Week. During second week of admission, while monitoring for rituximab infusion, his SpO2 was found to be 88% in room air. Child was comfortable with normal respiratory rate and had no cough, running nose, dyspnea, exertional intolerance, dark colored urine or cyanosis, and systemic examination was unremarkable. The possibility of methemoglobinemia as well as viral interstitial lung disease was considered; arterial blood gas analysis showed methemoglobin level of 14.9% (normal <2%) and arterial oxygen saturation (PaO2) of 90 mmHg. Dapsone and TMP/SMX were stopped, and he was followed up clinically with SpO2 monitoring once in 3-4 days. Hemoglobin remained constant at 11 g/dL and there was no evidence of hemolysis. Repeat methemoglobin level after two weeks was 0.3% with PaO2 of 109 mmHg.

Methemoglobinemia following prophylactic doses of TMP/SMX is extremely rare [1,2]. Although dapsone is a well-known cause of methemoglobinemia, it did not cause any symptoms in our patient for over 6 months. The other drugs being administered (cyclosporine and rituximab) are not known causes of methemoglobinemia in usual doses. The addition of cotrimoxazole might have caused a ‘dose-effect’ with dapsone resulting in methemoglobinemia. Methemoglobinemia following combination of dapsone with TMP/SMX combination has been reported in HIV patients receiving these drugs in therapeutic dosage for PCP [3]. Since TMP/SMX is used very commonly in pediatric oncology and immunodeficiencies, the early recognition of this complication by SPO2 monitoring may be warranted.

Nita Radhakrishnan and Ruchi Rai
Departments of Pediatric Hematology Oncology and Neonatology, Super Speciality Pediatric Hospital and PG Teaching Institute, Noida, UP, India.
*nitaradhakrishnan@yahoo.com
Autistic Regression: Should it Prompt Urgent EEG?

Autistic spectrum disorders (ASD) are being increasingly recognized in children. The exact cause of this condition is not clear and the work up is usually negative, thereby causing frustration in parents and treating physicians equally [1]. Treatment usually consists of speech therapy, occupational therapy and behavior modification. As it is usually a permanent condition, any intervention that changes the course of the disease is of immense importance. There is little role for pharmacotherapy except use of drugs like risperidone and stimulants [1].

There are broadly two groups in ASDs; one where children have features of autism since birth and in the other group (about one-third) babies are normal for the initial 9-18 months with some even using some meaningful words and having good interaction to later on lose language milestones and become socially withdrawn. The latter group is referred to as autistic regression [2]. An immune-mediated pathophysiology has been proposed, which is supported by indirect evidence of increased prevalence of autoimmune disorders in families of children with autistic regression as compared to healthy controls [1-3]. This subgroup of ASD when investigated early in the course of the disease sometimes shows epileptic abnormalities on EEG in the form of recurrent generalized spikes and sharp waves in the absence of clinical seizures. Use of antiepileptic drugs and immunomodulation in the form of pulse methylprednisolone followed by oral steroids along with levetiracetam and speech therapy. This intervention resulted in improved eye contact, improved comprehension of oral commands and reduction in hand stereotypes within a month. The EEG also showed normalization. These two cases underscore the need to sensitize pediatricians to identify these children early in the regression phase. We feel that a prompt EEG and consideration of immunomodulation along with other intervention, can go a long way in changing the developmental trajectory of these children. Prospective studies with clear protocols are required to confirm this finding. This condition is different from the well-described Landau Kleffner syndrome, which is seen in slightly older age group and the EEG findings there are slightly different [5].

We recently saw two toddlers who presented to us with reduced interaction, decreased response to being called, hand stereotypies and loss of use of few word they had attained. They did not have any clinical seizures. EEG showed recurrent generalized epileptiform discharges prompting us to give a trial of pulse methylprednisolone followed by oral steroids along with levetiracetam and speech therapy. This intervention resulted in improved eye contact, improved comprehension of oral commands and reduction in hand stereotypes within a month. The EEG also showed normalization. These two cases underscore the need to sensitize pediatricians to identity these children early in the regression phase. We feel that a prompt EEG and consideration of immunomodulation along with other intervention, can go a long way in changing the developmental trajectory of these children. Prospective studies with clear protocols are required to confirm this finding. This condition is different from the well-described Landau Kleffner syndrome, which is seen in slightly older age group and the EEG findings there are slightly different [5].

MAHESH KAMATE
Department of Pediatrics,
KLE University’s J.N Medical College,
Belgaum, Karnataka, India.
drmaheshkamate@gmail.com

REFERENCES