both intracerebral and subdural in location.1 The 'pure' presentation of menin-

giomas has been noted in cases with and without haemorrhage.2 Ischaemia, haemor-

rhage, and other types have been some of the immediate underlying causes. In this case, the history of headache and difficulty with word finding was consistent with the presence of a meningioma. The rapid clinical course, however, suggests that the intracranial haemorrhage was mainly responsible for the presenting symptoms. The mechanisms responsible for bleeding into a benign tumour are unknown. Highly vascular meningiomas may possess abnormal tangents of vessels; as the tumour grows, stretching of the vessels leads to weakening of the vascular walls.3 Alternatively, the cerebral oedema and venous obstruction commonly found with meningiomas may cause tumour infarction followed by haemorrhage.4 The anticoagulation of our patient would have increased the chance of bleeding into a tumour. It is notable, however, that there is only one other reported case of a subdural haemato ma with a meningioma in the presence of anticoagulation therapy.4 It is a routine policy of the neurological surgery service at this university to submit representa-
tive tissue from all evacuated hematomas for pathological analysis. Although the like-

lihood of finding anything other than blood clot in such a specimen is low, cases such as the subject of this report justify the routine because the results can affect the patient's follow up and management.

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3. Lazaro KP, Messer HD, Brinker RA. Intracran-


Cerebral localization in articulatory dyspraxia

In articulatory dyspraxia, multiple errors in articulation are produced in the absence of damage to the motor or sensory pathways directly controlling the articulatory muscu-

culation. It is distinct from, but frequently found in association with, motor dysphasia and oro-facial dyspraxia. This circumstantial evidence, together with information from imaging and necropsy studies, suggests that the cerebral substrate for the condition is damage to the inferior part of the dominant precentral gyrus. We describe a patient with a relatively "pure" articulatory dyspraxia caused by focal cerebral trauma and subsequent intracerebral haemorrhage in a small area of the left precentral cortex.

An 18 year old right handed male presented the day after being hit on the left temple by a golf ball. Immediately after the injury he suffered difficulty with speech, in that he was able to think of words but experienced difficulty in pronouncing them. He also noted some brief paraesthesiae in the right thumb. There was no complaint of limb or facial weakness. He was previously well and did not smoke. There was no family history of premature vascular disease.

General examination was normal apart from bruising and some soft tissue swelling in the left parietal region. He was fully con-

scious and alert with normal higher intellec-
tual function other than the abnormality of oral communication. There was a mild right upper motor neuron facial weakness but no other cranial nerve deficit. In particular, bul-

bar function was preserved with normal swallowing, cough, palatal, and tongue movements. No focal signs were apparent in the limbs and reflexes were normal and sym-

metrical with flexor plantar responses.

Detailed assessment of language function revealed normal auditory and written compre-

hension and no semantic or syntactic errors in his speech. There was no evidence of
damage to descending pathways controlling articulation and thus no dysarthria. However, he
displayed considerable difficulties with the control of articulation. His speech was

laboured and syllabic with disturbed intona-


tion. Multi-syllabic words were particularly difficult for him to say and the pronunciation of some vowels was inconsistent, with a tendency for both front and back vowels to centralise. He claimed that he could hear the correct sounds of words in his head but could not produce them. (Copies of sound record-
ings of the patient are available from JS on receipt of a blank cassette.) Reading and

writing were unaffected and there was no evidence of oro-facial dyspraxia. It was con-

cluded that he was suffering from articulatory dyspraxia without dysphasia. This was con-

firmed using the Boston Diagnostic Aphasia Examination.

A skull radiograph was normal but a CT brain scan two days after the injury revealed

soft tissue swelling over the left parietal bone and a small focus of superficial haemorrhagic

tissue in the left prefrontal region (figure a). A repeat scan 21 days after the injury was completely normal. A further scan was performed two years later. This demon-

strated a small area of focal cortical atrophy in the left fronto-parietal region at the site of the previous haemato ma (figure b). An electroen-
cephalogram at this time was normal.

