References


Chorea in a Child with Churg-Strauss Syndrome

The annual incidence rate of ischemic stroke in children younger than 14 years of age has been estimated to be 0.63/100,000 per year.1 The causes of ischemic stroke in childhood were reviewed by Kappele et al2 as head, neck, or throat injury; vascular abnormalities, cardiac disorders; blood diseases; infectious disorders; metabolic disorders; phakomatosis; and miscellaneous. Among the causes in the miscellaneous group, vasculitis is rare and Churg-Strauss syndrome has never been cited.3 We describe a child with Churg-Strauss syndrome revealed by a subacute chorea.

A 13-year-old girl was admitted to the hospital with movement disorders and a rash that appeared progressively over 3 days. The child was pregnant of a normal pregnancy. She had been treated since the age of 10 for asthma with aminophyllin and β-adrenergic agents. No allergen was found. Oral corticosteroid therapy was stopped 3 months before admission. On admission, her temperature was 38.5°C. Peak-flow value was 150 L/min. She suffered from brief, arrhythmic, involuntary movements involving the proximal parts of her arms and legs, and the orobuccolingual region. Neurological examination revealed hypotonia of her limbs. There were purpuric eruptions symmetrically involving the dorsal part of the metacarpus and the ankles and livedo reticularis involving both legs. The white cell count was 23 x 10^9/L, with 7.5 x 10^9/L eosinophils (32.6%). Hemoglobin, hematocrit, and platelet counts were normal, without anac- thytosis. The erythrocyte sedimentation rate was 26 mm/h. Serum electrophoresis showed a hypergammaglobulinemia. Levels of C3 and C4 were increased. Antinuclear antibodies, antimmunoglobulin antibodies, cryoglobulins, and immune complexes were absent. The serum immunoglobulin E level and the serum ceruloplasmmin level were normal. No bacterial, viral, or parasitic disease was found using blood cultures and serological tests. Hepatitis B serological tests were negative. Cerebrospinal fluid was normal. Chest x-ray, thoracic computed tomographic (CT) scan, transthoracic echocardiography, and optic fundi were normal. Brain CT scan without contrast revealed frontal and maxillary chronic sinusitis. A magnetic resonance imaging (MRI) study was performed 12 days after the

Fig 1. T2-weighted magnetic resonance image shows hyperintense signals in both globus pallidus (arrows).

Fig 2. T2-weighted magnetic resonance image shows multiple small, hyperintense images in subcortical white matter.
Cerebrovascular Events in Cardiac Catheterization

Neurological complications at cardiac catheterization (CC) are infrequent, occurring in approximately 0.2% of patients.¹ Posterior cerebrovascular events (CEs) seem to predominate with the brachial approach.² However, Keilson et al³ presented 13 patients (0.3%) with CE after femoral CC, and the posterior circulation was involved in seven cases.

To date, little is known about the frequency and vascular topography of CE and its relation to the catheterization route. We carried out a retrospective clinical study in 10,000 consecutive patients with CC between 1977 and 1990. All the patients were studied by the femoral approach, and 12 (0.12%) had CE. There were eight females and four males, ranging from 8 to 61 (mean, 48) years of age. Complications occurred either during catheterization (eight patients) or within 24 hours after the procedure (four patients). The main cardiac diagnosis was valvular heart disease in seven, ischemic heart disease in two, congenital heart disease in two, and infective endocarditis in one. Five patients showed evidence of focal disorder in the vertebrobasilar territory, three in the carotid territory, and four were of uncertain localization. Computed tomographic scans were performed beginning in 1978 (five patients). The neurological findings resolved completely within 24 hours in six patients. At 3 weeks, disability was minimal in three patients and moderate in two. One patient died 7 days after CE.

In conclusion, our incidence of CE in CC (0.12%) is similar to other studies.¹ ¹⁴ In agreement with Keilson et al,³ vertebrobasilar CEs also predominate in our series. The preponderance of posterior CEs is apparently independent from the CC approach (femoral versus brachial).

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References


Magnetic Resonance Imaging in Basilar Artery Dissection

Primary dissections of the basilar artery are rare. They usually result in brain stem ischemia and have a poor prognosis. We report a benign case in which subarachnoid hemorrhage (SAH) was the only manifestation. The diagnosis was suspected at angiography and confirmed by magnetic resonance imaging (MRI).

A 63-year-old woman suddenly developed a severe occipital headache and posterior neck pain associated with photophobia and vomiting. The headache persisted despite paracetamol treatment. Her temperature, which had been normal during the first 5 days, increased to 38°C (rectal). The patient was referred to the hospital 7 days after the onset of the headache.
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