

**Short report**

**EEG and serum prolactin studies in relation to transcutaneous stimulation of central motor pathways**

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**SUMMARY** Eight adult volunteers had EEG recordings and serial serum prolactin estimations performed both before and after a session of transcutaneous stimulation of the central motor pathways using the technique of Merton and Morton. No significant changes in either the EEG traces or in the serum prolactin values were detected.

The ability to study function in central motor pathways, using techniques of transcutaneous stimulation through the intact scalp, is an important recent development in clinical neurophysiology. In a conscious subject, a single large shock from a purpose-built device is applied to the scalp over the motor cortex with disc or pad electrodes. The resulting contraction in peripheral muscles can be recorded using conventional apparatus. Studies on normal adults and on patients with multiple sclerosis have recently been published.

The technique appears to be safe, and no adverse effects have been reported from amongst the several hundred subjects who have been tested. In addition, some of the original investigators have themselves received hundreds of stimuli without ill-effect. However, there have been no studies to delineate possible transitory physiological effects of transcutaneous stimulation.

Electroencephalograms (EEGs) taken immediately after unilateral electro-convulsive therapy (ECT) show marked slowing (1–4 Hz activity reaching 50–200 μV) on the side of stimulation which persists for at least half an hour. A ten to fifty-fold increase in prolactin secretion 15 minutes after ECT has also been documented. Generalised tonic/clonic and complex partial seizures have been shown to produce significant (two to three fold) rises in serum prolactin in both adults and in children and this finding is being used widely in clinical practice to discriminate between seizures and pseudo-seizures. The optimum time for estimating the prolactin level has been determined to be 15–20 minutes following the seizure.

Before the technique of transcutaneous stimulation is adopted as a routine procedure, particularly in children, it was considered worthwhile to study EEG and serum prolactin responses to transcutaneous stimulation in a group of healthy adult volunteers.

**Methods**

Eight healthy adult volunteers aged 24 to 55 years were studied. There were two males and six females. All were members of staff of the department or were medical colleagues. None were receiving medication. All gave informed consent, and the protocol for the study was approved by the Standing Committee on Ethical Practice of the Hospital for Sick Children. The EEGs were recorded from silver/silver chloride electrodes using previously described techniques and included overbreathing for three minutes and photic stimulation at a wide range of flash frequencies.

Immediately prior to the session of transcutaneous stimulation, the EEG headbox was disconnected from the appara-

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Table

<table>
<thead>
<tr>
<th>Subject (no)</th>
<th>Age (yr)</th>
<th>No. of stimuli to scalp</th>
<th>Range of values of serum prolactin (mU/l)</th>
<th>Post-stimulus</th>
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<tbody>
<tr>
<td>1</td>
<td>24</td>
<td>10</td>
<td>326–370</td>
<td>289–318</td>
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<tr>
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<td>10</td>
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<td>5</td>
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<tr>
<td>8</td>
<td>55</td>
<td>5</td>
<td>65–82</td>
<td>53–71</td>
</tr>
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</table>

Discussion

No previous studies of the effects of transcutaneous stimulation on the EEG have been reported. Although it was not practicable to record the EEG at the moment of the transcutaneous stimulus, the fact that no sustained EEG alteration occurs, (when using the numbers of transcutaneous stimuli with the stimulus intensities normally employed in clinical studies) is in marked contrast to the EEG changes reported after unilateral ECT. This is not surprising when the relative amounts of energy delivered to the patients are considered in the two situations. Assuming that there is no resistance in the electrode wires or in the scalp, and that all the energy is delivered to the patient, the maximum output of the Digitimer D180 (using a nominal time constant of 50 μs) would be about 0·25 joules, compared with the estimated 25–50 joules used in the ECT sessions recorded by Kris et al.6

Many conditions of mild to moderate “stress” have been shown to increase the serum prolactin. These include drugs such as butyrophenones, methyldopa and chlorpromazine, as well as anaesthesia and surgery.16 It is thought that prolactin secretion in all these situations (including ECT and seizures) is related to suppression of dopamine secretion in the arcuate and periventricular nuclei of the medial basal hypothalamus.8 13 No such rise in serum prolactin has been demonstrated in the present study, and it seems that transcutaneous stimulation of the motor tracts does not alter this dopamine system (either directly as a consequence of stimulation, or indirectly as a “stress” effect) at least using conventional clinical diagnostic techniques. It would obviously have been difficult to carry out this study in normal children, but there is no reason to suppose that EEG effects or prolactin would be affected any differently in a paediatric population.

We thank Dr Ann Harden for much help and advice, and for helping to interpret the EEG records. We also thank Miss Karen Huckin for taking the EEG records, and the other members of the Clinical
Neurophysiology Department for their cooperation in this study.

References


2 Marsden CD, Merton PA, Morton HB. Percutaneous stimulation of spinal cord and brain; pyramidal tract conduction velocities in man. J Physiol (Lond) 1982;328:6P.


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