levodopa, hydantoin, baclofen, valproate, gabapentin, and neuroleptics were prescribed to her, all of them in progressively increasing doses. These drugs were used singly and in association, all to no or minimal avail.

Her neurological examination showed muscle strength IV in all limbs, however every attempt to assess her strength led to worsening of the athetosis-dystonia. Her gait and coordination could not be assessed, since she was severely disabled by the involuntary movements and abnormal posture. There was predominance of flexion and abduction of the arms and legs, which were more pronounced in the fingers and toes (Figure). Sensitivity was normal, as were the cranial nerves. She was prescribed carbamazepine 200 mg/day, with increasing doses up to 600 mg/day within two weeks. Her response was dramatic, and she returned for a new assessment within a week. Although still presenting a degree of dystonia in all four limbs, she could walk unaided and use her both hands for daily activities.

Bilateral optical neuritis was developed nine months later. She continued her treatment with carbamazepine, azathioprine, and corticosteroid pulses when required. Three years and four relapses later the patient presents severe visual and motor disability.

We believe that this patient spent eight months without proper diagnosis due to the difficulties encountered by all the neurologists involved in her case. As very properly pointed out by Schmidt et al.\(^1\), the literature is scarce on NMO bouts manifesting as athetosis-dystonia.

References


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**Neurocysticercosis, immune status and immune response**

*Neurocisticercose, estado imunológico e resposta imune*

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Dear Editors,

A recent paper on neurocysticercosis and immune suppression is of interest\(^1\). Indeed, several observations on the co-occurrence of neurocysticercosis and immunosuppression can be seen. However, further studies are still required to conclude for any relationship. To develop any infection, the poor immune status of the affected patient must be accompanied. The host and parasite immune interaction seems to be a complex phenomenon. Focusing in neurocysticercosis, this is a chronic infection and the short-term evaluation of the immune status might not give the correct explanation on the findings. The detected immunosuppression might or might not be directly relating to the infection. Of interest, in tropical countries such as Thailand, there is still no evidence that neurocysticercosis increases its incidence among the immunodeficient subjects, such as HIV seropositive, and so on.

References

1. Bueno EC. Cysticercosis and the immunossupression: what are the mechanisms involved? Arq Neuropsiquiatr 2012;70:243-244.