

Abstract

Ataxia is a common clinical presentation. For the development of ataxia two neuronal pathways have been postulated. Those are the cerebellum with its connecting pathways or the proprioceptive sensory pathway. Clinically the two systems can be differentiated and it is the key factor in making the diagnosis. Diseases like infections, inflammatory and demyelinating conditions in the cerebellum or its connecting pathways can cause cerebellar ataxia and involvement this system contribute to most of the cases. Sensory ataxia can be the manifestation of either a large fiber peripheral neuropathy or a disease process of the dorsal column of the spinal cord. Further, the different components of the peripheral nerve can be involved which include dorsal nerve root, dorsal root ganglia or sensory nerve. So in patients with sensory ataxia it is essential to investigate and identify the exact component involved since it aids to guide the treatment as well as to understand the prognosis in different situations. In this case report I describe a sixty-two-year-old male patient diagnosed with hypertension and dyslipidemia for seven years duration who presented with progressive ascending bilateral lower limb numbness for four years, upper limb numbness for one year and associated gait imbalance with tendency to fall to sides for the same duration of time. Examination revealed an ataxic patient with a positive Romberg's test but other sensory, motor and cerebellar systems were normal. His brain and spinal cord imaging were normal and had a cerebral spinal fluid cyto-protein dissociation. Investigations with regard to peripheral neuropathies were negative and had a normal nerve conduction study but somatosensory evoked potential was absent on both lower limbs. A probable diagnosis of chronic inflammatory sensory polyradiculopathy was made and the patient responded to a course of intravenous immunoglobulins.