Infantile Tremor Syndrome

A previously normal, 15-month-old boy, born at term to nonconsanguineous parents, was hospitalized for generalized tremors for 3 days. Child was unable to cry and feed. He was exclusively breast fed. He was classified as grade 2 (IAP) malnutrition; he also had hyperpigmentation over limbs, pallor and hepatosplenomegaly. Tremors were absent during sleep, and got aggravated during activities (***Web Video* 1**). His hemoglobin was 5.8 g/dL with dimorphic blood picture. EEG was normal and MRI showed diffuse cerebral atrophy. Mother's serum B_{12} levels were low (<200 pg/mL) but child's serum B_{12} levels were normal, probably because of prior treatment with injectable B_{12}. A diagnosis of Infantile tremor syndrome (ITS) was made. Child received WHO protocol of management for moderate malnutrition. The child received blood transfusion, vitamin (A, D, B complex and C) and mineral (zinc, magnesium, calcium) supplementation. Propranolol (0.5 mg/kg/day) was started, and increased to 2 mg/kg/day till the tremor decreased in intensity and general condition of child improved. Kahn's nutritional recovery syndrome, infections (viral encephalitis/encephalopathy), phenothiazine toxicity, degenerative diseases, and enzyme defects in tyrosine metabolism leading to substantia nigra depigmentation are the differential diagnoses of ITS.

Infantile tremors are unique in that they are present only in awake state. Tremors are fast (7Hz) and coarse, and involve distal part of limb, especially head face and tongue.

WEB VIDEO 1 *Infant with characteristic tremors suggestive of Infantile Tremor Syndrome.*

Infants with ITS have difficulty in speech and produce sound like bleating of goat. They may also toss the head from side-to-side.

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NOTICE

Call for Submission of 'Clinical Videos'

Under this section, *Indian Pediatrics* publishes videos depicting an intricate technique or an interesting clinical manifestation, which are difficult to describe clearly in text or by pictures. A video file submitted for consideration for publication should be of high resolution and should be edited by the author in final publishable format. MPEG or MP4 formats are acceptable. The maximum size of file should be 20 MB. The file should not have been published elsewhere, and will be a copyright of *Indian Pediatrics*, if published. For this section, there should be a write-up of up to 250 words discussing the condition and its differential diagnoses. The write up should also be accompanied by a thumbnail image for publication in the print version and PDF. Submit videos as separate Supplementary files with your main manuscript. A maximum of three authors (not more than two from a single department) are permissible for this section. In case the video shows a patient, he/she should not be identifiable. In case the identification is unavoidable, or even otherwise, each video must be accompanied by written permission of parent/guardian, as applicable. Authors are responsible for obtaining participant consent-to-disclose forms for any videos of identifiable participants, and should edit out any names mentioned in the recording. The consent form should indicate its purpose (publication in the journal in print and online, with the understanding that it will have public access) and the signed consent of the parent/legal guardian. The copy of the consent form must be sent as supplementary file along with the write-up, and original form should be retained by the author. A sample consent form is available at our website *www.indianpediatrics.net.*