of cardiovascular risk factors.[8] Results from the screening tests for opportunistic infections and tumours, and the improvement in visual acuity after antiretroviral treatment support this hypothesis.[9] HIV infection has also been associated with relapsing-remitting neuritis with inflammation (MS-like neuritis), which responds well to corticosteroid treatment. Some researchers suggest administering penicillin even when serology tests for syphilis are negative due to the high frequency of co-occurrence of these 2 infections.[1]

Closely monitoring HIV-positive patients with posterior ischaemic optic neuropathy is essential due to the likelihood of subsequent acute retinal necrosis secondary to herpes zoster or CNS lymphoma. The likelihood of experiencing this complication increases in patients diagnosed with acquired immune deficiency syndrome. Optic neuropathy secondary to HIV infection does not seem to be correlated with either the CD4 lymphocyte level or the presence of opportunistic infections.[1]

Conclusion

Unilateral retrobulbar optic neuropathy is an infrequent manifestation of HIV infection. However, it should be included in the differential diagnosis of seropositive patients with atypical symptoms, since it may also constitute the initial manifestation of HIV infection. Diagnosis is made by exclusion, after ruling out presence of opportunistic infections, CNS neoplasm, or drug allergies.

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Conflicts of interest

The authors have no conflicts of interest to declare.

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The effect of manual therapy on tension headache☆

Efecto de la terapia manual en la cefalea tensional

Dear Editor:

It was with great interest that we read the article published by Lozano López et al.,[1] which presents a systematic review of the literature supporting manual therapy as an effective alternative pain relief technique in patients with tension-type headache (TTH). The most frequently used manual therapy techniques in the analysed studies were joint treatment, soft tissue mobilisation techniques, and muscle exercises.[2] Although these techniques have been shown to have a positive effect on TTH, the heterogeneity of patients' symptoms has not permitted the adoption of a standard protocol with a specific technique. In fact, many of these studies report better results when combining 2 or more manual techniques.[3] We agree that the diversity of interventions does not allow us to determine which technique was the most effective for TTH. In our view, however, results are significant in that applying these techniques decreased not only pain intensity but also headache frequency.[4]

Although the true cause of TTH is still to be determined, the frequent co-presence of such symptoms as trigger points

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in the head and neck,[5] cervical rigidity, and inhibition of local stabilising muscles underscores the need for a manual therapy programme addressing each of the many problems associated with TTH.

Manual therapy is a widespread treatment approach in some countries. However, in Peru and other countries in which manual therapy is a new specialty, treatment protocols for TTH are usually limited to pharmacological treatment and do not include physiotherapeutic management of the symptoms associated with TTH. Increasing numbers of manual therapists and further studies of manual therapy will be necessary to generate evidence and draw conclusions about the usefulness of this technique for managing TTH and associated symptoms.

Conflicts of interest

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Superior vena cava syndrome as a complication of intravenous immunoglobulin treatment☆

Síndrome de vena cava superior como complicación del tratamiento con inmunoglobulinas intravenosas

Dear Editor:

Intravenous immunoglobulins are a frequent treatment for a variety of neurological diseases.[1] This treatment has been associated with thromboembolic complications, with an incidence ranging between 1.2% and 11.3%.[2] The pathogenic mechanisms of the disease include increased plasma viscosity, increased platelet count and adhesion, and presence of procoagulant antibodies and coagulation factors not eliminated by immunoglobulin fractionation.[2,3]

Superior vena cava thrombosis in patients receiving intravenous immunoglobulins is an infrequent complication that has rarely been described in the literature.[4] Management of this complication may be difficult, especially in patients with a central venous catheter, since no specific management guidelines have been established to date.[4,5]

We present the case of a 57-year-old female smoker diagnosed with chronic inflammatory demyelinating polyneuropathy. She was in treatment with azathioprine, deflazacort 6 mg/24 h, and intravenous immunoglobulins dosed at 0.5 g/kg/day and administered over 12 hours per day for 4 days every month. She had no other relevant history. Immunglobulin therapy had been started 3 years earlier, by means of a subcutaneous reservoir attached to a catheter in the superior vena cava. The catheter had been implanted following multiple episodes of thrombophlebitis

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