Conduction block in the forearm associated with acute varicella zoster virus infection

We report the case of an adult patient with neuropathological evidence of persistent conduction block in the forearm segment of the left median nerve and absent responses from the sensory branch of the musculocutaneous nerve (MCN), which had developed during an episode of acute generalised varicella zoster virus (VZV) infection. Clinical manifestations of motor involvement in herpes zoster (HZ) are generally rare and usually due to central nervous system involvement. Motor peripheral nervous system manifestations do exist and have been ascribed to nerve root degeneration due to lymphocytic inflammation and vasculitis with possible spread into the spinal cord. Recently, conduction block has been identified for the first time as the cause of weakness in an immunocompromised patient with HZ, with evidence of extension of VZV infection along the median nerve on magnetic resonance imaging, but persisting conduction block has up to now not been described as a complication of acute VZV infection.

Case report

A 29 year old Caucasian electrician was seen for neurophysiological assessment with weakness of his left hand and numbness along the lateral aspect of his left forearm of 9 months' duration. The numbness had developed 9 days into a severe primary attack of chickenpox, which required hospitalisation. The weakness remained unnoticed by the patient until detection during routine follow up. Oral aciclovir had been commenced 3 days after the onset of the acute illness. No intravenous access had been used in the patient's left arm. The past medical history included an anecdotal first primary attack of chickenpox at the age of 4, but was otherwise unremarkable.

Findings on neurological examination were confined to the left arm. There was no muscle wasting or fasciculations and deep tendon reflexes were preserved. Muscle testing revealed weakness in the left hand corresponding to median innervated muscles: abductor pollicis brevis (APB) (4/5), opponens pollicis (4/5), and first and second lumbricals (4/5) (MRC rating scale). In addition, there was hypeaesthesia for light touch and pinprick in the territory of the sensory branch of MCN. Magnetic resonance imaging of both forearms was inconclusive with no evidence of significant signal alteration at the proposed site of the conduction block.

Motor nerve conduction studies revealed partial conduction block in the left median nerve between 9.1 and 11.1 cm above the proximal wrist crease (fig 1) with a reduced forearm velocity (34.6 m/s) and absent F-waves. The elbow mixed median nerve potential was smaller on the left than on the right (15.2 v 33.9 µV), thus confirming the presence of a partial conduction block in the forearm segment of the left median nerve. The sensory nerve action potential for the left sensory branch of MCN was absent with normal amplitudes and velocities from the right. Nerve conduction studies were normal for the right median as well as the ulnar and radial nerves bilaterally. Needle electromyography showed normal motor units with a reduced interference pattern and single fasciculations potentials in left APB and was normal in left first dorsal interosseus, flexor pollicis longus, biceps, and extensor digitorum communis.

Comment

Conduction block in acute VZV infection has, to the best of our knowledge, never been described before. Partial infarction of a mixed nerve in vasculitic mononeuritis multiplex can cause conduction block by selectively damaging Schwann cells, although axonotmesis with axonal damage and sensory-motor symptoms in the affected nerve would be more typical and should have been apparent during neurophysiological testing. Both the median nerve and the sensory branch of MCN share fibre supply from cervical nerve roots which later form the lateral cord, and they are often in close anatomical proximity in the arm due to frequent anatomical variations. The simultaneous involvement of the median nerve and the sensory branch of MCN might thus indicate a direct spread of the virus between the two nerves. Alternatively, indirect spread from the purely sensory branch of MCN via the spinal cord might have occurred. Autopsies of nervous tissue from HZ patients have shown VZV DNA and antigen to be present in damaged nerve fibres including motor neurons, suggestive of neuronal spread. Recently, conduction block in the forearm segment of the median nerve in a case of HZ has speculatively been attributed to local damage of Schwann cells of the motor nerves by direct local invasion or remote allergic mechanisms, although the exact pathophysiology in these cases remains to be established.

The patient was found to have fasciculation potentials but no other forms of spontaneous activity in APB, but in none of the other muscles tested. The observed fasciculation potentials most likely represent axonal hyperexcitability at the site of the conduction block in analogy to the presumed mechanism responsible for the occurrence of single and grouped fasciculation potentials in other neuropathies characterised by persistent conduction block.

