

Atypical Subacute Sclerosing Panencephalitis with Short Onset Latency

I read with great interest the case reported by the authors [1] describing the unusual latency period in subacute sclerosing panencephalitis (SSPE). The usual latency period of SSPE is 6-10 years from its onset as it is a slow virus neurodegenerative disorder. The exact factors and influences that allow the measles infection to persist are unclear, but may include several immunological factors [2]. Numerous alterations in M protein have been described in SSPE because of extensive point mutations in viral genome, possibly resulting in persistent viral infection [3].

Since it is a slow progressive neurodegenerative disorder a latency period of two month is very unusual. Authors have not described the pathogenesis behind this unusual occurrence. Moreover CSF analysis shows only

raised IgG levels with normal IgM levels but looking at short latency period there is more possibility of raised IgM levels instead of IgG measles antibody. Therefore this case is looking more likely a case of SSPE from congenital measles and in that case this latency becomes irrelevant. Serology of the mother can be helpful in these cases.

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Cholera-like Illness Due to *Aeromonas caviae*

A 2-year-old girl presented with rice watery stools and vomiting for 12 hours. There was no blood in the stools. On examination she had some dehydration. Stool microscopy and hanging drop revealed darting motile bacilli morphologically resembling *Vibrio cholera*. Her blood count and renal function tests were normal. Dehydration was corrected with IV Ringer lactate and she was commenced on Azithromycin. Her HIV status was non-reactive. Stool culture grew *Aeromonas caviae*, which was sensitive to doxycycline, chloramphenicol, furazolidine and resistant to nalidixic acid, ceftriaxone, co-trimoxazole and ampicillin. She was discharged after three days.

Aeromonas species are ubiquitous water borne medically important, Gram-negative, rod-shaped microorganisms [1]. Today, they are regarded not only as disease-causing pathogen of fish but are also responsible

for variety of complications in both immunocompetent and immunocompromised humans [2]. *Aeromonas* have gained importance as human pathogens causing gastrointestinal infections. They also cause extraintestinal infections such as cellulitis, wound infections, sepsis and urinary tract infections [1]. Deodhar, *et al.* [3] isolated *Aeromonas* from 45 (1.8%) of 2,480 patients with acute gastroenteritis. Out of 863 traveller's diarrhea patients returning from Asia, Africa, and Latin America, 2% of cases were caused by *Aeromonas* [4]. Studies have shown that three *Aeromonas* (*A. hydrophila*, *A. caviae* and *A. veronii* by Sobria) are responsible for ≥85% of human infections [2]. Clinical spectrum of *Aeromonas*-induced diarrhoea varies from toxigenic diarrhea to colitis and in developing countries it is predominantly toxigenic [3]. The most common presentation for *Aeromonas* gastroenteritis is secretory(watery) enteritis suggesting the toxigenic nature of the organism [2]. *Aeromonas* strains are almost universally susceptible to fluoroquinolones and exhibited multidrug resistance [2]. Bhowmika, *et al.* [1] isolated potentially pathogenic and