Germinomas are rare, most having been described in young male patients who had manifested with precocious puberty. Subsequently, a few other reports of intraspinal germinomas have been reported in the literature.

Radiation therapy is the treatment recommended for germinomas and most tumors respond well. However, prophylactic irradiation of the entire neuraxis is controversial, and Shibamoto et al. have concluded that the risk of a spinal metastasis from an intracranial germinoma is too low to warrant routine prophylactic spinal irradiation. Sole usage of radiation requires a dose of 40–55 Gy which can cause endocrine disorders and neurocognitive impairment. The risk of these side effects may be reduced by lowering the dose and field size of radiation for young patients, since late sequelae in survivors have been of major concern. To minimize the post-treatment adverse effects many centers now use induction chemotherapy followed by radiotherapy. Cisplatin-based chemotherapy has proved to be effective for the treatment of intracranial germ cell tumors. For pure germinomas, induction chemotherapy followed by whole brain radiotherapy up to 24 Gy has been shown to be very effective.

We elected to treat our patient with induction chemotherapy and craniospinal radiation therapy. Our patient remains in complete remission, but needs close long-term follow up.

Figure 2: Photomicrograph of the cervical lesion showing sheets of large polygonal cells with eosinophilic cytoplasm and central round nuclei. Focal lymphoid infiltrates are seen (arrow) (H & E stain 400´)
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staff or quacks in rural set-up and even urban slums and gets some symptomatic relief. As fluoroquinolones, which are recommended for treatment of multi-drug resistant tuberculosis by, WHO are also used frequently in patients of fever, making the disease partially responsive, which again complicates the picture. So by the time a child reaches to a pediatric or neurology center it is too late for complete cure. Cerebrospinal fluid (CSF) analysis should be part and parcel of workup of a febrile child unless we have a definite alternative explanation for fever or constitutional symptoms and the CSF should be examined by a competent microbiologist or clinician himself who should be familiar with the procedure. There should also be public and health personnel awareness about this aspect.

2. In the era of DOTS therapy there are separate guidelines for pulmonary (sputum positive) and extra-pulmonary (sputum negative) tuberculosis. Therapy for central nervous system (and extra-pulmonary) tuberculosis needs to be redefined in context to the DOTS regimen. Furthermore no guidelines exist as to the components and duration of treatment in case of multi-drug resistant tuberculosis.\(^3\)

3. Trial of newer therapies like anti TNF-α like drugs other than thalidomide are required.\(^3\)

4. Metabolic complications like hyponatraemia affects more than 50% of the patients of TBM. So appropriate fluid and electrolyte balance should be taken care off and use of fludrocortisone and demeclocycline may be useful which requires further trials.\(^3\)

5. Empirical therapy should be encouraged when there is strong clinical, epidemiological and laboratory support as delayed treatment have increased mortality and morbidity.

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