LETTERS TO THE EDITOR

A case of music imperception

Defective perception of music due to an altered capacity to discriminate the elementary components of musical stimuli (rhythm, pitch, timbre, intensity and duration) produces an alteration in the aesthetic enjoyment of and the emotional involvement in music.1 To our knowledge, there is no previous evidence of the existence of a condition in which the primary disruption is to the capacity to process the musical stimulus as a whole. We report a case of a young musician who, as a result of a right temporo-parietal lesion, presented with loss of the gestalt capacity to process music, with the consequent loss of aesthetic pleasure.

Our patient was a 24 year old male, who was an amateur musician and a skilful guitar player. He reported an early interest in music: during primary school he played keyboard instruments and during secondary school, the flute. He later started playing the guitar, attending private lessons for two years.

On 31 December 1987, after a muscular strain (jumping over a gate), he noticed he had difficulty in understanding "the nuances of words and inflection of sentences". The same day he realised that he had difficulties in understanding music: he could not perceive the structure of musical pieces clearly: the relationship between the accompaniment and the soloist was indiscernible, and aesthetic pleasure for the musical world had completely vanished. At the same time he complained of generalised headache, described as pressure, mostly on the right side.

On 5 January 1988, he came under our observation. He still complained of a receptive musical impairment, although less severe than at onset, while his previous prosodic difficulties and headache had disappeared. Neurological examination, tonal audiometry and standard neuropsychological examination were normal. In particular, he showed no language impairment; oral and written comprehension of complex passages was good. He was able to recognise simple and complex figures and recognise faces, both familiar and unknown, on comparison tasks. On a meaningful sound recognition test, he recognised animal, human and environmental sounds and voices, effortlessly. The patient was ambidextrous; there was no family history of left handedness.

Examination of musical abilities (recognition and production of physical features of musical sounds, pitch identification and/or reproduction of rhythm, melody and harmony; vocal and instrumental performance, and listening to musical compositions) were normal. However, he complained of difficulties from the very beginning for the listening task. On hearing the pieces played on the piano, he complained, "my perception is changed... it's flat, it's no longer 3-dimensional; it's only on two planes... there's no...". His difficulties increased as the presented compositions became more complex: "...this is even worse: I can distinguish the different instruments, but I can't perceive the whole... in jazz pieces, the relationships between the accompaniment and the soloist escape me."

An EEG showed slight right temporal abnormalities. A CT scan was scheduled, but the patient did not keep the appointment.

On 31 April 1988 he had a generalised tonic-clonic seizure: a CT scan (figure, left) and MRI (figure, right) showed the presence of a right temporo-parietal malacic area, involving the plica curva and supramarginal gyrus. This area was post-haemorrhagic, with peripheral haemosiderin deposits, and was surrounded by serpiginous hypointense images. A DSA showed an arterio-venous malformation (AVM), fed by right sylvian branches.

On 16 June 1990, he developed left hemianopia and headache due to a haemor-
actor, Leopoldo Frégoli, who was famous for his ability to impersonate people.

In their original description of this delusion, Courbon and Fail noted that their patient experienced other delusions whose contents were mainly erotic. The association of Frégoli delusion and erotomania has only been occasionally reported since, though in some Frégoli cases erotomania forms an obvious background possibility.2 A review of misidentification syndromes and sexuality by Barton and Barton noted that erotomania has been found to be a feature in various forms of delusional misidentification, and included an extended description of a case of a Frégoli-like delusion and erotomania, in which a female patient claimed that another patient was an ex-boyfriend, going under an assumed name, and that they were in love.

We describe a further case for whom the Frégoli delusion arose in the context of the form of erotomania known as de Clerambault's syndrome, in which patients suddenly arrive at the delusional belief that someone (usually of higher social standing) is in love with them.4 Although this patient had other delusions, the Frégoli and de Clerambault delusions dominated the clinical picture, and were strongly held and persistent.

The patient was a 35 year old, divorced, unemployed woman who lived on her own. She had a psychiatric history from the age of 16, and was diagnosed as suffering from chronic paranoid schizophrenia. She stopped medication 6 weeks before admission.

She was agitated and verbally hostile, and reported auditory hallucinations of famous actors who she said were her friends. She claimed to be telepathic, saying her actor friends put their thoughts into her head, and that their thoughts were broadcast to them. She showed grandiose delusions, believing she could arrange to stop all television and radio communications by telling her actor friends to go on strike using her "telepathic power."5

The patient believed that she was the girlfriend of Erik Estrada (an American actor and pin-up), with whom she communicated in writing and via telepathy. She also believed that Erik Estrada visited her city regularly, disguised as acquaintances or her current boyfriend. She stated that she knew her actual boyfriend was Erik Estrada in disguise due to the absence of a previous scar on his face. She was convinced that Erik Estrada was in love with her and planned to marry her one day.

Past medical history revealed childhood epilepsy until the age of 9 years, phenobarbital therapy for 2 years, and focal epilepsy at the age of 11 years. There was no family history of mental disorder. Routine haematological, biochemical and serological examinations were normal. Physical examination revealed no abnormality. An EEG showed moderate excess of mixed irregular and rhythmic slow activity at 2-6 HZ and 10-30uV in the central and post-central regions. She refused neuroimaging.

