
### Chronic hemidystonia following acute dystonic reaction to thiotepa-penicillin

Thiotepa-penicillin is a phenothiazine neuroleptic drug that blocks postsynaptic dopamine D2 receptors and is extensively used for the treatment of vertiginous symptoms. Its extrapyramidal side effects include acute and tardive dystonic reactions and a Parkinsonian syndrome. The acute reactions are usually self-limiting and brief and need no specific therapy. We report an unusual case of a chronic hemidystonia which began immediately after treatment with thiopepa.

A 47 year old man, with no previous personal or family history of neurological illness, was evaluated in December 1988 in our unit because of involuntary movements and postures of his right limbs. When he was aged 40 he developed a vertiginous syndrome (retroactively diagnosed as "vestibular neuritis") and was treated with thiopepa 6.5 mg three times daily. When he was discharged he was free of symptoms but when he was given the last dose (total dose 19.5 mg) there was a clinical picture of generalised dystonic posturing including orolucogryic crises, that was alleviated with biperiden 5 mg intravenously. Twenty four hours later, however, his dystonic postures and movements of the right limbs, neck and trunk that persisted until the day of his admission. Apart from his movement disorder, the general and neurological examination were normal. A blood cell count, biochemistry, urinalysis and copper studies in plasma and urine, were all normal, and serological tests for syphilis were negative. EEG, cranial CT and MRI showed no abnormalities. The dystonic movements improved moderately with biperiden 8 mg/day, although he has a persistent action dystonia of his right limbs, which is more noticeable during walking.

Dystonia has been classified according to distribution as focal, multifocal, segmental, or generalised, and when its distribution involves the ipsilateral arm, leg, and face, the term "hemidystonia" is applied. The presentation of a dystonic syndrome (in hemidystonia) has an important aetiological significance because in most cases there is CT evidence of contralateral basal ganglia damage. The lack of evidence of a structural lesion in the basal ganglia in our patient on CT and MRI, together with the onset of this clinical picture immediately after thiopepa-penicillin exposure, implies that hemidystonia may be caused by a dystonic synkinesia (in hemidystonia) published 1989;59:275-83.

### Bilateral metastases in the cerebellopontine angle

Only 0.2% of the pontocerebellar angle (PCA) tumours are metastases. To our knowledge, we report the first case of bilateral metastasis. In 1974, a 64 year old woman presented with a malignant melanoma of the left leg which was treated by excision and chemotherapy. An inguinal adenopathy developed in 1976 followed by a subcutaneous metastasis on the right deltoid region six years later were treated surgically. From June to July 1987 the patient experienced a right-sided hearing loss, an unsteady gait with vertigo, a swallowing impairment and dysphonia. The brain CT scan and the CSF analysis were unremarkable. The patient was admitted to our hospital on 20 July because of a right facial palsy and left hypoacusia. On the right side, there was involvement of the VIIth and VIIIth cranial nerves. On the left, the Vth, VIIth and VIIIth cranial nerves were involved slightly. The patient appeared ill but on skull examination there was no evidence of malignant melanoma.

The CT scan (fig a) showed two hyperdense lesions which on MRI (fig b) were isointense during T1 and hyperintense during T2. The first image, which was round, was in the right PCA and involved the brainstem and the cerebellum without invading them; the second, which was oval and smaller in size, was in the left PCA, without mass effect.

On 10 August 1987 a soft, haemorrhagic, yellowish, self contained (2 cm × 3 cm) tumour was found in the right PCA, disrupting the left cranial nerves, forcing back the brainstem on the median line, and spreading onto the jugular foramen. An identical tumour on the left (1.5 cm diameter) did not press on the brainstem but spread along the last cranial nerves without disrupting them. The histopathological examination showed that they were metastases of an undifferentiated cancer; cells of epithelial type were associated with long cells which looked like sarcoma. On electron microscopy, there was no melanoma, but small stick inclusions in the ergastoplasm cisterns (75% of cells), of variable orientation, often crossed and made from straight microtubules, suggesting a melanoma origin.

The patient died in October 1987. A necropsy examination could not be performed.

Cornil reported the first case of a metastasis developed in the PCA; the primary lesion was an oropharyngeal epiphelium. Since then, most of the unusual published cases are isolated ones, originating from histologically differing types such as: lung, breast, oropharynx carcinoma, 1 carcinomas of probably colon origin, 2 histiocytic malignant lymphomas, 3 malignant histiocytosis, 4 malignant fibrous xanthoma. 5 No case of melanoma was reported.

In our case, there were several inclusions of straight microtubules in the ergastoplasm cisterns on histopathological examination, similar to those observed in 6% of cases of
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