U S Raasch, J P Heath
Department of Clinical Neurophysiology, University Hospital of Wales, Cardiff, UK
Correspondence to: Dr U S Raasch, Department of Clinical Neurophysiology, University Hospital of Wales, Cardiff, UK; raaschs@cardiff.ac.uk

Written confirmation from the Local Research and Ethics Committee in Cardiff was obtained confirming that formal ethical approval was not needed for this case study.

doi: 10.1136/jnnp.2004.059147

Competing interests: none declared

References


Figure 1  Left median compound muscle action potentials recorded from abductor pollicis brevis muscle of a patient with previous varicella zoster virus infection and weakness in left median nerve innervated hand muscles. Stimulation sites at wrist and elbow (A) and 1.0, 2.5, 3.7, 5.3, 7.2, 9.1, and 11.1 cm above the proximal wrist crease (B). Gain 5 mV per division, sweep duration 20 ms (A) and 30 ms (B), respectively. Slowing of motor fibres and partial conduction block between 9.1 and 11.1 cm above the proximal wrist crease is demonstrated.

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Toscana virus causing severe meningoencephalitis in an elderly traveller

Toscana virus (TOSV) is classified in the sandfly fever virus group of arboviruses (family Bunyaviridae, genus Phlebovirus) along with Sicilian (SFSV) and Neapolitan (SFNV) Bunyaviridae sandfly fever virus group of arboviruses. TOSV is classified in the Mediterranean, Middle East, Western Asia, and North Africa—and the disease coincides with Sicilian (SFSV) and Neapolitan (SFNV) Bunyaviridae sandfly fever virus group of arboviruses. Toscana virus (TOSV) is classified in the Phlebotomus perniciosus and Phlebotomus perfiliewi. Circulation of TOSV follows the distribution of its vectors—that is, the Mediterranean, Middle East, Western Asia, and North Africa—and the disease coincides with the seasonal life cycle of insect vectors. Laboratory confirmation of clinically suspected cases can be carried out by detection of anti-TOSV IgG or IgM antibodies in blood and cerebrospinal fluid (CSF) using different techniques. Direct detection of virus is possible by cell culture or reverse transcription-polymerase chain reaction (RT-PCR) but will often fail because of the short term nature of the viraemia. Throughout the last decades there have been increasing numbers of cases of TOSV infection imported into northern Europe from endemic areas. Among other causes, it therefore now has to be considered in the differential diagnosis of acute aseptic meningitis.

### Case report

Four days after having returned from Malaga, Spain, in July 2004 an 80 year old woman was found in a state of deteriorated consciousness. There was enuresis and encopresis, probably as a result of an epileptic fit. Apart from adult onset diabetes mellitus the patient’s medical history was unremarkable. On admission to hospital, the patient was confused and agitated, with a body temperature of 39.5°C. There was neck rigidity but neurological examination showed no other abnormalities.

Routine clinical chemistry analyses on admission showed slight increases in liver enzymes (aspartate aminotransferase 50 U/l; alanine aminotransferase 87 U/l; γ-glutamyltransferase 93 U/l), erythrocyte sedimentation rate (18 mm/h), and glycated haemoglobin (HbA1C 7.6%). Examination of CSF revealed lymphocytic pleocytosis (265 cells/mm³) and raised protein (47 mg/dl) and lactate (4.3 mmol/l) (table 1). PCR for herpes simplex virus 1 (HSV1) and HSV2 was negative.

