

Case Series: 2 Post Covid Young Strokes-12 And 16 Years

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Date of Submission: 03-02-2022

Date of Acceptance: 16-02-2022

I. Introduction:

Stroke in young adults comprises 10-15% of all strokes among patients.¹

Approximately 15% of Ischemic strokes occur in young adults. This is the major cause of morbidity & mortality in young patients.

Incidence of young stroke is on the rise. Along with various traditional risk factors, there are some emerging vascular, genetic and other unidentified risk factors implicated in the etiopathogenesis of young stroke

Background

Recognition of underlying vascular and genetic risk factors² may improve the awareness and optimise the outcome in young stroke patients.

Recent advances in the imaging technique, genetic testing and newer vascular imaging techniques has identified frequent abnormalities within the intracranial arteries, now labelled with a nondescript general term arteriopathy³

The major causes of brain ischemia in children are

1. cardiac origin embolism
2. Arterial dissection
3. sinovenous thrombosis
4. coagulopathies
5. Arteriopathies.

Another important recent advance is development of registries and databases. Whether vascular or cardiac, these help the experts to develop effective guidelines for the prevention and treatment of young stroke patients

II. Case Report:

Cerebrovascular accident are more common in the Covid pandemic era.⁴

Ischemic stroke shows a 100 fold increase with very high mortality rate in adults. But in paediatric age group, this scenario is different.

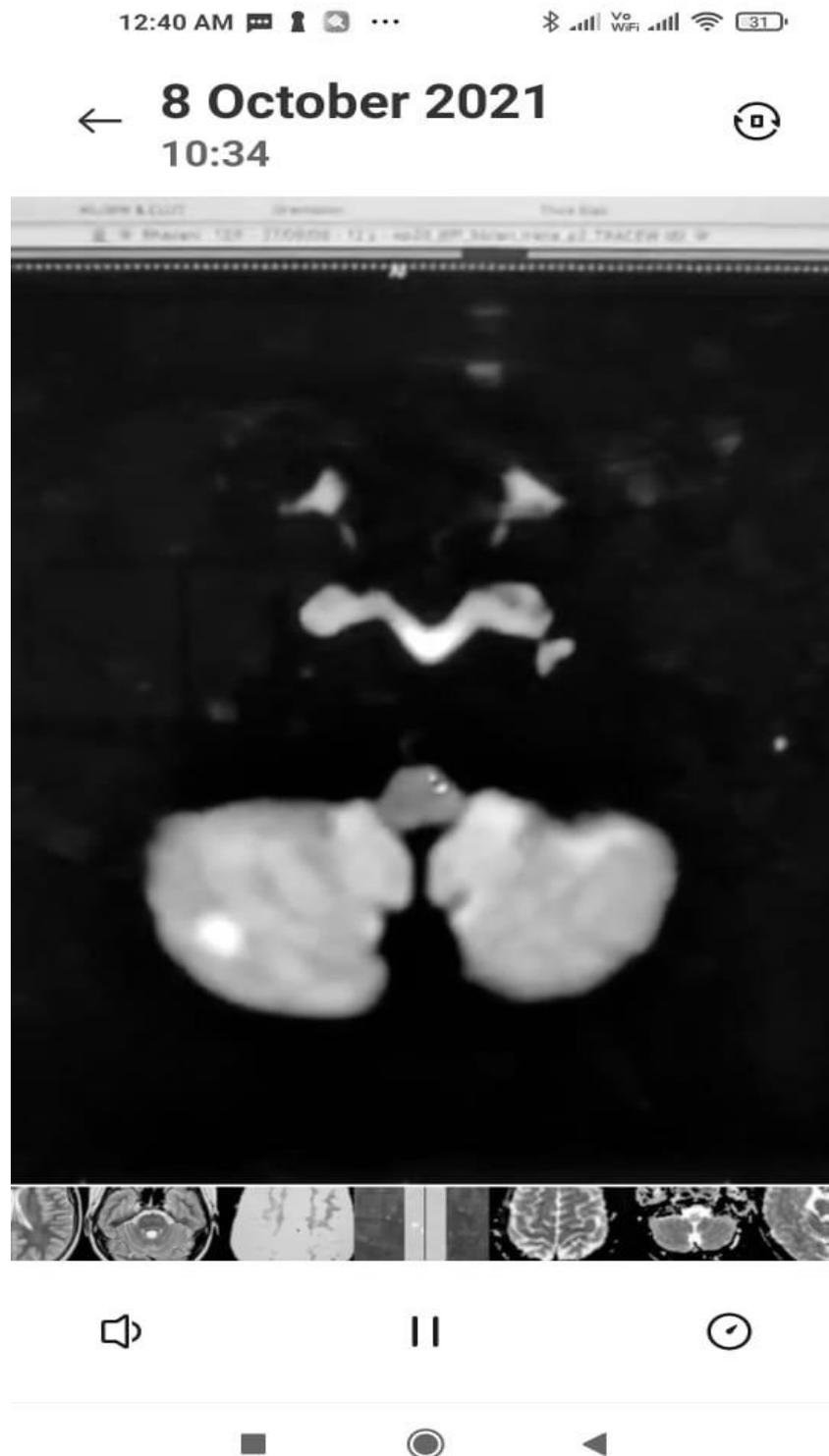
The evaluation strategy and clinical features⁵ in young children are entirely different.

