Summary

74 year old male patient with past medical history of diabetes mellitus for last fifteen years with peripheral neuropathy, no macrovascular or autonomic complications, with an HbA1C of 10.1% presented with right hip pain with restricted movements like walking and getting up from a seated position for three weeks duration. Pain was increasing in severity and persisted throughout the day and even during night. He also gave a history of double vision with left lateral gaze for past one month duration which was not preceded by headache, visual blurring ,red eye, proptosis and upper limb or lower limb weakness or numbness. On examination there was left lower limb proximal muscle weakness and wasting with absent knee jerk. Right hip movements were painful, tone was normal, power was more than grade three but full power assessment was difficult due to pain at hip. There was bilateral stocking type peripheral neuropathy and left lateral rectus palsy with no other long tract, cerebellar or cranial nerve involvement. Investigations revealed high ESR of 113mm in the first hour with slightly elevated CRP of 15mg/L, anaemia with haemoglobin of 10g/L and blood picture evidence of normocytic normochromic anaemia with marked rouleux formation. Renal functions were normal. Liver functions were normal except slightly reduced serum albumin 3.4g/dl (3.5-5.5g/dl). Serum calcium was normal. X ray pelvis had a large lytic area over the right ischium and inferior pubic ramus with rest of the skeletal survey been reported as normal and serum protein electrophoresis showed biclonal gammopathy. Bone marrow aspiration and trephine biopsy had evidence of hypercellular marrow with 50-60% of marrow infiltration by

plasma cells. Nerve conduction and electromyography of bilateral lower limbs confirmed the presence of bilateral sensory motor axonal peripheral neuropathy and bilateral chronic L3-L5 neurogenic changes due to either radiculopathy or amyotrophy. MRI of the lumbosacral spine ruled out compressive radiculopathy. Patient was diagnosed as having multiple myeloma and diabetic amyotrophy with left abducens nerve palsy and bilateral sensory motor axonal peripheral neuropathy with long standing diabetes with impaired glycaemic control. Oral hypoglycaemic agents were optimized and neuromodulator medication for chronic neuropathic pain was initiated. Patient was referred for haematoncology opinion, where he succumbed to illness following initiation of chemotherapy.