Int. j. adv. multidisc. res. stud. 2026; 6(4):1485-1486

Received: 02-07-2026
Accepted: 11-08-2026

International Journal of Advanced Multidisciplinary Research and Studies

ISSN: 2583-049X

Letter to the Editor

For Patients who Die from Weston-Hurst Syndrome, An Autopsy Could be Helpful to Confirm the Diagnosis

Josef Finsterer
Neurology & Neurophysiology Center, Vienna, Austria

Corresponding Author: **Josef Finsterer**

Letter to the Editor

We read with interest the article by Aidouni *et al*. about a 4-year-old girl who was diagnosed with Weston-Hurst syndrome (acute hemorrhagic encephalomyelitis (AHE)), who had initially been misdiagnosed with Guillain-Barré syndrome (GBS) because she first presented with ascending flaccid tetraparesis one week after a flu-like bronchopulmonary infection [1]. However, cerebral magnetic resonance imaging (MRI) revealed bilateral, confluent, T2- and fluid-attenuated inversion recovery (FLAIR)-hyperintense lesions in the white matter, and susceptibility-weighted imaging suggested hemorrhagic petechiae. Despite treatment with glucocorticoids and intravenous immunoglobulins, her condition continued to deteriorate, and the patient died of cerebral edema one day after admission [1]. The study is forward-looking, but several points warrant discussion.

The first point is that the cerebrospinal fluid (CSF) was not tested for neurotropic viruses (including severe acute respiratory syndrome (SARS)-corona virus-2 (CoV-2)), bacteria, protozoa, fungi, and parasites by means of rapid tests which provide a result within a few hours. CSF can also be analyzed using Gram staining within a few hours, allowing a bacterial infection to be either ruled out or confirmed. Even if the cell count and protein content in the cerebrospinal fluid are normal, this does not rule out viral meningitis or encephalitis, especially at the onset of the illness [2]. Other differential diagnoses for AHE that were not sufficiently ruled out include acute disseminated encephalomyelitis, hemorrhagic stroke, fulminant multiple sclerosis, primary central nervous system (CNS) vasculitis, venous sinus thrombosis, and malignancies [3].

Finally, no reference values for blood chemistry were provided. This makes it difficult to assess what is normal and what is abnormal.

A limitation of the study is that no autopsy was performed [1]. Autopsy could have supported the diagnoses, could have revealed the cause of the flu-like infection that preceded the brain catastrophe, and could have revealed signs of necrotizing vasculitis, which is believed to be responsible for the typical ring-shaped hemorrhages seen in AHE [4].

Declarations
Ethical Approval: Not applicable.

Consent to Participation: Not applicable.

Consent for Publication: Not applicable.

Funding: No Funding was Received.

Availability of Data and Material: All data are available from the corresponding author.

Author Contribution: JF: design, literature search, discussion, first draft, critical comments, final approval.

Disclosures: The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Compliance with Ethics Guidelines: This article is based on previously conducted studies and does not contain any new studies with human participants or animals performed by any of the authors.

Acknowledgements: None.

Keywords: Acute Hemorrhagic Encephalomyelitis, Cerebral Edema, Pulmonary Infection, Weston Hurst Syndrome, Outcome

References
1. Ei Aidouni G, Madani H, Merbouh M. Fulminant acute hemorrhagic encephalomyelitis mimicking Guillain-Barré syndrome in a child: A fatal case report. Radiol Case Rep, Jul 1, 2026; 21(10):4188-4193. Doi: 10.1016/j.radcr.2026.06.043
2. Achmeh B, Wahbi MN, Daood H. Acute hemorrhagic leukoencephalopathy: A case report and literature review. Ann Med Surg (Lond), Jul 8, 2024; 86(9):5497-5500. Doi: 10.1097/MS9.0000000000002353
3. Alawadhi A, Saint-Martin C, Bhanji F, Srour M, Atkinson J, Sébire G. Acute Hemorrhagic Encephalitis Responding to Combined Decompressive Craniectomy, Intravenous Immunoglobulin, and Corticosteroid Therapies: Association with Novel RANBP2 Variant. Front Neurol, Mar 12, 2018; 9:130. Doi: 10.3389/fneur.2018.00130
4. Bewersdorf JP, Koedel U, Patzig M, Dimitriadis K, Paerschke G, Pfister HW, *et al*. Challenges in HSV encephalitis: Normocellular CSF, unremarkable CCT, and atypical MRI findings. Infection, Apr 2019; 47(2):267-273. Doi: 10.1007/s15010-018-1257-7