Children have a good prognosis relatively. Here we are presenting two such young stroke which followed covid infection. Both of them have elevated covid antibody titres.

They were covid positive in the recent past and recovered well to present with CVA.

Case 1:





CASE 1

12 year old female child with normal developmental history, both mental and motor with comorbid illness.

Presented with acute onset fever for one day and recurrent episodes of seizures.

She had acute onset of giddiness, vomiting, unsteadiness, clumsiness and restlessness.

She was admitted and evaluated and found to be COVID positive.

Her image findings showed acute infarct in PICA territory.

She was treated with antiplatelets, anticoagulants and other supportive measures.

All other parameters including the coagulation profile, cardiac evaluation, metabolic evaluation were found to be normal. She recovered well

Case 2:

MRI STROKE PROTOCOL

Observation : T2, FLAIR, DWI - axial sections of the brain were studied.MR angiography of brain and neck was also done.Area of diffusion restriction with corresponding T2/FLAIR hyperintensity noted in left side of lower pons - Acute infarct.The cerebral white and grey matter grossly shows normal configurational pattern and signal intensities in T1 and T2 weighted scans.The basal ganglia, thalami, rest of the brainstem and cerebellum show normal M.R. morphology and signal intensities.The ventricular system appears normal. The C.S.F. in the cerebral sulci and the intracranial cisternal spaces show no abnormality. *Polypoidal mucosal thickening noted in right maxillary sinus.M.R. Angiography Brain : Right fetal PCA noted.Dominant right vertebral artery.Both sides internal carotid, anterior cerebral, middle cerebral arteries are normal. The basilar artery is normal. NECK ANGIOGRAPHY :Dominant right vertebral artery. Both common carotid arteries are of normal calibre. The bifurcations of both common carotid arteries are normal.The course and calibre of internal carotid artery on both sides are normal.There is no obvious stenosis of the internal carotid artery.

Impression : Acute infarct in left side of lower pons.MR angiography Brain : Right fetal PCA noted.Dominant right vertebral artery.MR Neck angiography: Dominant right vertebral artery.

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Physical Examination

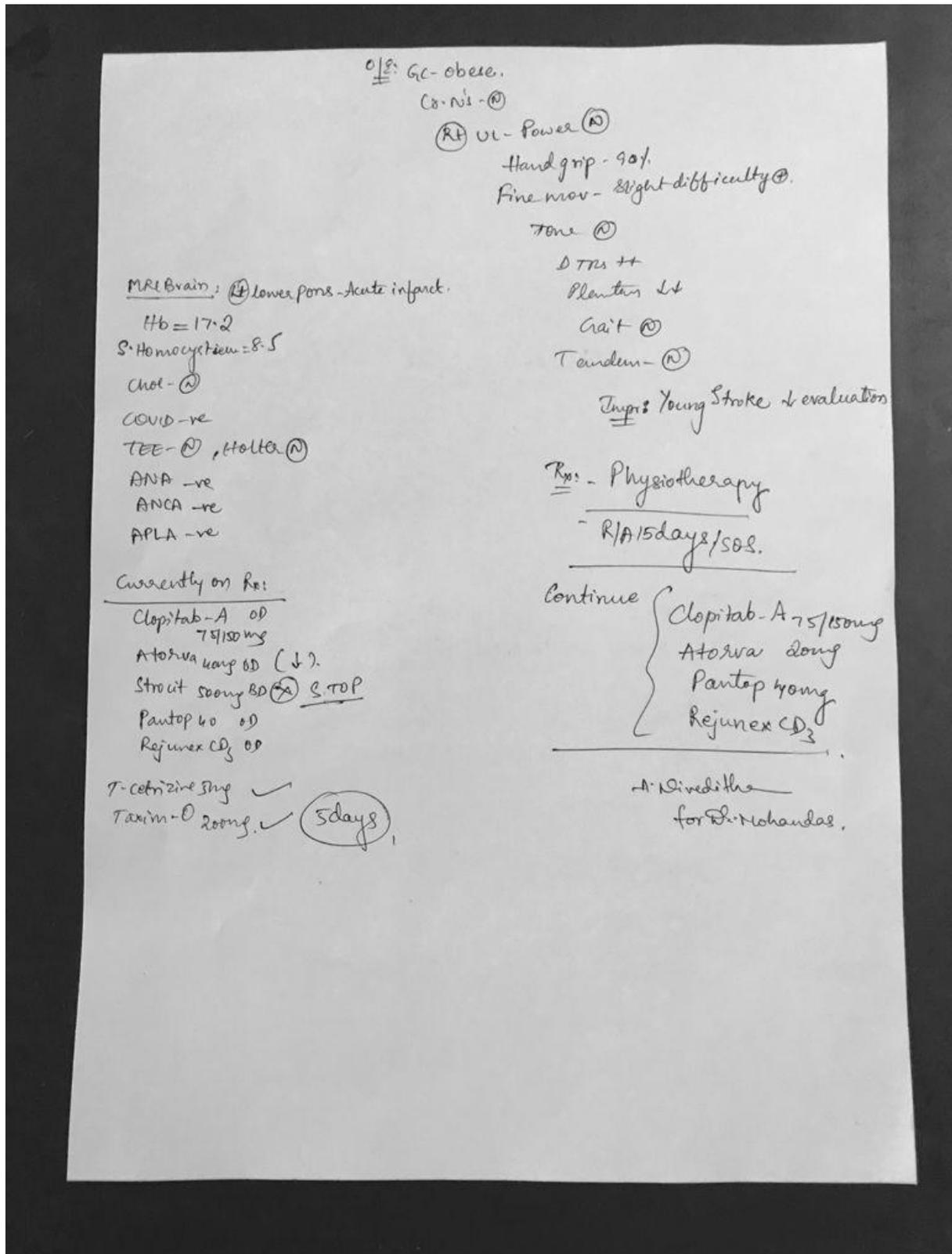
GCS-E4V5M6
 PUPILS-BL EQUALLY REACTING TO LIGHT
 RIGHT FACIAL PALSY+
 RIGHT UPPER LIMB PRONATOR DRIFT+
 RIGHT HAND GRIP WEAKNESS+
 PR-76bpm
 BP-120/60mmHg
 RR-18cpm
 TEMPERATURE-98 F
 SPO2-100% ON ROOM AIR
 GRSB-144mg/dl
 CVS-S1S2 HERAD
 RS-BL AIR ENTRY+
 P/A-SOFT,B5+

