MUMPS, MEASLES AND RUBELLA VACCINATION AND ENCEPHALITIS

A case of encephalitis in a 14 month old girl occurring 27 days after immunization with MMR vacine is reported from the Department of Child Health, Charing Cross Hospital, London, England. She was admitted with 24 hour history of fever and vomiting and a generalized convulsion and a fever (39°C). Shortly after admission she went into status epilepticus and the seizures continued for a further two hours despite heavy sedation. She required artificial ventilation for four days. She had received mumps, measles and rubella vaccine 27 days before admission. There was a fourfold rise in the S antibody titer to mumps virus by complement fixation. The family history was negative for epilepsy or febrile convulsions. Recovery was slow and when discharged 28 days after admission she had odd behavior and visual impairment. Recovery was complete after four months. (Crowley, S et al. Mumps, measles, and rubella vaccination and encephalitis. BMJ September 9, 1989; 299:660).

COMMENT. The authors found one case of mumps meningitis as a post immunization complication in a report from Canada but none in the United States. There were three unpublished reports of mumps meningoencephalitis associated with mumps, measles and rubella vaccine in the United Kingdom. It is suggested that at least 30 days follow-up is needed to exclude a possible neurological complication of the mumps vaccination. The failure to follow patients for a sufficiently long interval after immunizations might explain the lack of neurological complications reported with other vaccines.

INVOLUNTARY MOVEMENTS

IDIOPATHIC DYSTONIA

The natural history of early onset idiopathic torsion dystonia in 30 young patients is reported from the Instituto Neurologico "C. Besta", Milan, Italy. Twenty-one were sporadic and nine familial. Of the familial cases, eight had an autosomal recessive hereditary pattern and one an autosomal dominant pattern. All were of European origin and none were of Jewish origin. Quantitative criteria and a dystonic severity scale were used. Drug trials in eight patients were without benefit and stereotactic thalamotomy in ten patients relieved a unilateral action tremor. Age at onset ranged between one and ten years, maximum between five and ten years. An abnormality of gait was the presenting sign in 12. The disease became generalized in 17 and remained localized in 13. Early onset was characterized by a spontaneous tendency toward a stabilization of the motor disability following aggravation of the disability during the first seven years of the disease. Most retained functional independence and none showed mental deterioration, mood alteration or personality disturbance. The mean IQ in familial cases was 73.4 compared to 94.9 in sporadic cases. (Angelini L et al. Idiopathic dystonia with onset in childhood. J Neurol September 1989; 263:319-321).

COMMENT. In the majority of childhood cases the dystonia is generalized, in some segmental, involving more than one body part,

but none were focal and restricted to a single body part. Focal dystonia occurs only in those with adult onset. The observation of spontaneous stabilization in the patients of this study is of interest and the long term prognosis was relatively good.

PSYCHOGENIC TREMORS

The clinical presentations and criteria for diagnosis of psychogenic tremor in 24 patients are reported from the Department of Neurology, Kansas University Medical Center, Kansas City, KS. Two were adolescents and the remainder were adults; nine men and 15 women. The tremors were complex (resting, postural, and kinetic), and of abrupt onset with a variable course. The clinical characteristics included spontaneous remissions, clinical inconsistencies, changing tremors, unresponsiveness to drugs, exacerbation by attention, improvement with distractibility, responsiveness to placebo, absence of other neurologic signs, and remission with psychotherapy. Other medical factors suggesting a psychogenic etiology included multiple undiagnosed conditions, unwitnessed paroxysmal disorders, employment in allied health professions, litigation or compensation pending, secondary gain, psychiatric disease, and functional disturbances in the past. (Koller W et al. Psychogenic tremors. Neurology August 1989; 39:1094-1099).

COMMENT. Despite these clearly defined clinical features the diagnosis of psychogenic tremor is often difficult. Psychogenic and organic diseases may coexist and psychogenic tremor is usually a diagnosis of exclusion. In Pediatric Neurology practice, tremor is a frequent complication of valproate therapy for seizures and iatrogenic causes must be remembered in the differential diagnosis. The majority of patients with torsion dystonia in childhood are first diagnosed as hysteria. Acute dystonia is reported with cocaine withdrawal.

TOXIC DISORDERS

DYSTONIA AND COCAINE WITHDRAWAL

An acute dystonic episode in a 15-year-old girl during cocaine withdrawal is reported from the Departments of Neurology and Psychiatry, Albert Einstein College of Medicine, Bronx, N.Y. After 16 hours of observation in the hospital without receiving any drugs, she developed generalized dystonia, torticollis, extensor posturing, and high-pitched vocalizations. The episode subsided after administration of 50 mg IV diphenhydramine. She was discharged nine days later with diagnosis of adjustment disorder with depressed mood, and cocaine abuse. (Choy-Kwong M, Lipton RB. Dystonia related to cocaine withdrawal: A case report and pathogenic hypothesis. Neurology July 1989; 39:996-997).

COMMENT. There is a high frequency of neuroleptic-induced dystonia reported in cocaine users. Cocaine may lower the threshold to these reactions. This report indicates that dystonic reactions to cocaine withdrawal can occur in the absence of other drugs.