IMAGE SPOTTER

Clinical Images

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Identify the Images

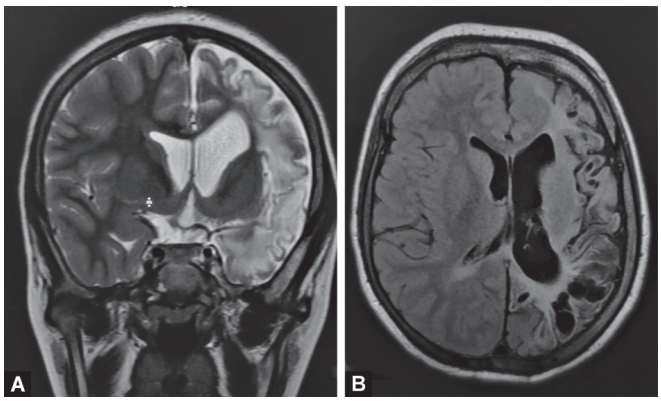

Fig. 1

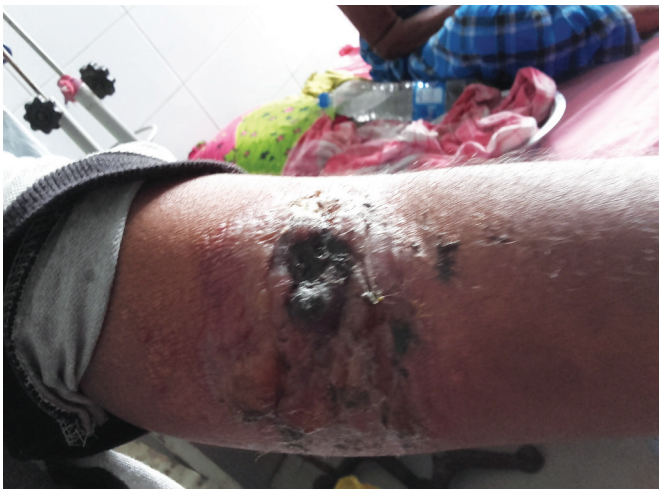

Fig. 3

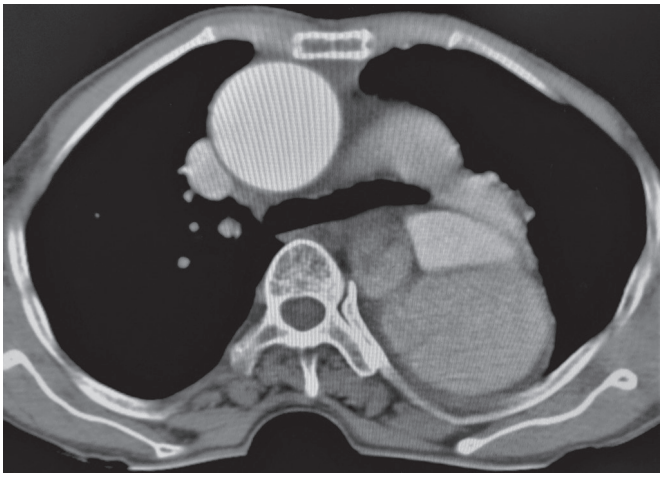

Fig. 2

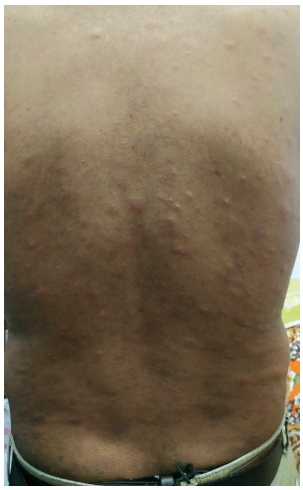

Fig. 4

Identify the Images

Image 1: Background

A 12-year-old male presented with a history of repeated episodes of generalized tonic-clonic seizure for the past 3 years. This was associated with a progressive decline in intellect and cognitive skills. There was no history of any weakness, sensory abnormalities, or abnormal movements of the body, during the day or sleep. Seizure control had been attempted with several antiepileptic drugs but none had worked satisfactorily. Clinical examination was remarkable for grossly affected higher mental function that rendered the rest of the examination difficult. A magnetic resonance imaging of the brain was done that revealed left-sided gross cerebral hemispheric atrophy with compensatory ventriculomegaly (Fig. 1). The differentials were Rasmussen encephalitis, Dyke–Davidoff–Masson syndrome, and hemimegalencephaly. Because of the progressive nature of the symptoms and no history of any neonatal central nervous system insult, the diagnosis of Rasmussen encephalitis was entertained. The patient was referred to neurosurgery for further management.

Answer: Rasmussen encephalitis

(**Acknowledgment:** Aditya Ganguly, Department of Medicine, Medical College, Kolkata, West Bengal, India)

Image 2: Background

A middle-aged diabetic, hypertensive male presented with severe acute tearing chest pain, radiating to the back that was rapidly followed by loss of consciousness. An emergency survey revealed tachycardia in the upper extremities but pulses were absent in the lower extremities. The chest and cardiac examination did not reveal any crackles near lung bases, gallop rhythm, or murmurs. Electrocardiogram and cardiac biomarkers were unremarkable. An urgent CT angiogram of the arch of the aorta and the descending aorta revealed a triple-barrel dissection of the descending thoracic aorta and a double-barrel dissection of the abdominal aorta (Fig. 2). The patient was urgently referred for surgery but he expired on the way.

Answer: Triple barrel aortic dissection

(**Acknowledgment:** Aditya Ganguly, Department of Medicine, Medical College, Kolkata, West Bengal, India)

Image 3: Background

A 33-years-old male presented with a painless ulcer with a black center over the left forearm (Fig. 3), which was preceded by a small blister-like lesion with surrounding erythema. He also complained of low-grade fever without any other symptoms. Systemic examinations did not reveal any abnormality. Gram staining and culture revealed the presence of *Bacillus anthracis*. He was started on oral doxycycline with significant improvement in symptoms within the next few days.

Answer: Cutaneous Anthrax

(**Acknowledgment:** Nandini Chatterjee, Department of Medicine, IPGMER and SSKM Hospital, Kolkata, West Bengal, India)

Image 4: Background

A 42-year-old gentleman presented to our facility with fever, arthralgia, redness of the eyes, and nodular erythematous skin eruptions mainly involving the back (Fig. 4). He had a history of successful completion of multi-drug therapy 4 months ago. Basic laboratory parameters were within normal limits except raised inflammatory markers. The histology from the nodular lesions showed intense perivascular neutrophilic infiltration in the dermis suggestive of erythema nodosum leprosum (ENL). The patient was started on systemic steroids with significant improvement in the signs and symptoms within the first two weeks. ENL is an immunological complication that mainly affects patients with lepromatous leprosy. It is associated with myriads of clinical features, such as nodular skin lesions, arthritis, neuritis, dactylitis, uveitis, lymphadenitis, and nephritis.

Answer: Erythema nodosum leprosum

(**Acknowledgment:** Atanu Chandra, Department of Medicine, RG Kar Medical College and Hospital, Kolkata, West Bengal, India)