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Correspondence

Acute encephalitis or encephalopathy: What next?

Sir,

I read with interest the editorial by Narain *et al*[1]. The authors tried to give an overview of a complex clinical syndrome with the available information to date. However, many unanswered questions remain, and the critical issues identified by the authors still baffle the reader. The authors described a clinical syndrome which varied from a toxic or metabolic encephalopathy and infectious encephalitis. While the case-fatality rates in the case series described here are high, there is no clarity as to what was the driver for this mortality: is it intractable seizures and is it metabolic as suggested in some as profound hypoglycaemia, while hypoglycaemia might have accounted for part of the clinical picture, the joint investigation team[2] found the cerebrospinal fluid (CSF) glucose to be normal in majority of the affected children (70%). Did they have airway compromise and died due to lack of ventilatory support, how many of the deceased had post-mortem studies as the limited magnetic resonance imaging studies showed diffuse encephalitis, what was their electrolyte status and the correction of electrolytes if any at the time of presentation? What is the explanation for normal CSF glucose and low blood glucose?

The authors refer to a study by Shrivastava *et al*[2] and other references in this article including NCDC bulletin[3]. Shrivastava *et al*[2] specifically discussed the localized outbreak of illness which was thought to be a toxic encephalopathy. In addition, authors discussed aetiology of illness ranging from scrub typhus, Japanese B encephalitis and included a specific reference to enterovirus mediated illness[4]. Clinical guidelines[5,6] referred to in this article refers to a clinical syndrome definition which is a Japanese B encephalitis case definition with fever and altered sensorium as predominant symptoms. Where is the overarching case definition for this syndrome?

Finally, the authors discuss opportunities for further work on this tragic clinical problem where the young lives are lost with not yet identifiable problem. The Indian government has already committed to substantial funding on possibly a multi-prong approach to control this[1].

However, where is the case definition or case management algorithms for clinicians working in remote villages or States? What decision support systems or diagnostic support are we offering them? If we have identified respiratory failure as the cause of death, is there any suggestion made for respiratory support in those States affected by the illness.

There is an urgent need for better surveillance of this illness; it is not clear from this when and how these data are going to be collected or used. How are the State government health sector and central government bodies working together and the coordination achieved? Is the NCDC proposing an outbreak management template for future use and investigative algorithm and a clinical management pathway for the future outbreaks? What is the role of national institutions such as ICMR-National Institute of Virology in this?

While the authors need to be applauded for highlighting this problem, there are many more unanswered questions or unclear proposed plans.

***Conflicts of Interest*:** None.

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