THE EDITORIAL COMMITTEE welcomes original papers, which should be addressed to the Editor, Journal of Neurology, Neurosurgery, and Psychiatry, BMA House, Tavistock Square, London WC1H 9JR. Papers are accepted on the understanding that the subject matter has not been and will not be published in any other journal. Papers should deal with original matter and the discussion should be closely relevant to this. Manuscripts should be typewritten in double spacing on one side of the paper only. Two copies (including figures and tables) should be submitted of which only one need be a top copy. A summary of about 50 words should appear at the beginning of each paper. The name(s) of the hospital or laboratory should also appear. Full postal address for correspondence and reprints should be supplied. Receipt of manuscripts will be acknowledged.

The Editor will welcome Short Reports or Preliminary Communications limited to about 1000 words and with no more than one figure and one table. Also welcome are Letters to the Editor.

ETHICS Ethical considerations will be taken into account in the assessment of papers (see the Medical Research Council’s publications on the ethics of human experimentation, and the World Medical Association’s code of ethics, known as the Declaration of Helsinki (see British Medical Journal 1964;2:177)).


ILLUSTRATIONS Photographs Unmounted photographs on glossy paper should be provided together with magnification scales when appropriate. Diagrams should be reduced to 2¾ inches (68 mm) wide, occasionally to 5¼ inches (145 mm). Lettering should be either Letraset or stencil and care should be taken that lettering and symbols are of comparable size. Illustrations should not be inserted in the text. They should be marked on the back with figure numbers, title of paper, and name of author. All photographs, graphs and diagrams should be referred to as figures and should be numbered consecutively in the text in Arabic numerals. The legends for illustrations should be typed on a separate sheet. Tables should be numbered consecutively in the text in Arabic numerals and each typed on a separate sheet. The format used in this issue of the Journal should be noted. Vertical lines will not be printed and usually there are only three horizontal lines in each table.

REFERENCES should be in the Vancouver style as in this issue. They should appear in the text by number only in the order in which they occur and should be listed on a separate sheet in the same order. Punctuation must be correct and journal titles should be in full or abbreviated in accordance with the Index Medicus. Thus:


A reference to unpublished work should not appear in the list but work “in press” may be included provided the name of the journal appears. The author is responsible for the accuracy of references.

REPRINTS Twenty-five reprints will be supplied free of charge. Additional reprints are available at cost if they are ordered when the proof is returned.

CORRECTIONS other than printer’s errors may be charged to the author.

COPYRIGHT © 1984 by JOURNAL OF NEUROLOGY, NEUROSURGERY, AND PSYCHIATRY. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means—electronic, mechanical, photocopying, recording, or otherwise—without the prior permission of the Journal of Neurology, Neurosurgery, and Psychiatry.

NOTICE TO ADVERTISERS Applications for advertisement space and rates should be addressed to the Advertiser Manager, JOURNAL OF NEUROLOGY, NEUROSURGERY, AND PSYCHIATRY, BMA House, Tavistock Square, London WC1H 9JR.

NOTICE TO SUBSCRIBERS The Journal is published monthly. The annual subscription rate is £47 in the United Kingdom and Republic of Ireland, and US $115 in all countries overseas. Payments for overseas subscriptions should be made in US dollars, or in other currency based on the prevailing exchange rate to the US dollar of that currency payable to the British Medical Association and addressed to the Subscription Manager, Journal of Neurology, Neurosurgery, and Psychiatry, BMA House, Tavistock Square, London WC1H 9JR. Orders can also be placed locally through any leading subscription agent or bookseller. (For the convenience of readers in the USA subscription orders, with or without payment, can also be sent to: British Medical Journal, Box 560B, Kennebunkport, Maine 04046, USA. All enquiries, however, must be addressed to the Publisher in London).
Spatial disorientation in right hemisphere infarction

Sir: Personal involvement in the care of a close relative can make reading a related paper especially interesting for a physician. It was in this sense that I read JD Meerwaldt's article about the prognosis of spatial disorientation due to right hemisphere infarction with particular interest. In his study only one of 16 patients did not recover completely within six months after an ischaemic stroke. I had had the unfortunate opportunity to follow my father's illness with the same syndrome and my comments seem relevant.

