Matters arising


Swash replies:

Wilson suggests that damage to the peripatellar nerve plexus could account for the defective movement sensation I have described after open lateral meniscectomy. This defect in sensation is not accompanied by any discernible change in static sense of position in the joint, although there is an associated alteration of motor control. These features are difficult to explain by dysfunction of any single class of sensory receptor. The concept that interruption of nerve pathways in the peripatellar plexus could result in interference with the accession of afferents emerging from intra-articular receptors, and with secondary afferents from muscles acting across the knee, is attractive and may be susceptible to experiment by local anaesthetic blockade of this plexus. These matters are important not only for theoretical reasons, but in the management of sports injuries, and in the understanding of falls in elderly persons with osteoarthritic joints.

Reference


Alternating unilateral jaw spasm due to metoclopramide

Sir: Thompson *et al.* described eight cases of unilateral jaw spasms of which three were masticatory in nature. Three of the eight cases were painful. None of the eight cases was drug induced. The following case illustrates once again that drug induced movement disorders often mimic the naturally occurring ones, even those that are rare.

A 66 year old woman was seen because of painful jaw spasms which began 2 hours previously. She described having spasms on each side in a seemingly random pattern. In the emergency room, she was witnessed by other observers to have two episodes of involuntary right jaw spasm, each lasting about 5 minutes. When I examined her no neurological abnormality was found and she had full range of motion of the jaw without any pain. She could not induce a spasm. After approximately 10 minutes she developed left masseter spasm with the jaw deviated mildly to the left. In addition, there was a mild dystonic contraction of the orbiculares oculi and oris. During this time speech was dysarthric due to jaw clenching and the patient complained of severe pain. A repeat neurological exam was otherwise normal. There was no other evidence of dystonia and movements in other body parts did not exacerbate the jaw spasm. Intravenous diphenhydramine 50 mg was given and the episode abated over 1-2 minutes. Diphenhydramine 50 mg was given orally in addition at that time and thrice daily for the next 3 days. There were no recurrences.

The patient had taken metoclopramide 10 mg tid for one month, ending one month before this episode, along with librax (chloridiazepoxide hydrochloride 5 mg, and clindinium bromide 2.5 mg) two tablets per day. Two days before the spasms she had resumed metoclopramide 10 mg tid and the day before she had stopped the librax. Other medications included macrodantin, sulfamethoxizole, trimethaphrin for a urinary tract infection and amiloride 5 mg hydrochlorthiazide 50 mg (Moduretic) for hypertension. Her past medical history included an incidental resection for bowel infarction, spastic colitis, hypertension, total abdominal hysterectomy and bilateral salpingo-oophorectomy for endometrial carcinoma 16 years Previously, cholecystectomy and appendectomy 48 years previously, kidney stones and recurrent urinary tract infections. She stated that she had suffered similar jaw spasms approximately 18 years before but she could not recall any details. For several years, she had had no neurological symptoms and between episodes of jaw spasms her neurological examination was normal. She had no jaw or dental problems. The onset of the syndrome in close association to starting metoclopramide, a dopamine blocking agent, stopping the anticholinergic agent clidinium hydrochloride and the striking reaction to diphenhydramine make the diagnosis of an acute dystonic reaction as certain as possible. The normality of her post-ictal examination also supports this.

This case is unusual for several reasons. As discussed in the paper by Thompson *et al.*, unilateral jaw spasms are themselves rare. Acute dystonic reactions, like primary dystonia is quite symmetric when it involves the jaw. Acute dystonic reactions are rarely painful. Oftentimes acute dystonic reactions can be overcome, at least temporarily, by volition, although once the conscious focus is lost the dystonia re-emerges. Acute dystonic reactions tend to last for hours if untreated. Finally, an intermittent alternating dystonia is (I think) unreported. An explanation for this extraordinary reaction is not apparent.

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Reference


Pseudotumour cerebri with amiodarone

Sir: The letter by Fikkers *et al.* prompts us to report a similar case of pseudotumour cerebri in a patient taking amiodarone.

A 52 year old man with Wolff-Parkinson-White syndrome was treated by amiodarone because of recurrent exercise-induced paroxysmal tachycardia. In November 1985 the dose was raised to 400 mg/day, five days a week. In January 1986 he noticed gradual loss of vision in the left eye; he felt tired and irritable. There was no headache, nausea or vomiting. The neurological examination on 3 February 1986 showed bilateral papilloedema; there were no focal or lateralising signs. The general examination was unremarkable. The blood pressure was 140/85 mm Hg and the electrocardiogram showed a sinus rhythm. Ocular examination revealed corneal deposits typical of amiodarone keratopathy. Visual acuity and colour vision were normal. There was a partial field defect in the nasal inferior quadrant of the left eye, confirmed by computerised perimetry. Pattern-shift visual evoked responses were within normal limits. Fluoroscopy showed dilatation of the peripapillary capillaries and increased fluorescence beyond the edge of the papill on the late views, consistent with bilateral papilloedema.

A CT scan of the brain and orbitae was normal. A dural sinus occlusion was excluded by a normal intravenous digital subtraction angiography of the intracranial vessels. Blood and urine tests were normal. At lumbar puncture, the opening pressure...
Alternating unilateral jaw spasm due to metoclopramide.

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*J Neurol Neurosurg Psychiatry* 1986 49: 1463
doi: 10.1136/jnnp.49.12.1463-a

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