A 9-year-old boy presented with a subacute febrile illness with bursts of conjugate horizontal saccadic oscillations on visual fixation (Figure and Video; available at www.jpeds.com) and cerebellar ataxia. Examination revealed hepatosplenomegaly and scrotal eschar. Magnetic resonance imaging of the brain was normal and lumbar cerebrospinal fluid showed lymphocytic pleocytosis (70 cells, protein 105 mg/dL). IgM enzyme-linked immunosorbent assay for scrub typhus was positive. Intravenous doxycycline and dexamethasone for 5 days resulted in complete recovery.

Ocular flutter is bursts of conjugate horizontal saccades without intersaccadic interval, occurring on visual fixation, irrespective of gaze direction and eye closure. Ocular movements are present in full direction, hence ocular flutter may lead to troublesome oscillopsia. Ocular flutter is usually present with ataxia and myoclonus and rarely can be isolated phenomenon. Ocular flutter is considered as a milder version of opsoclonus; ocular flutter or saccadic intrusions are usually horizontal, whereas opsoclonus are multidirectional. Pathogenesis of ocular flutter is related to dysfunction of omnipause neurons in the paramedianpontine reticular formation or fastigial nucleus of cerebellum. Damage to the GABAergic omnipause neurons or malfunction of glycine receptors causing a decrease in the efficacy of omnipause neuron-mediated inhibition leads to ocular flutter.

Hydrocephalus, midbrain glioma, demyelinating disorders, enterovirus encephalitis, Lyme disease, autoimmune encephalitis, heredodegenerative disorders, and head trauma are reported with ocular flutter. Ocular flutter in an index child is a rare clinical feature of scrub typhus cerebellitis. Immune-mediated pathogenesis (anti-GQ1b, anti-GAD antibodies) complements the role of steroids in early recovery.

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