late-onset cases, has yet to be clarified.\textsuperscript{1, 2} Olanow et al.\textsuperscript{3} reported excellent results with thymectomy in 12 patients with late-onset myasthenia gravis. One of these had a thymolipoma. This tumour has, to our knowledge, only been reported in the world literature as a cause for myasthenia gravis in two other cases.\textsuperscript{4, 5} We therefore present the fourth case in this paper.

In May 1980 a 61-year-old man noted diplopia for the first time. In September he complained of a weakness of the jaw and neck muscles, dysarthria and problems with swallowing. The examination was unremarkable, but there was weakness of the sphincter ani muscles with incontinence. The diagnosis was substantiated by observing the response to edrophonium chloride. Chest radiographs showed no mediastinal abnormalities. Thymectomy was discussed, but not performed. Treatment with pyridostigmine 250 mg per day improved the myasthenic symptoms apart from the weakness of the sphincter muscles. In July 1981 the patient made a spontaneous recovery and for three months no medication was needed. Then he relapsed, at which time the limbs also were affected. In October 1981 treatment with dexamethasone 16 mg per day was given for 10 days, and until January 1982 he did well on pyridostigmine 200 mg per day. Thereafter his myasthenic symptoms worsened, and treatment with pyridostigmine was initiated in an intensive care unit initially with 60 mg per day together with pyridostigmine up to 540 mg per day. In April 1982 he was discharged with only slight myasthenic symptoms, but the following day he was readmitted with acute myocardial infarction. During hospitalisation he suffered a second acute myocardial infarction from which he also recovered without serious complications. The patient gradually deteriorated despite treatment with pyridostigmine 300 mg per day and prednisone 15 mg per day. He had some degree of respiratory embarrassment, and among other complications was treated for an abscess of the lung. Talking and swallowing became difficult, and he needed a collar to support his neck.

In October 1982 transsternal thymectomy was performed and surprisingly 65 g of apparently thymic tissue was removed. Macroscopic findings: the tissue fragments measured 7 × 7 × 3 cm, 4-5 × 1 × 1 cm and 3 × 2 × 1 cm (three parts) and weighed 65 g. The tissue was soft, yellow and lobulated. A thin capsule covered almost the entire tissue. On cross-section it appeared to be mature adipose tissue divided into lobes by strands. The impression was that of a lipoma. Microscopically, the resected material was mature adipose tissue containing small nodules of thymic tissue with Hassal's corpuscles. This tissue composition is characteristic of a thymolipoma. During the next 2 months the patient made a remarkable recovery. From November 1982 until June 1983 he was not troubled by signs or symptoms of myasthenia gravis, and, except for a small dose of prednisone (10–15 mg per day) no medication was needed. But in June 1983 he again presented with slight myasthenic symptoms from the face, jaw and sphincters which were easily controlled by mestinon 30 mg four times a day.

Tumours of the thymus are uncommon. Thymolipoma, which is a benign tumour composed of thymic tissue and mature adipose elements, have constituted 2–9% of all thymic tumours.\textsuperscript{6} The nature of the tumour is unknown. The two most common clinical symptoms are dyspnoea and cough, but in about 50% of the reported cases thymolipomas were asymptomatic and were detected with routine chest radiography.\textsuperscript{7} The radiological appearance of the thymolipoma (or mediastinal lipomatosis of non-thymic origin) is variable.\textsuperscript{8} More than 40% of thymolipoma appeared as a cardiomegaly under X-ray examination.\textsuperscript{8} In all four cases of thymolipoma in association with myasthenia gravis, the thymolipomas were not detected by usual chest radiographs and conventional tomograms of the mediastinum. Computer tomography of the anterior mediastinum revealed a widening at the level of the great vessels in the case described by Otto et al.\textsuperscript{4} and might have revealed the tumours in the other three cases if it had been performed.\textsuperscript{8} Removal of the thymolipoma was in our patient followed by complete remission from myasthenic symptoms for six months when a slight relapse occurred. The patient reported by Olanow et al.\textsuperscript{3} made a complete recovery, whereas the patient reported by Otto et al.\textsuperscript{4} relapsed. The patient reported by Reitgen et al.\textsuperscript{3} showed dramatic improvement three months following thymectomy. In all four patients the tumour was totally removed.

I thank Dr Stein Poulsen for drawing my attention to the correct diagnosis in this case.

B MIKKELSEN
Neurology Dept.
Hjørring Hospital
9800 Hjørring,
DK Denmark

\textbf{References}


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\textbf{Spinal blastomyosisis—case report}

\textbf{Sir:} Blastomyosisis is a fungal infection primarily involving the lungs; haematogenous spread may secondarily involve skin and rarely brain.\textsuperscript{1} A spinal cord compression syndrome secondary to blastomyosisis of the vertebral bodies has been described\textsuperscript{2–7} but is particularly rare in this country.

