

LETTERS TO THE EDITOR

Regarding the article “belly dancer’s syndrome - A diagnostic challenge”

Sobre o artigo “síndrome da dançarina do ventre - Um desafio diagnóstico”

Anil Kumar Gupta¹



Dear Editor,

I trust this letter finds you well. I recently had the opportunity to read the intriguing article entitled “Belly dancer’s syndrome - A diagnostic challenge” published in Nascer e Crescer – Birth and Growth Medical Journal.⁽¹⁾ The case presented and its diagnostic challenges resonated with me and prompted me to share a similar clinical encounter I had in 1992.

In my clinical practice at Safdarjung Hospital, New Delhi, a 12-year-old girl presented with high-frequency, involuntary, rhythmic, and jerky movements of both shoulder girdle muscles accompanied by abdominal muscle contractions over the past month. Remarkably, the abnormal movements were present at rest but ceased during sleep, and there was no associated hiccup, fever, trauma, or other illness. There was no associated ataxia or cognitive decline. There was no history of seizures or drug intake and no aggravating or relieving factors could be identified. The abnormal movements were not sensitive to tactile or auditory stimuli. The family history was unremarkable, and the neurological examination, including fundus examination, was essentially normal.

On examination, the child displayed high frequency, upward, involuntary, jerky movements of both shoulders with palpable contractions of the upper abdominal muscles, pectoralis major, and biceps bilaterally. Fluoroscopy revealed violent contractions of both diaphragms with jerky movements of high amplitude. Despite a comprehensive neurological evaluation and normal results on cerebrospinal fluid analysis, magnetic resonance imaging, and electroencephalography, the case presented unique challenges.

Electromyography of the diaphragm and biceps muscles showed bilateral myoclonic bursts limited to C3-6 myotomes without denervation potential. Somatosensory evoked potentials were unremarkable. In the absence of cortical or subcortical/brainstem

involvement, the clinical diagnosis of idiopathic segmental spinal myoclonus was established. Oral clonazepam was initiated, but due to only partial response, oral tetrabenazine was added, resulting in complete resolution of the abnormal movements within two weeks. Attempts to discontinue medication at 3 and 6 months resulted in symptom recurrence, highlighting the need for long-term therapy.

Over a three-year follow-up, medication was gradually discontinued without recurrence of symptoms. I suggest that the case presented as “belly dancer’s syndrome” may be better characterized as post-traumatic segmental spinal myoclonus of the diaphragm, being electrophysiological studies challenging to perform. Moreover, the response to chlorpromazine in belly dancer’s syndrome is particularly interesting, considering that the present case required long-term antiepileptic medication.

The diagnostic complexity and variability of presentations of movement disorders should be acknowledged, as it highlights the importance of tailored assessment and treatment strategies.⁽²⁾ Hopefully, sharing this clinical experience will add valuable insights to the ongoing debate in the field.

Thank you for considering this contribution. I look forward to any feedback or further discussion on this topic.

AUTHORSHIP

Anil Kumar Gupta - responsibility for the study conception and design, data curation, analysis, interpretation, preparation of manuscript, and critical review for important intellectual content.

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1. Guru Gobind Singh Government Hospital, Delhi Government. New Delhi, Delhi-110027 India. dr.a.k.gupta@gmail.com

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CORRESPONDENCE TO

Anil Kumar Gupta
Guru Gobind Singh Government Hospital
Delhi Government
New Delhi, Delhi-110027, India
Email: dr.a.k.gupta@gmail.com

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