and 10 years (group B) and those surviving for more than 10 years (group A). The longest period of follow up in group A was 39 years, with a 4 year follow up period of 16-7 years. In group A there were three deaths, of which two were due to unrelated causes. One year before the death of case 3, he had a high fever and a CSF was obtained by lumbar puncture. Encephalitis japonica was diagnosed, he was given no specific treatment, and was discharged from hospital with unsteadiness of gait and subsequent convulsive seizures. One year later he complained of sudden headaches and convulsive seizures. He lost consciousness and died and there was no necropsy.

In group B (14 cases who survived between five and 10 years) 10 had died, eight due to recurrent tumour and two due to unrelated causes. The average age at operation and male/female ratio was 27-2 years and 8/7 in group A and 27-1 years and 10/4 in group B. The same surgical technique were used in both groups with the 10 of 15 cystic tumours in group A and nine of 14 in group B. Histologically, five cases were adamantinomatous, seven were squamous, and three were not determined in group A, and in group B six were adamantinomatous, two squamous, and two undetermined. The NOR numbers were determined in 19 cases from their paraffin embedded specimens. All cases had a low proliferative potential (NOR 1-76 (SD 0-21)) with no difference between the groups. (group A 1-73 (0-13), 10 cases; group B 1-80 (0-27), nine cases).

It is well known that optic or hypothalamic glioma, cerebellar astrocytomas, ganglioglioma, and some non-glial benign tumours display spontaneous cessation of their growth after an active proliferative growth period but such a phenomenon has not been documented for craniopharyngioma. Among the 15 cases who survived more than 10 years in our series, there was no death due to tumour recurrence or regrowth. By contrast, among those 14 cases who had less than 10 years survival, 10 patients died due to recurrence of the tumour. There are many statistical survival studies for craniopharyngioma but few dealing with long term survival.19 Each of these studies show that there is a risk of recurrence once patients survive for 10 years. For example, in the series of Yasargil et al, patients surviving 11 to 22 years after surgery, no recurrences occurred in 30 children and 33 adults—90% of these cases underwent total removal. Jose et al reported the follow up results of limited surgery and radiation therapy in 173 cases of craniopharyngioma with a median follow up of 12 years. The 10 and 20 year progression free survival rates were 83% and 79% and actuarial 10 and 20 year survival rates were 77% and 60% respectively.

In conclusion, our study supports other evidence in the literature that there may be spontaneous regression in the active proliferating potential of some craniopharyngiomas that is not predictable by the Ag-NOR technique. Of course, some craniopharyngiomas may always have a low proliferative potential and it is patients with these who survive for many years. Our data lends support to the policy of subtotal removal and subsequent adjuvant therapy in selected patients but a method for defining this subgroup remains unresolved.

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Psychosocial factors in chronicity of epilepsy

Research has shown that after a recent diagnosis of epilepsy psychosocial effects are closely related to the severity of the medical condition and the recency of the last seizure,1 which dramatising effect of the diagnosis cannot be viewed as the only or even the main predictor of psychosocial distress. Therefore, we must consider other factors. In this paper we sought to explore the effect of chronicity. A comparative study was conducted, based on a validated psychosocial inventory,2 of two groups of 62 subjects. These groups were matched for age (range between 17 and 57), sex, and employment type; duration of full time employment was similar as was tenure in current job. The chronic sample had a history of epilepsy spanning an average of 11 years (range between 5 and 37) and the non-chronic sample 5 years. The chronic group was matched with respondents to the National General Practice Survey of Epilepsy (NGPSE)3 drawn from a base of 594 patients registered by 275 primary care practices across the United Kingdom. The recently diagnosed sample had a history of epilepsy spanning a maximum of three years. The NGPSE is a population based national cohort study following up patients from the time of their first epileptic seizure. The importance of the NGPSE has been the ability to gain unbiased and comprehensive information on an unselected population based on prospective consecutive cases.

All patients in the chronic group had experienced more than 20 seizures. The recently diagnosed group included some patients who had experienced large numbers of seizures but over 50% of the group had experienced three or fewer seizures at the time of data collection. The chronic group were more likely to be registered disabled (p < 0.01), to have informed their employer of their epilepsy (p < 0.05), and to have had a seizure in public (p < 0.01).

