brain stem. In our case the lesion was involving the pons and medulla.

Laughter may be a rare and unusual presentation of a brain stem lesion (glioma) that has not been reported earlier.

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Post radiation monomelic amyotrophy

Lamy et al recently reported three cases of post radiation lower motor neuron syndrome presenting as monomelic amyotrophy.1 I would like to report a further case.

A thirty six year old man presented in 1989 with weakness abducting his left hip. Nineteen years before he had been treated for a left testicular seminoma with an orchidectomy and radiotherapy. The abdominal radiotherapy field dispensed a prescribed tumour dose of 32.5 Gy, and the para-aortic fields increased the dose to 50 Gy in twenty fractions. The fields included the lower 6 cm of the spinal cord, the whole cauda equina and the lumbosacral roots and plexuses. The initial weakness of the left leg has gradually progressed to weakness and wasting of all muscle groups with ankle dorsiflexion, hip flexion and abduction being more severely affected. He now walks with a stick. The limb is areflexic with a flaccid plantar response. There is no sensory loss or sphincter involvement. The right leg is not involved. Six months of treatment with prednisolone (20 mg per day) was of no benefit. Electrophysiological examination showed advanced denervation confined to the muscles of the left leg, with large amplitude motor unit potentials. An abnormal axon reflex and absent F wave in extensor digitorum brevis suggests a lesion at the root or anterior horn cell level. Motor atrophy was present, suggesting loss of lower motor neurones. The initial assessment was a radiation myelopathy.

Sellar tuberculosis

In Asian countries, before the advent of chemotherapy, tuberculomas accounted for about 30% of all intracranial lesions. They remain a major problem even though they are now less common due to anti-tuberculosis drugs and improved living conditions. Intrasellar tuberculomas, not uncommonly seen at post mortem examinations, rarely present clinically.2,3 Only five surgically verified cases have been reported to date.

A 40 year old man, resident of an area where tuberculosis is endemic, presented in January 1988 complaining of an intermittent, dull, generalised headache of two years duration, and progressive diminution of vision in both eyes over a period of six months. He was in good general health with no clinical signs of endocrinopathy. Visual acuity was reduced (right eye—finger counting 3 m; left eye—hand movement perception at one meter). Perimetry showed a restricted field of vision in the right eye, the left was unascertainable. He had bilateral optic atrophy, but no other neurological abnormality. The clinical diagnosis was a sellar tumour. Haematological and biochemical investigations were unremarkable except for an erythrocyte sedimentation rate (ESR) of 90 mm in the first hour. Radiographic examination revealed a sellar tumour which on a x ray of the skull. CT scan (figure) showed a uniformly hyperdense enhancing sellar mass with a suprasellar extension. An operation was performed on 14 January 1988 using a transsphenoidal transnasal route. The sellar floor and dura mater were intact. The dura mater was tough and thickened and when it was opened, a greyish white, soft mass in the suprasellar was revealed. It was adequately decompressed under intraoperative pneumoencephalography.

Microscopic examination showed that pituitary tissue had been partially replaced by granulomas comprising of epitheloid cells, Langhan type of giant cells surrounded by lymphocytes, and plasma cells. Minimal caseation was present in some granulomas. Tuberculoma of the pituitary gland was diagnosed. A postoperative Mantoux test was positive but spurtum culture for acid fast bacilli was negative. Treatment was started with isoxen, rifampicin and ethambutol. The patient developed hepatotoxicity to rifampicin, but isoxen and ethambutol were continued for nine months. He was in good health, had no headache, and vision in the left eye had improved (finger counting—3 m). The right eye vision showed no improvement in the constricted field (finger counting—6 m).

A pituitary tuberculosis is extremely rare but usually presents as a chiasmal syndrome. In two reported cases the lesion was successfully removed subfrontally.4,5 An exclusively intrasellar tuberculoma was approached transphenoidally and treated with isoxen only for three months. In our patient the lesion was intrasellar with a suprasellar extension. It could be treated, however, by a transnasal transphenoidal approach. There was little reason to suspect a pituitary tuberculoma before the operation except for the raised ESR. The transnasal transphenoidal approach allowed a subtotal removal of the tuberculoma while avoiding CSF contamination by tuberculous material.

Tuberculotic meningitis occurs in the majority of surgically treated intracranial tuberculomas without antituberculous chemotherapy.1-3 Chemotherapy should be given in a three drug combination for three months, followed by a two drug combination for a further 15 months.

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Figure CT scan showing sellar and suprasellar hyperdense lesion.
Post radiation monomelic amyotrophy.

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