Neuropsychological tests of face processing were also carried out. Details of the tests used are given in Young, et al., which includes data from 10 male controls aged 25-35 years, and from female patients 36-54 years. Her performance on the Warrington Recognition Memory Test, showed normal recognition memory for words but severely impaired recognition memory for faces.

The patient was started on a fluphenazine depot and her mental state improved considerably. Twelve months later, however, she still believes she is the "marry Erik" and that he continues to visit her regularly, albeit in disguise.

Her pattern of impairment on face processing tests was comparable to that found in another patient, the Frégoli case we investigated, in which the Frégoli delusion arose in the context of cerebral infarction of the right hemisphere.6 That case did not show our patient's flagrant erotomania, but there was a definite possibility of an erotomantic element in her delusion. She thought that she was being pursued by her cousin and a female accomplice, both of whom adopted different disguises. It was later found that some years previously the patient had a long love affair with this cousin (lasting over 20 years, and leading to the birth of her only child).

Data for this previous case are also presented in the table, for comparison with the patient we describe here. Both patients were impaired at recognising familiar faces, matching disguised faces, and showed much poorer recognition memory for faces than controls. Although the EEG suggested bilateral abnormalities for our present patient, these face processing impairments point toward involvement of the right cerebral hemisphere, which has been noted as a feature in other cases of erotomania and delusional misidentification.7

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Bilateral crossed optic ataxia in a corpus callosum lesion

Optic ataxia is a disorder of visually-guided hand movements, usually resulting from a lesion affecting the posterior parietal cortex.8 We recently observed a patient with bilateral crossed optic ataxia and a disconnection syndrome. MRI showed a large corpus callosal lesion without any other visible lesion.

A 37 year old right handed man was admitted to intensive care with an acute respiratory distress syndrome and a severe lung disease. The patient had a long history of alcoholism. One month later, the patient's condition had improved and he was alert and cooperative. On neurological examination, there were no sensory loss or motor weakness, no cranial nerve abnormalities, cerebellar syndrome or gait disturbance. Visual acuity was 10/10, bilaterally. The visual fields (Goldmann perimetry) and visual evoked responses were normal. Eye movements were recorded using electro-oculography. Horizontal smooth pursuit gain was normal, and horizontal visually-guided saccades had normal accuracy and latency. Higher cortical function testing showed a slight impairment of recent memory, but normal verbal comprehension, speech and reading. However, left ideomotor apraxia and left hand agraphia were present, suggesting the existence of a disconnection syndrome.

There was also left agraphos: the patient correctly named only 2 objects out of 12 when they were placed in his left hand, but made no errors when they were

Table  Performance of face processing tasks, and means and standard deviations for control subjects of comparable age. Data from another Frégoli patient,9 are presented for comparison (this patient was aged 68, so her performance has been compared to a different set of controls).

<table>
<thead>
<tr>
<th>Task</th>
<th>Previous case</th>
<th>Present case</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACIAL EXPRESSIONS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labeling</td>
<td>20/24</td>
<td>20/24</td>
<td>22.00</td>
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<tr>
<td>IDENTIFICATION OF FAMILIAR FACES</td>
<td></td>
<td></td>
<td>1-24</td>
</tr>
<tr>
<td>High familiarity faces</td>
<td>15/20***</td>
<td>12/20***</td>
<td>17.58</td>
</tr>
<tr>
<td>Occupation</td>
<td>8/20***</td>
<td>12/20***</td>
<td>16.17</td>
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<tr>
<td>Name</td>
<td>20/20</td>
<td>20/20</td>
<td></td>
</tr>
<tr>
<td>Unfamiliar faces</td>
<td>42/54</td>
<td>39/54</td>
<td></td>
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<tr>
<td>Correct rejections</td>
<td>13/24***</td>
<td>16/24***</td>
<td>21.60</td>
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<tr>
<td>UNFAMILIAR FACE MATCHING</td>
<td></td>
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<tr>
<td>Benton test</td>
<td>36/50***</td>
<td>33/50***</td>
<td>43.90</td>
</tr>
<tr>
<td>&quot;Disguise&quot; task</td>
<td>47/50</td>
<td>47/50</td>
<td>45.71</td>
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<tr>
<td>RECOGNITION MEMORY</td>
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<tr>
<td>Warrington RMT: Faces</td>
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<td></td>
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<tr>
<td>36/50***</td>
<td>33/50***</td>
<td>43.90 (3.65)</td>
<td></td>
</tr>
<tr>
<td>Warrington RMT: Words</td>
<td>47/50</td>
<td>47/50</td>
<td>45.71</td>
</tr>
</tbody>
</table>

[ Asterisks denote results that are significantly different from their control group. * p < 0.05; ** p < 0.01; *** p < 0.001. ]

12/00: significant discrepancy between faces and words scores.
Frégoli delusion and erotomania.

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