care centers also and these cases may be missed from the series of tertiary care centers.

While working in a medical college situated in a district place, we have managed six cases of anti-NMDAR autoimmune encephalitis (antibody confirmed) with poly-symptomatic presentation in the last four years. Four of them responded to just 3-6 monthly cycles of MP while only two (presented to us more than 4 weeks after onset) had to be given either IVIG or rituximab after methylprednisolone because of lack of response to MP in one week. Most of them could not afford IVIG/ rituximab, and received only MP. They showed good clinical response. None of the children who received MP have had any relapse (duration of follow-up: 6 month-4 years).

We want to suggest that all children with anti-NMDAR antibody encephalitis do not need aggressive immunomodulation with MP, IVIG and other agents. Many of them may just respond to 3-6 doses of MP alone. However more studies including milder cases from peripheral centers are needed to generate robust evidence on this aspect.

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AUTHORS' REPLY

We thank the readers for their interest in our publication [1]. Several expert recommendations for treatment for autoimmune encephalitis are available but there is no uniform standardized approach to therapy. However, the degree of aggressiveness of therapy needed may often be clinically guided by certain prognostic factors in an individual patient. Additionally, second-line agents such as rituximab or cyclophosphamide are used when first-line agents (steroids, intravenous immunoglobulin or plasmapheresis) fail. In a cohort of 577 patients with anti-NMDAR encephalitis, of whom 211 were children, 94% underwent first-line therapy/tumor removal, and 53% improved within 4 weeks. Most patients improved with immunotherapy, with 81% living independently two years after the diagnosis [2]. In this cohort, predictors of favorable outcome (including in 177 of 211 children) were early initiation of treatment and lack of intensive care unit (ICU) admission. Hence, authorities recommend escalation to second-line therapy if there is lack of significant improvement on first-line therapy in 10-14 days in anti-NMDAR encephalitis, especially among patients admitted to the ICU [3]. However, this brisk escalation may not be warranted for other autoimmune encephalitis and clinicians may wait longer before introducing second-line therapy [4].

While steroids are definitively therapeutic in this condition, there are certain issues with their use. Often, it is difficult to differentiate infectious causes of encephalitis from autoimmune encephalitis, and steroid initiation may be delayed. Additionally, the immunological effects of steroids are much more on T-cells compared to B-cells, and since autoimmune encephalitis is antibody-mediated largely, whether steroids alone would be as effective in all cases of autoimmune encephalitis is uncertain [5].

However, as the authors note, there are no clear guidelines on how frequently to repeat steroid dosing and the dosing interval is usually dictated by severity of the disease and the response of the child to therapy, including relapses. Indeed, all children may not warrant aggressive immunotherapy and it is better to individualize treatment rather than the 'one-size-fits-all' approach.

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