MRC Centre for Neuromuscular Diseases
The National Brain Appeal

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NHS Foundation Trust

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MEDICAL IN CONFIDENCE

Date: 28/11/2016
Clinic: MPL01 24/11/2016

Dr A Nesbit
Consultant Neurologist
Queen Victoria Hospital
Holtye Road
East Grinstead
RH19 3DZ

Dear Angus

Frank HOLLIS: DOB: 20/07/1957
26 The Driftway, Upper Beeding, Steyning, West Sussex. BN44 3JX

Thank you for asking me to see Mr Hollis, a 59-year-old, right-handed, retired analytical chemist whose specialty was mass spectrometry I note his extremely interesting collateral past medical history, following which all of his symptoms began. He was previously in fine health, but in February 2015 he developed a painful, swollen, hot left elbow, which sounds like a septic arthritis. He was given Flucloxacillin and took a lot of Ibuprofen. He developed a GI bleed and an iron deficiency anaemia, and had multiple gastroscopies. He was found to be profoundly Vitamin B12 deficient with a B12 of 85 and positive parietal cell antibodies, and therefore his Vitamin B12 was replaced. He continues to have replacement, taking this himself and injects 1 mg once per week, as otherwise he feels quite fatigued. He also takes an oral Vitamin B preparation, but I understand this does not have high levels of Vitamin B in it (I have checked his bloods today). As part of the biopsy taken in his gut he has been found to have carcinoid. The small carcinoid tumours are being monitored and there is no obvious symptomatology from these.

Carcinoids are not associated with any neuropathy of which I am aware and I could not find anything searching through PubMed or the neuromuscular database. Since April 2016 he has also been diagnosed with type II diabetes, now treated with diet as Metformin gave him diarrhoea (we do not know how much this can be related to his carcinoids). He has lost 12 Kg in weight deliberately and this is now under good control.

Other than the B12 he takes Gabapentin 300 mg tds. He is non-allergic, but intolerant of Metformin. He stopped smoking five years ago, having smoked for 40 years. He drinks about 20 units of alcohol per week. He is a pescatarian, with red and white meat being the only exclusions from his diet. Recently, he has also started to exclude gluten on the basis that he has some gluten antibodies.

There is no family history of neurological disease.

His history begins nearly six months after the original elbow problem. He was already having Vitamin B12 at this point and was well replaced. He developed tingly feet, starting in the big toes that spread slowly, followed shortly in the spring of 2016 by tingling in his fingers. Both hands were also affected at the same time. Sensory dysfunction had only risen into his feet by the time his fingers were affected. Now he has a short and long sock of sensory disturbance in his leg, and abnormal sensation perhaps to his proximal interphalangeal joints.

His balance has been slowly impaired. When he has been sitting for some time and stands up he feels as if he is standing on a trampoline and needs to hang on. Dodging people is difficult. He can put a sweat on still standing up but tends to lean on the wall whilst in the shower. He sleeps with a night light but has done all the time anyway. He feels as if his unsteadiness is coming from his legs, and there is no vertigo.

There is no bladder, bowel or erectile difficulty. He feels his legs are strong and he can walk 4 kilometres without difficulty. There were no other risk factors. He is not in a relationship. There are no symptoms of connective tissue disease other than the development of Raynaud's syndrome at the same sort of time as his other symptoms developed.

On examination, he walks with a slightly wide based and irregular gait. Turning is a little problematic. He finds hopping very difficult. There was some fairly dramatic falling on trying to perform a tandem walk, which was tricky.

Examination of the cranial nerves was normal. Examination of the limbs revealed no wasting or fasciculation. The right wrist was a little stiff, but there were no other extra pyramidal signs and he is aware that his right wrist has been stiff for years. Otherwise, tone was normal. Power was full in all groups. Reflexes were present at the left biceps and knees, absent at the ankles, and present with reinforcement elsewhere. The plantars were mute.

He has no pseudoathetosis, and his joint position sense is almost normal, perceived with large movements of the great toe, but is entirely normal in the upper limbs. There is a mid-length sock of pinprick abnormality, and vibration sense impaired at the tibial plateau. I could not identify any sensory loss in the arms.

Blood pressure was 178/98 lying and there was a drop to 146/94 standing, but there was RR variation and a tachycardia on standing. There are no other autonomic symptoms. At present, I would keep this in hand.

I could not find anything else upon systemic examination.

Taken purely on face value, this looks like an idiopathic axonal neuropathy, which both with his height and age would not be inconsistent. I have not seen his nerve conduction studies from Dr Chandresekera but I requested some more today, and hopefully I can then compare these with Dr Chandresekera for longitudinal change as well as look at both sets with regards to their diagnostic assistance.

Although it would make the diagnosis much more interesting, at present I do not think I would invoke another pathogenesis to his neuropathy, either related to Coeliac, Vitamin B12, or a connective tissue disease, and I do not think the GAD antibodies are relevant. These probably go along with his diabetes, albeit late onset. I think it is going to be likely that this an idiopathic axonal neuropathy, and as he is at the moment, I would not perform a sural nerve biopsy.

Therefore, at present, I would check the electrical studies and I have performed a full screen of bloods, repeating some of those that you have previously reported. If he has not had a local chest X-ray or CT, I think it would be worthwhile doing this, and I will see what has been done locally.

I have given him an appointment for six months to come back to see me as I am expecting a little longitudinal chain. Clearly, if something changes then he will get in contact in the interim.

Yours sincerely

Checked & electronically signed

Dr Michael Lunn MA FRCP PhD
Consultant Neurologist