

Complications include aspiration, and death from diaphragmatic paralysis. IB has been associated with sudden infant death syndrome (SIDS), accounting for 3-20% of cases in some studies. (Fox CK, Keet CA, Strober JB. Recent advances in infant botulism. **Pediatr Neurol** March 2005;32:149-154). (Respond: Dr Jonathan B Strober, Division of Child Neurology, UCSF, 500 Parnassus Ave, Box 0136, San Francisco, CA 94143).

COMMENT. Infantile botulism may mimic Guillain-Barre disease, congenital myasthenia gravis, and viral encephalitis, and unless suspected, can be difficult to diagnose. IB should be suspected, and an electromyogram ordered, in an afebrile infant who presents with feeding problems, bulbar symptoms, and paralysis. Early confirmation of the diagnosis by identification of botulinum toxin or organisms in the stool or serum, and treatment with human botulism immune globulin can decrease morbidity and the duration of hospitalization.

NEUROLOGIC SEQUELAE OF TUBERCULOUS MENINGITIS

A novel scoring system has been developed to predict neurologic sequelae (NS) in children with tuberculous meningitis, in a retrospective study of 20 cases treated during 1991-2001 at the University of California and Children's Hospital, San Diego, CA. Seven children developed severe NS and 1 child died during hospitalization. Tuberculous meningitis acute neurologic (TBAN) scores (range, 0-8) were based on weighted scores for the following: 1) mental status; 2) seizure; 3) cranial nerve abnormalities; 4) focal motor abnormalities; 5) increased muscle tone. Patients were assigned a TBAN score on day 0 and on day 3 of hospitalization. Those who had developed severe NS at 1 year follow-up had a higher score on day 0, and the difference became statistically significant by day 3 of hospitalization (5.5 versus 0.0, $P=0.02$). Sensitivity and specificity of the TBAN score (>4) on day 0 (75 and 92%) and day 3 (88 and 100%) were superior to the traditional clinical staging system (Lincoln et al, 1960) on day 0 (63 and 58%), to predict severe NS. (Saitoh A, Pong A, Waecker NJ Jr et al. Prediction of neurologic sequelae in childhood tuberculous meningitis. A review of 20 cases and proposal of a novel scoring system. **Pediatr Infect Dis J** March 2005;24:207-212). (Reprints: John S Bradley MD, Division of Infectious Diseases, Children's Hospital and Health Center, San Diego, 3020 Children's Way, MC 5041, San Diego, CA 92123).

COMMENT. A novel scoring system (TBAN) employing neurologic symptoms and clinical signs, and not relying on radiologic and laboratory findings, provides an objective marker for early response to therapy and predicting severe neurologic sequelae in children with tuberculous meningitis.

The problems concerning diagnosis and treatment of TM are reviewed by researchers at the Centre for Tropical Medicine, Oxford University, UK; and Hospital for Tropical Diseases, Ho Chi Minh City, Vietnam. (Thwaites GE, Hien TT. Tuberculous meningitis: many questions, too few answers. **Lancet Neurol** March 2005;4:160-170). Subtle behavioral changes can herald the onset of TM in some children; in others, the disease presents as pyogenic bacterial meningitis, with sudden onset and polymorphonuclear cell predominance in the CSF. Basal meningeal enhancement on MRI, tuberculoma, or both, are 89% sensitive and 100% specific for the diagnosis of TM. A bacteriologic diagnosis is made in about 80% of cases, and molecular techniques (nucleic-acid-amplification assays) have added little to

the diagnosis. Treatment lacks proof by controlled trials; isoniazid, rifampicin, pyrazinamide and either streptomycin or ethambutol are used in the first 2 months; isoniazid and rifampicin in the next 7-10 months; and in patients not suffering from HIV, dexamethasone is advised. Steroids improve survival but may not prevent disability. *M tuberculosis* resistant to antituberculosis drugs is an increasingly common clinical problem, and the use of WHO recommended alternative treatment with fluoroquinolones is restricted to case reports.

Of interest regarding the increasing importance of infectious disease in neurology, during 2004 one quarter of the case reports in *The Lancet* were patients with neurological infections. (Solomon T, Love R. **Lancet Neurol** 2005;4:139).

NEUROMUSCULAR DISORDERS

STEROIDS FOR CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY

The efficacy and safety of high-dose, intermittent IV methylprednisolone (IVMP) as initial and long-term maintenance therapy for chronic inflammatory demyelinating polyneuropathy (CIDP) were analyzed by a retrospective review of outcome data derived from patients' medical records between 1992 and 2003 at Washington University School of Medicine, St Louis, MO. Of 57 patients with clinical and electrophysiologic evidence of CIDP, 39 had sufficient data to classify and compare patients in 3 cohorts according to their primary treatment with IVMP, IVIg, or oral immunosuppression with prednisone or cyclosporine. There was no significant difference in mean improvement of quantitative muscle testing (hand dynamometer) at 6 months or at the last clinic visit (average 4.5 years later) among the 3 groups. At the last visit, 81% to 88% improved in all groups. Weight gain and cushingoid features were less frequent in patients treated with IVMP (19%) than in those receiving oral prednisone (58%). (Lopate G, Pestronk A, Al-Lozi M. Treatment of chronic inflammatory demyelinating polyneuropathy with high-dose intermittent intravenous methylprednisolone. **Arch Neurol** Feb 2005;62:249-254). (Respond: Glenn Lopate MD, Department of Neurology, Washington University School of Medicine, 660 S Euclid Ave, Box 8111, St Louis, MO 63110).

COMMENT. IVMP is as effective in improving and maintaining strength in patients with CIDP as is IVIg or oral prednisone, and has fewer adverse effects. The authors recommend IVMP as initial and maintenance therapy in CIDP patients with weakness or disability.

PUFFER FISH POISONING

The effects of puffer fish poisoning on peripheral nerve were investigated in 4 of 9 patients (7 adults and 2 children) treated at the Prince of Wales Hospital, Sydney, Australia. The patients had consumed soup made from 30 puffer fish. They experienced numbness of the lips approximately one hour later, and the numbness spread to the tongue, throat, and then hands and feet. Symptoms progressed rapidly, the gait became ataxic, and the reflexes were normal or depressed. Full recovery occurred within one week. The urine of each patient