

VERs from the right eye remained persistently abnormal (P100 latency 121 ms); also over the past eight months VERs from the left eye have become abnormal (P100 latency 118 ms). Brainstem auditory evoked responses became abnormal, on the left side six months after the onset of the illness, and on the right side 12 months after onset. These deteriorations occurred after two clinical exacerbations affecting the brainstem and preceded the third MRI scan. Electroencephalograms showed widespread delta activity most prominent frontally and also interseizure epileptiform activity.

We describe a patient who has a chronically active, diffuse relapsing and remitting meningo-encephalo-myelitis of unknown aetiology. It is similar to the case described by Monteiro and Correia<sup>1</sup> differing in the frequency of relapses, and partial remission, the presence of a chronic active diffuse process and the association with abnormal MRI scans.

There has been no evidence of sarcoidosis, systemic lupus erythematosus, cerebral vasculitis, cerebral lymphoma, Behçet's disease or cerebral Whipple's disease. An empirical course of sulphamethoxazole-trimethoprim was given without benefit.<sup>2</sup>

The natural history of the illness presented in this patient is not characteristic of accepted clinical patterns of multiple sclerosis. She has exhibited frequent, recurrent episodes of relapsing and active meningo-encephalo-myelitis with pyrexia and epilepsy. It is, however, conceded that the sites of involvement are elective sites in multiple sclerosis. Lumsden<sup>3</sup> stated that he could find "no meaningful pathological distinctions between acute disseminated encephalomyelitis and multiple sclerosis."

We believe that the description of rare but carefully documented cases of this type may provide useful information on the pathology and pathogenesis of relapsing meningo-encephalo-myelitis, and possibly also demyelinating disease. It may also be desirable to exclude the adjective "benign"

from the title "benign relapsing meningo-encephalo-myelitis".

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### Pain arising from the oesophagus may mimic glossopharyngeal neuralgia

A 51 year old female presented with a two year history of ear pain. Lancinating attacks lasting 3-4 seconds began on the left side of the throat and radiated towards the left ear. No specific precipitants could be identified and the symptom occurred at any time of day or night. She was otherwise symptom free and had no significant past medical history. Physical examination was entirely normal. A provisional diagnosis of glossopharyngeal neuralgia was made and the patient was started on carbamazepine. The initial response was promising but the pain recurred and persisted despite increased doses of carbamazepine and a trial of sodium valproate.

Eighteen months into therapy the patient began to complain of pain behind the sternum coinciding with the pain felt behind

the ear. Progressively the retrosternal component developed dyspeptic features though still episodic and related to the lancinating attacks of ear pain which remained strictly unilateral. The symptoms were now noticeably worse at night. Gastroscopy and pH monitoring were performed. A severe grade 3 oesophagitis was noted at endoscopy. Intra-oesophageal pH remained below 4.0 for 26% of the 24 hour study period (normal <3.4%). Reflux peaks correlated well with the patients symptoms. Omeprazole was started with resolution of ear pain and retrosternal discomfort over a period of 12 months review.

It has long been recognised that diseases of the oesophagus, notably gastro-oesophageal reflux and oesophageal spasm may mimic the pain of myocardial ischaemia.<sup>1</sup> Otolaryngological manifestations, though less widely known include otalgia, chronic pharyngitis and cervical pain two.<sup>2</sup> However, lancinating, unilateral pain confined to the throat and ear is a pattern more consistent with glossopharyngeal neuralgia.<sup>3</sup>

As medical and surgical therapy fails to relieve the pain in 30-40% of cases of glossopharyngeal neuralgia<sup>4,5</sup> the possibility that the pain may be referred from the oesophagus should be considered.

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