

The Self-Analysis of a Clinical Neurological Case

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Abstract

Being a professor of psychiatry I submit my own vascular stroke episode, the evolution of the symptoms and the treatment to recovery.

Keywords: Vascular stroke; Symptoms; Evolution

Short Communication

Here are the premises of the usefulness of the present text:

It has been proven by the history of each science in turn and again consistently supported by the philosophy of science that the inferential explicative and generative novel value of a case is far superior to any theoretical model [1].

Introspection is part of the universe of singularities, yet, it is sufficiently general to allow deductions and explanation of certain phenomena by means of similarity [2]. Most clinic psychiatric information is obtained by inter-meditative introspective method. Thus, we question the patient about experiencing suicidal ideas, or, if they hear or see things which others do not, in the absence of a hallucinatory behaviour. Information obtained in this introspective manner is then successfully used clinically, as objective information.

We have gained a segmental understanding of things, due to our education and exposure to specific scientific discourse, thus we see a mosaic made up of particularities which relate congruently but not continually [3]. Reality is, however, systemically holistic, a synthesis of particularities not merely their sum. We regard psychiatric, psychological, neurological, neuro-physiological, neuro-psychological phenomena as distinct. In fact, we are facing a psycho-neuro-scientific universe in which each specialization has its own field, but they are interdependent.

The way of the progress of science through science has exhausted its creativity. If the 18th and 19th century were the birth times of most sciences and the 20th century, their blooming period as independent disciplines, the 21st century is the time of inter-disciplinarily. The current stage of acquiring information is supported fore mostly by inter-disciplinarily.

Therefore, please allow me the analysis of the following case, which is unfortunately, mine.

I am a 67-year-old psychiatrist. When 60 I had an anterio-inferior myocardial infarction, followed by a stent implantation and a bypass-internal left mammary artery-anterior coronary artery. My blood pressure was 135-140 with 65 mmHg to 70 mmHg and I controlled it with co-aprovel 150 mg/morning while for blood coagulation I took Trombex 75 mg/evening. I had willingly ceased to take statines after

reading several studies which argued that it did not diminish in any way the decease rate after myocardial infarct, while posing other health risks. My cardiac evolution was good, I was clinically fit, with minor limitations. My cardiologic check-ups were worrisless. I had never had heart pace disruptions. I do not suffer from diabetes. I underwent two complete vascular check-ups.

In each case, the eco-Doppler revealed an atheroma slightly above the bifurcation. The obstruction was >50% for one and <50% for the other. The conclusion was that the cursor of the device was to blame. On the 14.01.2016, I was driving in a state of calmness and serenity, without any previous anger or strong emotion and I felt that the steering wheel was electrocuting my right arm. Startled, I lifted my hand to notice it more attentively and, to my utter surprise, I saw thin electric arches flashing between my fingers and the wheel. I immediately realized that these were hallucinatory phenomena [4]. but, a second later, my hand collapsed, as if struck by lightning. A traffic light was following. I pulled the car over. I tried to lift the upper part of my right arm with the left one and I noticed that it was numb/inert. Judging by how fast it was installing and knowing my history, I immediately realized that I was experiencing a Sylvian thromboembolic stroke. I automatically became some sort of a biological robot, emotionally insensitive but possessing reason and regarding myself as a clinical case. We are naturally built as proficient self-regulating systems. I intended to get home, to announce my family and to call the ambulance. Driving one handed, I reached my home in about 7 minutes (I was in proximity). After parking in the garage, I noticed that I was salivating on my right side. I felt my right cheek with my left hand and I noticed that it was numb. I went upstairs, holding my phone in my hand so I can announce my wife in case of blurred consciousness. Once I got upstairs, I checked and noticed that my right leg was fine but trying to get undressed using only your non-dominant hand is pitiful. I checked my blood pressure. It was 197/110 mmHg. I took a hypotensive pill and called my daughter to whom I could only say 'I have had a vascular attack. I am in my bedroom'. In approximately 5 to 6 minutes, both my daughters and wife arrived home, having called for an ambulance on the way. The ambulance arrived after 2 to 3 minutes. It took 10 minutes to reach the hospital, so from onset to hospitalization it took approximately 30 minutes. While in the ambulance, I noticed that I regained some vigour in my right arm and I could move imprecisely both my arm and forearm.

