Letters to the Editor

Sir,
I read with interest the article “central nervous system in inflammatory demyelinating disorders of childhood” (CIDD) by Mahesh et al published in the December issue of the Journal.[1] The authors have done a commendable job in getting a good work up done in their small series of 15 patients. Acute disseminated encephalo-myelitis (ADEM) is probably the most common of the CIDD group of disorders in any hospital-based study considering the seriousness of the illness. During the initial few hours or days of the illness there is a likelihood of mistaking it for other disorders. As the authors had rightly pointed out, prompt diagnosis and immediate institution of immune-modulatory therapy is mandatory if a good outcome is to be seen in ADEM without sequeale. However, they did not explain how ‘progressive multifocal leukoencephalopathy (PML)’ was excluded in the patient who was tested positive for HIV and died ultimately of the disease. The treatment protocol for PML would be totally different from what was followed in the index case. I feel that such ambiguous cases must be excluded before one groups them as CIDD. Four of the cases were in the category of ‘isolated clinical syndrome.’ It will be interesting to see these patients followed up for 5–10 years to find out if any of them develop features of multiple sclerosis. It is only then, that risk factors which facilitate the progression can be identified.

In their study of 25 patients with ADEM, Belopitoval et al,[2] found evidence of progression to clinically definite or laboratory-supported MS in 10 patients, when followed up for 2–8 yrs. Earlier we had observed in our article in 2005,[3] that multiple sclerosis is not uncommon in children in our country. The prognosis for visual impairment is the worst in children with multiple sclerosis. Other differences have also been noted in the clinical presentation of multiple sclerosis between children and adults. The definitions of the terms have undergone change since then but the concept of ‘recurrent ADEM’ existed earlier too.

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Sir,
We appreciate the comments made by Radhakrishna[1] and colleagues and would like to clarify few of the concerns raised by them. Childhood multiple sclerosis (MS) was not seen in our series with 15 patients of childhood inflammatory demyelinating disorders (CIDD). We fully agree that there is a need to follow the cases with the diagnosis of clinically isolated syndrome (CIS) for possible evolution into MS. We are following-up these patients every 6 months for possible recurrence of deficits or occurrence of new symptoms. This is one of the advantages of the new consensus definition as it separates Acute disseminated encephalomyelitis (ADEM) from CIS.[2] Previously, both of these were clubbed under ADEM. Patients with a diagnosis of CIS need a close follow-up as these patients, when compared with a diagnosis with ADEM, are at a higher chance of developing MS at follow-up. Although the concept of recurrent ADEM existed earlier, there was a lot of ambiguity in use of terms like recurrent ADEM, relapsing

Authors' reply
ADEM and multiphasic ADEM. The new consensus definition has cleared the confusion and given clear guidelines to the use of these terms. Uniform use of the consensus definition by all those involved in the treatment of CIDD would help in taking up large follow-up and therapeutic trials in patients with CIDD.

Coming to inclusion of one patient with HIV and ADEM in our series, we agree that progressive multifocal leucoencephalopathy (PML) was a possibility, although the normal premorbid state, short aggressive clinical profile, recent seroconversion of the patient and absence of opportunistic infections made us label it as ADEM. Specific polymerase chain reaction (PCR) tests for JC virus could not be carried out. There are reports of ADEM occurring in primary HIV infection. Because of similar findings, a differentiation of ADEM from PML may be impossible on the basis of magnetic resonance imaging features alone. Clinical and laboratory information is necessary. However, we do admit that in the absence of PCR for JC virus results, the possibility of PML cannot be ruled out in that particular patient, although it appeared unlikely.

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