<table>
<thead>
<tr>
<th>Reference range</th>
<th>Day 2</th>
<th>Day 6</th>
<th>Day 13</th>
<th>Day 27</th>
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</thead>
<tbody>
<tr>
<td><strong>WBC count (cells/mm³)</strong></td>
<td>0 to 5</td>
<td>265</td>
<td>60</td>
<td>30</td>
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<tr>
<td><strong>Lactate (mmol/L)</strong></td>
<td>1.1 to 2.2</td>
<td>4.3</td>
<td>3.1</td>
<td>2.5</td>
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<td><strong>Glucose (mmol/L)</strong></td>
<td>2.78 to 4.16</td>
<td>7.33</td>
<td>6.16</td>
<td>4.88</td>
</tr>
<tr>
<td><strong>Total protein (mg/dl)</strong></td>
<td>15-45</td>
<td>47</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td><strong>Oligoclonal banding</strong></td>
<td>Negative</td>
<td>Negative</td>
<td>One band</td>
<td>Negative</td>
</tr>
<tr>
<td><strong>Tau protein (μg/ml)</strong></td>
<td>&lt;350</td>
<td>194</td>
<td>NA</td>
<td>191</td>
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<tr>
<td><strong>(12-Microglobulin (mg/l))</strong></td>
<td>&lt;2</td>
<td>NA</td>
<td>5</td>
<td>3.2</td>
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<tr>
<td><strong>Neurone specific enolase (ng/ml)</strong></td>
<td>&lt;12.5</td>
<td>8.2</td>
<td>7.5</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>S-100 protein (μg/ml)</strong></td>
<td>&lt;2300</td>
<td>NA</td>
<td>1030</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Anti-TOSV antibodies in serum</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IgG IFA</strong></td>
<td>&lt;1:10</td>
<td>1:20</td>
<td>1:80</td>
<td>1:2560</td>
</tr>
<tr>
<td><strong>IgM IFA</strong></td>
<td>&lt;1:10</td>
<td>&lt;1:10</td>
<td>&lt;1:10</td>
<td>&lt;1:10</td>
</tr>
<tr>
<td><strong>IgG EIA</strong></td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>IgM EIA</strong></td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>Anti-TOSV antibodies in cerebrospinal fluid (CSF)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IgG IFA</strong></td>
<td>&lt;1:10</td>
<td>1:640</td>
<td>1:2560</td>
<td>1:5120</td>
</tr>
<tr>
<td><strong>IgM IFA</strong></td>
<td>&lt;1:10</td>
<td>1:80</td>
<td>1:320</td>
<td>1:160</td>
</tr>
<tr>
<td><strong>IgG EIA</strong></td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>IgM EIA</strong></td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Anti-TOSV IgG titres ranged from 1:640 to 1:10240 in serum and 1:20 to 1:5120 in CSF. IgG levels for SFNV ranged from 1:320 to 1:2560 and from 1:20 to 1:160, respectively. IFA IgM titres could only be detected in serum, ranging from 1:80 to 1:160 for TOSV and from 1:40 to 1:80 for SFNV.

The presence of a pattern of cross reactivity typical of TOSV infection supported a preliminary diagnosis of acute TOSV encephalitis. For confirmation, the specificity of antibodies was demonstrated by a commercially available TOSV IgG/IgM enzyme immunosorbent assay (EIA) using recombinant antigens (Disease Diagnostica, Milan, Italy). The IFA results for serum samples were confirmed by EIA. Nevertheless, EIA appeared more sensitive than IFA in detecting CSF IgM antibodies (first positive result for CSF IgM on day 2). In contrast, IgG in CSF samples was only inconsistently detected by EIA (negative results for CSF IgG in EIA on days 2, 13, and 27).

The patient was transferred to the neurological critical care unit and treated empirically with intravenous ceftriaxon, levofloxacin, and aciclovir until diagnosis of TOSV meningoencephalitis was confirmed. Consciousness deteriorated subsequently, leaving the patient in a comatose state for three days. On day three after admission a generalised seizure occurred. Electroencephalography (EEG) showed signs of diffuse encephalopathy with basal activity at 6–7 Hz and symmetrical slow waves. Computed tomography and magnetic resonance imaging of the brain showed diffuse atrophy without evidence of focal lesions. Measurement of Tau protein, S100 protein, and neuron specific enolase in the CSF revealed no signs of neuronal cell damage. Nevertheless, raised β2-microglobulin levels and oligoclonal banding showed that there was an intrathecal immune reaction (table 1).

Ten days after admission the patient recovered from her comatose state. A slow improvement in her level of consciousness and her general condition was observed subsequently as the fever resolved.

One month after admission CSF and liver enzymes were nearly normal. EEG showed an increase of basal activity to 8 c/s. Slightly impaired cognitive functions could still be observed (mini-mental state examination score 17/30).

### Comment

Besides Rift Valley fever virus, TOSV is the only member of the Phlebovirus group causing aseptic meningitis. Previously, severe neurological manifestations have been described only occasionally. Within three to six days after infection symptoms such as fever, myalgia, headache, vomiting, and neck rigidity do occur, but a lesser degree of encephalic involvement has generally been reported. As in other viral meningitides, symptoms of aseptic meningitis related to TOSV infection disappear completely within a few days. Asymptomatic infections and infections without CNS involvement also occur.

