LETTERS TO THE EDITOR

The moving ear syndrome: a focal dyskinesia

Although segmental dystonia of the cranial and upper limb muscles is well recognised, restricted and isolated dystonic movements of cranial muscles such as those of the pinna are extremely uncommon. Dystonic movements of the auricular muscles are termed "bobby dancer's dyskinesia" (dyskinesia of the abdominal wall), an axial torsion dystonia, and four cases of "moving ears" have been reported including two patients with unilateral involuntary twitching of the right pinna. We report a further two cases of unilateral movement disorder affecting the ear, one patient responding well to local injections of botulinum toxin.

Patient 1, a 23 year old white warehouseman complained of twitching of his right pinna since January 1994. Within three months of development of the involuntary movement he experienced right temporal pain and a fluttering noise in the left ear. There was no family history of any neurological disorder. The patient had no history of any serious illnesses in the past and was not on medication.

There was a continuous semirhythmic contraction of variable amplitude at a rate of 80/min which affected both ears and the scalp muscles above the ear. The involvement of the ear was more pronounced on the right. There was no palatal tremor or other dystonias. Electromyography from the frontalis and auricular muscles showed sustained anterior muscle activity before starting neuroleptic drugs. Ten cases of "ear wigglers" due to tics of the ear were described by Keshavan. However, ear tic is unlikely in this patient as the movements were slow, rhythmic and not suppressed on voluntary muscle contraction. In our patients, the slow often sinusuous movements of the ear with a superadded jerky element are suggestive of focal dystonia with myoclonic jerks. Also the presentation with a focal non-progressive movement disorder in adulthood is suggestive of dystonia. The reasonable responses to clonazepam in patient 1 and botulinum toxin injection in patient 2 suggest that the dystonic nature of these movements may be helped by standard treatment strategies for focal dystonia.

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Acute anterior horn cell disease reemerging poliomyelitis as a manifestation of respiratory syncytial virus infection

Respiratory syncytial virus (Paramyxoviridae family) is an infectious agent of remarkable interest as it is the major cause of lower respiratory tract disease in young children. It can also cause infection in adults, although it is not so severe and does not have as much epidemiological importance as in infants. Despite a high prevalence of respiratory syncytial virus infection, examples of neurological disease with a causal role have rarely been reported. Our patient developed an acute flaccid tetraplegia preceded by a meningoencephalitis with serum antibodies to RSV and CSF neutrophilia, and a CSF protein of 1.04 g/l. The CSF had 70 white cells/mm³ (90% lymphocytes, 1.5 g/l protein, and 66 mg/dl glucose (103 mg/dl serum)) and was positive for RSV antigen by reverse transcriptase-PCR.

The patient had been admitted with respiratory distress, fever, vomiting, and paralytic ileus for 4 days. Chest X-ray showed bilateral pulmonary infiltrates. A lumbar puncture was performed and the CSF results were as follows: 3 g/l protein, and 77 mg/dl glucose. Antirespiratory syncytial virus antibody titre of 1/400 in serum and 1/1 in CSF were detected by direct immunofluorescence. Twenty five days later titre had increased to 1/1000 in serum and 1/10 in CSF. In addition the respiratory syncytial virus from CSF and bronchial aspirate samples was cultured in VERO and MRC-5 cell lines and identified using direct immunofluorescence (Monofoil Screen RSV, Sanofi). The serological tests for other viruses and bacteria commonly associated with acute anterior horn cell disease were negative. The patient was treated with ribavirin (200 mg orally every 6 Riley DE, Lang AE. Movement disorders. In: Bradley WG, Daroff RB, Fenichel GM, Marsden CD, eds. Neurology. Philadelphia: W.B. Saunders, 1994:573-589.


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