I arrived at the emergency unit where they confirm the right upper hemiparesis and dysarthria. I could not perform fine movements with my right arm.

BP=160/90 mmHg

Glycemia=110 g/dl

Cholesterol=258 mg%

I told everybody that this was a thrombotic stroke and that the high blood pressure was reactive, but, due to the BP level, the brain CT was delayed. 16 days later, in an Angio MRI, the origin of the thrombosis could be seen-a soft atheroma on the aortic arch, an area which I had not investigated before.

The symptomatology evolution is interesting and inferential. Peripherally, I regained force in my right arm, then in the hand and fingers, but without aimed purpose, meaning, I could not use them for what I wanted to do: button or unbutton clothes, get dressed etc. I only managed to do that specific action after another 3 weeks. I am used to shaving with my right hand, but it was impossible to fix the razor on my cheek even by using the mirror. I would fix the razor with my left hand and drew it with my right. Only after 35 days did, I manage to shave with my right arm. It all showed that, in extension, the muscular force, the spontaneous movements, the fine untargeted movements, the ones with complex address, all occupied different areas of the neuronal geography. Going from one recovery stage to another, implied moving from one neural space to another.

Deglutition was possible only in case of solid food and not for liquids, which implies much finer co-ordination. This lasted for about 3 weeks. At first I discovered and then perfected the technique of pouring water and other liquids by tilting my head to the left as to use the left deglutition muscles or I would choke.

There was a lack of coordination between the left and the right side of deglutition. Consequently, the two categories had two different neural coordination centres, which stopped coordinating. My right face paresis created two difficulties. First, mastication was possible but moving the food towards the pharynx was scarce, thus food was deposited in a bag under the numb cheek, as in the case of hamsters. It was a rather embarrassing experience as I had to isolate myself and remove the unchewed food by using a finger. The first muscles to recover were the ones responsible for smiling, and then the tone of the cheek increased, enabling me to get rid of the 'hamster bag'. The right eye lid muscles followed and 60 days later I was able to wink with my right eye without closing the left one as well.

The electrical stimulation recovery was much delayed due to the fact that during my fifth day in hospital, I caught a minor flu, which was gone in about three days, but which left me with a terrible cough. Practically, for the next 10 days and nights, I walked continually, coughing continually, like in a coughing status similar to an epileptic status.

I was desperate, being aware of the possible consequences and of the fact that no remedy had a therapeutic effect. While coughing the intracranial pressure rises, abruptly multiplying, and thus facilitating the transformation of a thrombotic stroke into a double thrombotic and haemorrhagic stroke with infamous prognosis. The pulmonology exam, the X-ray and the ENT exam were all negative.

I realized then (5 days after the stroke I checked out of the hospital and took the problem into my own hands) that I was dealing with a pathological reflex, given the state of my brain [5]. I attacked it with

Tegretol and Paxilidone. It died out after 24 hours, but this association turned me into a vegetable. Although the stroke occurred in the anterior part of the brain, and the cough main mechanisms are far from that area, the pathological reflex was installed and the entire brain was suffering from the shock.

The cough pointed out that a part of the brain, a part of the neuronal population, can organize in an autonomous system, separated from the rest of the nervous system, functioning automatically, recharging in the same way as instincts do the neuronal populations recharge automatically and, when lacking a natural way to discharge, they discharge automatically.

Another pathologic surprise was the emotional instability with an affective invariable. The affective system is the resonance box of each event, information and it translates the meaning of that certain information with our ontogenetic print. It responds to stimuli, reacting under the control of conscious reason, which corrects and tempers down 'echoes'. In my case, the neuronal block of the affective system was functioning automatically, uncontrollably, disconnected from the rest of the system. Images which were mildly compassionate, films, or fiction would provoke me to weep bitterly, while watching myself unable to control anything. The connections of that neuronal block had disappeared [6]. I was witnessing my own self being made up of block-systems all disconnected from each other and able to function on their own. Actually, the resonance box stayed connected with memory. That was the first time I became anxious, as such emotional instability removes one from the social circuit. It was over in about 10 weeks after self-medication with Tianeptine 10 mg twice daily.

