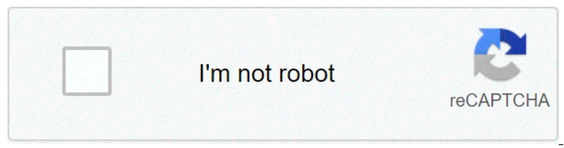

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Restless leg syndrome associated with multiple sclerosis. ISABELLA RINCHINI 1 CASE REPORT 1, Livia Pasquali 1, Ilaria Calabrese 1, Alfonso IUDICE 1 1 Neurology Unit, Department of Clinical and Experimental Medicine, University of Pisa Abstract We report the case of an 83-year-old woman suffering from leg syndrome without Rest (RLS) since 2002 and multiple sclerosis (MS) since 2007, when 72 and 77 respectively respectively. He had been diagnosed as RLS five years before MS, with the support of a polysomnographic exam. The clinical diagnosis of ms of her took place at the age of 77, while she complaining about difficulties on foot and abnormal sensitivity in the lower limbs, especially in the evening. Associated symptoms including dysesthesia on the left leg and arm and left emitrunk, reduction of visual housing, blurred and fatigue vision. The cerebral magnetic resonance has shown multiple injuries in white matter, in contrast to the vascular but suggestive disease for demylinizing disease. She was admitted to the hospital, where the examination of spinal fluid and a second magnetic resonance confirmed the diagnosis. Since the patient regularly performed medical examinations and magnetic resonance controls that showed no increase in burden or pathological improvement injuries, but highlighted a slow worsening of the ambulation. Due to the patient's eté, a disease that modifies therapy for MS has not been established, but only symptomatic agents have been administered. Keywords: seamless leg syndrome; Comorbidità A case of high-late multiple debut sclerosis casual to leg syndrome without resting CMI 2014; 8 (1): 19-23 Case Report Corresponding Author Dr. Isabella Righini Neurology Via Roma 67 â € "56126 Pisa Isabella.Righini@gmail.com Disclosure Authors declares to have no conflicts of interest related to the issues discussed in this article because © we describe this case despite the high prevalence of restless leg syndrome (RLS) in multiple sclerosis (MS), the present case is interesting for an onset of MS and the association with a RLS preceding the diagnosis Clinic of the Demilinant Disease Case Relations Pr It is a woman of 83- presented other symptoms include fatigue and dysesthesia on left limbs and left emitrusco, reduction of visual housing with blurred vision, reduction of the visual field on the left side. In the past history, you have undergone a joint prosthesis of the hip in 2001, she has had arterial hypertension and hypercholesterlamemia since 2004, and surgery for gray cataract in the left eye in 2006. The patient also reported her greater anxiety and insomnia. In 2002 she performed an electromyography exam and a polysomnographic confirmation recording. Nightly sleep showed greater sleeping latency, a shortest sleep time, less sleep efficiency, a higher excitement index, and a longer Rem sleep latency than healthy laboratory controls. Furthermore, the patient fragmentation index, the periodic index of leg movements and the periodic leggory index of the legs were all high, leading to the diagnosis of restless leg syndrome (RLS). Five essential criteria for the diagnosis of restless leg syndrome [1]: Everyone must be satisfied a desire to move legs usually but not always accompanied by or feeling from uncomfortable and unpleasant sensations in the legs the desire to move their legs and any Unpleasant accompanying sensations begin or worsen during periods of rest or inactivity how to lie down or sit the desire to move your legs and any accompanying unpleasant sensations are partially or totally raised by movement, such as walking or stretching, at least until the activity continues the desire from The legs and any unpleasant sensations accompanying during rest or inactivity occur only or are worse in the evening or night night During the day the occurrence of the above features are not exclusively accountable as primary symptoms to other medical or behavioral conditions (e.g. Myalgia, venous stasis, edema of the legs, arthritis, cramp legs, positional discomfort, touching of the usual foot) as walking difficulty increased over time A magnetic skull resonance (MRI) was performed in 2007. The examination showed more lesions of white matter whose morphology and localization were strongly suggestive for a demielinating and inconsistent disease with vascular lesions or other disorders. An ophthalmological examination found an atrophy of the left-eyed bottom, probably related to a demielinating disease. The neurological examination showed an ataxia with muscle spasticity, especially on the right side, the horizontally and vertically limitation of the movements of the eyes