limbs versus the lower extremities (cruciate palsy, brachial diplegia) is seen in the traumatic central cord syndrome or cervical spondylotic myelopathy of elderly patients. Brachial diplegia due to pyramidal tract involvement was first described by Mohr, while the term man-in-the-barrel syndrome (MIBS) was coined by Sage and Van Clitert to describe the clinical aspect of the patient with disproportionate weakness of both arms, while maintaining mobility of face and lower limbs (as though the trunk of the patient is stuck on a barrel). The term cruciate palsy is best used for lesion of corticospinal tracts in the medulla, while exclusive use of the term MIBS for bilateral frontal lobar lesions as in the original description would provide more clarity to the terminology. MIBS is seen commonly after cardiac tamponade, aortic surgery, systemic hypoperfusion and hypovolaemic shock, head injury, anoxic damage to the cortex in the area of somatotopic representation of the arms. There is only one report of tumors being responsible for MIBS—tha due to cerebral metastases from undifferentiated carcinoma lung. Multicentric glioma presenting as MIBS has not been reported earlier.

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Reference


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Acute painful peripheral neuropathy due to metronidazole
Sir,
Metronidazole is a 5-nitroimidazole compound that has potent activity against anaerobic bacteria and several protozoa. Peripheral neuropathy is its rare side effect. We report an unusually rapid development of peripheral neuropathy due to metronidazole. A 45-year-old lady received oral metronidazole for the treatment of vaginitis. After 3 days of treatment, after receiving 3.6 g of metronidazole, she developed severe burning pain in both the feet and aching pain in the muscles of the thighs and calves. On the seventh day she developed burning pain in the hands and fingers and severe aching pain in the muscles of forearms and arms. There were no history of diabetes mellitus, chronic alcohol intake, renal failure, occupational toxin exposure or chronic diarrhoea. She consumed wholesome non-vegetarian diet. There was no history of arthritis, skin rash, recurrent oral ulcers, uveitis, xerostomia or xerophthalmia.

Examination revealed a well-nourished middle-aged lady. There was no pallor, hyper-pigmentation, and evidence of nutritional deficiencies or hypopigmented skin lesions. She weighed 65 kg and her height was 154 cm. Her blood pressure was 120/70 mm Hg. She had no organomegaly. Detailed neurological examination was normal. Her hemogram, peripheral smear, fasting blood sugar, serum creatinine and serum vitamin B12 level were normal. Antinuclear antibodies were negative.

Electrophysiological studies done on the 10th day of illness revealed prolonged distal motor latency (6.5 ms for a distance of 90mm) of posterior tibial nerve, prolonged distal motor latency (5.3 ms for a distance of 90mm) and mildly reduced compound muscle action potential amplitude (3.1mV) of the peroneal nerve and decreased sensory nerve action potential amplitude (2.0 mV) of the posterior tibial nerve. Nerve conduction studies of median, ulnar and sural nerves were normal. Metronidazole was discontinued and symptomatic therapy (Carbamazepine and Gabapentin) was given. She found significant relief of symptoms. After 3 months, she continued to take carbamazepine and gabapentin for symptomatic relief. A repeat nerve conduction study at 3 months did not show any improvement in the abnormalities. Applying the Naranjo’s algorithm, our patient’s neuropathy could be considered a “probable (score +5)” adverse effect of metronidazole.

The cumulative neurotoxic dose of metronidazole in the lit-
erature varied from 13.2 grams\textsuperscript{[3]} to 228 grams.\textsuperscript{[4]} The duration of therapy after which neuropathic symptoms developed varied from 11 days\textsuperscript{[3]} to 6 months.\textsuperscript{[4]} The 3 days of latency and 3.6 g of cumulative dose observed in our patient are the smallest reported so far. It is noteworthy that, in the case reports from India,\textsuperscript{[3,5]} the cumulative dose of metronidazole was low (13.2-18 grams) and the latency to symptom onset very short (11 days to 18 days) when compared to patients from the West. This may reflect a genetic susceptibility to the neurotoxic effects of metronidazole or a genetic variation in the metabolism of metronidazole in Indian patients.

To conclude, we report an unusually rapid development of peripheral neuropathy after starting metronidazole. Its early recognition and rapid withdrawal of the drug are important, as the neuropathy can be disabling and persistent.

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References

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Idiopathic primary pan intraventricular hemorrhage in a child

Sir,

Primary intraventricular hemorrhage (PIVH) is defined as hemorrhage restricted to the ventricular system without apparent brain parenchymal involvement. Idiopathic PIVH (IPIVH, whereupon no clear evidence of a source is found) has been reported in only six cases, all of whom were adults.\textsuperscript{[1,2]} We present the case of a 7-year-old female with IPIVH, with pertinent discussion.

With a past history of mild headaches over 6 months, this girl awoke with a severe headache and nausea, becoming subsequently unresponsive (with no apparent seizure activity noted). She was rushed to an adjacent hospital where a computed tomography (CT) scan of the head revealed a pan-intraventricular hemorrhage with ventricular dilatation [Figure 1]. An external ventricular drain (EVD) was placed with an extremely high opening pressure and the CSF was drained continuously. The patient improved post-operatively and over the next 24 hours was able to interact with her parents and follow some commands. A post-EVD placement CT revealed no new bleed, adequate EVD placement, and a right basal ganglia hypodensity. Approximately 36 hours post-presentation, she became acutely unresponsive to central stimulation with fixed and dilated pupils, with the EVD still functional and draining bloody fluid. The patient’s pupils became fixed and dilated, and she was unresponsive to deep central stimulation. No significant vital sign change was noted leading up to the event, and the phenytoin level was slightly supratherapeutic, with no evidence of coagulopathy. Subsequent CT over 8 hours showed no new findings. No seizure