The table shows the percentage of patients who indicated a moderate or severe problem of adjustment in each of the 14 areas comprising the psychosocial inventory.

<table>
<thead>
<tr>
<th>Area of Adjustment</th>
<th>Moderate (26)</th>
<th>Severe (65)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 Acceptance of the diagnosis</td>
<td>26</td>
<td>65*</td>
</tr>
<tr>
<td>A2 Fear of having seizures</td>
<td>75</td>
<td>69</td>
</tr>
<tr>
<td>A3 Fear of stigma affecting employment</td>
<td>48</td>
<td>53</td>
</tr>
<tr>
<td>A4 Lack of confidence about the future</td>
<td>24</td>
<td>68*</td>
</tr>
<tr>
<td>A5 Lack of confidence about travelling</td>
<td>15</td>
<td>39*</td>
</tr>
<tr>
<td>A6 Adverse effect on social life</td>
<td>29</td>
<td>62*</td>
</tr>
<tr>
<td>A7 Adverse effect on leisure</td>
<td>27</td>
<td>66*</td>
</tr>
<tr>
<td>A8 Change of outlook on life</td>
<td>29</td>
<td>67*</td>
</tr>
<tr>
<td>A9 Difficulty with the family</td>
<td>21</td>
<td>32</td>
</tr>
<tr>
<td>A10 Attitudes to taking medication</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td>A11 Attitude to the medical profession</td>
<td>26</td>
<td>41</td>
</tr>
<tr>
<td>A12 Emotional or emotional reactions</td>
<td>26</td>
<td>43*</td>
</tr>
<tr>
<td>A13 Feeling of increased social isolation</td>
<td>27</td>
<td>58*</td>
</tr>
<tr>
<td>A14 Lack of energy/lethargy</td>
<td>29</td>
<td>53*</td>
</tr>
</tbody>
</table>

*p < 0.05.

The findings from this study are important for two reasons: firstly, they illustrate that a potent factor affecting psychosocial adjustment is chronicity; secondly, they emphasise that in most areas stigma is not inherent in the condition, and furthermore that there are wide individual variations. We have focused on chronicity but there are of course other factors involved in the process of adjustment. The problems of psychosocial adjustment are clearly relevant.
Letters to the Editor

for the person with epilepsy, but these findings also show that poor adjustment is not inevitable.

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Spinal somatosensory potential monitoring in three cases of neurological deterioration after laminectomy for cervical spondylotic myelopathy

Posterior cervical laminectomy is a widely accepted treatment for multisegmental cervical spondylotic myelopathy, particularly when the condition is associated with a narrow spinal canal.1 After laminectomy, some patients complain of increased weakness and paraesthesiae of the arms. This clinical finding is consistent with segmental damage either at the spinal cord or nerve root level. We report three patients of transient neurological deterioration in whom spinal somatosensory potential monitoring during operation gave useful information on the pathophysiology of the postoperative deficit.

Cervical spinal somatosensory potentials were recorded during operation, before and after laminectomy. The potentials were evoked by electrical stimulation of the median nerve at the wrist. Rectangular pulses (0.5 ms duration and amplitude 4/3 of the motor threshold) were delivered at 1 cycle/s. After exposure of the cervical laminae, the recording electrode (Medtronic Sigma 3483 or Quad 3487A) was placed in the epidural space, medially over the posterior columns. The reference electrode consisted of a 14 G needle inserted into the paraspinal muscles immediately caudal to the skin incision. A total of 50–150 stimuli were applied and averaged; analysis time was 50 ms with a horizontal resolution of 98 μs per point. An open bandpass (2–5000 Hz) was set and the negative upward convention was used. The potentials were analysed for latency, amplitude, duration, and waveform. The single components were labelled according to their polarity and to the expected latency.

Anaesthesia was induced with thiopental sodium (5 mg/kg) and fentanyl (0-002 mg/kg) for the person with epilepsy, but these findings also show that poor adjustment is not inevitable.


Cervical epidural somatosensory potentials evoked by median nerve stimulation at the wrist (0.5 ms, 1 cycle/s, 4/3 of motor threshold) recorded before and after laminectomy for cervical spondylotic myelopathy.
Psychosocial factors in chronicity of epilepsy.

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