, a nitric oxide precursor that specifically targets the proposed mechanism of stroke-like episodes in MELAS. Stroke-like episodes are thought to result from impaired endothelial vascular relaxation leading to a mitochondrial angiopathy and subsequent vasoconstriction and hypoxemia in the affected brain regions. Nitric oxide synthase, found within endothelial cells, converts L-arginine to nitric oxide to allow for vasodilation. A small, unblinded study of 24
patients by Koga et al. and several case reports have shown that L-arginine therapy can be beneficial in reducing the severity and disability due to stroke-episodes.⁸ Oral arginine administered in between stroke-like episodes may also reduce the frequency and severity of future stroke-like episodes.¹ The 2015 consensus statement from the Mitochondrial Medicine Society recommends the use of arginine in patients with MELAS who are suffering from acute stroke-like episodes based on this data.⁹ Citrulline, another nitric oxide precursor, has also been proposed as a therapeutic modality; however, further studies are needed to elucidate its role in acute stroke-like episodes.¹⁰¹¹

Most lesions that develop during stroke-like episodes reduce in size or completely resolve on follow-up scans, particularly early in the disease, with a clinical correlation of complete functional recovery.⁴,⁵ Some lesions, however, may develop into chronic areas of cortical laminar necrosis.⁴ Eventually, patients with MELAS accumulate disability over time resulting in neurologic deterioration and premature death, though rate and severity of progression is widely variable. Juvenile onset of symptoms portends an overall worse prognosis.¹²

This case offers a reminder of the perplexing symptoms that can occur in patients with MELAS. Among patients who are susceptible to multifocal brain injury, such as those with mitochondrial conditions, any neurologic change—even those that seem to defy classic neurologic localization—may represent brain involvement and warrants expedited neuroimaging.

**Figure 1:**
Title: Axial DWI sequence of brain MRI showing restricted diffusion in the bilateral somatosensory cortices
Video:
Title: Axial DWI sequence of brain MRI
Legend: Inferior-to-superior axial DWI slices of brain MRI showing restricted diffusion in the bilateral somatosensory cortices

Link-http://links.lww.com/WNL/B486

References


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