Letters

Effects of dexamethasone in myotonic muscular dystrophy

Sir: Myotonic muscular dystrophy may shorten life especially when the function of cardiac, respiratory and deglutition muscles is severely impaired. It is difficult to evaluate the separate roles of myotonia and/or dystrophy in muscle dysfunction; however, it seems that weakness is due to both. Certain therapeutic trials have found some relief of myotonia with quinine procanamide, phenytoin, ACTH and prednisone\(^1\) but these and other drugs which were used, showed no beneficial effects on the progressive weakness. We report a case in which coincidental use of high dose dexamethasone resulted in a marked improvement on both weakness and myotonia in a patient with myotonic muscular dystrophy.

A 64 year old male was evaluated for progressive ptosis, dysarthria and dysphagia. Two years prior to admission, he noticed the gradual onset of limb weakness with difficulties in speech and swallowing, all of the signs becoming quite prominent in the last four months. Past medical history was significant for cataracts, known for 12 years. Several members of the family are known to suffer from myotonic muscular dystrophy.

Typical clinical features of myotonic dystrophy were present including marked grip and percussion myotonia of distal limb muscles and tongue; however, mild left hemiparesis including the homolateral lower face was also noted. Needle electromyography was characteristic for myotonic dystrophy with the presence of “dive-bomber” myotonia. Sodium phenytoin (300 mg) daily failed to have any beneficial effect. On the 14th hospital day, the patient developed a sudden dense left hemiparesis due to a large space-occupying lesion in the right parietal area, shown on CT scan. Treatment with 24 mg daily of oral dexamethasone resulted in mild improvement in the hemiparesis, while a dramatic change occurred in the patient’s motor functions. Clinical and electrical myotonia practically disappeared and the patient could eat, talk and grip as easily “as when he was healthy”.

The beneficial effect of systemic corticosteroids (cortisone, prednisone) and ACTH on myotonic muscular dystrophy and “myotonia congenita” have been known since 1950.\(^3\) Although some beneficial effect on muscle weakness was seen in boys with Duchenne muscular dystrophy,\(^4\) it is generally agreed that in myotonic dystrophy steroids may improve myotonia only, possibly by its membrane stabilising properties. It is reasonable not to use steroids routinely in myotonic muscular dystrophy. However, steroids should be considered for short term use especially when swallowing and respiration are severely impaired.

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References

Heat stress and neuroleptic drugs

Sir: Several lines of evidence point to an involvement of hypothalamic and nigral dopaminergic systems in thermoregulation.\(^1\) Intolerance to heat has been described as one symptom of Parkinson’s disease,\(^2\) and blockade of hypothalamic and striatal dopamine receptors seems to be the pathophysiological mechanism of the “neuroleptic malignant syndrome” which is characterised by hyperpyrexia and extrapyramidal signs.\(^3\) In addition to the interference with central thermoregulation, neuroleptic drugs also suppress sweating by their peripheral anticholinergic effect. The potentially dangerous impairment of heat dissipation in neuroleptic-treated patients is illustrated by the report of fatal heat strokes in connection with unusually high summer temperatures.\(^4\) On the other hand, pheno- thiazines, by causing vasodilatation and abolishing shivering, may at low ambient temperatures lead to hypothermia.\(^5\) Thus, neuroleptics markedly impair temperature regulation, producing a poikiloithermic state rather than the normal isothermic state.

Heat stress in the sauna bath is part of everyday life in Finland, where psychiatric in-patients also have the opportunity of at least one bath per week. Since sauna bathing has become increasingly popular also in other countries during the last decades, the number of patients on neuroleptic drugs enjoying this habit may be growing. Against this background we found it worthwhile to explore, whether our patients on neuroleptic drugs run a recognisable risk by exposing themselves to the high temperatures encountered in the Finnish sauna.

The study was done in a mental hospital in Eastern Finland which serves the needs for psychiatric care of a population of about 250,000. Sixteen in-patients (10 men and 6 women, mean age 30.5 ± 6.6 years) were chosen for the study and their informed consent was obtained. They were in good physical health and had been on one or two neuroleptic drugs for at least 5 months prior to the study. The drugs used were haloperidol, perphenazine and thioridazine (five patients each), chlorpromazine, chlorprothixene and fluphenazine (four, two and two patients respectively). As controls (N = 14) we used age-matched male and female nurses. Oral temperature, heart rate and blood pressure were taken four times: (1) immediately before entering the sauna (2) after an initial period of 10 minutes in the sauna (64.3 ± 6.6 °C, dry atmosphere), (3) after a second period of 12 minutes duration in the heat, and (4) after a 30 minute cooling off period. Measurements were taken outside the heated unit at an ambient temperature of 25–28°C.

Rise and normalisation of the body temperature was almost identical in patients and controls (table). In both groups heart rate increased and diastolic blood pressure decreased in response to the heat stress. One patient on heavy medication (chlorprothixene 400 mg/day) reported a sensation of fainting during the trial. His blood pressure fell to 78/60 mmHg, but rise in tem-

### Table

**Oral temperatures during heat stress in a sauna bath (for detail see text).**

<table>
<thead>
<tr>
<th>Measurements</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuroleptic-treated patients</td>
<td>36.9 ± 0.6</td>
<td>37.9 ± 0.3</td>
<td>38.5 ± 0.3</td>
<td>37.2 ± 0.3</td>
</tr>
<tr>
<td>Controls</td>
<td>36.9 ± 0.4</td>
<td>37.7 ± 0.2</td>
<td>38.4 ± 0.4</td>
<td>37.2 ± 0.4</td>
</tr>
</tbody>
</table>

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perature from 37.2°C to 38.0°C was not abnormal. Reduced sweating was obvious in the patients; however, for technical reasons, objective data could not be obtained.