The brain involvement in this case caused a severe, long lasting impairment of consciousness, seizures as an unusual clinical manifestation, and a prolonged convalescence period. Seldom reported before, raised liver enzymes can be interpreted as a sign of a systemic infection with involvement of the liver.
Owing to the large variety of pathogens causing acute aseptic meningitis, clinicians rely on rapid laboratory confirmation of suspected cases by standard methods such as RT-PCR or the plaque reduction neutralisation test (PRNT). Nowadays, PRNT is rarely used owing to its complexity and time consuming nature, while RT-PCR appears inadequate because of the short duration of the viraemia. Recently developed EIA formats can establish the presence of infection by detecting specific IgM in acute phase samples and were able to confirm TOSV infection in this case. With millions of travellers and increasing TOSV infections around the Mediterranean basin, commercially available EIA methods will be of growing importance. In addition to other severe travel related diseases, TOSV infections now need to be considered by physicians.  

J Kuhn, H Bewermeyer, U Hartmann-Klosterkoetter  
Department of Neurology, Kliniken der Stadt Köln, Krankenhaus Merheim, Cologne, Germany  
P Emmerich, S Schilling  
Bernhard Nocht Institute For Tropical Medicine, Department of Virology, Hamburg, Germany  
M Valassina  
University of Siena, Department of Molecular Biology, Microbiology Section, Laboratory of Virology, Siena, Italy  

Correspondence to: Dr Jens Kuhn, Department of Neurology, Kliniken der Stadt Köln, Krankenhaus Merheim, Östermerheimerstrasse 200, 51109 Cologne, Germany; Kuhnj@kliniken-koeln.de; JKuhn11@aol.com  
doi: 10.1136/jnnp.2004.060863

References

Intracerebral haemorrhage in CADASIL
Cerebral autosomal dominant arteriopathy with subcortical infarcts and leucoencephalopathy (CADASIL) is a rare hereditary disease characterised by recurrent transient ischaemic attacks, strokes, and vascular dementia. Pathological studies reveal multiple small infarcts and diffuse white matter changes as well as vascular alterations most prominent in small arteries. The presence of granular osmiophilic material in arterial walls on ultrastructural examination is pathognomonic. Mutations in the notch3 gene located on chromosome 19 are associated with the disease. Here we report a patient with an unusual clinical course with recurrent intra-cerebral haemorrhage.

Case report
A 47 year old woman was admitted after a fall at home, followed by several minutes of unconsciousness. Her past medical history was uneventful. In particular, there was no history of migraine or depression, and she was not taking any drugs. On admission, her husband reported memory deficits for several weeks. Initially, the patient complained about headaches and mild dysarthria. Moderate left sided hemiataxia and pronation of the left arm were present. Blood pressure was raised to 220/120 mm Hg

Figure 1  Bleeding in the left cerebellar hemisphere as shown in pd-T2 tse (A) and T2* (D). White matter lesions in the FLAIR sequence (B, E); note the lesions in the external capsule which are often present in CADASIL (B). (C) Acute ischaemic lesions in the right hemisphere in a diffusion weighted image. (F) Multiple microbleeds shown in T2*. CADASIL, cerebral autosomal dominant arteriopathy with subcortical infarcts and leucoencephalopathy; FLAIR, fluid attenuated inversion recovery.
without a known history of arterial hypertension. Neuropsychological deficits were prominent in impaired semantic, visual-spatial, and mnemonic functions and in deterioration in cognitive speed. Concentration and mathematical problem solving were also reduced, indicating severe cognitive impairment. Initial cranial computed tomography revealed a haemorrhage of 20 mm diameter in the left cerebellar hemisphere. Subsequent magnetic resonance imaging (MRI) with T2* gradient echo (GE) showed more than 25 small haemorrhages distributed over the entire brain. T2-weighted scans showed white matter lesions with periventricular emphasis (Fig 1). Serum markers for vasculitis and coagulation indices were normal, as was the cerebrospinal fluid. An ophthalmological examination showed hypertensive changes. Ultrasound sonography of the extracranial examination showed hypertensive changes. Without the white matter pathology in our patient may appear relatively sparse, lesions in the external capsule and the temporal lobe typical of CADASIL were present. We conclude that CADASIL should be considered in patients with cerebral haemorrhage, and careful blood pressure management is particularly important in CADASIL patients, as the risk of vessel rupture and subsequent intracerebral haemorrhage appears to be further increased compared with patients with arterial hypertension alone. While there is no effective treatment for CADASIL, control of arterial hypertension may slow the rate of deterioration in this disabling and devastating disorder.

