

Letters

methysergide, but is not a serotonin antagonist. An autoimmune basis has been proposed for ergot-induced retroperitoneal fibrosis⁵ and a common autoimmune mechanism has been postulated for retroperitoneal fibrosis and for fibrosis in other sites such as the mediastinum.⁶

All patients receiving bromocriptine for Parkinson's disease require regular monitoring of neurological, psychiatric, cardiovascular and other effects. During follow-up the clinical features of pleuroperitoneal fibrosis and retroperitoneal fibrosis should be sought. This case and others¹⁻⁴ show that a useful screening test for both conditions is the ESR. Chest radiography ray and plasma creatinine measurement may also be indicated.

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Dystonia complicated by respiratory obstruction

Sir: It is not often that dystonia is complicated by respiratory obstruction requiring emergency medical care. We have recently reported two patients who developed dys-

tonic stridor during the course of Parkinson's disease; an urgent tracheostomy was performed in one case.¹ The present case is a 29 year old lady with idiopathic generalised dystonia who required endotracheal intubation and then a permanent tracheostomy for severe laryngeal adductor dystonic spasm.

The patient had been dysphonic from the very onset of her disease at the age of 13 years when she presented with dystonic posturing of the left arm and leg. Initially, she had a quiet dysphonia but from about the age of 26 her speech became unintelligible. At about age 18, she developed retrocollis, left lateral torticollis and axial dystonia with twisting of the trunk to the left. Various drug therapies were tried; including levodopa, which caused confusion and floppiness, benzhexol, which caused hallucinations, tetrabenazine and carbamazepine which were ineffective. Her retrocollis progressed and though she remained ambulant, a posterior cervical ramisection was done at age 27 without success. Regular botulinum toxin injections into orbicularis oculi were commenced a year previously for blepharospasm.

For 2 years, she had experienced episodes of severe generalised muscular spasm, each characterised by opisthotonus, difficulty in breathing and profound diaphoresis. These episodes had become progressively worse having increased from once per month to two or three times daily and from 20 minutes to 3 hours in duration. Recently, she was admitted as an emergency with inspiratory stridor. Parenteral diazepam produced some benefit but respiratory distress promptly recurred. At laryngoscopy, adductor spasm was seen and a nasotracheal tube passed immediately. After discussion with the patient and her mother, a tracheostomy was performed the next day. This proved very effective and there were no further episodes of respiratory distress.

Tracheostomy is apparently very rarely performed for laryngeal adductor dystonia, which may occur (as in this case) in the setting of generalised dystonia, or as an isolated phenomenon.² A more destructive operation, such as ablation of one vocal cord or rendering it paralysed by nerve section may also be considered.^{3,4} There is limited experience with botulinum toxin injection into the laryngeal muscles but this is an attractive option under investigation.⁵

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Parkinsonism in neurobrucellosis

Sir: Since the first description by Hughes in 1897,¹ neurobrucellosis has been the subject of excellent reviews,^{2,3} but in some countries where it is infrequent it still poses a diagnostic and therapeutic problem because of its wide clinical spectrum and the lack of extraneurological findings. Meningitis, meningoencephalitis, meningomyelitis and meningomyelodradiculitis are the most frequently reported forms of nervous system affection.

We report an exceptional neurologic manifestation of brucellosis. A 68 year old woman, living and working under conditions favouring brucella infection, sought medical attention for nocturnal fever, arthromyalgia and profuse sweating 5 months previous to her admission. Brucellosis was suspected and she was treated with streptomycin 1g IM daily and doxycycline by mouth 100mg bid for 30 days, with complete recovery. Two months later, an increasing slow and unsteady gait with tremor in both hands appeared. A clinician diagnosed Parkinson's disease and tried levodopa treatment without improvement; bromocriptine did not help. Then the patient was transferred to our hospital. On admission, general physical examination was negative, tests of higher cortical functions, plantar responses and cranial nerves were normal, deep tendon reflexes were brisk (degree 4/5) and bilateral disabling hypokinesia with cogwheel rigidity and rest-



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