
LETTER TO EDITOR (VIEWERS CHOICE)

CAN RETINA BE NORMAL IN AICARDI SYNDROME?

Asok Kumar Datta, Indrajit Mondal

A three and half years old muslim girl, born of a non-consanguineous marriage was admitted with uncontrolled recurrent infantile spasms since 4th day of birth for which she was hospitalized 15 times and had received anticonvulsive treatment initially with monotherapy and then gradually polytherapy. She was delivered by caesarean section and cried immediately after birth. She had no other perinatal complications. There was gross developmental delay. She neither developed social smile nor could she sit or stand. She was not able to hear or see. Her mother, 29 years old had two successive abortions in early months, first one at 4 months and second one at 2 months of gestation. On examination the patient had spasticity. Examination of the fundus was normal. Other systems were normal. Investigations showed cortical dysrhythmia on EEG. MRI of brain showed partial agenesis of corpus callosum mainly in posterior portion of the body and splenium, thalamus and periventricular region. Cross sectional MRI study revealed mild hyper intensities in bilateral putamen. Thus she was diagnosed as Aicardi syndrome without retinal involvement.

Aicardi syndrome is a severe neurodevelopment disorder initially thought to be the triad of partial agenesis of corpus callosum, choroidretinal lacunae and infantile spasm. It is an X- linked dominant disorder affecting only females, usually males are not compatible with extrauterine life except some 47XXY (1). Infantile spasm usually starts in earlier and is very difficult to control. There is global mental retardation, visual defects and hearing defects. Other features present in subsets of affected individuals are costovertebral anomalies, facial dysmorphism, hand abnormalities, hypopigmentary skin lesions, multiple nevi, and an increased occurrence of rare vascular malformations and tumors along with other brain malformations (2,3). Choroidretinal lacunae are considered one of the pathognomonic sign of Aicardi

syndrome though in some cases it may not be present (4) as was seen in our patient.

Acknowledgement: Dr. Shyamal Mitraneogi, Professor and Head of the Department of Radio-diagnosis for helping us in radiological investigations and interpretation

Competing Interests: None

Authors contribution: AKD was responsible for patient care and writing of manuscript, IM helped in performing different investigations. All authors have read and approved the manuscript

REFERENCES

1. Hopkins IJ, Humphrey IK, Keith CG, Susman M, Webb GC, Turner EK. The Aicardi syndrome in a 47 XXY male. *Aust Paediatr J.* 15: 278-280
2. Hopkins B, Sutton VR, Lewis RA, Van den Veyver I, Clark G. Neuroimaging aspects of Aicardi syndrome. *Am J Med Genet A.* 2008; 146A: 2871-2878
3. Sutton VR, Hopkins BJ, Eble TN, Gambhir N, Lewis RA, Van den Veyver IB. Facial and physical features of Aicardi Syndrome: infants to teenagers. *Am J Med Genet A.* 2005; 138A: 254-258
4. Chevrie JJ, Aicardi J. The Aicardi syndrome. In: Pedley TA and Meldrum BS, eds. *Recent Advances in Epilepsy.* Edinburgh: Churchill Livingstone; 1986:3

From: Department of Pediatrics, Burdwan Medical College, India.

Address for Correspondence: Dr Asok Kumar Datta, Ulhas, CRAV 01, Joteram, Burdwan-713101. India. Email: asokdatta31@yahoo.com

E-published: 1st September 2011. **Art#58**
