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A rare cause of seizure with benign course in a child

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A 7-year-old male diagnosed case of B-cell acute lymphoblastic leukemia, intermediate risk group, central nervous system Status 1, received the first dose of methotrexate (2 g/m²) as consolidation. Serum methotrexate level at 42 h was <0.1 mmol/L and leucovorin rescue was administered as per protocol. On day 5 of therapy, he developed generalized tonic-clonic seizures without associated with any fever. The patient was started on Inj levetiracetam. His hemogram showed hemoglobin 9.6 g/dL, total leukocyte count 2100/cumm (N35% L60% M9% E5%), and platelets 76,000/cumm. Biochemistry revealed normal results of renal and liver function tests; serum electrolytes were also within normal limits. A computed tomography scan of the brain revealed no abnormality. Magnetic resonance imaging revealed hyperintensities with diffusion restriction in the bilateral deep white matter region [Figure 1a and b]. A diagnosis of methotrexate-induced leukoencephalopathy (LE) was made based on clinical and characteristic radiological features. The patient became symptom-free by 2 days and methotrexate was omitted from further courses of consolidation. Common causes of seizures in a leukemic child include stroke, infections, metabolic abnormalities, or cancer itself. Methotrexate-induced LE should

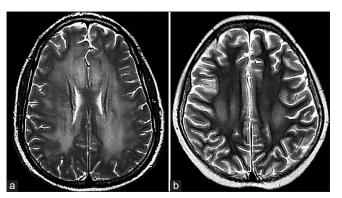


Figure 1: Magnetic resonance imaging (MRI) brain images from a 7-year-old male child suffering from acute lymphoblastic leukemia who presented with new onset seizures while on high dose methotrexate chemotherapy; (a) MRI brain (T2) and (b) MRI brain (T2 fluid-attenuated inversion recovery) showing: Hyperintensities in bilateral deep white matter region.

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be kept in mind in any patient presenting with subacuteonset neurological features 3–11 days after intravenous or intrathecal methotrexate therapy.^[1,2]

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Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflicts of interest

There are no conflicts of interest.

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