

Summary

Mr M, a 65 years old functionally independent smoking male who was a determined patient to have hypertension, however not on general treatment presented with sudden onset left sided face, arm and leg weakness with dysarthria and dysphagia without visual impairment. Clinical examination revealed left sided hemiplegia associated with left upper motor type facial nerve weakness and palatal weakness. His blood pressure was 130/90 mmHg. An ejection systolic murmur was heard over the aortic area which was compatible with an aortic stenosis. His lower limb pulses were feeble, presuming peripheral vascular disease. An acute stroke was suspected and non-contrast CT brain done, which demonstrated right middle cerebral arterial territory infarct involving the internal capsule and surrounding basal ganglia. A diagnosis of lacunar circulation infarct was made. He was managed without thrombolysis therapy. During the ward stay he was screened further for vascular risk factors. His lipid profile uncovered dyslipidaemia and 2D echo had aortic stenosis and left ventricular hypertrophy. Carotid duplex was negative for plaques and other investigations were normal. He developed mild depression and a lower respiratory tract infection which was managed medically. With the assistance of the multidisciplinary team a comprehensive management was done with special emphasis on rehabilitation. After discharge he was followed up at neurology clinic and rehabilitation arranged at rehabilitation hospital Ragama. Home environment modification and provision of walking aids were done. Despite the fact that his Barthel's index was 2/20 on admission, it enhanced to 5/20 on discharge and 10/20 after one month.