COMMENT. Children diagnosed with benign congenital hypotonia in infancy should be reexamined at intervals through early childhood and should receive extended occupational and other therapy to build muscle strength, balance, and coordination. Hypotonic infants may appear to recover near normal tone by 6 years of age but demonstrate clumsiness and generalized muscle weakness on tests of motor proficiency. My own clinical experience would substantiate these findings. Whereas the office neurological examination appears normal, the mother complains that the child lacks normal stamina, tires easily on extended walks, and often wants to be carried. The symptoms described are sometimes suggestive of a possible myasthenia.

ACQUIRED NEONATAL BRACHIAL PLEXUS PALSY

Three infants presenting at 3, 15, and 21 days of age with brachial-plexus neuropathy were found to have a group-B streptococcal osteomyelitis, as reported from the British Columbia's Children's Hospital, Vancouver, Canada. Osteomyelitis was not recognized initially because the infants were afebrile and generally well. Patient 1 was normal at birth and for the first two days. The parents observed the left arm limp and painful when touched or moved on the 3rd day. An initial diagnosis of traumatic birth injury was changed at 15 days, on examination by neurologists, when the shoulder became warm and swollen, and reflexes were found intact. Blood cultures grew group-B streptococcus and radiographs showed a lytic lesion in the left humerus. EMG and nerve conduction studies on day 28 were consistent with brachial-plexus neuropathy. Intravenous penicillin for 6 weeks was followed by complete recovery by 3 months. Patients 2 and 3 had a similar history and recovered following penicillin therapy. (Sadleir LG, Connolly MB. Acquired brachial-plexus neuropathy in the neonate: a rare presentation of late-onset group-B streptococcal osteomyelitis. Dev Med Child Neurol July 1998;40:496-499). (Respond: Dr Mary B Connolly, Division of Neurology, Department of Paediatrics, British Columbia's Children's Hospital, 4480 Oak St, Vancouver, BC V6H 3V4, Canada).

COMMENT. The authors provide a list of the non-traumatic causes of brachial-plexus neuropathy. In addition to the most common obstetrical injury, a variety of rare, non-traumatic forms are reported, including vaccinations, cytomegalovirus, toxoplasmosis, congenital syphilis, and other infections. Brachial-plexus palsy associated with osteomyelitis may represent a pseudopalsy secondary to pain, or a true paralysis with involvement of the nerves by ischemia or swelling. Nerve conduction studies in the present case reports favor a true paralysis. Early diagnosis and intravenous penicillin therapy result in full recovery. Possible infection in bone should be considered in newborn infants who present soon after a non-traumatic birth with a painful limb paralysis resembling Erb's palsy, despite the absence of fever. For reports of the outcome and diagnosis of obstetric brachial plexus palsy, see Progress in Pediatric Neurology III, PNB Publishers, 1997;pp357-359.

INFLAMMATORY DEMYELINATING POLYRADICULOPATHY

A clinical and electrodiagnostic, retrospective study of 43 children with acute inflammatory demyelinating polyradiculopathy (AIDP) is reported from the Service de Neuropediatrie, Hopital de Bicetre, France. Age of onset ranged from one to 18 years, less than 3 years in 35%. An antecedent infection occurred within 2 months of onset in 74%. Presenting symptoms included pain (47%), weakness (23%), ataxia (15%), and sensory signs (5%). When the neurological impairment had ascended and reached a plateau, weakness was noted in 100%, pain in 63%,