paraneoplastic encephalitides. Clinical suspicion for ovarian teratoma is warranted in young women presenting with non-infectious, nonlimbic encephalitis syndromes.

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Novel Variant of Miller Fisher Syndrome Occurring With Tumor Necrosis Factor α Antagonist Therapy

Miller Fisher syndrome (MFS) is characterized by the acute onset of external ophthalmoparesis, ataxia, and areflexia, and it is highly correlated with the presence of anti-GQ1b antibodies. Here we present a case with a limited variant of MFS characterized by mild ophthalmoparesis, pupillary unresponsiveness, lid twitches, and lid hops in the presence of an extremely high anti-GQ1b antibody level differing from the previously described tumor necrosis factor α (TNFα) antagonist-associated MFS cases.

Video at jamaneurology.com

Figure. Horizontal and Vertical Eye Movements

Report of a Case | A 43-year-old woman presented to the acute medical team with a 3-day history of worsening diplopia. She initially noticed blurring of distance vision, which then progressed to horizontal diplopia in primary gaze, worsening on gaze to the left-hand side. She also had a mild, nonspecific bitemporal headache. She denied any other neurological symptoms. The patient provided written informed consent to report her case.

Her medical history included mesenteric ischemia thought secondary to factor V Leiden mutation. This required resection of the small bowel and subsequent anticoagulation with long-term warfarin therapy (target therapeutic range of international normalized ratio, 2.0-3.0).

She had been diagnosed as having ulcerative colitis 12 years prior to her neurological presentation. This had been treated with azathioprine for 7 years then methotrexate. She had commenced treatment with infliximab 9 weeks prior to presentation owing to a corticosteroid-resistant severe flare-up of her ulcerative colitis. She had received 2 infusions of infliximab and was due to receive a third infusion on the day of her presentation with diplopia.

On presentation, visual acuity was 20/20 in both eyes but N14 for near with clear media and healthy optic discs and maculae. Pupils were mid-dilated and unreactive to light and accommodation. There was a mild asymmetric global ophthalmoparesis with both horizontal and vertical separation of images. There was no ptosis but upper eyelid twitches were evident on vertical eye movements with lid hops on horizontal gaze. Orbicularis oculi function was normal (Video and Figure, which demonstrates upper eyelid twitches on vertical eye movements, lid hops on horizontal eye movements, and unreactive pupils).

The neurological examination was otherwise normal; in particular, the tendon reflexes were normal and symmetric, plantar responses were down going, and there was no ataxia.
A provisional diagnosis of acute autoimmune ophthalmoplegia was made. Investigations included a normal full blood cell count and renal, liver, thyroid, and bone profiles, as well as negative anti-acetylcholine receptor and anti-Musk antibody test results. The erythrocyte sedimentation rate was 43 mm/h (to convert to mm/h, multiply by 1) and C-reactive protein level was 26 mg/L (to convert to mmol/L, multiply by 9.524) attributable to her active bowel disease. Magnetic resonance imaging of the brain and magnetic resonance venogram were normal. The anti-GQ1b IgG antibody titer was 6400, supporting the diagnosis of an isolated autoimmune acute ophthalmoplegia variant of MFS occurring with TNFα antagonist therapy.

Treatment with intravenous immunoglobulin or plasmapheresis was considered; however, it was not given because of the relatively mild symptoms, potential risks of treatment, and likely lack of impact on long-term recovery. Instead, occlusion was used to eliminate diplopia with reading glasses for near tasks.

Two weeks later, the ophthalmoplegia was unchanged but the eyelid twitches and hops had reduced and the pupillary light responses had improved. By 10 weeks after presentation, all symptoms and signs had resolved and anti-GQ1b IgG antibody titer had reduced to 200.

Discussion | Tumor necrosis factor α antagonists have been reported to be associated with, or cause, central and peripheral nervous system demyelination including multiple sclerosis–like symptoms, as well as 2 cases clinically compatible with MFS, neither of whom had anti-GQ1b antibodies. The temporal association of infliximab therapy suggests that TNF antagonism may have caused or permitted the development of MFS in this case, although the mechanism involved is unclear.

This case extends the spectrum of TNF antagonist–associated neurological disorders and provides further evidence that these are immune mediated. Clinicians should be vigilant for the potential broad-ranging, although uncommon, neurological adverse effects of these drugs.

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COMMENT & RESPONSE

Use of Descriptive Terms in Medical Records
To the Editor | I read with interest the comments by Dr Berger1 on his experience in which he was advised by a fellow academic colleague that it was inappropriate to include terms describing a patient’s race/ethnicity or country of origin in medical documentation. This guidance was undoubtedly offered with well-meaning intentions. As a neurologist who completed residency training (in Ohio) in the mid-1980s, I share Dr Berger’s amazement and dismay at receiving this advice. I completely agree with Dr Berger that having this information available in the medical record can be critical when including or excluding diagnostic possibilities and can as well be influential for individual disease management. I also agree that adding this information can help the physician to better understand each patient’s uniqueness, which, in turn, can enhance physician-patient communication.

It is true that socially accepted descriptive terms for race, ethnicity, and to a lesser extent country of origin change over time. Verbiage in medical records and journal articles from the early to mid-20th century would often be deemed inappropriate in today’s context. While there is always potential for inclusion of inappropriate terminology in medical documentation, I submit that this potential is low given the desire of most physicians to avoid intentional or unintended conflict or harm to patients, with a secondary motive of avoiding libel litigation. The increasingly open access of medical documentation to patients and third-party entities is another important factor to limit inclusion of inappropriate material. As Dr Berger correctly pointed out, it is not only certainly feasible, but should be the expectation to use currently accepted demographic terms in medical documentation in a nonjudgmental, nonpejorative manner.

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