One of the most interesting aspects to follow was the evolution of my speech defects. The first shocking thing was on the day the stroke, when I discovered that, in order to speak, I had to hold the right half of my lips with my fingers. Their numbness made my speech hard to grasp. But my left half was functioning. In about 10 days I was able to give up this speech strategy. Another aspect amused and worried me at the same time. I meant to say one thing and spoke another. Thus, I meant to say 'I would have liked' and ended up saying 'You would have liked'. Instead of 'these conditions' I said 'these conclusions'. It was as if I had ordered a mechanical arm to pick a certain word from a shelf and it always picked the word next to it. No matter how much I repeated, I still had 'conclusions' instead of 'conditions'. So, the error was stable. But I was not only mistaken words, but vowels as well. I would swap 'e' for 'l' and 'o' for 'u' and vice-versa. With consonants, I had difficulty only with more complex groups which merged. For instance, I pronounced several times 'esteem' instead of 'extreme'. My fluency was affected and some phonemes disappeared if I intended to speak at my usual pace. Thus, when I meant 'I want two' I would pronounce 'I want oo'. If I made the effort to speak slowly, these mistakes did not happen. I had to slow down my speech speed. My thought could access the word and sound base but the speech command was imprecise at my previous speech rate, which was natural and familiar.

In the final evolution of dysarthria, moving from one word to another in fluent speech depended on the speech pace. If I spoke fast, my 'mechanic arm' did not manage to 'pick the entire word', thus twisting and jumbling syllables or connecting words by dropping the first syllable of the next word. I had the strange sensation that my 'mechanic arm' was crushing words. If I paid attention and exercised control and slow down my speech, the defect would disappear. It was as if this executive function occurred on two levels- the frontal one (the thought) and dorsally (word base), thus pointing out to at least three neuronal transmitters of this function: the thought, the arm and

the base. The difficulty occurred when accuracy was needed while moving between these transmitters and speed made things more difficult.

All these speech difficulties gave in in about 12 weeks. They were the most lasting ones. As medication, I used Plavix 0-0-1, Aspirin 150 mg 0-0-1, Co-aprovel 150/12.5 1-0-1, Crestor 20 mg 0-0-1, Nootropil 1200 mg 1-1-0, Pramiracetam 600 mg 0-1-0, continuously, and for 10 days/month rapid intravenous infusions with saline solution and 2 ampoules of Cerebrolysin daily, associated in the same mix with Thiossen 1 ampoule daily. I was assisted by a physiotherapist. The facial electro-therapy consisted of 18 sessions initially and then two sessions every weekend. I performed my own speech practice in the mirror. Actually, with the exception of medication [7] and facial electro therapy, the rest of the treatment was self-practice: with the muscles of the right arm, with the facial muscles, speech practice in front of the mirror. Not lastly, the Schultz autogenic training, which I have been practicing since youth, was very helpful.

Conclusions

- In the situation of a pathological vascular event is preferable to examine the entire vascular system, for prophylactic purposes.
- No therapeutic approach can replace the recovery resources of the body, just as antibiotics do not help in AIDS treatment. We conclude that all treatments appeal to enabling and strengthening natural mechanisms of compensation and recovery and they cannot be approached in a reductionist manner, neither biologically, nor psychologically. They must address all pathological and sanogenic segments of four levels of each human being.

- There are pathological conditions which can determine the disconnection of certain neuronal populations, of certain segments of the brain, and that these disconnected segments can function automatically and independently, according to specific stimuli, without total or partial possibility of conscious control.
- The case points out that the structure-function relation in the case of the CNS is more complex and subtler than we know at present. Centre's like the Broca map type seem to be nuclei with neurological functions and they have behind them a super-structure which is not clearly located, it is diffuse and connexial and links various specific structural-functional segments in the brain. In other words, it is more comprehensive to regard the brain as having a double structural component, one clearly located and with phylogenetical origins and a diffuse one resulting from the functional development of the brain. The diffuse structure is the one which gives unity and systemic globalist to the brain.

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