Dostoevsky's epilepsy induced by television

The great Russian writer Fyodor Dostoevsky (1821–81) had a special type of epilepsy that was described by himself as sudden and brief episodes with an "aura" consisting of pleasure, happiness, and comfort, followed by tonic-clonic seizures. This type of epilepsy has been called "ecstatic epilepsy" or "Dostoevsky's epilepsy," although it has been suggested that some historic personalities had the same type of seizures. Dostoevsky projected his affecitive experiences on to his literary characters—for example, in the case of Prince Myshkin in The idiot.

We report a 25 year old woman, without prior personal or familial history of neurological disease, who was evaluated because of a 10 year history of recurrent paroxysmal "ecstatic" episodes induced by close proximity to a television screen. The episodes began abruptly with fixed posture and isolation from the external environment, which was followed by a sensation of "internal peace," calmness, and intense pleasure without sexual connotations. She compared this sensation with "being drugged," and to a sense of full personal satisfaction, as "watching the sea". Her relatives had to separate her from the television to control the situation. Three episodes were followed by tonic-clonic seizures. When the patient was under an emotional stress, she alone was able to induce the episodes by placing herself in front of the television set. The episodes were easily induced and were independent of the content of the television programme. Neurological examination, interictal EEG, cranial CT, and MRI were normal. An EEG obtained while she was approaching the television screen showed generalised spike and polyspike wave complexes lasting three seconds during which she had a mild degree of impaired awareness.

Our patient had "ecstatic epilepsy," similar to that described by Dostoevsky. This type of epilepsy has rarely been reported. She is exceptional because of the induction by television and the presence of generalised-epileptiform activity. Of the reported patients, only two had focal abnormalities in the brain, consisting of a right temporal tumour, and a right temporal epileptiform activity.

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Influence of obtaining a neurological opinion on the diagnosis and management of hospital inpatients

There are relatively few clinical neurologists in the United Kingdom (about 1,234,000 population). Most are based at regional neurosciences centres but regularly visit district general hospitals. A few general hospitals are served by physicians with an interest in neurology. As a contribution to debate about the future provision and distribution of neurological services in general hospitals, we have audited the impact of obtaining the opinion of a clinical neurologist on the diagnosis and management of inpatients under other specialties in a multidisciplinary (nursing) hospital (The Royal Free Hospital).

Referrals of inpatients were recorded over a six month period. The notes of the 169 patients seen were then reviewed and the following information recorded: age and sex of the patient, date of admission and of the neurological opinion, specialty of the referring consultant, diagnosis at referral, neurologist's diagnosis, and suggested management and outcome. Referral patients were assessed by both consultant and trainee neurologists. If initial assessment by a trainee did not yield a clear diagnosis, the patient was immediately reviewed by a consultant. When the diagnosis remained uncertain, ultimate outcome was ascertained by review of the patient's hospital records 12–18 months after the opinion.

Of the 169 patients seen, 80 were male and 89 female. Mean age was 54 (range 7–92 years). The table gives the specialty of the admitting referring consultant and the diagnoses made by the neurologists.

As a consequence of the neurological consultation 91 patients (54%) had their diagnosis confirmed. A further 30 (18%) had their diagnosis changed. Examples included changes from the referring doctor's diagnosis of cerebrovascular disease to Wernicke's encephalopathy (one patient), from epilepsy to other causes (including pseudo seizures, cardiogenic syncope, and postural hypotension—seven patients in total), from cerebral disc to spasmogenic torticolis (one patient), from dementia to phenytoin toxicity (one patient), from subarachnoid haemorrhage to middle cerebral artery infarct...
(one patient), and from Parkinson's disease to other causes (cerebrovascular disease and cortical atrophy, one patient each). A new diagnosis was made in 25 patients (15%) in whom there had been no pre-existing diagnosis (table). In 14% of the patients the diagnosis remained unclear even after neurological assessment. Neurological consultation led directly to a change in management in 52 patients (31%). In most patients this was a change in drug treatment. However, there were instances of emergency medical treatment as a direct result of the neurological opinion—for example, two patients with Wernicke's encephalopathy. Two others required urgent neurosurgical intervention, one for hydrocephalus, the second for spinal cord compression.