The patient received regular speech therapy over the following three months at the end of which his speech had improved considerably so that his friends and relatives considered it normal. However, he was still aware that he had to exercise more conscious control over the production of speech. When seen two years after the insult, his speech seemed normal but he reported that he still made several errors in articulation each day. He continued to play golf at the same club with a handicap of five.

Articulatory dyspraxia is a distinctive dis-
turbance of articulation in the absence of direct damage to motor or sensory pathways relevant to articulation and is therefore a true dyspraxic syndrome. It is probably under-
diagnosed in patients with dominant hemi-

sphere strokes, being confused with the associated dysphasia. The term articulatory dyspraxia is generally attributed to Liep-

mann5 and was popularised by Critchley.6 However, numerous other terms have been used to describe the disorder including aphemia, pure anarthria, pure word dumb-

ness, and pure motor aphasia.6,7

The often close association of articulatory dyspraxia with oro-facial dyspraxia and expressive dysphasia suggests that the areas of brain responsible for the three conditions lie close together in the inferior aspect of the dominant precentral gyrus. Post-mortem studies in two right handed patients with comparatively "pure" articulatory dyspraxia demonstrated lesions in the inferior motor strip of the left hemisphere.8 These lesions included damage to both cortical and subcor-
tical tissue. CT and MRI studies in a further patient showed a similar though more exten-
sive lesion affecting large areas of precentral and postcentral white matter.8 The latter

authors also reported a left handed patient with the disorder caused by a corticosubcor-
tical haemorrhage in the lower part of the right precentral gyrus. Angiography demon-

strated an underlying arteriovenous malforma-

tion.

In the present right handed case, also with a
relatively “pure” articular dyspraxia, the responsible lesion was smaller than in these other case reports. The traumatic haemorrhage destroyed a small area of the inferior aspect of the left precentral gyrus leading to scarring and shrinkage of the Rolandic opercu- lum by the time the second scan was performed two years later. It is impossible to conclude whether damage to the cortex alone was responsible for the disorder or whether subcortical trauma led to additional cortical disconnection, particularly in view of the inner “dumb-bell” area of haemorrhage seen on the initial scan. Presumably, there is a relatively small lesion of the Rolandic responsible for the organisation of articulation in the dominant precentral gyrus close to, but dis- tinct from, Broca’s area which when damaged produces the curious syndrome of articula- tory dyspraxia.

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1 Liepmann H. Das krankheitsbild der apraxie (“motorischen asymbolie”) auf grund eines falles von einseitiger apraxie. Monatschrift fur Psychiatrie und Neurologie 1900;8:15-40.

BOOK REVIEWS

All titles reviewed here are available from the BMJ Bookshop, PO Box 295, London WC1H 9TE. Prices include postage in the United Kingdom and for members of the British Forces Overseas, but overseas customers should add £2 per item for postage and packing. Payment can be made by cheque in sterling drawn on a United Kingdom bank, or by credit card (Mastercard, Visa or American Express) stating card number, expiration date, and your full name.

The New Genetics of Mental Illness.

This is an important and timely book. The contributors are distinguished in their fields and it ranges over a wide spectrum of disorders. The early chapters attempt to explain the complexities of modern genetics but without some background knowledge they would be difficult to digest. Once over this initial barrier, the enthusiasm begins to break through and large amounts of data are presented very clearly. Chapter four by Professor J H Edwards encapsulates the underlying message of the book. Modern genetic methods are extremely powerful when dealing with hereditary diseases. They rapidly lose focus and power when this is not the case. Unfortunately, this is not so with the majority of psychiatric disorders so that vast and complex studies are needed to make even small advances. Unfortunately, four of single point mutations cannot be justified.