A Ragoschke-Schumm, H Axer, O W Witte, S Issmann Department of Neurology, Hans-Berger-Klinikum, Friedrich-Schiller-University Jena, Jena, Germany

C Fitzek Department of Diagnostic and Interventional Radiology, Friedrich-Schiller-University Jena

M Dichgans, N Peters Department of Neurology, Klinikum Grosshadern, Ludwig-Maximilians-University, Munich, Germany

J Mueller-Hoekcer Department of Pathology, Ludwig-Maximilians-University

Correspondence to: Dr med Andreas Ragoschke-Schumm, Department of Neurology, Friedrich-Schiller-University Jena, Erlanger Allee 101, D-07747 Jena, Germany; andreas.ragoschke-schumm@med.uni-jena.de

doi: 10.1136/jnnp.2004.059212

Competing interests: none declared

References


Catastrophic primary antiphospholipid syndrome presenting as status epilepticus

Antiphospholipid syndrome (APS) is defined as the occurrence of arterial or venous thrombosis or recurrent miscarriage, with raised titres of antiphospholipid antibodies, namely lupus anticoagulant (LA) or anti-cardiolipin antibodies (aCL). The ultrasonographic form of APS is catastrophic antiphospholipid syndrome (CAPS) or Asherson’s syndrome. Proposed diagnostic criteria for definite APS are: multiorgan failure, development of manifestations within 1 week, demonstration of antiphospholipid antibodies and histopathological evidence of microthrombosis (positive predictive value 99.4%). *Predicators include infection, surgery, and childbirth. Patients typically develop widespread thrombotic microangiopathy with marked thrombocytopenia. Clinically apparent cerebral infarction occurs much less frequently than in uncomplicated APS but the major pathological manifestation of CAPS is cerebral microthrombosis at postmortem examination.

CASE REPORT

A 30 year old woman delivered her first child following a full term uncomplicated pregnancy. Three weeks later, she developed headache and transient hemiparesis. The following day she had an episode of status epilepticus, bit her tongue, and held both arms stiffly in the air for about 1 minute. On admission to hospital, she was pyrexic and developed generalised tonic clonic seizures. There was no relevant previous medical history and she was not taking any medication. Blood tests, including erythrocyte sedimentation rate (ESR) and C reactive protein (CRP), were normal. Computed tomography scan of the brain and analysis of the cerebrospinal fluid (CSF) were normal. Gynaecological examination showed no retained products of conception. The seizures proved refractory to treatment with intravenous lorazepam. She was transferred to a specialist neurological centre that day.

On arrival she was agitated, disoriented and pyrexic (38°C). Generalised tonic clonic seizures continued. Nasogastric intubation was normal except that all limb reflexes were pathologically brisk and plantar responses were extensor. General examination was unremarkable. Despite being given “loading” doses of phenytoin, phenobarbitone and magnesium sulphate, the seizures continued. She was anaesthetised and intubated, and mechanical ventilation was introduced.
Treatments with high dose intravenous aci-
clor for presumed viral encephalitis was
commenced.

Investigations revealed a normal full blood
count and film with a platelet count of
267 x 10^9/L. ESR and CRP were mildly raised
at 46 mm/h (normal 1–20) and 28.7 mg/l
(normal 0–3). Serial measurements of plate-
let count, ESR, and CRP did not show any
significant change throughout the illness. All
other blood tests including coagulation
screen were normal or negative.

Magnetic resonance imaging of the brain
was normal with no evidence of venous sinus
thrombosis, cerebral infarction or haemor-
rhage. A second lumbar puncture revealed an
opening pressure of 30 cm H_2O. CSF analysis
showed clear colourless fluid with 4 lympho-
cytes/mm^3, a red cell count of <1/mm^3, total
protein of 0.35 g/l and a CSF/plasma glucose
ratio of 4.4:8.9 mmol/l. CSF and serum
oligoclonal bands were negative. Multiplex
PCR for CSF herpes was negative.

