


MINISTRY OF EDUCATION AND SCIENCE OF THE KYRGYZ REPUBLIC

Osh International Medical University

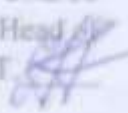
Department of Clinical Disciplines

Department of Therapeutic Specialties Programs

REVIEWED

At the department meeting, protocol No. _____
From "11" 11 2024
Department, Nurlanova N.N. 

APPROVED

Chair of the UMS OMMU
Pr No. 3 dated 11/11 2024 Head 
Toktonazarova N.T.

EXAMINATION STATION PASSPORT

«Myasthenia gravis»

Discipline: Neurology

Compiled by: Karaev A.

2024

Neurology Station

Materials and equipment for the station:

1. Neurological hammer
2. Tonometer for measuring blood pressure.

Clinical case

Patient: Bazarbaev Israilzhan, born in 1958

Complaints upon admission: choking when eating, difficulty swallowing, nasal voice, hoarseness, difficulty and rapid fatigue when talking, general weakness

Medical history: according to the patient, he has considered himself ill for about 4 years. The onset of the disease was gradual, against a background of generally satisfactory health. The first symptom was weakness of the eye muscles, which intensified in the evening. Then, the left upper eyelid gradually began to droop. She consulted a neurologist about this and is taking 60 mg of Kaleemin 3 times a day. About 3 months ago, she noticed similar symptoms on the opposite side, and ptosis of the right eyelid developed. Two weeks ago, blepharoplasty was performed on both eyelids. After the operation, she experienced severe weakness, shortness of breath, coughing, choking when eating, and fatigue when talking, so she went to the clinic, where she was hospitalized for examination and treatment.

Medical history: social and living conditions are satisfactory. No occupational hazards. Bad habits: denies. Allergic history: Population "A". Risk factors: gender, age. Objective data on admission: General condition is moderately severe. Nutrition is adequate. Skin is clean, normal color. Lymph nodes are not enlarged. Nasal breathing is free, chest is cylindrical. Breathing over the lungs is hard, with fine bubbling rales. RR-22 per minute, SPO₂- 98%. Heart area is unchanged. No pathological pulsations. Heart sounds are muffled, rhythm is regular. Blood pressure is 130/90 mmHg. Heart rate is 88 beats per minute. The jugular veins are not swollen. The veins of the lower extremities are normal. The tongue is moist and clean. The abdomen is soft and painless. The liver is not enlarged according to Kurlov's measurements. Percussion symptom along the XII rib is negative. No peripheral edema. Stool is regular and well-formed. Urination is free and regular.

Neurological status: conscious. Oriented to place and time. Moderate dysarthria. Decreased concentration and memory for current events. CMN: asymmetry of the eye slits due to right ptosis, pupils OD=OS, rounded. Direct and consensual pupil reaction is reduced on both sides. The range of motion of the eyeballs is not limited. Horizontal nystagmus on both sides. Decreased convergence on the left. Vertical and horizontal diplopia is noted, disappearing when one eye is closed. No facial asymmetry. Dysphonia. Tongue dextra. Uvula sinistra. Tendon and periosteal reflexes are symmetrical, of medium intensity. Muscle strength and tone within normal limits. + Marinescu-Rodovici symptom on the right. Paresthesia-type sensory disturbance in the distal parts of the lower extremities. No meningeal signs. Stable in Romberg's position. Coordination tests missed on both sides, without intention. Pelvic functions are controlled. What is your next step? You have 10 minutes to collect a focused history, perform a focused examination, and prescribe treatment. Standardized patient assessment sheet.

Resident _____ Year _____

№	Stages	Mark of completion		Patient response and action
		Points	Points	
Real medical history. Examined.				
1.	Did you ask what symptoms the patient had?	0-1		Choking while eating, difficulty swallowing, nasal voice, hoarseness,

2.	Did you ask when they got sick?	0-1		difficulty and rapid fatigue when talking. The patient has considered himself ill for 4 years.
3.	Did you ask if they had headaches?	0-1		No
4.	Did you ask what they thought caused their illness?	0-1		Cannot be linked to anything specific
5.	Did you ask if there were daily fluctuations?	0-1		Yes
6.	Did you ask what medications they were taking?	0-1		Kalimin
Physical examination. Examiner				
7.	Did you wash your hands before and after the examination?	0-1		Yes
8.	Did you assess the patient's general condition?	0-2		Yes
9.	Did you examine the skin?	0-2		Cold
10.	Did you give the patient a thermometer to measure their body temperature?	0-2		Yes. Temperature 36.8°C.
11.	Did you assess the condition of the respiratory organs? Did you listen to the lungs with a stethoscope and count the respiratory rate?	0-2		Respiratory rate 22 per minute, breathing weakened in the lungs due to paresis of the respiratory muscles, auscultatory clear, without wheezing or crepitus.
12.	Did they palpate the heart area and determine the boundaries of relative cardiac dullness by percussion?	0-2		The borders of relative cardiac dullness are enlarged upward and to the right.
13.	Did they auscultate the heart? Heart sounds and murmurs. Heart rhythm, heart rate, pulse, blood pressure.	0-2		Heart rate is 88 per minute. Blood pressure is 130/90 mmHg.
14.	Did they assess neurological status?	0-2		There is generalized paresis of the skeletal muscles, bilateral ptosis, and diplopia.
Laboratory tests				
15.	Complete blood count (CBC) and standard biochemical tests (glycemia, cholesterol, kidney and liver tests)	0-3		Complete blood count: General clinical and biochemical tests within normal limits
16.	ECG	0-3		ECG: Sinus rhythm, heart rate 88 beats per minute. Normal EOS position. Repolarization disorders
17.	Echocardiogram	0-3		No a-zones or hypokinesis detected. Chamber sizes within normal limits.
18.	Chest X-ray	0-3		No abnormalities
Communication skills. Examiner				
19.	Greet and introduce yourself? Say goodbye?	0-1		Yes Yes
20.	Did you ask permission to examine him?	0-1		Yes, the patient agreed.
21.	Did you inform him of the preliminary diagnosis, possibly generalized myasthenia gravis?	0-5		Yes, explained the clinical picture.
22.	Did you explain the consequences if the patient does not undergo	0-1		Worsening of myasthenia gravis.

