



A case of acute respiratory distress syndrome with sixth cranial nerve palsy

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A 56-year-old man with a history of cigarette smoking was admitted to our intensive care department for pneumonia-related oxygen dependence. Two weeks previously (during a vacation in the countryside), the patient had developed confusion, headaches with photophobia, diplopia and fever. A neurological examination revealed drowsiness and binocular diplopia caused by left sixth cranial nerve palsy (Fig. 1a, b). Following lumbar puncture, bacterial cultures and PCR assays of the cerebrospinal fluid were negative. Magnetic resonance imaging of the brain was unremarkable.

The patient rapidly developed acute respiratory distress syndrome and shock, requiring invasive mechanical ventilation and the administration of noradrenaline (Fig. 1c).

Bronchoalveolar lavage cultures and PCR virus screens were negative. However, positive (1/128) indirect immunofluorescence assays for IgG against *Chlamydia psittaci* (performed twice, 3 weeks apart) were consistent with a *C. psittaci* infection. The patient's family had plumed poultry during their vacation, suggesting a possible source of infection. Treatment with doxycycline resulted in a favourable outcome.

Psittacosis is associated with a range of central or peripheral nervous system impairments. Consequently, *C. psittaci* infection should always be considered in the differential diagnosis of pneumonitis accompanied by neurologic signs.

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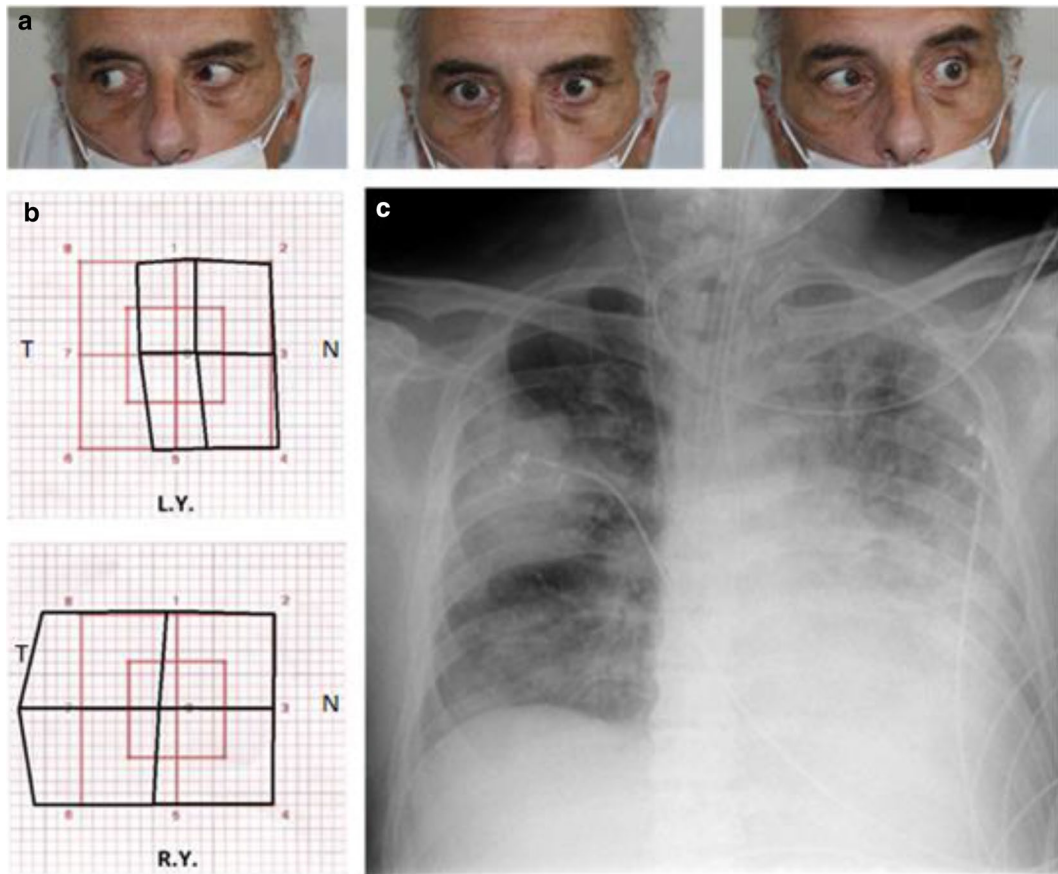


Fig. 1 **a** Ocular motility photographs, showing impaired abduction of the left eye (right panel). **b** Measurements from sequential Lancaster red-green tests, confirming the impairment of abduction in the left eye. T temporal, N nasal. **c** An X-ray of the chest revealing the bilateral diffuse whiteout characteristic of acute respiratory distress syndrome

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Compliance with ethical standards

Conflicts of interest

All authors declare that they have no conflicts of interest.

Informed consent

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