

# A Case Study of Quadriparesis in Pregnancy

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**Abstract-** This case report depicts a patient of abrupt onset quadriparesis at term pregnancy and highlights the problems of addressing not only the neurological issues but also pregnancy complications, fetal distress, operational delivery, and the associated danger of autonomic hyperreflexia.

**Index Terms:** quadriparesis, term pregnancy, ATT, TB.

the c3–c4 level, both of which are most likely caused by tuberculosis. Following the meeting with the neuro physician, the patient's ATT was initiated, and the neurological problems were treated. By week 36 of pregnancy, the patient's condition had much improved. She was able to actively assist in performing upper-limb movements, but the lower limbs have not made much progress. The patient was ambulatory and appeared healthy when she finished her pregnancy.

## I. INTRODUCTION

Although it is uncommon, pregnancy-related tuberculosis has been identified as a severe cause of morbidity and mortality[1]. I describe a case of a primigravida with a term pregnancy who developed quadriparesis suddenly in this article. Regardless of the origin, acute spinal cord compression poses the danger of autonomic hyperreflexia which may be challenging to treat. It is a potentially fatal condition. The fetus is also at high risk, and fetal factors greatly influence clinical judgment. The story that follows highlights the necessity of effective teamwork in the management of such patients

## II. THE CASE STUDY :

A 25-year-old primigravida who was 32 weeks along in her pregnancy had intermittent fever for the previous two months, appetite loss for the previous month, and acute neck pain. Within a few days, she also developed bilateral upper and lower limb paralysis, numbness, and bladder and bowel incontinence. She had frequent antenatal care elsewhere throughout her pregnancy. She was found to have a normal sensorium, no cranial nerve involvement, grade zero motor function in both lower limbs, grade 3 motor function in the right upper limb, and grade 4 motor function in the left upper limb, along with objective loss of pain, touch, and joint position feeling below C5. Both the motor and sensory engagement were asymmetrical, favoring the left side over the right. Moreover, she had retained urine. Her deep tendon reflexes included missing triceps and brachioradialis, bilaterally enlarged biceps (right more than left), sluggish lower limb reflexes, and a quiet planter response. A flat umbilicus, poor coughing, tachypnea, hypotonia in both lower limbs, and hypotonia in the right wrist and fingers were further noteworthy observations. The special senses were within normal limits and there was no indication of meningeal irritation. An MRI of the cervical spine showed bone failure and spinal cord compression at

## III. DISCUSSION :

Hematogenous or lymphatic secondary infections are the main routes by which spinal TB develops. In more than 50% of cases of spinal TB, the Pott's spine is affected by tubercular spondylitis. Depending on the region of involvement, patients with this condition have low back discomfort, vertebral deformity, psoas abscess, etc Spine tuberculosis during pregnancy is quite uncommon. Pott's spine can be treated conservatively with multidrug antitubercular chemotherapy if it is not complicated by neurological deficiency or severe vertebral body destruction. It is appropriate to supplement with pyridoxine and move quickly while wearing a suitable brace. Surgery to decompress Pott's spine may be necessary if neurological problems make it more challenging. While some specialists recommend operating after delivery, others favor early surgical decompression in all[2].

Due to restricted accessibility, surgery during pregnancy is challenging and puts the developing fetus at risk for preterm labor and anesthesia. While ATT can successfully cure paraparesis or paraplegia in some individuals, other patients urgently need cord decompression, particularly those who have growing neurological impairments or who are resistant to chemotherapy. Individuals with a limited neurological deficit and short symptom duration have a better probability of making a full or nearly full recovery[3]. Preterm labor, autonomic hyperreflexia, decubitus ulcers, and urinary tract infections are more common in pregnant women with quadriparesis. In our case, none of these were present. The choice to perform an elective cesarean depends on the individual circumstances. Delivery by vagina is secure. Early i/v/o spinal tuberculosis induction is not recommended.

## IV. CONCLUSION :

Quadriparesis and tuberculosis in pregnancy are uncommon, but when they do occur, these patients must be

addressed using a multidisciplinary approach to reduce risks and complications, as well as maternal or fetal morbidity and mortality.

cases of spinal tuberculosis with neurological deficits during advanced pregnancy have been reported in The Spine Journal, Volume 11, Issue 1, January 2011, Pages e9–e16.

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