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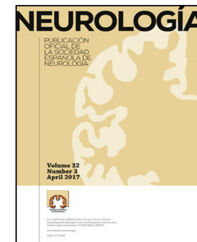

LETTERS TO THE EDITOR

Incidence of Guillain—Barré syndrome during Zika virus outbreak☆

Incidencia del síndrome de Guillain-Barré durante el brote del virus Zika

Dear Editor:

We read with great interest the article ''Incidence of Guillain—Barré syndrome (GBS) at a secondary centre during the 2016 Zika outbreak.''[1] Del Cario Orantes et al. conclude that ''cases of Guillain—Barré syndrome increased during the Zika outbreak, with increases in incidence and the number of cases per month; however, no direct causal relationship could be established between these 2 conditions.''[1] We would like to share some ideas and experiences on this subject. Firstly, the increased incidence of GBS may or may not be related to Zika virus infection. Several possible concurrent problems, such as other infections or vaccination during the study period, may give rise to increased incidence. In our setting in tropical Asia, where Zika virus is also endemic, increased incidence of GBS has not been observed.[2] Most cases of Zika virus infection in our setting are asymptomatic and present no complications. [3] Considering that Zika virus infection may be asymptomatic, the exact calculation of GBS incidence is difficult, and diagnosis of Zika virus infection related to GBS is problematic in any situation.[4]

☆ Please cite this article as: Joob B, Wiwanitkit V. Incidencia del síndrome de Guillain-Barré durante el brote del virus Zika. Neurología. 2020;35:126.

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Horner syndrome secondary to cephalic paravertebral migration of local anaesthetic☆

Síndrome de Horner por migración paravertebral cefálica del anestésico local

Dear Editor:

Horner syndrome (HS), first described in humans in 1869 and in animals in 1852, is a possible complication associated with different techniques for controlling regional postoperative pain (intradural, epidural, or brachial plexus), with an incidence below 1.8%. We present a case of HS associated with the use of a thoracic paravertebral catheter to control postoperative pain after pulmonary resection by thoracotomy.

Our patient was a 58-year-old female smoker with drug-controlled arterial hypertension and insulin-dependent diabetes mellitus, receiving treatment with immunosuppressants to treat rheumatoid arthritis. She presented symptoms of diarrhoea and asthenia. A chest radiography revealed pulmonary consolidation in the middle lobe, which was diagnosed as pulmonary adenocarcinoma (clinical stage IA) after a CT-guided transthoracic needle biopsy. In the anaesthetic induction phase, a paravertebral catheter was placed to control postoperative pain, which had to be removed due to extravasation of blood through the device. During the procedure, we observed a haematoma fully dis-

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