He is presently 82 years old, and was in excellent health until three years ago. He had a few brief episodes of dizziness prior to May 1981, when he fell off his bicycle as a result of one such episode. On initial neurological examination he had mild left sided hemiparesis, left homonymous hemianopia in addition to the usual right parietal signs: constructional and dressing apraxia, prosopagnosia and profound spatial disorientation. This was so severe that he could not find his way in and around the house that he had lived in for over 15 years. CT scan and angiograms were not performed, but he had no midline shift on his echoencephalogram and the EEG showed right temporo-parietal slowing only. He was discharged from hospital with the diagnosis of an ischaemic stroke due to probable middle cerebral artery occlusion.

I first had the opportunity to examine him about two months after the initial event. By then the hemiparesis had almost completely disappeared, and there was only visual extinction, but no hemianopia, on the left side. He still had difficulties with dressing himself and was unable to "build" a house from matches. He was unable to name directions, could not describe how to get to the houses of his children, how to find the local railway station, market place etc. He recovered from some of his symptoms by July 1983, when last examined. He still complained of stiffness in his left arm, made frequent mistakes with naming directions and was unable to get home from a distance of a few hundred yards. The disorientation was especially noticeable in darkness, and a light had to be left on in his bedroom to help his orientation in the evening and at night.

It would not be prudent to compare the results of a test done on 16 patients with the clinical findings on one patient. The discrepancy between the quick recovery in Meerwaldt's 15 cases and my father's slow and incomplete recovery, however, is quite noticeable. Age difference might have been one of the reasons (my father was 80, the oldest in Meerwaldt's study 70). Meerwaldt commented on the difference between his and Benton's findings, and explained it on the basis of different aetiologies and presence or absence of cerebral oedema. My father in all probability, although there was no CT scan or angiographic proof, had an ischaemic infarct, and should be comparable to Meerwaldt's cases. I am inclined to believe that the discrepancy is basically artificial and related to the unnatural examination technique used by Meerwaldt. Neither the rod, nor the line orientation test can be used as substitutes for testing in real life situations and for inquiring from relatives about the patients' behaviour. This, of course, is difficult to quantitate and difficult to use in scientific research. This method alone, however, is unlikely to provide us with the information about prognosis in this syndrome that practising neurologists are looking for. It would be advisable to complement it with corresponding clinical information in similar future studies.

Leslie Suranyi MD
238A Augustus St
Cornwall, Ontario K6J 3W3
Canada

Matters arising


Meerwaldt replies:
In a previous article about spatial disorientation1 26 patients with an infarct in the posterior region of the right hemisphere were tested two weeks and one year after the stroke. Five patients showed only a partial recovery of spatial functions and had still symptoms which could be attributed to disturbances of spatial perception. These five patients had the largest lesions on CT scanning.

The findings in these patients are in accordance with those described by Dr Suranyi concerning his father. As no CT scan was made, exact information about the aetiology, location and the volume of the lesion is lacking, but possibly he had a large lesion as our patients had. I agree with Dr Suranyi that neither the rod orientation test nor the line orientation test can be used as substitutes for testing in real-life situations, but I would state that none of the patients who showed a complete recovery of spatial disorientation as tested with the rod orientation test had any complaints after one year which could be attributed to disturbances of spatial perception.

DR JD MEERWALDT
Department of Neurology,
University Hospital Dijkzigt,
Dr. Molewaterplein 40,
3015 GD Rotterdam,
The Netherlands


Notice

European Society for Neurochemistry, 5th General Meeting will be held in Budapest, 21–26 August 1984.

For all information contact: Prof. E.S. Vizi, c/o Congress Secretariat, Fifth Meeting of ESN, Motesz, POB 32, Budapest, H-1361, Hungary.