

Benign Acute Childhood Myositis due to Toxoplasmosis

Şule Yıldırım¹ · Fatih Battal¹ · Hakan Aylanç¹ · Mustafa Tekin¹ · Nazan Kaymaz¹ ·
Fatih Köksal Binnetoğlu¹ · Naci Topaloğlu¹

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To the Editor : A previously healthy 5-y-old boy was admitted to the emergency department with the complaint of leg pain and refusal to walk. Ten days ago he had a period of low-grade fever and fatigue that recovered spontaneously. Twenty-four hours before the admission the leg pain began and then he refused to walk. He was living in a village and had a history of contact with cats. On physical examination, he was well, afebrile and other vital signs were within normal limits. There was no lymphadenopathy or hepatosplenomegaly. Neurologic examination was normal. Extremity examination revealed bilateral calf tenderness on palpation. His gait was stiff-legged and flat-footed; he had difficulty in walking. Complete blood count and basic metabolic profile were normal. Creatine kinase (CK) increased to 809 U/L, three times normal (26–308 U/L). Urinalysis was normal and negative for myoglobin. Serology was performed to establish the etiology. It supported the acute toxoplasma infection and no other agent. His serologic results for *T.gondii* were as following; IgG Dye test was 6000 (positive ≥ 16), IgM ELISA was 10 (positive ≥ 2) and IgG avidity was 1.8 (low ≤ 20). He completely recovered and could walk independently on the 5th day of follow up. His CK returned to normal (126 U/L) and was diagnosed as benign childhood acute myositis (BCAM) after a toxoplasma infection.

Benign childhood acute myositis is a muscle syndrome that is most commonly seen after a viral infection [1]. The most common presentation of the disease is acute refusal to walk or altered gait during walking. Although the most common etiologic agents are influenza type A and B viruses, the

other agents are also reported in the literature [2, 3]. Toxoplasmosis is mostly subclinical or asymptomatic infectious disease in healthy children. Myocarditis and myositis are reported as rare clinical findings [4].

The other clinical findings of BCAM are male predominance and serum CK increase. If the CK levels are too high, patient should be monitored in terms of rhabdomyolysis and renal failure [5]. Duration of symptoms are short and the recovery is spontaneous; therefore, further investigations are unnecessary unless the diagnosis is suspected [3].

In patients with acute gait disturbances if there are no alarming symptoms, BCAM should be considered certainly before unnecessary and invasive investigations. Viral serologic investigations are helpful in supporting the diagnosis.

Compliance with Ethical Standards

Conflict of Interest None.

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✉ Şule Yıldırım
sule.yildirim@comu.edu.tr

¹ Department of Pediatrics, Faculty of Medicine, Çanakkale Onsekiz Mart University, 17000 Çanakkale, Turkey