EEG confirmed a diffuse encephalopathic
process with unequivocal epileptiform activ-
ity over the frontal regions bilaterally with some
periodic complexes more prominent on
the right. A second lumbar puncture revealed an
opening pressure of 30 cm H_2O. CSF analysis
showed clear colourless fluid with 4 lympho-
cytes/mm^3, a red cell count of <1/mm^3, total
protein of 0.35 g/l and a CSF/plasma glucose
ratio of 4.4:8.9 mmol/l. CSF and serum
oligoclonal bands were negative. Multiplex
PCR for CSF herpes was negative.

Use of mirror dystonia as
guidance for injection of
botulinum toxin in writing
dysfunction

The successful application of botulinum
Toxin (BTX) injections in the treatment of focal
hand dystonia is largely dependent on careful
evaluation and selection of muscles to be
injected. It has been suggested that patients
should be examined for abnormal postures at
rest and while carrying out the affected task
in question as well as other tasks (such as
using a cup or a comb). Simple techniques
such as the localisation of subjective pain and
fatigue accompanied by palpation of the area
of discomfort can also be used.

Mirror dystonia consists of dystonic pos-
tures and movements of the dominant hand
while writing or performing other tasks with
the non-dominant hand. We present a series of
six patients who were successfully injected
with BTX using mirror dystonia as an
additional tool for muscle evaluation.

We carried out a retrospective review of the
case records of consecutive patients with
writing dysfunction with mirror dystonia (writing
tremor) who had been injected with
BTX type A (Botox®, Allergan Pharmaceu-
ticals, Irvine, California, USA) between
November 2000 and October 2002 at our
movement disorders clinic. Our study was
limited to patients with writing dysfunc-
tion who displayed mirror dystonia while
writing with their non-dominant hand. We
specifically examined patients for mirror
dystonia by asking them to write using their
non-dominant hand while resting the
dominant hand on the ulnar side of the
forearm (unaware of our focus on the
detection of mirror dystonia of the resting
limb). Patients were injected under EMG
guidance, using an Allergan® EMG needle.
We recorded the muscles injected and the
dose each muscle received. Peak effect
was measured as the maximum benefit
obtained from the injection. It was rated
on a 0 to 3 global impression scale (0 = no
effect; 1 = mild improvement; 2 = moderate
improvement; 3 = marked improvement). The
presence and severity of adverse events
was also recorded. We also looked at the
concordance between observation of the
dominant limb in the action of writing and
observation of the mirror dystonia movements of the same limb while writing with the non-dominant hand. The formulation and preparation of BTX was carried out using standard methods. Overviews of the demographic, clinical, and treatment variables are presented in Table 1. We identified six patients with writing dysfunction (M/F:1/5, mean age 46 years (range 30 to 75), mean duration of disease 7.16 years (range 2 to 13)). Four patients (cases 1, 2, 3, and 6) had writer's cramp and two (cases 3 and 4) had features overlapping writing tremor with writer's cramp. Three patients reported marked (cases 1, 2, and 5), two moderate (cases 3 and 4), and one mild improvement (cases 6). We further identified two subgroups: four patients where mirror dystonia consisted of any combination of extension/abduction of the thumb, fingers, and wrist (subgroup A: cases 2, 3, 4, and 5) and two patients where mirror dystonia consisted of hyperflexion of wrist or thumb and fingers (subgroup B: cases 1 and 6). In subgroup A two patients experienced marked improvement and two had moderate improvement following injections. Two of these four patients did not show mirror dystonia movements when seen 15–17 weeks later at the time they were due for repeat injections. In subgroup B one patient experienced marked improvement and one mild improvement. None of our patients had evidence of mirror dystonia in the non-dominant hand when writing with the dominant hand. Regarding adverse events, transient weakness was experienced by four patients (for one to four weeks). No other adverse events were reported.

Concordance in the action of writing and observation of the mirror dystonia movements in the same limb was found in four patients. In three there was enrichment of the observation in that additional muscles could be shown to be active. The two discordant patients had writing tremor with no overt deviation noted when the dominant hand wrote.