Treatment Summary

Discussion

16 year old boy with no known co-morbidities, presented with complaints of weakness of right upper limb and deviation of angle of mouth to left with slurring of speech at around 10.00AM on 15/9/2021. He was admitted for further evaluation and management. He was diagnosed to have stroke in young with left pontine infarct with right faciobrachial palsy with dysarthria. Grave prognosis, complications and risk of progression of the disease explained to patient's attendants. TEE showed normal sized cardiac chambers with normal LV systolic and diastolic function without any LAA/LAA clot or vegetations. ANA profile, C-ANCA, P-ANCA, APLA reports were negative. HbA1C was 5.7%. Serum homocysteine and fasting lipid profile were normal. COVID-19 TRUNAT was negative, 24-hour holter monitoring and thrombophilia reports awaited. He was treated with antiplatelets, statins, neuroprotectives, IV fluids, physiotherapy and supportive care. Patient vitals stable and is being discharged at request. Reports enclosed.

Date & Time	Clinical Notes / Investigations	Treatment
SpO ₂ : 99%	→ C/o (R) UL weakness & deviation Angle of mouth to (L) side ∴ 140K, (15/9/21) Improved c Rx in 3-4 days. → Stress related to NEET exam. → No previous h/o similar (complaints) headaches/exercise intolerance.	<ul style="list-style-type: none"> 12th standard completed. NEET BIPC. Paternal cousin had migraine & stroke at 26 yrs. Sleep, App @ Bladder, Bowel regular. NO known comorbidities.



CASE 2

16 yrs old, developmentally normal boy with no comorbidities, presented with weakness of left UL and LL and LMN facial palsy and slurring of speech, was admitted on 15/09/2021 GCS E4V5/M6 ANA profile, negative TEE – Normal, Lipid profile – Normal, MRI revealed.

Acute infarct in the left side of lower pons. He was found to be COVID positive. He was treated with antiplatelets, Statins, Neuroprotectives, IV fluids, physiotherapy and supportive care.

III. Discussion:

Mechanisms of COVID-19 Associated Cerebrovascular Manifestations are Impaired Coagulation, ACE2 receptor binding, CNS Vasculitis, Critical illness hypoxemia and Antiphospholipid antibody induction.

Ischemic stroke is the most common stroke subtype observed in association with SARS-CoV2 infection. Patients with severe infection and those with underlying vascular risk factors are at higher risk of developing stroke. A significant observation is the high incidence of large vessel occlusion(LVO) in these patients. Patients are younger as compared to contemporary negative controls and historical controls, with no known risk factors for LVO

Classification of COVID-19 Related Stroke

1. Probable Association: Either SARS-CoV2 detected in CSF or other sample or there is evidence of SARS-CoV2 – specific antibody in serum indicating acute infection; and

No other known traditional cardiovascular risk factors

2. Possible Association: Either SARS-CoV2 detected in CSF or other sample or there is evidence of SARS-CoV2 – specific antibody in serum indicating acute infection; and

Other traditional cardiovascular risk factors

IV. Conclusion:

Finally paediatric stroke neurology a new breed, have sprung up who help the paediatricians and neurologist who care for stroke patients. More often than in adults, the cause of childhood stroke remains obscure, even after thorough evaluation. This was the basic inspiration for me to present these two cases in this elite forum.

Reference:

1. Stroke in young adults: Current trends, opportunities for prevention and pathways forward

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Dr.P.Jasmine kalyani MD.,DM, et. al. “Case Series: 2 Post Covid Young Strokes-12 And 16 Years .” *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, 21(02), 2022, pp. 09-13.