With six to seven new inpatients being referred each week, providing an opinion constituted a significant "hidden" component of the neurologists' work. Translated to the practice of a single handed neurologist in a district general hospital, it is about equivalent to one additional outpatient clinic weekly.

Despite this, the impact of a neurological opinion on inpatients in a general hospital has not previously been investigated separately. One study of admissions to a district general hospital1 suggested that 19% of patients had a neurological complaint as the primary diagnosis, with a further 2% having a neurological disorder contributing to their need for admission. This pilot study indicates that neurologists have a role in the management of a significant proportion of these inpatients, and is a useful preliminary for a more systematic cost-effectiveness analysis of a neurologist's workload. In particular, the traditional image of the neurologist as a pure diagnostician is belied by the fact that neurological consultation led directly to a change in the management of almost one third of cases.

Incidence and outcome of self inflicted gunshot wounds to the head in peace and war: a retrospective survey

We have compared the incidence of self inflicted gunshot wounds to the head identified either as attempted suicide, self inflicted accidents, or deaths at the scene (thereafter transported to forensic medicine) between the four year periods of 1987-90 and 1991-4 in the north eastern region of Croatia, which includes the residents of Osijek (total population about 500,000). During the second time period, Croatia was involved in homeland war. During 1991 and 1992, the population was reduced by one tenth. There was about a fourfold increase in self inflicted gunshot wounds to the head during wartime.

All gunshot injuries to the head were considered for active surgical management based on the principles of debridement of the missile tracts, and evacuation of haematomas but with a less radical approach to removal of penetrating bone fragments—that is, only if readily accessible based on accurate localisation with ultrasonography. Autologous dural grafts, antibiotic prophylaxis (penicillin G, aminoglycosides, metronidazole) and antiseizure medication were used.1 Enhanced C1+ was performed postoperatively if there was any suspicion of intracranial infection.

Of the 29 admissions during 1991-94, 20 died, seven made a good recovery, and two were left severely disabled. Mortality in the accidental group (n = 4; one death) was lower than in the suicidal group (n = 25; 19 deaths). Mortality after admission among the self inflicted injuries (69%) was higher than in the war inflicted (46%; \( \chi^2 = 4.797; P = 0.03 \)) but numbers were insufficient for detailed comparison of risk factors.

In conclusion, the stress of war was associated with a fourfold increase in self inflicted gunshot wounds to the head, with a high mortality of 69% in those admitted to hospital despite conventional active management.

Only two of 21 patients with a Glasgow coma score ≤ 6 survived whereas seven of the nine survivors had a Glasgow coma score of 8–15 at presentation. Nineteen of the 20 deaths had a Glasgow coma score of 3–6 on admission. Our practice concurs with that in other countries where experienced surgeons would be prepared to treat functional gunshot wounds who were not posturing (Glasgow coma score 6–8) and certainly all patients who are not comatose preoperatively.1

Reversible hyperperfusion of the right medial temporal lobe in transient global amnesia

Transient global amnesia is a clinical syndrome characterised by a sudden onset of anterograde and retrograde amnesia in the absence of other neurological signs and symptoms, resolving within 24 hours. Its aetiology remains unknown although transient ischaemic attacks, epilepsy, or migraine have been proposed as possible causes.1 Functional imaging studies performed during the amnesia should provide a better understanding of the pathogenesis.

We report a 72 year old right handed woman with transient global amnesia. Her medical history was uneventful except for

<table>
<thead>
<tr>
<th>Specialty of the referring consultant</th>
<th>Number of patients</th>
<th>Type of neurological disorder diagnosed</th>
<th>Total number of patients</th>
<th>Number of patients in each category in whom diagnosis was changed by neurologists</th>
<th>Number of patients in each category in whom diagnosis was made by neurologists (no pre-existing diagnosis)</th>
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