

INFECTIOUS DISORDERS

VARICELLA-ZOSTER VIRUS AND RAMSAY HUNT SYNDROME

Fifty two children, aged 2 to 15 years, diagnosed with Ramsay Hunt syndrome (RHS) in a 20 year period between 1976 and 1996 are reported from the Facial Nerve Clinic, Ehime University Hospital, Japan. Eighteen were under 6 years of age (preschoolers) and 34 were older children. The diagnosis of RHS was made from signs of facial palsy, herpetic vesicles on the auricles or oral mucosa, and vestibulo-cochlear dysfunction. Vesicles, occurring in 81% of patients, developed several days after the facial palsy in 50% of cases. Hearing loss was detected in 24% of children, 11% complained of tinnitus, and 17% had vertigo. Symptoms in children were milder than in adults, and the prognosis was better. Complete recovery of facial palsy occurred in three quarters, and none had a severe residual paralysis. Hearing recovered in two thirds. In patients without vesicles, diagnosis was confirmed by a complement-fixation assay of the serum, when the VZV-specific antibody increased four-fold between acute and convalescent phases. None had received varicella vaccine. (Hato N, Kasaki H, Honda N et al. Ramsay Hunt syndrome in children. Ann Neurol August 2000;48:254-256). (Respond: Dr Kasaki, Department of Otolaryngology, Ehime University School of Medicine, Shigenobu-cho, Onsengun, Ehime, 791-0295, Japan).

COMMENT. The clinical symptoms of Ramsay Hunt syndrome are milder in children and the outcome better than in adults. Children have stronger specific immunity against the varicella-zoster virus, and this may minimize the reactivation of the virus. Delayed appearance of vesicles may lead to misdiagnosis as Bell's palsy. Early administration of acyclovir will improve the prognosis of the facial palsy and hearing loss.

VASCULAR DISORDERS

PROGNOSIS OF ISCHEMIC STROKE: THE U.K. EXPERIENCE

The outcome of 128 children diagnosed with ischemic stroke at Great Ormond Street Hospital, London, between 1990 and 1996, was evaluated first, by a parental questionnaire and subsequently, with physiotherapist and occupational therapist ratings of motor and behavioral function, and quantitative measures of cognitive function by a neuropsychologist. Data were not available for 23 patients, but 15 (11%) had died. Patients were aged 3 months to 15 years at the time of the stroke (median age, 5 years), and follow-up ranged from 3 months to 13 years (median duration, 3 years). Among 90 patients evaluated, the risk factors for stroke were moyamoya in 17, cardiac lesion in 15, sickle cell anemia (8), CNS infection (5), malignancy (6). Hemiparesis resulted in 75, and 30 presented with seizures. Outcome, defined by normal or impaired activities of daily living, was good in 40% and poor in 60%. Correlation of parents' responses with the medical and therapist evaluations was good, but not with measures of psychological function. The younger the child at the time of the stroke, the worse the prognosis. (Ganesan V, Hogan A, Shack N et al. Outcome after ischaemic stroke in childhood. Dev Med Child Neurol July 2000;42:455-461). (Respond: V Ganesan MD, Wolfson Centre, Mecklenburgh Square, London WC1N 2AP, UK).

COMMENT. The incidence of good prognosis (40%) and fatalities (11%) in this study was identical to that reported in the recent Netherlands study (see Ped Neur Briefs June 2000;14:41).