We also made a retrospective study by questioning all our staff members about cases of unconsciousness and/or epileptic seizures which they could recall in inpatients taking a sauna bath. In cases, where names were remembered, we looked up the hospital records for details. Thus, seven convulsive seizures and two cases of unconsciousness were found to have occurred in the last 20 years. One patient had died from aspiration of vomitus. All but one central seizure occurred in patients with previously diagnosed epilepsy. The two cases of unconsciousness seem to have been due to heat stroke, but data on body temperature were not available.

This study shows that in spite of the fact that neuroleptic drugs can derange thermo-regulation, sauna bathing in a moderate form seems to be reasonably safe for somatically healthy patients on these drugs. However, it should be remembered that during prolonged exposure to heat stress, these substances, having a variety of pharmacological actions which interfere with temperature regulation, carry the risk for hazardous hyperthermia. Although no abnormally high body temperatures were recorded in the patient group, symptoms caused by vegetative nervous system dysregulation, especially orthostatic hypotension, seems to be a possible complication. Keeping the exposures to high temperature short (<10 minutes), allowing for cooling off in between, and taking care of a sufficient fluid intake should minimise the risk of hazardous hyperthermia in patients on neuroleptics.

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References


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Wernicke aphasia and cardiac embolism

Sir: It has been suggested that Wernicke aphasia is usually due to cerebral (cardiac) embolism,1 with the implication that cardiac emboli cause infarction in different sites than are associated with carotid artery disease. To test this hypothesis we have looked at the clinical and CT evidence of the localisation of the sites of infarction in the dominant hemisphere of a group of dysphasic patients separated into a subgroup with presumed cardiac emboli and another with presumed carotid artery disease.

Dysphasic stroke patients were reviewed by a retrospective case note study. Cardiac embolism was assumed to be likely in those with atrial fibrillation (n = 27). Additional evidence of cardiac disease was present in seven of the patients (rheumatic heart disease in six, alcoholic cardiomyopathy in one). In a second subgroup of 67 cases a clinical diagnosis of ischaemic stroke causing dysphasia had been made but there was no evidence of cardiac disease and the patients were in sinus rhythm. More direct evidence of carotid artery disease was present in 33 of these patients from their angiography or Doppler studies.

The clinical and neuropsychological assessments were reviewed for evidence of the localising implications of the type of dysphasia detected. Broca, Wernicke, and global aphasia was recognised, as was a syndrome implying parietal lobe localisation (conduction aphasia with or without dysgraphia and dyscalculia or other elements of Gerstmann’s syndrome). Patients with mild dysphasia could often not be classified and are listed as “unclassified”.

CT scan reports were studied for evidence of the localisation of cerebral infarction in the dominant hemisphere.

The type of dysphasia encountered in the “cardiac” and “carotid” groups is set out in table 1. Wernicke aphasia was noted in 15% (4/27) of the “cardiac” embolic group but in only 4.5% (3/67) of the carotid disease cases. The difference is not, however, significant at conventional levels (Chi squared 3.2 p < 0.07).

CT scans were available in 16 of the “cardiac” group and 38 of the noncardiac or carotid group. The siting of the infarcts in the two groups is shown in table 2. A temporal lobe lesion was found in 31% (5/16) of the scanned cardiac cases, but in only 3.5% (2/58) of the carotid group (Chi squared with Yates correction 11.6 p < 0.01).

This review of the clinical picture of the type of dysphasia encountered in stroke patients has suggested that there is a difference between the effects of cardiac embolism and the infarction due to presumed carotid artery disease. Wernicke aphasia was more common in the group of patients with atrial fibrillation whose cerebral infarct was assumed to be due to cardiac embolism. The CT scan data also revealed temporal lobe infarction to be more common in the “cardiac” group.

This small study thus tends to confirm the clinical suspicion that embolic infarction in the temporal lobe with appropriate clinical sequelae is more frequent when emboli

Table 1 Type of dysphasia in infarcts of different aetiology

<table>
<thead>
<tr>
<th></th>
<th>Global</th>
<th>Broca</th>
<th>Wernicke</th>
<th>Parietal</th>
<th>Unclassified</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiac (A.Fib.)</td>
<td>11</td>
<td>3</td>
<td>4* (15%)</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>2. Carotid</td>
<td>23</td>
<td>6</td>
<td>3 (4.5%)</td>
<td>8</td>
<td>27</td>
</tr>
</tbody>
</table>

*Chi squared 3.2

Table 2 CT scan localisation of infarcts of different aetiology

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Frontal</th>
<th>Temporal</th>
<th>Parietal</th>
<th>Occipital</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiac (A.Fib.)</td>
<td>0</td>
<td>6</td>
<td>5* (31%)</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2. Carotid</td>
<td>4</td>
<td>30</td>
<td>2 (4.5%)</td>
<td>13</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

*Chi squared 11.6 p < 0.01
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