and a pathological reflection of the plantar skin on the right foot. Therefore, it was admitted to the hospital, where the following exams were carried out: Doppler ultrasound of cerebro-afferent ships and transcranial vessels Doppler: no abnormal findings have been detected; Visive potentials evoked (VEPS): the bilateral reduction of amplitude has been observed; The spinal potential of the lower limbs (SEP): the anomalous conduction of the central time of the engine was found bilaterally; Trigeminal facial reflection: there was the discovery of disorder of the PONs on the left side and of the bulb bilaterally; Lumbar exaggeration for puncture and spinal fluid: there was evidence of 11 oligoclonal bands; Cranial MRIs: new intracranial lesions have not been detected compared to the previous imaginary nor to the improvement of the gadolinium. The results allowed a diagnosis of multiple sclerosis (MS) (Table I). Clinical presentation Additional data 2 attacks; objective clinical trials of 2 injuries or objective clinical trials of 1 injury with reasonable historical evidence of an attack 2 Attacks; Clinical objective test of 1 diffusion of lesions in space, demonstrated by: 1 T2 lesion in at least 2 of 4 regions typical of CNS ms-types (periventricular, juxtacortical, infatentato or spinal cord); or wait for another clinical attack that implys another site of the CNS site 1 attack; Objective clinical trials of 2 lesions of diffusion over time, demonstrated by: simultaneous presence of injury of improvement of the asymptomatic gadolinium and not collected at any time; or a new lesion T2 and / or GADOLINIUM-MORILINIO on the MRI follow-up, regardless of its timing with reference to a basic scan; or wait for a second clinical attack 1 attack; Objective clinical trials of 1 lesion (medically isolated syndrome) dissemination in space and time, demonstrated to dispose of: 1 T2 lesion in at least 2 of 4 typical MS-type regions of CNS (perventricular, juxtacortical, infratentorial or spinal cord); Or wait for a second clinical attack that involves a different CNS site for DIT for: simultaneous presence of improvement lesions of the asymptomatic gadolinium and not collected at any time; or a new lesion T2 and / or GADOLINIUM-MORILINIO on the follow-up MRI, regardless of its timing with reference to a basic scan; or to wait for a second clinically insidious progression tests for dis in the brain based on 1 T2 Lesions in the MS -Features (periventricular, juxtacortical or infatentorial) regions; Tests for dis in the spinal cord based on 2 T2 lesions in the cable; CSF positive (isoelectrical evidence focused on oligoclonal bands and/or high IgG index) Table I. Diagnostic criteria for multiple sclerosis. Modified by [2] CNS: Â Central nervous system; CSF: â fluidDis: spreading in space; DIT: spreading over time; IgG: Ã, immunoglobulin g; MRI: Ã, magnetic resonance imaging; MS: Ã, multiple sclerosis; PPMS: Primary progressive multiple sclerosis has been performed a high-dose intravenous intravenous corticosheroid therapy and paresthesie paresthesia decreased. Because of its age, a disease that modifies the therapy for MS has not been initiated. Although the diagnosis of MS was made in 2007, the symptoms were in effect before, at least when he was 72 years old, but were probably attributed to RLS. The evidence of an optical atrophy in the left eye to ophthalmological evaluation at the time of diagnosis of MS supports this hypothesis. In this way, the diagnosis of an MS was established at the age of 77, but the disease probably started years earlier. A pharmacological symptomatic treatment was prescribed with prepabilatin and zolpidem, although with a low level of patient compliance. Since then, the patient continues to carry out periodic clinical checks and periodic examinations of the magnetic resonance, until now showing the stabilization of the MS lesion load. Despite this, the patient complains of a gradual increase in gait and paresthesias difficulties on the left side of the body. The main questions a doctor should ask himself in this situation Despite the age of the patient, are neurological symptoms compatible with a demyelinating disease? Are the characteristics of the magnetic resonance really suggestive for a demiliating disorder? Are clinical disorders of the patient the real beginning of MS or some previous symptoms have been neglected? What therapeutic strategy does MS deserve late debut? What level of therapeutic adherence should we expect from the patient? Multiple Sclerosis Discussion with debut after 50 years of age is usually described as LOMS, i.e. Last Multiple Sclerosis Onset. Although not common, with a prevalence calculated between 4% and 9,6,% this form of SM is usually