We report the case of a previously fit 52-year-old Greek male who began to complain of interscapular pain 16 months prior to admission in June 1981 to the National Hospital for Nervous Diseases, London. Plain spinal radiographs at that time taken by the patient’s brother, who is a radiologist, were reported normal. The pain spontaneously improved and then worsened and five months prior to admission radiography revealed partial collapse of the 4th and 5th dorsal vertebrae with destruction centred on the intervening disc space. The patient had a strongly positive Mantoux test and raised sedimentation rate. The patient was treated with antituberculous therapy without biopsy and presented to us with a three months’ history of progressive cord compression. For the last fifteen years the patient had lived in Africa, particularly in Nigeria, Libya and...
French Guinea, as well as visiting neighbouring countries. The patient had also spent several weeks in North America.

On admission the patient looked ill and pale and there was dorsal spine tenderness. He was however afebrile and neurological examination revealed a pyramidal paraparesis. There was bilateral ankle clonus and the plantar responses were extensor.

The patient's ESR was 64 mm/hr and the white cell count was 13,100/cubic ml. Plain radiographs and metrizamide myelography showed vertebral body collapse with large bilateral paravertebral abscesses and a complete block opposite the affected disc space. Culture of the CSF was negative. Costo-transversectomy was performed and a large abscess was drained; examination of the pus revealed a fungal infection. It was necessary to culture the organism before definitive diagnosis could be made; at room temperature on Sabouraud's agar a white mould was isolated and smooth walled conidia produced terminally on hyphae were identified by microscopy. The mould converted to yeast phase on Brain Heart Infusion agar at 37°C. Yeasts with broad based buds as well as short mycelial fragments were formed and the appearances and behaviour of the organism were typical of Blastomyces dermatitidis.

The patient was treated initially with bed rest and amphotericin B with flucytosine. After identification of the organism the flucytosine was stopped and the amphotericin B given with daily doses of mannitol, as there was derangement of both liver and kidney function. After a full course of amphotericin B and gradual mobilisation the patient returned home and when seen 18 months later had made an almost complete recovery and was walking unaided. Chest radiographs revealed that the paravertebral masses had disappeared.

The diagnosis of blastomycosis in the spine depends on culture of the fungus and is radiologically often confused with tuberculosis. A co-infection of Blastomyces dermatitidis and Mycobacterium tuberculosis was found in 11% of 194 cases, but was excluded in our patient by the negative culture of the abscess. Complement fixation and precipitin tests and intradermal injection of blastomycin are negative in 25-75% of cases of proven blastomycosis and unreliable in the diagnosis of the disease. Infection with Blastomyces dermatitidis is considered to occur primarily in the lungs, following inhalation of spores, though the natural habitat of the fungus is not clear. The infection mostly infects middle-aged, previously healthy males in Africa or the Americas. Often there is a previous history of high alcohol consumption as in our patient. Amphotericin B is the treatment of choice and a full course must be given; our patient received a total of 2,200 mg. The importance of obtaining histological tissue prior to treatment of vertebral body disease is self-evident even in this country.

C KRARUP
CH DAVIS
L SYMON
BN HARDING
RJ HAY

Gough Cooper Department of Neurological Surgery and Department of Neuropathology The National Hospital for Nervous Diseases Queen Square London WC1N 3BG and London Hospital for Tropical Diseases

References

Letters

According to a recent review by Fisher, pure sensory stroke is "the most common lacunar manifestation". However, few cases have been reported with positive CT findings. This discordance may be explained by the small size of these lacunes, which are unresolved by CT scanners. On the other hand, although larger lesions may be limited to the posterolateral part of the thalamus, as in our patient, adjacent structures are probably involved as well in most cases, giving rise to more than purely sensory symptoms.

GIANLUCA LANDI*
NICOLETTA ANZALONE*
UMBERTO VACCARI†
Neurological Clinic II, * and the Department of Neuroradiology, † University of Milan, Milan, Italy

References


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The Montreal Neurological Institute and Hospital. The 50th Anniversary celebrations will be held 23-26 September, 1984. Information concerning the symposia, lectures, films, etc., can be obtained from: Synapse-50, Montreal Neurological Institute and Hospital, 3801 University Street, Room 638, Montreal, Quebec, H3A 2B4 Canada.

Correction

Spinal blastomycosis—case report

It is regretted that in this letter (J Neurol Neurosurg Psychiatry 1984;47:217) the figure legend was incorrect. It should be: "Thickly encapsulated PAS positive budding yeasts with broad based attachment between daughter yeasts typical of blastomycosis."

Notices

The Volvo awards for low back pain research

In order to encourage research in low back pain, the Volvo Company of Göteborg, Sweden, also this year has sponsored three prizes of US $6000.00 each. Awards will be made competitively on the basis of scientific merit in the following three areas: (1) Clinical studies, (2) Bioengineering studies, (3) Studies in other basic science areas. Enquiries should be addressed to Professor Alf L Nachemson, Department of Orthopaedic Surgery I, Sahlgren Hospital, S-413 45 Göteborg, Sweden.