The importance of recognition of mirror dystonia in patients with writing dysfunction has been previously highlighted by Jedynak et al. They reported that 29 of 65 patients with writer's cramp had evidence of mirror dystonia and suggested that mirror dystonia may be useful in muscle selection (it may help in the differentiation between primary and compensatory movements). Borgohain et al also reported on the subject; however, that work has only been published in abstract form. The investigators proposed that mirror dystonia used as a guide for muscle selection for BTX injections may reduce the difference in outcome between extensor and flexor writer's cramp and suggested that mirror dystonia was a superior method for muscle selection compared with compensatory movements.

Although the mechanism of mirror dystonia remains unclear it has been suggested that it is likely to be related to the metabolic abnormalities shown to involve the primary sensorimotor and supplementary motor cortices in patients with focal hand dystonia. Magnetic cortical stimulation has confirmed that corticocortical inhibition is reduced over both hemispheres.

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex</th>
<th>Age</th>
<th>Duration</th>
<th>Type</th>
<th>Mirror dystonia</th>
<th>Muscles selected (dose)</th>
<th>Benefit</th>
<th>Adverse effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>75</td>
<td>13 years</td>
<td>WC</td>
<td>Flexion of thumb and index finger</td>
<td>R FPL 12.5 U, R FDS 25 U</td>
<td>Marked</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>42</td>
<td>8 years</td>
<td>WC</td>
<td>Dorsiextension of thumb, index wrist and finger</td>
<td>R EPL 7.5 U</td>
<td>Marked</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>48</td>
<td>3 years</td>
<td>WT</td>
<td>Dorsiextension of fingers (not thumb) and wrist</td>
<td>R ECU 10 U</td>
<td>Moderate</td>
<td>Transient (one month) weakness of extension of 2nd, 3rd, and 4th digits</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>38</td>
<td>2 year</td>
<td>WT</td>
<td>Hyperextension of the thumb</td>
<td>R EDC 10 U, R FCU 10 U</td>
<td>Marked</td>
<td>None</td>
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<tr>
<td>5</td>
<td>F</td>
<td>30</td>
<td>11 years</td>
<td>WC</td>
<td>Dorsiextension of index finger</td>
<td>R EIP 10 U</td>
<td>Marked</td>
<td>None</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>43</td>
<td>6 years</td>
<td>WC</td>
<td>Flexion of wrist and fingers</td>
<td>R FCR 12.5 U, R FCU 25 U</td>
<td>Mild</td>
<td>Weakness lifting objects</td>
</tr>
</tbody>
</table>

*Patient injected in FCU owing to discomfort in the volar aspect of the forearm.*

**Table 1**: Demographic variables, clinical features, and response to botulinum toxin treatment in our series of patients with writing dysfunction associated with mirror dystonia.

Acknowledgements

This work was presented in part at the American Academy of Neurology 55th Annual Meeting in Honolulu, Hawaii, 1 March to 4 April 2003.

C Singer, S Papapetropoulos

Department of Neurology, University of Miami School of Medicine, Miami, Florida, USA

L Vela

Fundación Hospital Alcorcón, Alcorcón, Madrid, Spain

Correspondence to: Dr Carlos Singer, Associate Professor of Neurology, University of Miami, School of Medicine, 1501 NW 9th Avenue, Miami, FL 33136, USA; csinger@med.miami.edu

doi: 10.1136/jnnp.2004.062265

Competing interests: none declared

References


Drug induced pseudolymphoma secondary to ethosuximide

Ethosuximide is an antiepileptic succinimide, widely used in the treatment of absence seizures. Haematopoietic complications associated with the administration of this drug have included leucopenia, agranulocytosis, platelet suppression, and eosinophilia.1 We report a patient with pseudolymphoma induced by ethosuximide, a complication never reported previously.

Case report

A 12 year old boy presented with a two months history of fever, weight loss (3 kg), and painful swellings on the neck, axillae, and both inguinal regions. The patient had been on ethosuximide for three months for childhood absence epilepsy. It was being given at a dose of 30 mg/kg/day, in three divided doses, and the seizures had been under reasonable control.