more aggressive than the youth form called YOMS, that is Young Onset Multiple Sclerosis. In fact, LOMS' secondary progression time is quite shorter and the primary progressive course is more commonly observed in older patients. At first, clinical symptoms usually involve the engine (90% vs. 67% of the youth form) and the cerebellar system. There are no differences between LOMS and YOMS cases for sensory disorders, ataxia, alterations of eye movements, cognitive symptoms and fatigue [3,4.] A typical LOMS resonance shows supratentorial and infratentorial lesions, but more frequently spinal cord injuries are detectable. Although magnetic resonance has high sensitivity, specificity is limited due to the concomitant presence of microangiopathy linked to age in these patients, which limits a precise diagnosis. de la Seze et al. conducted a clinical study in LOMS patients evaluating the sensitivity and specificity of Barkhof MRI criteria for MS [5.] The results of the studies have shown that in this group of patients Barkhof criteria are less specific. In addition, injuries that improve gadolinium are not frequently detected, probably due to a predominance of a degenerative process instead of inflammation. Authors suggest to perform a spinal fluid and VEP examination in LOMS patients, to add specificity to magnetic resonance. In fact, the oligoclonal bands are present in LOMS in the same percentage of YOMS patients. A major problem emerging from clinical studies is a usually delayed diagnosis in LOMS patients. A differential diagnosis should always be investigated. Common differential diagnoses include: Brain or spinal vascular syndromes; problems related to hypertension; Compressive myeloids; Primary or secondary vasculitis; Metabolic diseases; Degenerative syndromes; nutritional deficits; chronic infections (i.e syphilis, Lyme disease, HTLV-1, HIV;) Paraneoplastic syndromes [6.] Another interesting feature of this case, but described in the literature, is the comorbidity with the Syndrome of Restless Legs (RLS.) RLS is defined as disorders of theInvoluntary legs, with unpleasant sensitivity, starting or worsening during sleep. Disorders improve with movement [1.] RLS pathophysiology is probably related to a dopaminergic system dysfunction, as the current test suggests. In 2008, a multicenter study [7] showed greater RLS prevalence in patients with SM compared to healthy controls. Also, RLS comorbid seems to look More frequent in elderly subjects, in patients with a long history of MS, with relevant disabilities and an involvement of pyramid and sensory systems evaluated by the expanded disability status scale (ESS game). Another hypothesis emerging from the same study is the existence of a secondary shape of RLS, due to the same MS. This hypothesis is supported by some tests, since the association with a greater level of disablement implies a more aggressive course than MS. The start of RLS usually follows the diagnosis of MS (about 5 years later) and the symptoms are usually asymmetrical. However, in a small subgroup of patients, RLS can come before the diagnosis of MS. Key points The start of MS in elderly subjects is unusual and is described as Loms (Multiple Sclerosis Late Onset) when the start takes place after the age of 50 Loms has some clinical and neuroradiological characteristics typical: prevalence of motors symptoms and cerebellars; Low frequency of injuries increasing gadolinium. MRI typical characteristics are more frequently represented by multiple degenerative lesions with respect to inflammatory areas in these MS patients of the ordinary high the differential diagnosis with other diseases of white matter is essential, that is to say vascular, infectious, paraneoplastic, metabolic disorders or shortcomings nutritional, which could delay the correct diagnosis The association between the multiple leg syndrome and the restless leg syndrome is sometimes observed and has already been reported, especially in the elderly therapeutic algorithm patients in clinically isolated syndrome (CIS) will participate in the Clinical and neuroradic follow-up strategy Immunomodulatory drugs: Clinically define multiple sclerosis (CDMS) Relax Primary Primary Secondary Progressive Therapy Progressive Therapy Induction Immunomodulatory Therapy Immunosuppressive Therapy First Line Therapy Immunomodulatory Drugs: Immunosuppressive Medications: M ITOXANTRONE NATALIZUMAB CYCLOPHOSPHAMIDE IFNÍ²1B MITOXANTRONE Therapy Second Line Immunosuppressive Drugs: Natalizumab Fingolimod MithoxAntrone Others (Azathioprine, Cyclophosphamide) Maintenance Therapy: Immunomodulatory Therapy Therapy Thereably Stem Cell Transplant Autologous References 1. 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