nerve fibres which originate in the visual association field go to the ipsilateral motor association field via the ipsilateral parieto-occipital area. The other half of the nerve fibres, which originate in the same visual association field, go to the contralateral motor association field via the ipsilateral parieto-occipital area and thereafter via the posterior part of the corpus callosum. A lesion in the parieto-occipital area might interrupt the connection between the visual association and motor association fields. If the lesion is small, one of the two pathways which go to the motor or contralateral motor association field can be disturbed. It will be difficult therefore for the patient to grasp an object in the contralateral homonymous visual field with a unilateral, either right or left, hand. If at lesion is large, it will be difficult to grasp an object in the contralateral homonymous visual field with bilateral hands because of damage to both pathways.

Symptoms similar to optic ataxia can be seen in patients with motor disturbance, cerebellar symptoms, somatosensory disorders, visuo–spatial agnosia, apraxia, or visual field defects. Rondot et al maintained that these symptoms would be excluded in diagnosing optic ataxia, but most of the reported cases of optic ataxia had some of these other symptoms.

Our report of the existence of pure optic ataxia also reported by Piccirilli et al,1 Hirose et al,2 implies that optic ataxia can exist as a symptom independent of those symptoms we describe previously. Our CT findings and those by Hirose et al revealed that the lesion is located at the junction between the parietal and occipital lobes.

In Piccirilli’s case, the patient had difficulty in grasping an object in his hemivisual field using his left hand. Hirose et al3 reported that the lesion was large, similar to that of Piccirilli’s. In our case, the patient could not grasp an object in his left hemivisual field using his left hand.

These three cases strongly support the anatomical explanation of optic ataxia offered by Rondot et al.

We conclude that optic ataxia is an important symptom which indicates the existence of a parieto-occipital lesion.

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that this sport may be a frequent cause of exertional muscle necrosis. These cases suggest two other considerations: 1) as all the patients were young and athletic, the occurrence of rhabdomyolysis appears related to the specific characters of body building, which uses muscles less involved in other physical activities; 2) rhabdomyolysis is probably much more frequent than observed.

In conclusion, body building must be included among the causes of exertional rhabdomyolysis and caution must be recommended in practising this sport.

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Body building and rhabdomyolysis.

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