Physical examination on presentation revealed enlarged lymph nodes on the both sides of the neck, axillae, and inguinal regions. All the nodes were non-tender, firm, measuring 1 to 2 cm in diameter, and freely mobile. The liver and spleen were not palpable and all other systems were normal. A full blood count revealed a leucocytopenia of 3.6 x 10^3/μl (48% neutrophils, 3% eosinophils, 40% lymphocytes, and 9% monocytes) and a decreased platelet count of 119.0 x 10^3/μl. Studies for serological markers revealed no acute or chronic infection with cytomegalo-virus, Epstein–Barr virus, herpes simplex virus, or toxoplasmosis.

An excisional biopsy of a 2 cm cervical node was done. Frozen section diagnosis was consistent with lymphoma. Permanent sections showed a diffusely polymorphic lymphoid hyperplasia with effacement of the normal architecture; there was an admixture of lymphoid cells, including small and large lymphocytes and plasma cells (fig 1). Leucocyte phenotyping, using the ABC immunohistochemical method, showed heterogeneous T cell and B cell populations: T cell subsets included CD45RO and CD30. B lymphocyte markers included CD20. One day after ethosuximide discontinuation the fever disappeared. The lymph nodes were noticed to have decreased in size on the second week and completely regressed on the end of the second month. The leucocyte and platelet counts normalised after two weeks of ethosuximide withdrawal. Positive rechallenge resulted in drug induced fever and enlargement of the lymph nodes after one week of ethosuximide administration.

Comment

Lymphadenopathy has been recognised as a complication of drug treatment, particularly with antiepileptic drugs, since the first report of phenytoin-induced pseudolymphoma in 1940.2 Since then, this idiopathic reaction has also been described with carbamazepine, lamotrigine, nifedipine, thiadiazide, atenol, amiloride/hydrochlorothiazide, mexiletine, penicillamine, captopril,enalapril, and methotrexate.3 Most of these are associated with cutaneous pseudolymphomas, but the antiepileptic drugs are more likely to precipitate cervical lymphadenopathy.

Pathologically, the term “pseudolymphoma” has been used to describe lymphoid cell proliferation with effacement of nodal architecture, so that there is a false appearance of benignancy.3 Although the precise pathogenesis of this drug reaction is unknown, pseudolymphoma may develop as a hypersensitivity reaction when a drug or one of its structural ligands acts as an antigen, triggering an immune reaction. Alternatively, the drug in question may promote a dysregulated immune response to another drug or non-pharmacological antigen.4

Ethosuximide is widely used in the treatment of absence seizures. On the basis of more than a decade of studies on its cellular effects, the mechanisms of action are thought to include blockade of the low threshold, T-type Ca" current and a reduction in both the non- inactivating Na" current and the Ca" activated K" current in thalamic and cortical neurones.5

The most common dose related side effects are gastrointestinal complaints (nausea, vomiting, and anorexia) and central nervous system (CNS) effects (drowsiness, lethargy, euphoria, dizziness, headache, and hiccup). Some tolerance to these effects develops. Parkinson-like symptoms have been also reported. Urticaria and other skin reactions, including Stevens–Johnson syndrome, as well as systemic lupus erythematosus, eosinophilia, leucopenia, thrombocytopenia, pancytopenia, hepatic dysfunction, and aplastic anaemia, also have been attributed to ethosuximide.6

In this case, the disappearance of lymphadenopathy with withdrawal of the drug, and its prompt reappearance when the drug was reintroduced, suggests a strong cause–effect association between ethosuximide and lymphadenopathy. To our knowledge, this is the first case report of ethosuximide induced pseudolymphoma and the second to report lymphadenopathy as an adverse effect of ethosuximide.7

M R Masruha, C M Marques, L C P Vilanova
Department of Neurology and Neurosurgery, Federal University of São Paulo, São Paulo, Brazil

M T de Seixas Alves
Department of Pathology, Federal University of São Paulo

M F P Peres
Research and Teaching Institute, Albert Einstein Hospital, São Paulo

M G Rodrigues
Department of Paediatrics, Federal University of Espírito Santo, Espírito Santo, Brazil

Correspondence to: Dr Marcelo Rodrigues Masruha, Division of Child Neurology, Department of Neurology and Neurosurgery, Botucatu Street 720, Federal University of São Paulo, São Paulo 04023-9000, Brazil; mmrsruha@ig.com.br
doi: 10.1136/jnnp.2005.064923

Competing interests: none declared

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