To the Editors:

Multiple sclerosis in Sri Lanka

Multiple sclerosis (MS) is uncommon in Asia and has not been reported from Sri Lanka. We here report 2 patients with MS.

Case 1

A 46-year old woman with numbness and weakness of legs and unsteadiness of gait for 3 years, with a history of left-sided visual loss with incomplete recovery and left hemianaesthesia with complete recovery, showed, on examination, bilateral visual impairment, left optic atrophy, papillitis of right eye, spastic paraparesis and truncal ataxia. Magnetic resonance imaging (MRI) revealed multiple plaques in the periventricular regions and corpus callosum. Visual evoked potentials (VEPs) were abnormal bilaterally. Brain stem auditory evoked responses (BAERs) were normal.

Case 2

A 21-year old man with recent onset of unsteady gait and visual impairment, with no previous history of neurological symptoms had, on examination, reduced visual acuity and papillitis bilaterally with cerebellar signs. Pyramidal, brain stem, sensory or sphincter involvement were absent. MRI showed multiple plaques in periventricular regions, corpus callosum, internal capsule, brain stem and cerebellum. VEPs were abnormal bilaterally. BAERs were normal.

Both patients fulfilled the diagnostic criteria for MS (1). Neither had a history of living overseas, a Caucasian ancestry or a relevant family history. Markers of CSF IgG synthesis were absent in both, and routine haematological, biochemical and vasculitis screening were normal. Both recovered from their symptoms following intravenous methylprednisolone therapy.

MS is characterised by dissociation of neurological features in time and space. Clinical manifestations reflect the sites of predilection for demyelination (periventricular white matter, corpus callosum, optic nerves, brain stem, cerebellum and spinal cord) (1). Diagnosis of MS is aided by MRI (demyelination plaques involving the sites of predilection), demonstration of intrathecal IgG synthesis (CSF oligoclonal bands, increased CSF-serum IgG index) and abnormal evoked potentials (visual and brain stem auditory) (1).

Prevalence of MS increases with latitude, but environmental and hereditary factors may influence geographical distribution (2). Prevalence is low in Asia, especially in

the Indian subcontinent, Clinial heterogeneity is seen between geographical regions (3). CSF markers for intrathecal LgG synthesis are rarely observed in Asian countries (4).

MS should be a diagnostic consideration in patients with recurrent neurological manifestations, as diagnostic facilities and effective therapies are now available.

References

1. Poser CM, Paty DW, Scheinberg L, McDonald WI, Davis FA, Ebers GE, et al. New diagnostic criteria for multiple sclerosis: guidelines for research protocols. *Annals of Neurology.* 1983: **13:** 227-31.
2. Kurtzke JF. Epidemiologic contributions to multiple sclerosis; an overview. *Neurology.* 1980; **30:** 61-79.
3. Weinshenker BG, Bass B, Rice GPA, Noseworthy W, Carriere W, Baskerville J, et al. The natural history of multiple sclerosis: a geographically based study 1 .Clinical course and disability. *Brain.* 1989; **13:** 227-31.
4. Chopra JS, Radhakrishnan K, Sawhney BB, Pal SR, Banerjee AK. Multiple sclerosis in north-west India. *Acta Neurologia Scandinavica.* 1980; 62: 312-21.

Bimsara Senanayake, Udaya Ranawaka, *and* **Jagath Wijesekara,** *Neurologists, Institute of Neurology, National Hospital of Sri Lanka.* *(Revised version accepted 5 November 2001.* *Correspondence to UR, E-mail: udayaran@yahoo.com)*