23.	dispensary observation? Did you discuss further treatment tactics (conservative or surgical treatment)?	0-5	Adequate anticholinesterase therapy.
24.	Did you explain the consequences of not undergoing treatment?	0-4	Yes. Since there is a possibility of a serious complication such as a myasthenic crisis with the development of acute respiratory failure.
Total:			
<i>If the examinee scored:</i> 45-50 points - "excellent" 36-44 points - "good" 26-35 points - "satisfactory" 25 points and below - "failed"			

Observer's full name and signature _____

Date and time _____

Legend for the patient

Bazarbayev Israilzhan, born in 1958

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Objective data on admission: General condition is moderately severe. Nutrition - adequate. Skin is clean, normal color. Lymph nodes are not enlarged. Nasal breathing is free, chest is cylindrical. Above the lungs, breathing is hard, with fine bubbling rales. RR-22 per min, SPO2- 98%. Heart area unchanged. No pathological pulsations. Heart sounds muffled, rhythm regular. Blood pressure 130/90 mmHg. Heart rate 88 beats per minute. Neck veins not swollen. Veins of lower extremities normal. Tongue moist, clean. The abdomen is soft and painless. The liver is not enlarged according to Kurlov's measurements. The symptom of tapping on the XII rib is negative. There is no peripheral edema. Stool is regular and well-formed. Urination is free and regular.

Neurological status: conscious. Oriented in place and time. Moderate dysarthria. Decreased concentration and memory for current events. CMN: asymmetry of the eye slits due to right ptosis, pupils OD=OS, rounded. Direct and consensual pupil response reduced on both sides. Range of eye movement not limited. Horizontal nystagmus on both sides. Reduced convergence on the left. Vertical and horizontal diplopia noted, disappearing when one eye is closed. No facial asymmetry. Dysphonia. Tongue dextra. Uvula sinistra. Tendon and periosteal reflexes are symmetrical, of moderate intensity. Muscle strength and tone are within normal limits.+ Marinescu-Rodovici symptom on the right. Paresthesia-type sensory disturbance in the distal parts of the lower extremities. No meningeal signs. Stable in Romberg's position. Coordination tests are off target on both sides, without intention. Pelvic functions are controlled.

Data from laboratory and instrumental examination methods:

Complete blood: Hemoglobin - 143 g/L, Erythrocytes - $4.88 \times 10^{12}/L$, Leukocytes $7.86 \times 10^9/L$, ESR - 13 mm/hour, Eosinophils-Monocytes - 12.3%, Lymphocytes - 30.8%, Thrombocytes - $177 \times 10^9/L$.

OAM: color - yellow, transparency - cloudy, density - 1030, pH - 6.5, protein - 0, flat epithelium - 3-4-5, leukocytes - 1-2-2, salts - 0, mucus - 0.

Biochemical analyses: ALT- 30.6, AST-29.3, urea- 5.89, total protein-72.6; total bilirubin-7.3; direct. Bilirubin-0; Thymol test-1.96. Blood creatinine-89.9, residual nitrogen-19.76. Blood sugar-5.78. Total cholesterol-4.91; Postprandial glucose-14.86. Glycohemoglobin - 10.0; tests from 07/01/25 Blood glucose - 5.40, Blood glucose after eating - 7.70; Calcium - 3.90. Procalcitonin - 0.22; Sodium - 143.0.

Instrumental:

1. Ultrasound of the abdominal organs and retroperitoneal space dated 06/25/26: Echo-enhancement of hepatomegaly, diffuse changes in the liver parenchyma similar to fatty hepatosis, diffuse changes in the pancreas similar to lipomatosis, chronic cholecystitis, and microliths in both kidneys.
2. MSCT OGK dated 25.06.25: MSCT data may correspond to chronic bronchitis with mediastinal lymph node adenopathy. Osteochondrosis of the thoracic spine. No data on infiltrative changes in the lungs were obtained. In the field of study - multiple cystic formations of the liver parenchyma (inflammatory in nature? Simple cysts?).

Conclusion:

Based on the examination data, taking into account the complaints, anamnesis, objective and neurological examination, as well as laboratory and instrumental examination data, the patient was diagnosed with widespread muscle weakness (myasthenia gravis) isolated to the skeletal muscles, with a predominance in certain muscle groups (orbicularis oculi, bulbar, and respiratory), due to neuromuscular transmission block (motor end plate dysfunction), based on which the diagnosis is likely to be:

DS: Myasthenia gravis, moderate severity, stationary form class II B, incomplete compensation against the background of AHE.

5. Examination plan (check the appropriate box).

1. Interview.
2. Medical history.
3. Patient examination.
5. Objective data.
6. Neurological status.
7. Laboratory data.
8. Discussion of the diagnosis, treatment tactics, etc.
9. _____
10. _____
11. _____

Doctor (Last name, first name, initials, legibly)