Psychiatry needs some proven aetiological substrate. Every new advance is pursued with vigour and hope. Every new hormone assay, every new immunological test, every new imaging technique is applied to cohorts of psychiatric patients. Now we have the new genetics and it would be wonderful if it provided us with some markers to underpin our diagnoses. This book brings us down to earth and explains how unlikely that is. Abnormalities of mind remain tough nuts to crack.

This is a recommended text, especially for dewy eyed trainees hoping to net a Nobel prize with a bit of genetic research.

CM TONKS


Research in migraine and new drugs to com- bat it, progress apace. Olesen has gathered a large number of authorities to produce a highly technical book devoted mainly to cerebral blood flow studies. It is clear there remain serious limitations in the methods applied; different workers appear to obtain divergent results. Transcranial Doppler which shows velocity and by inference flow in the basal arteries, leaves much to be desired. There is no definitive test for TGA and a HMPAO tracer applied to SPECT studies of static tissue flow. The results are confusing. The editor’s early work is confirmed: regional oligaemia in the occipital lobe(s), its failure to conform to arterial territories, its slow spread which usually outlasts the aura, and its confinement to classic migraine with normal results in common migraine. Cluster headache shows normal cerebral flow but dilatation of basal arteries. There is much more of interest, but interpretation is clouded by uncertainties, some of clinical definition, some technical.

Although the publishers and editor make no mention of a conference, the book reads very much like one. Each section ends with a summary by one of the experts, and one (Nyberg-Hansen) lets slip “a recent study reported at the symposium ...” but to be fair, he does not say which one. If this is a symposium in print, why is this not plainly stated? If not, then the editing, writing and format should be improved.

Olesen’s book is a valuable source of con- temporary data for migraine researchers.

JMS PEARCE


Very few subjects in neuropsychiatry have succeeded in exerting such a sustained hold as the clinical investigation of Psychoses of Epilepsy; while among psychiatrists in particular this group of disorders has taken on a new significance in the search for an organic model for psychosis. Publication of this book is therefore timely.

The first half of the book examines the existing classifications for the epilepsies and for the psychoses and provides a summary description of the aetiological and nosological function. Aetiology, phenomenology and treatment of the inter-ictal, post-ictal and post-operative psychoses are dealt with in the second half. The clinical sections in particular are densely referenced and the book is a valuable resource for those wishing to pursue studies in this area. Methodologically, many of the studies fall rather short of the mark which may explain why so many of the controversies—forced normalisation, laterality of focus and so on—continue to rage unabated. The author’s concluding sum- maries at the end of each section, lucid and balanced, are therefore most welcome. The book is not without its blemishes. The burning of the midnight candle is evident in a liberal sprinkling of factual errors. The reviewer was grateful to find mention of several of his papers but dismayed to encounter sizeable numerical mis-quotations in two of them. This aside, the book can be confiden- tly recommended to those with an interest in understanding the organic contribution to abnormal experience and behaviour.

BK TOONE


This monograph begins with a review of the literature on the clinical syndrome of Transient Global Amnesia. This is followed by a discussion of the aetiological theories for this disorder. It is immediately apparent that many of the previously published series have been heterogeneous, containing not only patients with the distinctive disorder described by Fisher and Adams but also patients with additional, and atypical, clinical features suggesting a different aetiology. A list of 114 patients with TGA begins by defining strict diagnostic criteria. The clinical features and epidemiology of the syndrome are reviewed including several descriptions of the author’s personal observations of patients during attacks. The convincing epidemiological evidence against a thrombo-embolic cause for typical TGA is presented and the understanding of the organic contribution discussed. The author concludes that TGA fulfilling his diagnostic criteria is a benign disorder with a good prognosis and a low risk of recurrence except in a small subgroup of patients who subsequently develop epilepsy.

In contrast, TGA with atypical features has a poorer prognosis and is thought frequently to be a manifestation of cerebrovascular dis-
Cerebral localisation in articulatory dyspraxia.

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