Lumbosacral meningoradiculitis associated with Chlamydia pneumoniae infection

Infections due to *Chlamydia pneumoniae* have recently been identified \(^1\) and usually give rise to oropharyngeal and pulmonary complications. Neurological manifestations have not, to our knowledge, been described. We report the case of a child presenting with lumbosacral meningoradiculitis.

A nine year old child without a previous medical history presented with a cough and rhinitis beginning on the 21 August 1990 and lasting six days. His temperature had not been recorded. He was treated initially with amoxicillin which was stopped on the 27 August due to an erythematous macular rash on the knees and thighs. On the 31 August the patient complained of weakness of the lower extremities, predominantly the hips and thighs, resulting in a waddling gait and an inability to rise from a crouching position. Neurological examination on the 8 September revealed significant back stiffness, bilateral Lasegue’s sign, motor weakness of the lower extremities, especially affecting flexion and adduction of the thighs, less so the flexors and extensors of the legs. Knee jerk was absent on the right, diminished on the left. Ankle jerks were intact. Plantar responses were flexor. There were no objective sensory deficits nor spasticity dysfunction. Lumbar puncture (8 September) obtained clear fluid containing 6 lymphocytes/μl, 97 mg% protein and normal glucose. Saccoradiculography was normal. Electromyography of the lower limbs (10 September) was normal as were nerve conduction velocities. Clinical recovery wasgradual and almost complete by six months.

Acute and convalescent serum taken 16 days apart disclosed the following infectious agents: *Mycoplasma pneumoniae*, *Legionella pneumophila*, *Rickettsia bernsteini*, *coxiella burnetti*, herpes simplex virus, herpes zoster virus, Epstein-Barr virus, cytomegalovirus, measles, mumps, adenovirus, enterovirus (*Echoviruses 7, 25, 30, 33, Coxsackieviruses A9 and B2*). Indirect immunofluorescence techniques \(^4\) were used to determine serum and CSF antibodies against various *Chlamydia* species (table). These showed a recent infection with *Chlamydia pneumoniae*, indicated by an elevated titre of serum IgM which disappeared by the fifth month. Furthermore, there was no correlation between the serum/CSF antibody ratio for measles and herpes zoster virus.

<table>
<thead>
<tr>
<th>Serum</th>
<th>IgM</th>
<th>IgG</th>
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<tbody>
<tr>
<td>Serum</td>
<td>64</td>
<td>64</td>
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<tr>
<td>CSF</td>
<td>&lt;16</td>
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*Table Antibody levels in serum specimens and CSF to Chlamydia (Chl) species by indirect immunofluorescence test*


Postoperative fourth ventricle tension pneumocephalus

We report an unusual case of postoperative tension pneumocephalus (PTP) after posterior fossa surgery carried out with the patient in the sitting position.

A 65 year old man was admitted to our hospital in May 1987 because of dizziness, vertigo, vomiting and diplopia. He had right extra motor ocular muscle paresis and right sided ataxia. CT showed a haematoma in the right hemisphere which was cerebellar. The clot was larger than 3 cm, but there was no hydrocephalus (figure 1a). General anesthesia was administered via endotracheal intubation and consisted of a mixture of 60% nitrous oxide, oxygen and halothane. He was placed in the sitting position. Hyperventilation and furosemide were used to reduce brain bulk. A right suboccipital craniectomy was per-